

Senate Budget and Fiscal Review

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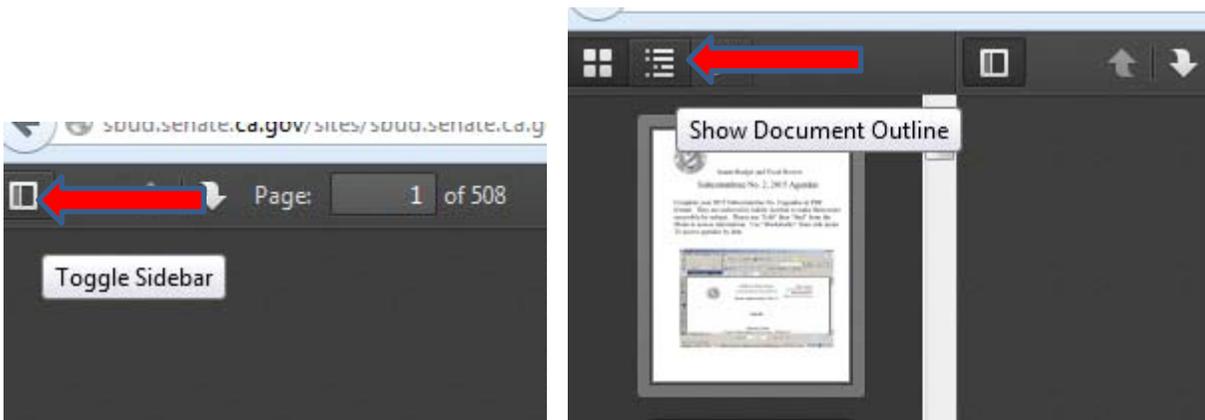
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Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.



March 5, 2015

9:30 a.m. or Upon Adjournment of Session

Room 4203, State Capitol

Agenda

(Michelle Baass)

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PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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4120 Emergency Medical Services Authority**1. Overview**

The Emergency Medical Services Authority (EMSA) develops and implements emergency medical services systems (EMS) throughout California and sets standards for the training and scope of practice of various levels of EMS personnel. The EMSA also has responsibility for promoting disaster medical preparedness throughout the state and, when required, managing the state's medical response to major disasters.

Budget Overview. The budget proposes expenditures of about \$32.2 million (\$8.4 General Fund and \$2.7 million federal funds) and 71 positions for EMSA. See table below for more information.

Table: EMSA Budget Overview

Fund Source	2013-14 Actual	2014-15 Projected	2015-16 Proposed	BY to CY Change
General Fund	\$6,509,000	\$7,684,000	\$8,419,000	9.57%
Federal Trust Fund	\$1,698,000	\$3,500,000	\$2,653,000	-24.20%
Reimbursements	\$11,524,000	\$16,392,000	\$16,826,000	2.65%
Special Funds	\$3,637,000	\$4,030,000	\$4,294,000	6.55%
Total Expenditures	\$23,368,000	\$31,606,000	\$32,192,000	1.85%
Positions	66.7	70.2	71.2	1.42%

Outstanding Supplemental Report. As part of the 2014 budget, supplemental report language was adopted requiring EMSA to provide to the Legislature by January 10, 2015. The report, which has not yet been provided to the Legislature, is to include information on:

1. A detailed description of existing state and local resources, including resources managed by other state and local entities, that would be available in the event of a major medical disaster.
2. The projected time from when a disaster occurs to when resources would be fully deployed.
3. The number of individuals existing resources could serve in a major medical disaster.
4. A summary of existing funding for emergency preparedness in California and any anticipated reductions in funding over the next two fiscal years.
5. A comparison of California's emergency medical response infrastructure and capacity for a major medical disaster compared to the infrastructure and capacity available in other states of similar size, such as New York and Texas.

6. A description of how California's emergency medical response infrastructure and capacity could be improved and the resources necessary to implement such improvements.

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 programs and budget.
2. What is the status of the report due to the Legislature?

2. Disaster Preparedness and Emergency Response Resources for California

Budget Issue. EMSA requests \$500,000 General Fund and two permanent Senior Emergency Services Coordinators. The additional funding and new positions would be utilized to reestablish the southern California component of the California Medical Assistance Team, stabilize existing disaster medical preparedness programs, and coordinate joint activities with the Department of Public Health's (DPH) Emergency Preparedness Office including catastrophic event planning, and emergency operations center planning and development. Specifically, this proposal would fund:

- **California Medical Assistance Team (CAL-MAT) Program Stabilization (\$205,000):** EMSA would contract with a southern California Local Emergency Medical Services Agency to manage the southern California administrative functions associated with the reestablishment of a southern California Medical Assistance Team. (EMSA currently has one California Medical Assistance Team located in Northern California.)
- **California Medical Assistance Team Senior Emergency Services Coordinator (\$147,500):** A Senior Emergency Services Coordinator would coordinate the Northern California Medical Assistance Team to include administrative functions, training and assist with the maintenance of the three California Medical Assistance Team caches. This position would provide guidance to the southern California Local Emergency Medical Services office overseeing California Medical Assistance Team to include monitoring deliverables contained within the contract. This Senior Emergency Services Coordinator would also coordinate with DPH the activities related to Catastrophic Event Planning.
- **Ambulance Strike Team Senior Emergency Services Coordinator (\$147,500):** A Senior Emergency Services Coordinator would support the Ambulance Strike Team Program, the Training and Exercise Program, and Emergency Operations Center planning and development. This would also include auditing of the Disaster Medical Support Units placed with local providers and Disaster Medical Support Unit communications training that is not currently being provided.

Background. EMSA's Mobile Medical Assets Program is multi-tiered. The multi-tiered program is comprised of:

- **Tier One** - Ambulance Strike Teams represent the first tier of the Mobile Medical Assets Program and are organized groups of five ambulances, one support vehicle, and one Ambulance Strike Team leader to provide rapid response in meeting emergency medical transport needs in large-scale emergencies or disasters. There are 41 pre-designated teams throughout California with Disaster Medical Support Units provided by EMSA. The Disaster Medical Support Unit provides enhanced communications ability to support field deployment, including medical supplies and provisions for Ambulance Strike Team personnel. Ambulance Strike Teams respond within 2 hours of request.
- **Tier Two** - California Medical Assistance Teams represent the second tier of the Mobile Medical Assets Program and are teams activated by EMSA to provide medical care during

disasters. The three teams are rapidly deployable and ready to treat patients within hours at field treatment sites, shelters, existing medical facilities, alternate care sites, and mobile field hospitals. Teams are self-sufficient for 72 hours and include physicians, nurses, pharmacists, and logistical and support staff.

- **Tier Three** – Mobile Field Hospitals (MFH) represent the third tier of the Mobile Medical Assets Program. One MFH is currently being stored in EMSA’s Response Station Warehouse in Sacramento with on-going bio-medical equipment maintenance being performed. Deployment for this MFH is now estimated to be between 72-96 hours. The other two MFHs are in donated storage in delayed deployment status in the Sacramento area. These two MFHs are not being maintained. EMSA identified federal Hospital Preparedness Program funding to maintain the one MFH through the current year ending June 30, 2015. As of July 1, 2015, all MFHs will be considered non-deployable without extensive rehabilitation to equipment and supplies.

Emergency Operations Center Coordination is a role EMSA fulfills in cooperation with the Governor’s Office of Emergency Services (OES) and in partnership with DPH and in accordance with the State Emergency Plan.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open for further review and pending receipt of the supplemental report by EMSA, mentioned in the previous issue, regarding the state’s emergency medical services capacity.

Given past reductions in federal and General Fund support for EMSA, Subcommittee staff inquired about the EMSA’s prioritization of the activities proposed in this request over other EMSA-related programs such as Mobile Field Hospitals (MFHs). According to EMSA, with the decline of state and federal funds, the state has had to rethink surge capacity and prioritize needs. The first and second tiers are paramount for the state to mount a credible initial response to a disaster. Stabilizing the ability of the state to provide the second tier of the Mobile Medical Assets Program is a higher priority of the state, and provides CAL-MAT capability in Southern California. The CAL-MAT teams are multi-functional and are able to provide medical treatment for a variety of missions such as medical shelter operations, augmenting or replacing hospital staff and operating independently in a field medical station. The MFHs would require significant funding to maintain the program along with funding to restore the hospitals to a deployable condition. The two staff positions requested in the proposal stabilize the ability of the state to coordinate medical and health operations in the Emergency Operations Center environment as well as participate in critical medical and health disaster planning activities integrating those of both EMSA and DPH. In addition, one of these positions will develop and support a Southern California CAL-MAT.

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

1. Please provide a brief overview of this proposal.
2. Please explain EMSA’s rationale in prioritizing the resources in this proposal over other emergency preparedness resources, such a mobile field hospitals.

3. Document Imaging Workload and Efficiencies

Budget Proposal. EMSA requests one permanent Office Technician, three Seasonal Clerks and \$366,000 (Emergency Medical Services Personnel (EMSP) Fund) in 2015-16 to address increased workload associated with the document imaging of paramedic licensure and enforcement files. See table below for summary of this request.

Table: Proposal Funding Summary

	Fiscal Year		
	2015-16	2016-17	2017-18
Temporary Help	\$167,000	\$0	\$0
Office Technician	\$199,000	\$193,000	\$193,000
EMSP Fund Authority Request	\$366,000	\$193,000	\$193,000

Background. The Emergency Medical Technician (EMT) 2010 Registry was designed to create operational efficiencies by streamlining both the paramedic application process and investigatory process through an online licensing and document imaging system.

According to EMSA, the workload associated with the document imaging of existing paper files was underestimated and current staffing levels are insufficient to meet the workload associated with integrating the very large amount of paper documents with the EMT 2010 Registry. Currently, the document imaging system is only being used to scan and convert new and renewal paramedic applications that were received during the 2013-14 and 2014-15 periods. Existing resources have been unable to maintain the level of scanning necessary to keep up with the incoming applications and Paramedic Licensure Unit is backlogged with two months of applications. Approximately 44,094 paramedic licensure and enforcement files still require document scanning and uploading. Due to the underestimation of staff hours required for document imaging, the Paramedic Licensure Unit at this time is unable to allocate sufficient resources to address the current backlog of files requiring document imaging. Until the backlog of existing files are scanned and uploaded to the document imaging system, staff will continue to spend excessive time tracking down and re-filing paper copies.

EMSA charges fees for the licensure and licensure renewal of paramedics in an amount sufficient to support the paramedic licensure and enforcement program at a level that ensures qualifications of the individuals licensed to provide quality care. Fees collected are deposited in the EMSP Fund, which was established in 1989 by the Legislature in the State Treasury. Monies in the EMSP Fund are held in trust for the benefit of the EMS Authority’s paramedic licensure and enforcement program. A fee increase is not necessary to support this proposal.

Subcommittee Staff Comment and Recommendation—Hold Open. No issues have been raised with this proposal; however, it is recommended to hold this item open pending receipt of the report due to the Legislature discussed in Issue 1.

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

1. Please provide an overview of this proposal.

4140 Office of Statewide Health Planning and Development

1. Overview

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.

Budget Overview. The budget proposes expenditures of \$147.5 million (\$1,000 General Fund) and 483.6 positions for OSHPD.

Table: OSHPD Budget Overview

Fund Source	2013-14 Actual	2014-15 Projected	2015-16 Proposed	BY to CY Change
General Fund	\$0	\$75,000	\$1,000	-98.67%
Federal Trust Fund	\$1,288,000	\$1,449,000	\$1,440,000	-0.62%
Reimbursements	\$7,468,000	\$7,860,000	\$7,861,000	0.01%
Mental Health Services Fund	\$23,457,000	\$55,921,000	\$25,954,000	-53.59%
Other Special Funds	\$103,215,000	\$117,336,000	\$112,264,000	-4.32%
Total Expenditures	\$135,428,000	\$182,641,000	\$147,520,000	-19.23%
Positions	445.1	476.6	479.6	0.63%

Subcommittee Staff Comment. This is an informational item.

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

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

2. Elective Percutaneous Coronary Intervention Program Outcomes Reporting

Budget Issue. OSHPD requests two permanent positions, one Research Scientist III and one Research Program Specialist I, and increased expenditure authority of \$372,000 in 2015-16 and \$319,000 ongoing from the California Health Data and Planning Fund for the implementation of SB 906 (Correa), Chapter 368, Statutes 2014. This bill establishes the Elective Percutaneous Coronary Intervention (PCI) Program and requires OSHPD to produce annual risk-adjusted public performance reports on participating hospital's PCI-related mortality, stroke, and emergency Coronary Artery Bypass Graft outcomes.

Background. SB 891 (Correa), Chapter 295, Statutes 2008, established the Elective PCI Pilot Program in the California Department of Public Health (DPH) which authorized up to six eligible acute care California hospitals with licensed cardiac catheterization laboratory services but without onsite surgical backup to perform scheduled, elective PCIs. SB 357 (Correa), Chapter 202, Statutes 2013, extended the Elective PCI Pilot Program until January 1, 2015, and required the oversight committee to conduct its final report by November 30, 2013. The bill required DPH, within 90 days of receiving the final report from the oversight committee, to prepare and submit its report to the Legislature on the initial results of the Elective PCI Pilot Program.

The Elective PCI Pilot Program established an advisory oversight committee to oversee, monitor, and make recommendations to the DPH concerning the results of the pilot program and whether elective PCI without onsite cardiac surgery should be continued in California. Six hospitals – Los Alamitos Medical Center, Sutter Roseville Medical Center, Kaiser Walnut Creek Medical Center, Doctors Medical Center-San Pablo, Clovis Community Medical Center and St. Rose Hospital-Hayward – participated in the pilot program.

The *Advisory Oversight Committee Report to the California Department of Public Health* and the subsequent report, *The Elective Percutaneous Coronary Intervention (PCI) Pilot Program: Report to the Legislature*, showed that the morbidity and mortality results of procedures from the pilot hospitals during the program's duration were consistent with the morbidity and mortality results from hospitals not enrolled in the pilot program. Thus, there was no increased risk to patients in allowing elective PCIs to be performed at hospitals without onsite cardiac surgery.

SB 906 makes permanent the Elective Percutaneous Coronary Intervention Program as of January 1, 2015. This bill requires DPH and OSHPD to obtain and use data collected by the American College of Cardiology's National Cardiovascular Data Registry, a national cardiovascular registry, to adopt and validate risk-adjustment models and annually report each certified hospital's PCI performance outcomes with regards to patient mortality, stroke, and emergency coronary artery bypass graft surgery.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as staff continues to evaluate the need for two permanent positions.

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

1. Please provide an overview of this proposal.
2. How will OSHPD work with stakeholders to ensure these reports are consumer-friendly?

3. Oversight of Peer Personnel Support-Investment in Mental Health Wellness Act of 2013

Oversight Issue. A 2013 budget trailer bill, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, established the Investment in Mental Health Wellness Act of 2013 which invests a total of \$206.2 million in mental health wellness. Of this total amount, \$2 million (Mental Health Services Act Fund - State Administration) was to provide training in the areas of crisis management, suicide prevention, recovery planning, and targeted case management and to facilitate employment of peer support classifications.

In April 2014, OSHPD awarded contracts to four organizations to support peer personnel by providing training in one or more of the following: crisis management; suicide prevention; recovery planning; targeted case management; and other related peer training and support functions to facilitate the deployment of peer personnel as an effective and necessary service to clients and family members and as triage and targeted case management personnel. The organizations awarded include:

Table: Contracts Awarded Regarding Peer Personnel Preparation, April 2014

Organization Contracted	Contract Amount	Contract Term
Contra Costa Behavioral Health	\$436,386.00	4/9/2014 – 6/30/2016
Mental Health Association of San Francisco	\$500,000.00	4/9/2014 – 6/30/2016
National Alliance on Mental Illness San Diego	\$456,755.00	4/9/2014 – 6/30/2016
Recovery Opportunity Center	\$500,000.00	4/9/2014 – 6/30/2016

Contractors are required to meet the following objectives:

- Develop and document career pathways for positions employing peer personnel that provide entrance to the public mental health system with defined opportunities to advance across healthcare systems (a defined career pathway). The identified positions must be able to be filled by Peer Personnel.
- Recruit Peer Personnel from the following populations and/or communities for participation in the defined career pathway: individuals and their families who currently are or who have received mental health, behavioral health, and/or substance use services, and individuals with health or mental health education and/or experience who can address cultural, diversity and language proficiency needs.
- Establish/expand an educational or training program that provides training that meets public mental health system needs, aligns with MHSA, provides field work, and includes career counseling and placement.
- Increase the total number of peer personnel employed in the public mental health system by recruiting and retaining peer personnel in identified entry-level positions.

To meet the aforementioned objectives, there are various tasks in which contractors are required to engage. Each contractor submitted a proposal including a work plan and timeline for how their

organization will complete the tasks. Each contractor has identified specific methods and partners to achieve its contractual obligations, based on their respective target community. This may include:

- Counties behavioral health departments partnering with training organizations to develop and implement a peer training program to place peers within their county.
- Community based organizations partnering with various counties in a region to provide training, job placement, mentoring and career pathway development for peer personnel.
- Training organizations collaborating with various public mental health system employers to train peers within their organization.

OSHPD requires contractors to submit quarterly progress reports that document and monitor progress towards meeting the objectives. These progress reports measure the contract's effectiveness by:

- Providing detailed information on progress made towards every contract deliverable.
- Requiring data collection via surveys to program participants such as peer personnel in field placements and employers.
- Identifying successes, challenges, and lessons learned from engaging in program activities.

In addition to progress reports, the contract specifically includes an evaluation deliverable with earmarked funds for contractors to evaluate their program and submit an annual evaluation report to OSHPD. Finally, contractors are required to present on their progress, lessons learned and evaluation to the Workforce, Education, and Training Advisory Committee.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide an overview of this issue.
2. Please provide an overview of the outcomes from the existing contracts and how these contractors are meeting the goals outlined in the Investment in Mental Health Wellness Act of 2013.

4. Oversight of 2014 Song-Brown Residency Program Funding

Oversight Issue. The 2014 budget included the following augmentations related to the Song-Brown Program:

- Song-Brown Program – New Residency Slots. Augmented OSHPD’s budget by \$4 million (California Health Data and Planning Fund) to fund new residency slots in the Song-Brown Health Care Workforce Training Program over the next three years. Adopted trailer bill language to specify criteria for this funding, including that priority shall be given to support new primary care physician slots and to physicians who have graduated from a California-based medical school.

The Request for Assistance for this program was released on January 22, 2015 and the deadline to apply for this funding is March 30, 2015. OSHPD anticipates 13 programs will apply and 26 residents would be funded. The decisions on funding are projected to be made at the April 28-29, 2015 California Healthcare Workforce Policy Commission.

- Song-Brown Program Residency Program. Approved \$2.84 million (California Health Data Planning Fund) per year for three years to expand the Song-Brown program. Adopted trailer bill language to expand the eligibility for Song-Brown residency program funding to teaching health centers and increased the number of primary care residents specializing in internal medicine, pediatrics, and obstetrics and gynecology. Approved one three-year limited-term position to develop and implement the program expansion.

The Request for Assistance for this program was released on January 22, 2015 and the deadline to apply for this funding is March 30, 2015. OSHPD anticipates 25 programs will apply and 53 residents would be funded. The decisions on funding are projected to be made at the April 28-29, 2015 California Healthcare Workforce Policy Commission.

Background. Song-Brown provides grants to support health professions training institutions that provide clinical training for family practice residents, family nurse practitioner, primary care physician assistant, and registered nurse students. Residents and trainees are required to complete training in medically underserved (Health Professional Shortage Areas, Medically Underserved Areas, Medically Underserved Populations, Primary Care Shortage Areas, and Registered Nurse Shortage Areas), underserved communities, lower socio-economic neighborhoods, and/or rural communities. According to OSHPD, Song-Brown funded programs have led practitioners to be at the forefront of curricula development and clinical care for many contemporary challenges facing California’s healthcare system such as homeless, refugee, and immigrant health. Various studies indicate that residents exposed to underserved areas during clinical training are more likely to remain in those areas after completing their training.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide an overview of this item.

0530 California Health and Human Services Agency

1. Office of Systems Integration – CalHEERS Oversight

Oversight Issue. Concerns have been raised regarding the processes by which stakeholder input is provided to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) project to aid decision-making, coordination, and rollout of system changes. Recently a 24-month roadmap for CalHEERS changes was released and it appears that changes to implement requirements of the Affordable Care Act (ACA) and state law regarding Medi-Cal continue to be delayed without any insight or justification for the delays provided to external stakeholders.

For example, under the ACA, former foster youth qualify for Medi-Cal coverage until age 26, regardless of their income. This law, which has been in effect since January 1, 2014, is still not programmed accurately into CalHEERS resulting in enrollment delays, enrollment in the wrong affordability program, or denial of Medi-Cal for these former foster youth. Changes necessary to correctly implement former foster youth coverage in Medi-Cal are not scheduled until February 2016. Similarly the changes to incorporate the Medi-Cal Access Program (formerly Access for Infants and Mothers-AIM) into CalHEERS are still not scheduled to be programmed into CalHEERS.

Background. The ACA requires a single, accessible, standardized paper, electronic, and telephone application process for insurance affordability programs, which require a joint application for Medi-Cal and Covered California. The joint application is required to be used by all entities authorized to make an eligibility determination for any of the insurance affordability programs. (Medi-Cal and Covered California with a premium or cost-sharing subsidy are “insurance affordability programs.”)

CalHEERS is the information technology system that is used to support this application process. The primary business objective of CalHEERS is to provide a ‘one-stop shop’ to determine eligibility for California’s health coverage programs offered by the Exchange and the Department of Health Care Services.

The CalHEERS Project is jointly sponsored by the Exchange and the Department of Health Care Services (DHCS). The CalHEERS Project has acquired Accenture, LLP as a prime vendor to develop the CalHEERS solution that will support the implementation of a statewide healthcare exchange.

The Office of Systems Integration (OSI) has been chosen by the Exchange to provide project management services during the design, development and implementation and system stabilization of the CalHEERS solution to help meet the federally mandated timelines and requirements.

CalHEERS Quality Assurance Team. OSI’s CalHEERS Quality Assurance (QA) team coordinates improvement efforts to enhance the project’s processes and protocols, including, but not limited to release management, change management, and meeting structures, in order to improve the collaboration and communication between the CalHEERS project and the project sponsors and stakeholders. To date this team has focused internally on the project stakeholders (e.g., Covered California, DHCS, county eligibility systems, County Welfare Directors Association, Department of Social Services, and the California Health and Human Services Agency).

This QA team has worked with the CalHEERS leadership team, project sponsors, and partners to identify the range of governance challenges and establish a common understanding of needs. After reviewing a variety of organization models, decision-making hierarchies, and project best practices, the OSI QA team drafted several recommendations to help improve the timeliness, collaboration, and transparency of project decision-making. The team is currently reviewing the recommendations with project stakeholders to gather feedback and establish a foundation for implementing the changes.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions on this topic. Subcommittee staff requested the list of OSI recommendations to help improve the timeliness, collaboration, and transparency of CalHEERS project decision-making and these recommendations have not yet been provided to the Subcommittee.

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

1. Please describe the governance structure of CalHEERS and OSI's role in regard to CalHEERS.
2. Please provide a high-level of OSI's recommendations in regard to CalHEERS governance and transparency of decision-making.
3. What is your understanding of the criteria that CalHEERS project sponsors use in establishing the release schedule?
4. Given that OSI's vision is to be the "trusted leader in the management and delivery of large, complex technology projects, enabling improved service delivery to the people of California," what do you think OSI's role is or should be in regard to ensuring that CalHEERS project sponsors consider and evaluate **external** stakeholder input regarding CalHEERS changes and releases?

2. Office of the Patient Advocate

Budget Issue. The Office of Patient Advocate (OPA) requests \$206,000 in 2015-16 and \$182,000 ongoing to convert one limited-term position, expiring June 30, 2015, to a permanent position, a data warehouse, and other services to implement the Complaint Data Reporting Project. The source of funding for this proposal is the Managed Care Fund (90 percent) and the Insurance Fund (10 percent).

Background. SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014 revised the responsibilities of OPA to: (1) clarify that OPA is not the primary source of direct assistance to consumers; (2) clarify OPA’s responsibilities to track, analyze, and produce reports with data collected from calls, on problems and complaints by, and questions from, consumers about health care coverage received by health consumer call centers and helplines operated by other departments, regulators or governmental entities; (3) require OPA to make recommendations for the standardization of reporting on complaints, grievances, questions, and requests for assistance; and (4) require OPA to develop model protocols, in consultation with each call center, consumer advocates and other stakeholders that may be used by call centers for responding to and referring calls that are outside the jurisdiction of the call center or regulator.

SB 857 requires OPA to collect, analyze, and report complaint data from the Department of Managed Health Care (DMHC), Department of Insurance (CDI), Department of Health Care Services (DHCS), and Covered California. OPA requests to convert the limited-term position previously approved by the Legislature to a permanent position to support this workload.

**Table: Health Consumer Complaint Data from Consumer Assistance Call Centers
Status as of: February 20, 2015**

Mandated Reporting Agency/ Department	Met with OPA on SB 857 Framework, Requirements, Timeline	Provide Information and Materials Associated with the Baseline Report	Provided Feedback to OPA on Standardized Data Collection Tool, Coding, and Tracking	Provided One Month of Pilot Test Data (# Complaint Records) in Prescribed Standardized Format
DMHC	Yes	In Process	Yes	1,265
CDI	Yes	In Process	Yes	256
DHCS	Yes	In Process	Yes	Total: 4,497 <ul style="list-style-type: none"> • Managed Care-4,001 • Fee-For-Service-319 • Dental-132 • Mental Health-27 • HIPAA-13 • Fiscal Intermediary-5
Covered CA	Yes	In Process	No	225

Table: Complaint Data Reporting Milestones and Timeline

	Completed Milestones
July 2014 - February 2015	1. OPA issued the “Recommendation Report for Complaint Data Reporting.” 2. OPA held planning and development meetings with the state reporting entities. 3. OPA conducted an analysis of reporting elements. 4. OPA, in conjunction with stakeholders, used complaint codes and categories to standardize the data submissions. 5. OPA developed and issued Complaint Data Workbook. 6. Reporting entities submitted test complaint data in December and January. 7. OPA reviewed and analyzed the pilot test data and provided feedback to reporting entities. 8. OPA reached agreement with reporting entities on workbook reporting, data glossary, and data definitions. 9. OPA modified and finalized the Complaint Data Workbook. 10. OPA issued the Final Complaint Data Workbook. (2014 data) to reporting entities.
2015	Work in Progress
March	<ul style="list-style-type: none"> • Submission (2/20/15 – 3/6/15) by reporting entities of complaint data from calendar year 2014. • Data validation and quality assurance. • Data analysis begins. • Issuance of a supplemental survey to reporting entities to collect additional materials and information.
April	<ul style="list-style-type: none"> • Data analysis continues. • Submission of responses and materials (e.g., protocols, methodologies) to supplemental survey by reporting entities. • Analysis of survey submissions and preliminary findings. • Initiate report development. • Development of OPA website pages for complaint data report and data findings.
May	<ul style="list-style-type: none"> • Consultation with reporting entities on preliminary findings and draft report. • Quarterly Stakeholder Meetings – Status updates and input.
June	<ul style="list-style-type: none"> • Report review and approval. • OPA website deployment activities.
July	<ul style="list-style-type: none"> • Posting by 7/1/15 of Baseline Report to the OPA website. • Submission by 7/1/15 of the Complaint Data Analysis to the Legislature.

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

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

1. Please provide an overview of this proposal and an update on Complaint Data Reporting project.

3. High Cost Drug Proposal

Budget Issue. The Governor’s budget includes funding of \$100 million General Fund in 2014-15 and \$200 million General Fund in 2015-16 to pay for new breakthrough drugs, such as those used to treat Hepatitis C. The budget does not allocate this funding to specific departments. The Governor’s budget includes these additional funds, given the uncertainty around the cost and utilization of these drugs. The individuals who may potentially be treated with the new Hepatitis C drugs include inmates in state prisons, patients in state hospitals, individuals enrolled in Medi-Cal, and individuals enrolled in the AIDS Drug Assistance Program (ADAP).

The Department of Health Care Services (DHCS), Department of Public Health (DPH), Department of State Hospitals (DSH), and the California Department of Corrections and Rehabilitation (CDCR) are already providing Hepatitis C drugs under their 2014-15 and 2015-16 budget authority. See table below for estimates of department/program funding included in the Governor’s budget.

Table: Summary of Hepatitis C Treatment Funding in Governor’s Budget

Department/ Program	Estimated Number of Persons Receiving Treatment		Estimated Total Cost		Estimated General Fund	
	2014-15	2015-16	2014-15	2015-16	2014-15	2015-16
DPH/ADAP	69	135	\$3.5 million	\$5.8 million	0	0
DHCS	1,000	1,000	\$105.7 million	\$105.7 million	\$51.1 million	\$51.1 million
DSH	75	Unknown	\$7.1 million	Unknown	\$7.1 million	Unknown
CDCR	NA	NA	\$10 million	\$10 million	\$10 million	\$10 million

Note: DSH and CDCR pharmacy budgets are not specifically categorized by disease or drug. The numbers reflected above are estimates.

Budget Bill Provisional Language. The budget proposes provisional budget bill language to notify the Legislature of the expenditure of these funds as follows:

“Notwithstanding any other provision of law, items of appropriation in this act may be adjusted, as determined by the Director of Finance, to reflect changes to General Fund and Federal Trust Fund expenditures resulting from high cost medications. Adjustments authorized pursuant to this section shall be implemented upon notification to the chairpersons of the committees in each house of the Legislature that consider appropriations and the chairperson of the Joint Legislative Budget Committee.”

Workgroup. As part of this proposal, the Administration plans to convene a workgroup that will address the state's approach regarding high-cost drug utilization policies and payment structures. The workgroup will inform the state's guidelines for which individuals enrolled in state programs are eligible for treatment with the new Hepatitis C drugs, and to the extent possible, the state will try to generate a consistent set of treatment guidelines that can be implemented across state programs.

According to the Administration, the workgroup and proposal are focused on Hepatitis C treatments, but it expects that the workgroup will discuss additional medications in the future. The workgroup members are currently state departments and county representatives: the California Health and Human Services Agency, the California Public Employees Retirement System, the California State Association of Counties, the California State Sheriffs' Association, Covered California, the Department of Corrections and Rehabilitation/California Correctional Health Care Services, the Department of Finance, the Department of General Services, the Department of Health Care Services, the Department of Industrial Relations, the Department of Managed Health Care, the Department of Public Health, the Department of State Hospitals, the Department of Veterans Affairs, and the University of California.

The first workgroup meeting will be held in early March. The Administration is first coordinating with state departments and county entities and is working on a stakeholder engagement strategy. The workgroup plans to focus on key policy questions.

Marketplace Changes. Federal regulations prohibit the U.S. government from setting the price of pharmaceuticals. However, private insurance companies and government agencies are able to negotiate prices. In December 2013, the U.S. Food and Drug Administration (FDA) approved Sovaldi for the treatment of Hepatitis C. While this drug has been found to be very effective in curing Hepatitis C, a 12-week treatment costs \$84,000. In December 2014, FDA approved another Hepatitis C treatment regime called the Viekira Pack, made by AbbVie. Insurance companies now had another Hepatitis C treatment option comparable to Sovaldi, and this competition has led to deals between drug companies and insurance companies.

State Discounts for these High-Cost Drugs. DHCS had existing rebate agreements for Hepatitis C drugs Victrelis and Riba; and has recently reached agreement for supplemental rebates with the maker of Sovaldi and Harvoni.

California ADAP is a member of the ADAP Crisis Task Force (ACTF), which is a national-level negotiating body that represents all ADAPs in the country. The ACTF enters into negotiated, voluntary, confidential supplemental rebate agreements with drug manufacturers. In January 2015, the ACTF reached a new negotiated pricing agreement between pharmaceutical company AbbVie and the ADAPs for ombitasvir/paritaprevir/ritonavir tablets; dasabuvir tablets (Viekira Pak™). AbbVie is the first company to offer ADAPs a negotiated discount on the price of a Hepatitis C virus medication. ADAP receives the negotiated discount in the form of supplemental drug rebate. This supplemental rebate is in addition to the federally mandated 340B rebate.

DSH does not negotiate directly with pharmaceutical companies. DSH purchases pharmaceuticals through contracts negotiated by the Department of General Services (DGS).

The Department of Corrections and Rehabilitation/California Correctional Health Care Services receives contracted pricing discounts on Hepatitis C pharmaceuticals.

LAO Findings and Recommendation. The LAO agrees with the Administration’s general approach to setting aside resources for this purpose and finds that there is considerable uncertainty associated with the actual future costs for the state. The LAO withholds recommendation on the amount of funds to be set aside to pay for the new high-cost drugs pending further information regarding the cost and projected utilization of the drugs. The LAO recommends the Legislature add additional requirements to the provisional budget language proposed by the administration in order to ensure legislative oversight of these funds.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as more details are provided. Subcommittee staff requested the list of key policy questions that this workgroup plans to consider and the Subcommittee has not yet received this information from the Administration.

Additionally, the Administration has not provided any details as to the basis for the \$300 million General Fund reserve. The Governor’s budget includes \$51.1million General Fund (with additional matching federal funds) for the Medi-Cal program’s Hepatitis C treatment costs. It is not clear why four times that amount is requested to be placed in a reserve for uncertainty.

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

1. Please provide an overview of this proposal.
2. Why does the Administration find that a special reserve of General Fund is necessary for the state program costs for Hepatitis C treatment?
3. What is the basis for the \$300 million General Fund placeholder?
4. What is the Administration’s estimate for current year expenditures related to Hepatitis C that exceed budget act authority?
5. What will be the process for the Legislature and external stakeholders to participate in this workgroup?
6. Please provide a brief review of the changing marketplace (new drugs, discounts, rebates) in regard to Hepatitis C drugs. Does the Administration’s placeholder funding include the consideration of the higher discounts that certain companies are offering in response to more drugs entering the market?
7. Why doesn’t this proposal include any investments in the prevention Hepatitis C infection, such as providing more access to testing and resources for syringe exchange programs? Please explain.

4265 Department of Public Health

1. Overview

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

According to the 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 comprises seven major program areas. See below for a description of these programmatic areas:

- (1) **Center for Chronic Disease Prevention and Health Promotion** – This center works to prevent and control chronic diseases, such as cancer, cardiovascular diseases, asthma, adverse pregnancy outcomes, and diabetes; to reduce the prevalence of obesity; to provide training programs for the public health workforce; to prevent and control injuries, violence, deaths, and diseases related to behavioral, environmental, and occupational factors; to promote and support safe and healthy environments in all communities and workplaces; and to prevent and treat problem gambling.
- (2) **Center for Environmental Health** – This center works to protect and improve the health of all California residents by ensuring the safety of drinking water, food, drugs, and medical devices; conducting environmental management programs; and overseeing the use of radiation through investigation, inspection, laboratory testing, and regulatory activities.
- (3) **Center for Family Health** – This center works to improve health outcomes and reduce disparities in access to health care for low-income families, including women of reproductive age, pregnant and breastfeeding women, and infants, children, and adolescents and their families.
- (4) **Center for Health Care Quality** – This center regulates the quality of care in approximately 8,000 public and private health facilities, clinics, and agencies throughout the state; licenses Nursing Home Administrators, and certifies nurse assistants, home health aids, hemodialysis technicians, and other direct care staff.
- (5) **Center for Infectious Disease** – This center works to prevent and control infectious diseases, such as HIV/AIDS, viral hepatitis, influenza and other vaccine preventable illnesses, tuberculosis, emerging infections, and foodborne illnesses.

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

(7) **Public Health Emergency Preparedness** – This program coordinates preparedness and response activities for all public health emergencies, including natural disasters, acts of terrorism, and pandemic diseases. The program plans and supports surge capacity in the medical care and public health systems to meet the needs during emergencies. The program also administers federal and state funds the support DPH emergency preparedness activities.

Summary of Funding for the Department of Public Health. The budget proposes expenditures of \$3.1 billion (\$124.4 million General Fund) for the DPH as noted in the Table below and 3838 positions. Most of the funding for the programs administered by the DPH comes from a variety of federal funds, including grants and subventions for specified areas (such as drinking water, emergency preparedness, and Ryan White CARE Act funds). Many programs are also funded through the collection of fees for specified functions, such as for health facility licensing and certification activities. Several programs are funded through multiple sources, including General Fund support, federal funds, and fee collections.

The budget includes \$800.9 million for state operations and \$2.3 billion for local assistance. See tables below for more information on the proposed budget.

Table: DPH Budget Overview

Fund Source	2014-15	2014-15	2015-16	BY to CY
	Enacted Budget	Revised	Proposed	Change
General Fund	\$118,121,000	\$119,639,000	\$124,393,000	5.31%
Federal Trust Fund	\$1,722,538,000	\$1,742,541,000	\$1,750,166,000	1.60%
Special Funds & Reimbursements	\$1,178,230,000	\$1,106,174,000	\$1,239,329,000	5.19%
Total Expenditures	\$3,018,889,000	\$2,968,354,000	\$3,113,888,000	3.15%
Positions	3795.7	3795.7	3838.1	1.12%

Table: DPH Program Funding Summary

Program	2013-14 Actual	2014-15 Projected	2015-16 Proposed
Public Health Emergency Preparedness	\$85,207,000	\$98,188,000	\$98,335,000
Chronic Disease Prevention and Health Promotion	265,305,000	303,433,000	344,851,000
Infectious Diseases	578,237,000	572,688,000	603,412,000
Family Health	1,549,830,000	1,640,859,000	1,674,457,000
Health Statistics and Informatics	25,879,000	27,434,000	27,666,000
County Health Services	14,627,000	15,638,000	15,112,000
Environmental Health	312,548,000	87,421,000	90,822,000
Licensing and Certification	174,856,000	209,322,000	241,449,000
Laboratory Field Services	10,499,000	13,372,000	13,452,000
Administration	32,678,000	34,742,000	35,979,000
Distributed Administration	-32,679,000	-34,743,000	-35,980,000
Total Expenditures (All Programs)	\$3,016,987,000	\$2,968,354,000	\$3,109,555,000

State Auditor – DPH High-Risk Agency. On March 3, 2015, the State Auditor notified the Legislature that DPH remains a high-risk agency due to weakness in program administration and because it has been slow to implement recommendations, especially those that have a direct impact on public health and safety. DPH noted that most of the department’s outstanding recommendations involve either licensing or laboratory field services, which represent only two of the over 200 programs at DPH, and that the challenges found within these areas are not indicative of the department as a whole.

Subcommittee Staff Comment. 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. What is DPH’s response to the State Auditor’s notification that DPH remains a high-risk agency? What is DPH doing to address these recommendations?

2. Office of AIDS (OA): AIDS Drug Assistance Program (ADAP) Update

Background. The Office of AIDS has two programs within ADAP that provide access to life saving medications for eligible California residents living with HIV/AIDS. These are:

A. Medication Program – In this program, ADAP pays prescription drug costs for drugs on the ADAP formulary for the following coverage groups:

1. ADAP-only clients, for whom ADAP pays 100 percent of the prescription drug costs because these clients do not have a third-party payer.
2. Medi-Cal Share of Costs clients, for whom ADAP pays 100 percent of the prescription drug cost up to the client’s share of cost amount.
3. Private Insurance clients, for whom ADAP pays prescription drug co-pays and deductibles.
4. Medicare Part D clients, for whom ADAP pays the Medicare Part D drug co-pays and deductibles.

B. Insurance Assistance Programs – These programs pay for private health insurance premiums or Medicare Part D premiums for clients co-enrolled in ADAP. These are for the following three types of health insurance:

1. Non-Covered California private insurance – OA – Health Insurance Premium Payment Program (OA-HIPP)
2. Covered California private insurance – OA HIPP Covered California
3. Medicare Part D – OA Medicare Part D

See tables below for ADAP budget summary and caseload estimates.

Table: Governor’s Estimated ADAP Expenditures for Current Year and Budget Year (dollars in millions)

Fund Source	2014-15 Budget Act	2014-15 Revised	2015-16 Proposed
General Fund	\$0	\$0	\$0
AIDS Drug Rebate Fund	\$278.6	\$247.5	\$288.6
Federal Funds – Ryan White	\$107.8	\$131.2	\$108.1
Reimbursements from Medicaid Waiver (Safety Net Care Pool Funds)	\$53.6	\$6.2	\$18.2
Total	\$440.0	\$384.9	\$415.0

Table: Estimated ADAP Clients by Coverage Group for Medication Expenditures

Coverage Group	2014-15		2015-16	
	Clients	Percent	Clients	Percent
ADAP-only	15,275	45.2%	15,500	44.5%
Medi-Cal	606	1.8%	581	1.7%
Private Insurance	8,878	26.0%	9,591	27.6%
Medicare	9,123	27.0%	9,123	26.2%
Total	33,791	100%	34,795	100%

Table: Estimated ADAP Clients by Coverage Group for Insurance Assistance Programs

Coverage Group	2014-15		2015-16	
	Clients	Percent	Clients	Percent
OA - HIPP	1,288	32.9%	1,097	21.8%
OA- HIPP Covered California	1,826	46.7%	3,104	61.8%
OA – Medicare Part D	797	20.4%	821	15.6%
Total	3,911	100%	5,021	100%

Current Year Changes. Compared to the 2014 Budget Act, estimated expenditures for current year have declined by 12.5 percent. This decline is due to the following factors:

- Covered California – A larger number of clients enrolled in Covered California during 2013-14 (913 clients) than was initially predicted.
- Medi-Cal Expansion – A larger number of clients are transitioning to Medi-Cal than was initially estimated.
- Hepatitis C – Fewer clients are predicted to access hepatitis C virus treatment than was initially estimated.

Budget Year Changes. Compared to the 2014 Budget Act, OA estimates that expenditures during 2015-16 will decline by 5.7 percent, but increase compared to the revised current year projection. This increase is due to new clients enrolling in ADAP. Covered California and Medi-Cal expansion had and will continue to have substantial impacts on the number and type of clients receiving ADAP services in 2014-15 as clients transition out of ADAP or to a different client group within ADAP. However, as these programs will be fully implemented at the end of 2014-15, OA expects that the number of clients leaving or changing client groups will stabilize and that client caseloads will again increase due to persons being newly diagnosed with HIV. Additionally, ADAP assumes the loss of Safety Net Care Pool Funds with the expiration of the current 1115 Medicaid Waiver. (These funds carried less restrictions than the use of Ryan White federal funds.)

ADAP Eligibility and Current Cost-Sharing. Individuals are eligible for ADAP if they:

- Reside in California;
- Are HIV-infected;
- Are 18 years of age or older;
- Have an adjusted federal income that *does not exceed* \$50,000;
- Have a valid prescription from a licensed Californian physician; and,
- Lack private insurance that covers the medications or do not qualify for no-cost Medi-Cal.

The ADAP is the *payer of last resort*. Individuals who have private health insurance, are eligible for Medi-Cal, or are eligible for Medicare, must access these services *first*, before the ADAP will provide services.

ADAP clients with incomes between \$45,961 (over 400 percent of poverty) and \$50,000 are charged monthly co-pays for their drug coverage which is established annually at the time of enrollment or recertification.

ADAP Rebate Fund. Drug rebates constitute a significant part of the annual ADAP budget. This special fund captures all drug rebates associated with ADAP, including both mandatory (required by federal Medicaid law) and voluntary supplemental rebates (additional rebates negotiated with drug manufacturers through the ADAP Taskforce). Generally, for every dollar of ADAP drug expenditure, the program obtains 70 cents in rebates. This 70 percent level is based on an average of rebate collections (both “mandatory” and “supplemental” rebates).

Federal HRSA Maintenance of Effort (MOE) for Ryan White CARE Act. The federal Health Resources and Services Administration (HRSA) requires states to have HIV-related non-HRSA expenditures. California’s HRSA match requirement for the 2014 federal Ryan White Part B grant year (04/01/2014-03/31/2015) is \$65,162,316. California’s match requirement will be met using DPH OA General Fund Support expenditures (\$3.62 million) and local assistance expenditures for OA’s HIV Surveillance (\$6.65 million) and Prevention (\$2.85 million) programs, as well as HIV-related expenditures from the California Department of Corrections and Rehabilitation (up to \$56.72 million) for a total of \$69.84 million.

Payment of Out-of-Pocket Medical Costs through OA-HIPP. As part of the 2014 budget, the Legislature adopted trailer bill language that allow OA-HIPP to pay for out-of-pocket medical expenses. OA anticipates this to begin January 2016. OA estimates that 711 additional clients will enroll in OA-HIPP Covered California due to this policy.

2014 Budget Act Augmentation – HIV Prevention Demonstration Projects. The 2014 Budget Act included an ongoing \$3 million General Fund augmentation for HIV Demonstration Projects.

ADAP Enrollment Workers. The budget includes \$2 million (rebate and federal funds) to local health jurisdictions for the costs associated with the administration of ADAP enrollment. These funds are allocated based on the proportion of ADAP clients the local health jurisdiction enrolled during the prior year. Local health jurisdictions may distribute the funds to ADAP enrollment sites, use the funds to support the local ADAP coordinator function, or spend the funds on equipment/supplies necessary for ADAP enrollment. These funds are fixed and do not change based on enrollment numbers.

These enrollment workers help ADAP clients navigate the various health affordability and coverage programs, such as Covered California and OA’s Insurance Assistance Programs (e.g., OA-HIPP).

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending updated information at May Revision.

Questions. The Subcommittee has requested the Office of AIDS to respond to the following:

1. Please provide an overview of the ADAP budget.
2. Please provide an update on the transition of ADAP clients to Medi-Cal and Covered California.
3. Please provide an update on the \$3 million General Fund augmentation in the 2014 Budget Act (and ongoing) for HIV Demonstration Projects.

4. Please provide an update on the implementation of last year's trailer bill language to pay out-of-pocket medical costs through OA-HIPP.
5. Given the projected increases in ADAP enrollment and the increasing complexity of health affordability and coverage programs, how has OA considered the impact on ADAP enrollment workers and state support for these processes?

3. OA: ADAP Client Eligibility Verification Resources

Budget Issue. DPH requests \$536,000 in expenditure authority from the AIDS Drug Assistance Program Rebate Fund and five positions to manage the increase in client eligibility verification workload within the AIDS Drug Assistance Program (ADAP). These positions are needed to ensure program integrity and to comply with federal Health Resources and Services Administration (HRSA) client eligibility verification requirements.

Background. Statewide, local enrollment sites employ ADAP enrollment workers who are trained on proper client enrollment policies and procedures. Enrollment workers maintain secure paper-based client files at their respective local ADAP enrollment sites and enroll eligible clients electronically via ADAP's Pharmacy Benefits Manager, which provides centralized Pharmacy Benefits Manager services to ensure qualified ADAP clients receive direct prescription medication services from approximately 4,000 pharmacies in the California ADAP network.

ADAP state staff conduct periodic site visits to monitor ADAP's 175 local enrollment sites and review a small sample of client file documents to verify local enrollment workers are making proper client eligibility determinations. In addition, ADAP staff also provides technical assistance to local health jurisdictions and perform other tasks to administer the program and ensure eligible clients have access to their medications.

In November 2013, HRSA conducted a comprehensive site visit of DPH HRSA-funded Ryan White Part B Care Programs. HRSA reported the following findings:

1. "ADAP eligibility determination and ultimate approval rests solely on individual enrollment workers at local sites throughout the state. Documentation is not reviewed by another individual (local or state), leading to the potential for fraud and abuse of the system."
2. HRSA recommended that the Office of AIDS develop a centralized electronic system with uploading capability that will allow a secondary review of all ADAP client applications within CPH.

To address these issues, DPH amended the ADAP Pharmacy Benefits Manager contract to grant both DPH ADAP staff and ADAP local site enrollment workers the ability to add, store, view, and delete scanned ADAP client eligibility documents. This change meets the HRSA recommendation for a centralized electronic system, and once implemented, will reduce the amount of time it takes for DPH to ensure that client supporting documentation is consistent with eligibility criteria and will address the risk of potential program fraud or abuse.

By federal statute, HRSA funds may not be used for any item or service "for which payment has been made or can reasonably be expected to be made" by another payment source (Sections 2605(a)(6), 2617(b)(7)(F), 2664(f)(1) and 2671(i) of the federal Public Health Service Act). The statute requires grantees to verify client eligibility, and a HRSA policy notice released in 2013-14 clarified that client re-certifications must:

- At least once a year, verify that individual residency, income, and insurance status continues to meet the eligibility requirements, and verify that HRSA is the payer of last resort; and
- A second process at least once a year must include the collection of more in-depth supporting documentation similar to that collected at the initial eligibility determination.

According to DPH, the current staffing levels in ADAP are inadequate to review all projected 34,795 client files for 2015-16, resulting in ADAP continuing to be noncompliant with HRSA policies. Streamlining and making the verification process more efficient for review electronically at the state level does not solve the need for additional ADAP staff because ADAP staff are required to verify eligibility of all clients upon initial enrollment and upon annual recertification based on their month of birth. Under the new electronic system, in 2015-16 the Office of AIDS estimates it will take staff an average of 30 minutes per file to review ADAP client eligibility. For 2015-16, the Office of AIDS plans to reassign ADAP Branch staff (11 full-time equivalent) to perform this task; these staff are capable of reviewing 24,403 ADAP client files to verify eligibility. Additional staff could review another 10,392 client files; this would allow the Office of AIDS to become compliant with HRSA for 34,795 ADAP client files in FY 2015-16. Failure to comply with HRSA's site visit finding could result in future audit findings and potentially result in the loss of HRSA federal funds (\$167.2 million in FY 2014-15). A loss of HRSA federal funds would result in negative service impacts to clients.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal.

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

1. Please provide an overview of this proposal.

4. OA: ADAP – Modernization

Issue. The Subcommittee is in receipt of proposals to expand eligibility for the AIDS Drug Assistance Program (ADAP) medication program and the ADAP insurance assistance programs--the OA-Health Insurance Premium Payment (HIPP) program. These proposals, which may result in program savings in out years because of the current drug rebate return, and include:

- a. Update Family Size - Financial eligibility for OA-HIPP and ADAP are the same. Currently the programs serve individuals with incomes up to \$50,000 annually based on federal adjusted gross income (FAGI) with no regard for family size. The result is that a single individual is treated the same as a person with dependents. Historically, ADAP served primarily single men with no dependents. Changes in the epidemic, changes in marriage and family rights for the LBGT community as well as new insurance coverage opportunities through the Affordable Care Act (ACA) make it important to consider the programs' eligibility standards regarding family size.
- b. Increase Income Limit - Another issue for consideration is increasing the income limit of \$50,000 for these programs, which is estimated to be 447 percent federal poverty level (FPL) to 500 percent FPL or \$58,350 for a single individual and \$98,950 for a three-person household. Currently five other high income states operate programs with this income eligibility, including Maine, Maryland, Massachusetts, New Jersey and the District of Columbia.

This is not a proposal from the Administration.

Technical Assistance from DPH. Subcommittee staff requested technical assistance from DPH regarding the fiscal impact of this proposal. According to DPH, its preliminary estimate suggests that this proposal, if implemented, would cost roughly \$5-6 million in 2015-16, but would result in savings in subsequent years. The cost to ADAP would be higher in the first year of the program change than would be expected in subsequent years, assuming ADAP's current drug rebate return rates, because of the standard six month delay in receiving rebate after expenditures. This estimate includes costs/savings for both the ADAP medication program and the ADAP insurance assistance programs (OA-HIPP).

DPH OA estimates initial first year costs of \$5.5 million in 2015-16 as result of increasing the ADAP income eligibility limit to 500% FPL based on modified adjusted gross income (MAGI) and the six-month delay in rebate collections. See table on next page. ADAP would utilize available rebate funds and federal funds to cover these additional program expenditures. The federal Health Resources and Services Administration (HRSA) requires that any available 340B mandatory rebate funds be used before federal funds at the time each invoice is paid, so OA cannot predict exactly which portion will be covered by rebate versus federal funds.

Table: OA's Estimated Impact for 2015-16

500% FPL INCOME ELIGIBILITY FOR ADAP*, 2015-16					
	Coverage Group				
Line Item	ADAP Only	Medi-Cal SOC	Private Insurance**	Medicare Part D	Total
Premium Expenditures	\$0	\$0	\$1,959,935	\$11,107	\$1,971,042
Medical OOP Expenditures	\$0	\$0	\$19,822	\$0	\$19,822
Drug Expenditures	\$7,945,636	\$193,813	\$2,870,589	\$521,073	\$11,531,110
Rebate received in 2015-16	\$1,555,657	\$0	\$5,419,521	\$1,007,624	\$7,982,802
Net Expenditures	\$6,389,979	\$193,813	-\$569,175	-\$475,444	\$5,539,173
Clients	363	26	1,066	172	1,626

*Includes both the ADAP medication program and the ADAP insurance assistance programs.

** Includes all ADAP Private Insurance clients who may or may not be co-enrolled in OA-HIPP.

After the initial first year costs, rebate would consist of a full year of rebate revenues, and the proposal would result in annual program savings of about \$2.4 million, assuming our current rebate return rates. See table below.

Table: OA's Estimated Impact for Out Years.

500% FPL INCOME ELIGIBILITY FOR ADAP*, FUTURE YEARS					
	Coverage Group				
Line Item	ADAP Only	Medi-Cal SOC	Private Insurance**	Medicare Part D	Total
Premium Expenditures	\$0.00	\$0.00	\$1,959,935	\$11,107	\$1,971,042
Medical OOP Expenditures	\$0.00	\$0.00	\$19,822	\$0.00	\$19,822
Drug Expenditures	\$7,945,636	\$193,813	\$2,870,589	\$521,073	\$11,531,110
Projected Full Year of Rebate	\$3,111,315	\$0	\$10,839,042	\$2,015,248	\$15,965,604
Net Expenditures	\$4,834,321	\$193,813	-\$5,988,696	-\$1,483,068	-\$2,443,629
Clients	363	26	1,066	172	1,626

*Includes both the ADAP medication program and the ADAP insurance assistance programs.

** Includes all ADAP Private insurance clients who may or may not be co-enrolled in OA-HIPP.

DPH OA estimates 1,626 new clients will enroll in ADAP as result of increasing the ADAP income eligibility limit to 500% FPL based on MAGI. Of these new ADAP clients, OA estimates that 425 will also co-enroll in ADAP's insurance assistance programs.

At this time, OA is unable to determine the number of enrollees that would lose coverage based on the change in income eligibility because ADAP recently began collecting household income and OA does not have a full fiscal year of data to provide an estimate. The only clients who would lose coverage would be clients who are married or in a domestic partnership with a substantially higher income earning spouse/partner. This would include, for example, a client earning \$30,000 annually with a spouse who earns \$60,000 annually in which the couple has no children. Their annual household income is \$90,000, which is above 500% FPL for a household of two. OA assumes that the number of clients who would lose coverage would be small and have assumed it to be zero in the above estimate.

Currently, the ADAP enrollment application process asks for family size and household income but the Pharmacy Benefits Manager (PBM) electronic application system would need to be updated to capture MAGI. OA would work with the PBM to make the necessary changes and conduct training for enrollment workers on the new updates. One-time costs, which would be subject to negotiation with the PBM, may be needed to implement the system change.

According to DPH, to the extent that reserves are sufficient to cover the additional program expansion, this policy change would not impact the General Fund in 2015-16. ADAP would utilize available rebate funds and federal funds for additional program expenditures in 2015-16 if this policy change were implemented. The Fund Condition Statement reflects a sufficient Special Fund reserve of \$11.6 million in 2015-16. Beyond the budget year, OA estimates this proposal will result in savings since estimated rebate from the first full year of implementation, received in the second full year of implementation, will exceed estimated expenditures in the second full year of implementation. This assumes the rebate percentage return rate remains steady. Any change to the rebate return rate will impact our estimate.

If ADAP expands access to the new hepatitis C virus (HCV) medications to include all ADAP clients co-infected with HCV regardless of liver disease stage and ADAP realizes a significant increase in utilization of HCV medications, this could put pressure on rebate funds and federal funds.

Subcommittee Staff Comment and Recommendation—Hold Open. Modernizing ADAP could reduce ADAP expenditures while providing benefits to more people living with HIV/AIDS.

It is recommended to hold this item open as discussions continue on this proposal.

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

1. Please provide an overview of this issue and DPH's technical assistance.

5. Infant Botulism Treatment Program: Production Lot 6

Budget Issue. DPH requests a one-time increase in expenditure authority of \$2 million Infant Botulism Treatment and Prevention Fund in 2015-16 for the Infant Botulism Treatment and Prevention Program (IBTPP) to address the manufacturing costs for the current lot production of BabyBIG®.

Due to the collection of additional blood plasma from out of state donors to ensure an adequate supply of BabyBIG®, several manufacturing steps in the current lot 6 production cycle will be moved to 2015-16. These manufacturing processes are a key component to sustain the statutorily-mandated production, distribution, regulatory compliance, and other activities for DPH's public service orphan drug BabyBIG® (Human Botulism Immune Globulin).

Background. BabyBIG® is used for the treatment of infant botulism. The use of BabyBIG® shortens the average hospital stay from six weeks to two weeks and reduces hospital costs by \$103,000 per patient (2012 dollars). Since licensure of BabyBIG® in October 2003 by the federal Food and Drug Administration (FDA), more than 1,000 patients nationwide have been treated; thereby avoiding more than 70 years of patient hospital stays and more than \$100 million of hospital costs (2012 dollars). Use of BabyBIG® in California saves Medi-Cal approximately \$2.1 million per year, and results in cost avoidance savings to California hospitals of approximately \$4 million annually, and approximately \$11 million nationwide annually. Estimates of hospital cost savings were derived from the statewide clinical trial conducted from 1992 through 1997 and adjusted for current dollars (based on the federal Bureau of Labor Statistics, medical costs inflation). DPH is the only source of BabyBIG® in the world.

A \$45,300 fee is collected for BabyBIG® from hospitals and insurance companies and is deposited in the Infant Botulism Treatment and Prevention Fund, a special fund used for the mandated activities per Health and Safety Code Section 123704 which includes producing and distributing BabyBIG® to patients needing this treatment. The Infant Botulism Treatment and Prevention Fund is projected to have a fund balance reserve in excess of approximately \$7.4 million at the end of 2014-15.

A 2014-15 budget change request was approved that increased the appropriation authority by \$3 million in 2014-15 and \$951,000 in 2015-16 to address the increased costs due to new requirements from the FDA that increased costs for production. The prior budget request did not cover costs necessary to obtain the out of state blood plasma collection since the entirety of those costs was not known at the time.

Due to the higher usage level of BabyBIG® in the past 2-3 years, there is a need to increase the supply of BabyBIG® to treat more patients. Using more donors will ensure a sufficient supply is manufactured for the current lot 6 production to meet the public health need. The cost to obtain the blood plasma from out of state donors is anticipated to be \$2.25 million with \$1.77 million incurred in 2014-15 and \$480,000 in 2015-16. An inadequate supply from in-state donors has led to the necessity of the collection of blood plasma from donors in other states. This will shift several production steps originally anticipated to be completed in 2014-15 to now begin in 2015-16. These steps include the FDA regulatory assessment and evaluation, preparing and submitting chemistry, adhering to manufacturing and controls, vaccine stability testing, and qualification testing. Expansion of out of state blood plasma collection activities, including increased regulatory costs occurring in 2014-15, were not included in the

2014-15 BCP ID-01 since the entirety of those costs was not known at that time. These production activities require an additional \$2 million expenditure authority for 2015-16, the final Lot 6 production year.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended to approve this item to ensure that this program continues to provide life-saving medicine, support and diagnostic and other services for infants with botulism.

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

1. Please provide an overview of this issue.

6. Oversight of Licensing and Certification Program

Background. The California Department of Public Health’s (DPH) Licensing and Certification Program (L&C) is responsible for regulatory oversight of licensed health facilities and health care professionals to ensure safe, effective, and quality health care for all Californians. L&C fulfills this role by conducting periodic inspections and compliant investigations of health facilities to ensure that they comply with federal and state laws and regulations. L&C licenses and certifies over 7,500 health care facilities and agencies in California, such as hospitals and nursing homes, in 30 different licensure and certification categories.

The federal Centers for Medicare and Medicaid Services (CMS) contracts with L&C to evaluate facilities accepting Medicare and Medicaid (Medi-Cal in California) payments to certify that they meet federal requirements. L&C evaluates health care facilities for compliance with state and federal laws and regulations, and it contracts with Los Angeles County to license and certify health care facilities located in Los Angeles County.

L&C’s field operations are implemented through district offices, including over 1,000 positions, throughout the state, and through the contract with Los Angeles County.

In addition, L&C oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

Long-Standing Problems with L&C. There have been long-standing concerns about the L&C program. Multiple recent legislative oversight hearings, including those conducted by Senate Budget and Fiscal Review Subcommittee No. 3, an audit released by the California State Auditor in October 2014, and media reports have highlighted significant gaps in state oversight of health facilities and certain professionals that work in these facilities.

These issues include:

- **CMS Concerns with L&C.** On June 20, 2012, the federal Centers for Medicare and Medicaid (CMS) sent a letter to DPH expressing its concern with the ability of DPH to meet many of its current Medicaid survey and certification responsibilities. In this letter, CMS states that its analysis of data and ongoing discussions with DPH officials reveal the crucial need for California to take effective leadership, management, and oversight of DPH’s regulatory organizational structure, systems, and functions to make sure DPH is able to meet all of its survey and certification responsibilities.

The letter further states that “failure to address the listed concerns and meet CMS’ expectations will require CMS to initiate one or more actions that would have a negative effect on DPH’s ability to avail itself of federal funds.” In this letter, CMS acknowledges that the state’s fiscal situation in the last few years, and the resulting hiring freezes and furloughs, has impaired DPH’s ability to meet survey and certification responsibilities.

As a result of these concerns, CMS set benchmarks that DPH must attain and is requiring quarterly updates from DPH on its work plans and progress on meeting these benchmarks. The state was in jeopardy of losing \$1 million in federal funds if certain benchmarks were not met. (Ultimately, \$138,123 in federal funding was withheld.)

- **Insufficient Oversight of Los Angeles County Contract.** As discussed earlier, L&C contracts with Los Angeles County to license and certify health facilities in Los Angeles County. As revealed in March 2014, facing a backlog of hundreds of health and safety complaints about nursing homes, Los Angeles County public health officials told inspectors to close cases without fully investigating them. According to an April 21, 2014 letter from the federal CMS, the state was in jeopardy of losing federal funding if certain performance and management benchmarks regarding the L&C's investigation of complaints and L&C's oversight of the Los Angeles contract and are not met. (Ultimately, \$251,515 in federal funding was withheld.)
- **State Auditor Concerns with L&C.** In October 2014, the State Auditor released a report regarding the L&C program. The findings from this report include:
 - DPH's oversight of complaints processing is inadequate and has contributed to the large number of open complaints and entity reported incidents. For example, the Auditor found more than 11,000 complaints and entity-reported incidents open for an average of nearly a year.
 - DPH does not have accurate data about the status of investigations into complaints against individuals.
 - DPH has not established formal policies and procedures for ensuring prompt completion of investigations of complaints related to facilities or to the individuals it certifies.
 - DPH did not consistently meet certain time frames for initiating complaints and ERIs.
- **Unable to Understand Workload and Staffing Needs.** During the 2014-15 budget subcommittee process, the Administration admitted its current methodology to assess workload demands and needs was flawed and that it had no proposals to increase staffing related to its workload for health facilities. As an example of the unreliability of the methodology, it estimated that it would need 70 less staff, while the prior year's estimate indicated that L&C needed 122 more staff.

In the past, there has been a reluctance to add L&C positions because, in addition to the flawed methodology, it has been difficult to fill Health Facility Evaluator Nurses (HFEN) positions and; consequently, these classifications had a high vacancy rate. (HFENs are registered nurses who conduct health facility surveys and respond to complaints.)

- **Credit to Health Facilities Instead of Investing in Workforce.** For each of the last two years, L&C credited health facilities with over \$11 million from the special fund reserve instead of using these funds to address the problems with this program. Although L&C fees are to be used

to support the work associated with enforcing state laws and requirements, DPH was resistant to using this resource to hire more staff to improve its oversight of health facilities.

2014-15 Budget. During last year's budget subcommittee process, DPH indicated that it understood these concerns and was in the process of conducting a complete evaluation of its program. Prior to the completion of this evaluation, the Administration was not receptive to any additional resources to improve its health facility-licensing program.

Consequently, in an effort to provide transparency and accountability of the L&C program, the Legislature adopted trailer bill language¹ that required L&C to:

- Report metrics, beginning October 2014 and on a quarterly basis, on: (1) investigations of complaints related to paraprofessionals certified by DPH; (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 by December 1, 2014.
- Hold semiannual meetings, beginning August 2014, for all interested stakeholders to provide feedback on improving the L&C program to ensure that Californians receive the highest quality of medical care in health facilities.

See the following website for the publication of this data:

<http://www.cdph.ca.gov/programs/Pages/CHCQPerformanceMetrics.aspx>

The 2014 budget also included (1) one-time funding of \$1.4 million from the Internal Departmental Quality Improvement Account to conduct business process improvement projects for its Central Applications Unit and Professional Certification Branch and contract for a project manager and consultant to facilitate and coordinate the multi-year implementation of the Hubbert System Assessment recommendations and (2) 18 two-year limited-term positions and \$1,951,000 (Licensing & Certification Special Fund) to support timely investigations of allegations/complaints filed against certified nurse assistants (CNAs), home health aides (HHAs), and certified hemodialysis technicians (CHTs).

In response to CMS' concerns, highlighted above, L&C contracted with Hubbert System Consulting for an organizational assessment of its effectiveness and performance. This assessment includes 21 recommendations for program improvement.

¹ SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014

Budget Proposal. The Governor’s budget includes the following requests related to the L&C program:

- **L&C Workload** - An increase of \$19.8 million in 2015-16 for 173 permanent positions and 64 two-year, limited-term positions, for a total of 237 positions (123 positions will become effective July 1, 2015 and 114 positions will begin on April 1, 2016), and an increase in expenditure authority of \$30.4 million in 2016-17 from the L&C Special Fund to address the licensing and certification workload. This request attempts to address the L&C’s past failures to complete its survey workload and close/complete complaint investigations. The additional staffing would be used to:
 - Reduce the number of open complaints and entity-reported incidents;
 - Decrease the average number of days to close complaint and entity-reported incident investigations;
 - Increase the percent of immediate jeopardy complaint and entity-reported incident investigations that investigated within 24 hours (those constituting an immediate jeopardy to the health or safety of a patient).
- **L&C Quality Improvement Projects** – An increase of \$2 million in 2015-16 from the Internal Departmental Quality Improvement Account to implement quality improvement projects recommended by Hubbert Systems Consulting for the Licensing and Certification Program.
- **Los Angeles County Contract** - An increase in expenditure authority of \$9.5 million from the L&C Special Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County. This proposal includes \$2.6 million to fully fund the current contract positions at current Los Angeles County salary rates, and \$6.9 million to fund 32 additional Los Angeles County positions to enable the county to address long-term care facility complaints and entity-reported incidents, and investigate aging long-term care complaints and entity-reported incidents (Tier 1 and Tier 2 federal workload²).

For the past 30 years, DPH has contracted with Los Angeles County to provide federal certification and state licensing surveys and investigate complaints and entity reported incidents for approximately 2,500 health facilities in Los Angeles County. In July 2012, the contract was renewed for a three year period with an annual budget of \$26.9 million to fund 178 positions. However, due to a salary increase negotiated by Los Angeles County nurses, the current budget only funds 151 of the authorized positions. L&C used its state staffing model to assess Los

² Tier 1 workload includes federal recertification and life safety code surveys for skilled nursing facilities and intermediate care facilities for individuals with intellectual disabilities, recertification surveys for home health agencies, all complaints and entity-reported incident investigations prioritized as having a potential for immediate jeopardy, and sample validation and complaint validation surveys for general acute care hospitals, home health agencies, hospices, and ambulatory surgery centers. Tier 2 workload includes federal targeted recertification surveys for end stage renal dialysis clinics, hospices, rehabilitation clinics, ambulatory surgery centers, rural health clinics, transplant centers, and outpatient physical therapy providers and long-term care complaints and entity-reported incident investigations prioritized as non-immediate jeopardy, high and lower.

Angeles County's long-term care and non-long term care workload. L&C determined that to complete state licensing and federal certification activities, and investigate aging complaints and entity-reported incidents, Los Angeles County would require approximately \$41.3 million and 281 positions. This proposal focuses on a portion of the total assessed workload. Once Los Angeles County has hired and trained the additional positions requested in this proposal, L&C may request additional resources for Los Angeles County to complete additional workload. This incremental approach gives Los Angeles County time for recruitment and training. It takes 12-14 months for a newly hired nurse surveyor to complete all required training and become proficient.

L&C's review determined that 32 additional positions and \$6.9 million in additional funds are necessary to meet required responsibilities within reasonable timelines for completing Tier 1 and Tier 2 federal workload, including investigating long-term care complaints, and aging long-term care complaints and entity-reported incidents. In 2015-16 costs for the requested additional positions and to fully fund all current contracted positions salaries is \$9.5 million. The state has recently entered into contract negotiations with Los Angeles County regarding the renewal of this contract, which expires June 30, 2015.

- **Los Angeles County Contract Monitoring** – An increase of \$378,000 from the L&C Special Fund and three 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. In order to begin the on-site oversight immediately, the department plans to administratively establish three positions in 2014-15.

In addition, the Governor’s budget includes the following estimates in regard to L&C accounts:

Account/Fund	Purpose	2015-16 Budget (in thousands)	
State Health Facilities Citation Penalties Account	Used primarily to pay for temporary managers and/or receivers for SNFs. Funds (\$1.2 million) from this account are also used to support the Department of Aging’s Long Term Care Ombudsman programs.		
		Beginning Balance	\$11,272
		Revenues	\$2,661
		Expenditures	\$3,337
		Fund Balance	\$10,596
Federal Health Facilities Citations Penalties Account	Used to fund innovative facility grants to improve the quality of care and quality of life for residents of SNFs or to fund innovative efforts to increase employee recruitment or retention subject to federal approval.		
		Beginning Balance	\$3,880
		Revenues	\$1,002
		Expenditures	\$937
		Fund Balance	\$3,909
Internal Departmental Quality Improvement Account	Used to fund internal L&C program improvement efforts. Funded by administrative penalties on hospitals.		
		Beginning Balance	\$14,654
		Revenues	\$3,892
		Expenditures	\$2,292
		Fund Balance	\$16,254

Nurse Surveyor Vacancy Rates. According to a December 2014 report, the HFEN vacancy rate varies from 2.5 percent to 16.67 percent in the different field offices, with an average vacancy rate of about 7.2 percent.

LAO Findings and Recommendations. The LAO recommends approval of the proposals regarding Los Angeles County Contract Monitoring and L&C Quality Improvement Projects. The LAO withholds recommendation on the proposals regarding the Los Angeles County Contract and L&C Workload pending receipt of information on the ability of using professional position classifications other than Health Facility Evaluator Nurses (HFENs) to perform licensing and certification survey or complaint workload. Additionally, the LAO recommends the Legislature require the department to incorporate meaningful performance measures and benchmarks into the Los Angeles County contract and impose withholds of funding if the county fails to achieve these measures. The LAO further recommends that the contract, up for renewal in July 2015, be renewed for a one-year period in order to allow for annual adjustments to the performance measures and benchmarks. The LAO believes this approach to structuring the Los Angeles County contract will improve the county’s accountability to the state and incentivize improvements in quality, efficiency and effectiveness.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on these proposals. While the Governor’s budget represents an acknowledgement by the Administration of the long-standing problems at L&C and makes an attempt to address the inconsistent and untimely enforcement of federal and state laws regarding health facilities licensure and certification, the following issues should be considered.

- **First Step, But Temporary Nature of Staffing Proposal Does Not Address Ongoing Workload.** As discussed above, the budget proposes an additional 237 positions, of which 64 would be limited-term, to address the outstanding and ongoing workload of the L&C program. Of these limited-term positions, 42 are HFENs (nurse surveyors) and seven are HFEN supervisors—the positions for which the L&C program has had the most difficult time hiring and retaining (both of these positions are registered nurses).

The state makes a significant investment in the training of HFENs and acknowledges that it takes 12 to 14 months for HFEN to complete the training necessary to become proficient and work independently. Consequently, these positions would only be available to actively complete workload for one year, since these positions are authorized for only two years. Given that L&C's problem is not just closing a backlog of complaints, but also timely investigation and completion of new complaints and surveys and monitoring for compliance with state health facility licensing requirements (which are generally more stringent than the federal requirements), it is not clear why these positions should be limited-term. Instead, once the backlog is addressed, these trained and skilled surveyors could be directed to address other workload activities that are not the focus of this Governor's proposal.

- **Continued Oversight on Overall Plan to Improve the Program.** As discussed above, a complete assessment of the L&C program was completed in August 2014. This assessment includes 21 recommendations to allow for meaningful and measurable improvements in the program. It will be important for the Legislature to continue its oversight of the L&C program and ensure that DPH is accountable for taking the steps necessary to accomplish this major program improvement effort.
- **Stronger State Oversight of Los Angeles County Contract.** The state's contract with Los Angeles County expires June 30, 2015. DPH anticipates that contract negotiations with Los Angeles County will begin in February. As noted above, the budget proposes three positions to provide on-site monitoring of the Los Angeles County contract and an increase of \$9.5 million to augment the Los Angeles County contract (\$2.6 million to fully fund the current contract positions at current Los Angeles County salary rates, and \$6.9 million to fund 32 additional Los Angeles County positions). It will be important for DPH to ensure that this new contract contains clear and specific performance metrics to ensure that Los Angeles County appropriately performs this workload on behalf of the state. Additionally, this new contract should include protections for the state if Los Angeles County does not meet these performance metrics.
- **Los Angeles County Contract Being Negotiated.** As discussed above, the state has recently entered into contract negotiation discussions with Los Angeles County regarding the renewal of this contract. Los Angeles County has raised concerns that the Governor's proposal does not sufficiently fund the workload as it does not take into consideration the county's salary rate, employee benefits, indirect costs, or county productive work hour formula, nor does it reflect the appropriate ratios of supervisor, support, or medical consultant positions. DPH indicates it is aware of these concerns and is taking Los Angeles County's concerns under advisement as it continues negotiations. Consequently, there is potential that the funding level reflected in the Governor's budget for this contract could change pursuant to the negotiation.

- **Significant Fund Balances Could Be Used for Long-Term Care Ombudsman Program.** Currently \$1.2 million from the State Health Facility Citation Penalties Account is used to support the Department of Aging’s Long-Term Care Ombudsman Program. The Long-Term Care Ombudsman Program investigates elder abuse complaints in long-term care facilities, including skilled nursing facilities (SNFs) which are regulated by L&C.

While no data exist to prove or quantify this, it is reasonable to assume that the ombudsman program’s presence and advocacy on behalf of SNF residents improves quality of life for these residents and improves a SNF’s compliance with state and federal laws. This is because the ombudsman is often able to intervene on behalf of a resident and investigate and resolve complaints before they result in more serious and costly cases of abuse and neglect.

Consequently, in an effort to address L&C problems from another perspective, the Legislature may want to consider using L&C special funds to augment the Long-Term Care Ombudsman Program in regard to its work on facilities regulated by L&C. As noted above, there is a \$10.6 million fund balance in the State Health Facilities Citation Penalties Account and a \$16.2 million fund balance in the Internal Departmental Quality Improvement Account. A modest investment (\$1 to \$2 million) from one or both of these funds could fund significant efforts to protect the residents of these facilities.

Statute requires any funds greater than \$10 million in the State Health Facilities Citation Penalties Account be reverted to the General Fund. In 2012-13, 2013-14, 2014-15 (projected), and 2015-16 (projected), the fund balance of this account was greater than \$10 million and; consequently, state penalties were deposited into the General Fund.

- **Outstanding Report Will Provide Valuable Information.** A 2014 trailer bill, SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014, requires DPH to assess the possibilities of using professional position classifications other than Health Facility Evaluator Nurses (HFENs) to perform licensing and certification survey or complaint workload by December 1, 2014. Given the difficulty in recruiting and retaining nurse surveyors it is important to understand if certain activities performed during surveys and inspections can be carried out by other personnel classifications; thereby, improving L&C’s ability to retain quality staff and complete its workload in a timely manner. The Legislature has not yet received this report, which is critical in the evaluation of the L&C budget.

Questions. The Subcommittee has requested the L&C Program to respond to the following:

1. Please provide a brief summary of the L&C budget estimate and the major changes to the L&C budgeting methodology. Why is the department more confident that this revised methodology will provide a more accurate estimate of workload?
2. Please provide an overview of the budget proposals. How do these proposals address the findings in the State Auditor’s report and the CMS letters? Specifically, how do they address the following concerns:
 - a. DPH’s oversight of complaints processing is inadequate and has contributed to the large number of open complaints and entity reported incidents.

- b.* DPH does not have accurate data about the status of investigations into complaints against individuals.
 - c.* DPH has not established formal policies and procedures for ensuring prompt completion of investigations of complaints related to facilities or to the individuals it certifies.
 - d.* DPH did not consistently meet certain time frames for initiating complaints and ERIs.
 - e.* DPH's inadequate oversight of district offices to ensure adequate staffing and that investigation of complaints are initiated and completed in a timely fashion.
3. Please describe the long-term efforts DPH is undertaking to address the concerns with the L&C program.
 4. Please provide an update on the contract negotiations with Los Angeles County.

7. Licensing and Certification Fees

L&C Health Facility License Fees. Existing statute requires the L&C Program to annually publish a Health Facility License Fee Report (DPH Fee Report) by February of each year. The purpose of this annual DPH Fee Report is to provide data on how the fees are calculated and what adjustments are proposed for the upcoming fiscal year.

Licensing fee rates are structured on a per “facility” or “bed” classification and are collected on an initial license application, an annual license renewal, and change of ownership. The fees are placed into a special fund—the Licensing and Certification Special Fund.

The fee rates are calculated as follows:

- Combining information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital).
- Calculating the state workload rate percentage of each facility type in relation to the total state workload.
- Allocating the baseline budget costs by facility type based on the state workload percentages.
- Determining the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.
- Dividing the proposed special fund cost per facility type by the total number of facilities within the facility type or by the total number of beds to determine a per facility or per bed licensing fee.

The department proposes to:

1. Increase fees by 20 percent on those facilities that would have received an increase as share of their percentage of the state’s total workload.
2. Keep fees at 2014-15 level for those facilities that would have had decreased fees as a share of their percentage of the state’s total workload.

The DPH Fee Report provides considerable detail regarding these calculations, as well as useful data on L&C workload associated with the various types of health care facilities, along with a clear description regarding the details of the methodology. This report can be found at:

<http://www.cdph.ca.gov/pubsforms/fiscallrep/Documents/licCertAnnualReport2015.pdf>

Table: Proposed Health Facility License Fees

License Fees by Facility Type			
Facility Type	Fee Per Bed or Facility	FY 2014-15 Fee Amounts	FY 2015-16 Proposed Fee Amounts
Acute Psychiatric Hospitals	Bed	\$ 266.58	\$ 319.90
Adult Day Health Centers	Facility	\$ 4,164.92	\$ 4,997.90
Alternative Birthing Centers	Facility	\$ 2,380.19	\$ 2,380.19
Chemical Dependency Recovery Hospitals	Bed	\$ 191.27	\$ 229.52
Chronic Dialysis Clinics	Facility	\$ 2,862.63	\$ 2,862.63
Community Clinics	Facility	\$ 718.36	\$ 862.03
Congregate Living Health Facilities	Bed	\$ 312.00	\$ 374.40
Correctional Treatment Centers	Bed	\$ 573.70	\$ 688.44
District Hospitals Less Than 100 Beds	Bed	\$ 266.58	\$ 319.90
General Acute Care Hospitals	Bed	\$ 266.58	\$ 319.90
Home Health Agencies	Facility	\$ 2,761.90	\$ 2,761.90
Hospices (2-Year License Total)	Facility	\$ 2,970.86	\$ 2,970.86
Hospice Facilities	Bed	\$ 312.00	\$ 374.40
Intermediate Care Facilities (ICF)	Bed	\$ 312.00	\$ 374.40
ICF - Developmentally Disabled (DD)	Bed	\$ 580.40	\$ 696.48
ICF - DD Habilitative	Bed	\$ 580.40	\$ 696.48
ICF - DD Nursing	Bed	\$ 580.40	\$ 696.48
Pediatric Day Health/Respite Care	Bed	\$ 150.41	\$ 180.49
Psychology Clinics	Facility	\$ 1,476.66	\$ 1,771.99
Referral Agencies	Facility	\$ 2,795.53	\$ 2,795.53
Rehab Clinics	Facility	\$ 259.35	\$ 311.22
Skilled Nursing Facilities	Bed	\$ 312.00	\$ 374.40
Surgical Clinics	Facility	\$ 2,487.00	\$ 2,984.40
Special Hospitals	Bed	\$ 266.58	\$ 319.90

Data Source: FY 15-16 Licensing Fees Chart

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the L&C program.

Questions. The Subcommittee has requested the L&C Program to respond to the following:

1. Please provide an overview of the changes in health facility fees.
2. Why are changes in the fees necessary this year?

8. Genetic Disease Screening Program Update & AB 1559 (2014)

Budget Issue. DPH proposes total expenditures of \$119.4 million (Genetic Disease Testing Fund) for the Genetic Disease Screening Program (GDSP). This reflects a net increase of \$2.5 million (Genetic Disease Testing Fund) as compared to the current-year. This program is fully fee-supported. See table below for funding summary.

Table: Genetic Disease Screening Program Funding Summary

	2014-15	2015-16	BY to CY
	Revised	Proposed	Change
State Operations	\$28,792,000	\$28,922,000	\$691,000
Local Assistance	\$87,947,828	\$90,488,306	\$1,834,306
Total	\$116,739,828	\$119,410,306	\$2,525,306

Included in the GDSP budget estimate are the following proposals:

- **Expanding California’s Newborn Screening Program** – DPH requests one permanent position and \$1.975 million from the Genetic Disease Testing Fund in 2015-16 of which \$1.825 is one-time funding and \$150,000 is requested to be appropriated annually thereafter to implement with AB 1559 (Pan), Chapter 565, Statute of 2014, which expands the statewide Newborn Screening Program to include screening for adrenoleukodystrophy (ALD) as soon as ALD is added to the federal Recommended Uniform Screening Panel (RUSP).

ALD is an X-chromosome linked genetic disorder that is passed down from mother to son. The worst form affects young boys. Once symptoms present themselves, it progresses quickly and it is usually too late to do anything meaningful to mitigate the effects of the condition. Correct diagnosis based on symptoms is difficult due to the rarity of the disease and the nature of the early symptoms – which are behavioral and are often misdiagnosed as Attention Deficit Disorder, mental retardation, depression and even Multiple Sclerosis in the adult form.

Although there is no cure for ALD, early detection allows for early interventions which significantly enhance the health outcomes of children diagnosed with ALD. In addition, early detection of ALD by newborn screening can significantly minimize the financial burden to the family and the health care system and improve the outcome of treatment.

In the absence of early detection, an annual treatment cost for a child with ALD who has a late diagnosis (after symptoms appear) is estimated to be \$7.0 - \$8.2 million over 25 years. Whereas a child diagnosed through newborn screening is estimated to be \$3.1 - \$3.2 million, over the same time period.

Based on an assessment of laboratory and processing costs, an increase of \$11.00 to the current NBS Program fee of \$111.70 is required. The NBS program is fully fee-supported, as required by state statute, and the \$11.00 fee increase will provide the revenue to ensure the expansion is

fully implemented and sufficient resources are available on an ongoing basis. This funding will support expenditures associated with the ongoing workload of processing blood specimens at the DPH Genetic Disease Laboratory, staff needed to perform the actual blood screen, testing chemicals, equipment and supplies used to assay results. Funding will also be utilized to support follow-up costs for screen positive cases, such as case management, some of the diagnostic work-up, confirmatory processing, provider and family education, informative result mailers as well as incorporation and maintenance on an on-going basis of ALD into the Screening Information System (SIS).

Cost savings is thought to be as much as \$5.1 million for each newborn diagnosed with ALD. The GDSP expects to diagnose approximately 10 cases of ALD per year with potential savings to the health care system relating to those identified cases of approximately \$50 million dollars. Approximately 46 percent of California's population under the age of 18 has health coverage through a government run insurance company such as Medi-Cal. Savings to Medi-Cal could be nearly \$23 million.

Of the \$1.975 million being requested, \$1.825 million will fund one-time costs to upgrade the Screening information system to incorporate ALD and \$150,000 will fund 1.0 Research Scientist II which will support testing activities.

Background—Genetic Disease Testing Program. The Genetic Disease Testing Program consists of two programs—the Prenatal Screening Program and the Newborn Screening Program. Both screening programs provide public education, and laboratory and diagnostic clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided as part of the fee payment. The programs are self-supporting by fees collected from screening participants through the hospital of birth, third party payers, or private parties using a special fund—Genetic Disease Testing Fund.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending May Revision updates.

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

1. Please provide an overview of the Genetic Disease Screening Program and budget.
2. Please provide an overview of the proposal related to AB 1559. Please describe the timing of ALD being added to the federal Recommended Uniform Screening Panel and the resources proposed in this budget request. What if ALD is not added to this screening panel, how would the department use these resources?

9. Food Safety Inspection

Budget Issue. DPH requests six permanent positions and \$804,000 (Food Safety Fund) in the Food and Drug Branch (FDB) to carry out statutorily mandated responsibilities to inspect food processors and distributors. DPH will utilize registration fee revenues collected specifically for this purpose to fund the activities.

Background. California Health and Safety Code (H&S) Section 110045 mandates that FDB enforce the provisions of the Sherman Food, Drug and Cosmetic Law (Sherman Law). H&S 110466(b) mandates FDB register food processors and distributors and conduct routine inspections of these facilities to verify they are operating under sanitary conditions. These activities are critical to ensure the safety of the food supply and reduce the incidence of food contamination and food-borne illness outbreaks.

FDB is required to inspect each new applicant's place of business prior to initiation of operations and before issuing an applicant's registration to ensure operation in conformance with the law. FDB is also required to conduct annual inspections at each food processor and distributor unless a lesser frequency, established by a risk assessment, is determined to be appropriate. FDB has established a three-tier risk-based inspection program that requires inspection of high risk firms annually, moderate risk firms every two years, and lower risk firms every three years. The risk assessment takes a variety of factors into consideration, including but not limited to, the commodity produced, the vulnerability of the population served by the company, compliance history, and process controls that have been implemented to control hazards associated with the foods produced or held. Based on the firm's compliance history, consumer complaints or reports of product contamination, FDB may inspect food processors on a more frequent basis than the indicated risk categorization.

FDB currently has 17 field staff positions, located in district offices throughout the state, which are funded by food processor registration fees. These fees are deposited in the Food Safety Fund, a special fund for use in conducting food inspection and enforcement activities. Fund revenues have steadily increased as a result of the increase in registrants. FDB is able to inspect approximately 3,300 firms annually, inclusive of pre-registration inspections, re-inspections and complaints.

FDB has seen an increase in the number of registration applications for food processors and distributors over the last five years. The inventory of registered firms has steadily grown from 5,300 in 2008 to 6,700 in April of 2014; a 26% increase in firms. However, staffing levels have not increased to keep pace with the new workload generated by this growing inventory. The current workload in the program requires 23 positions; however, FDB only has 17 positions budgeted. FDB requests an additional six full-time permanent Environmental Scientists to ensure that resources are available to complete this mandated workload.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further review of this proposal.

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

1. Please provide an overview of this issue.

10. Food Safety Stipulated Judgment Appropriation

Budget Issue. DPH requests four five-year limited-term positions and \$716,000 (Food Safety Fund) to implement the food safety transportation enforcement activities as a result of the Sysco Corporation stipulated judgment. DPH also requests budget trailer bill language (TBL) to amend Health and Safety Code Section 110050 to authorize the deposit into the Food Safety Fund of awards to the department pursuant to court orders or settlements for food safety-related activities.

Background. DPH is mandated pursuant to Health and Safety Code Section 110045 to enforce the provisions of the Sherman Food, Drug and Cosmetic Law, ensuring that food is not adulterated, misbranded or falsely advertised. The Food and Drug Branch (FDB) conducts inspections and investigations of food processors and distributors to ensure they are operating in compliance with the law and that foods produced are safe, unadulterated and properly labeled. FDB is also responsible for ensuring that perishable foods are stored, transported and distributed under sanitary conditions and proper temperature controls to prevent microbial growth. These activities are critical to reduce the incidence of food contamination and food-borne illness outbreak events.

In July 2013 an investigation of Sysco Corporation was initiated by FDB as a result of a referral from an NBC news affiliate that had been investigating claims that Sysco was transporting and dropping off highly perishable foods at unrefrigerated public storage units for later pick-up and delivery to food facilities in the personal vehicles of Sysco Marketing Associates. The resulting investigation by FDB verified a significant gap in Sysco's food safety program. This investigation found gross violations including storing potentially hazardous foods in unregistered facilities, transporting and storing potentially hazardous perishable food in unrefrigerated conditions, and not protecting products from potential contamination. A review by FDB of distribution records associated with the Sysco Corporation over the last four years identified 23,827 violations related to storing foods in unregistered facilities; 405,859 violations related to holding and distributing misbranded food products; 156,740 violations related to failing to store and distribute potentially hazardous foods at temperatures below 45 degrees Fahrenheit, and a variety of other violations to bring the total violation count to 1,149,025. This investigation has led to other complaints and additional findings of inappropriate transportation and distribution practices. At the same time, these activities were occurring away from Sysco's registered distribution centers, in which the distribution centers were being operated in substantial conformance with the law, and routine inspections conducted by FDB did not uncover these illegal activities until an informant alerted the media.

Settlement of a Civil Complaint filed by the Santa Clara County District Attorney's Office as a result of FDB's investigation of Sysco Corporation includes \$3.3 million specifically earmarked for DPH to conduct food safety transportation enforcement activities within the state and identify other operations that are illegally storing and distributing perishable and non-perishable food in a manner that does not protect them from contamination.

The Sysco Corporation stipulated judgment is providing funding to support four positions for five years to focus on investigating food transportation safety and taking the necessary enforcement actions to ensure conformance with the law and protection of the food supply. The settlement funds provide DPH

with the opportunity to address a significant food safety issue without increasing fees on the food industry.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further review of this proposal.

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

1. Please provide an overview of this issue.
2. Once these limited-term positions and funding expire, how will DPH conduct food safety transportation enforcement activities?

11. USFDA Tobacco Retail Inspection Contract

Budget Issue. DPH requests nine limited-term positions and \$1,078,000 additional Reimbursement authority coinciding with the remainder of DPH’s contract with the federal Food and Drug Administration (FDA) for its Stop Tobacco Access to Kids Enforcement (STAKE) Unit to inspect 20 percent of tobacco retailers annually in California.

Background. At the state level, since 1995 the Food and Drug Branch (FDB) has enforced the provisions of the Stop Tobacco Access to Kids Enforcement (STAKE) Act, which requires retailer compliance checks using teenage operatives, assessing and collecting penalties, serving legal notices on violators, administering penalty appeal hearings and managing a toll-free telephone number to report illegal tobacco sales to minors.

In 2009, the U.S. Family Smoking Prevention and Tobacco Control Act (FSPTCA) was signed into federal law. The FSPTCA provides the FDA authority to regulate tobacco products and ban the sale of tobacco to minors. The FSPTCA requires FDA to contract with states and territories in the U.S. to conduct youth tobacco enforcement (illegal tobacco sales to youth and advertising/labeling inspections). FDA initiated a three year contract with DPH starting on October 1, 2014 to continue FSPTCA-required tobacco enforcement activities. These activities are performed by the STAKE Unit.

According to DPH, by reducing the availability of tobacco to underage youth, young people will be more likely to not use tobacco, or to reduce their use of tobacco. This leads to positive health outcomes, such as increased quality and years of healthy life, as identified in the US Department of Health and Human Services’ strategic plan as one of the overarching goals of the federal Healthy People 2020 initiative.

DPH implemented the FDA requirements over the last three years and now needs to reach the 20% inspection mandate. The contract with the FDA effective October 1, 2014 mandates that DPH must perform inspections of 20 percent of all 37,000 licensed tobacco retailers in the state; this would equate to approximately 7,400 retailers for California. DPH will administratively establish positions to begin inspections in the current year. The positions requested would then give DPH the ability to conduct the 7,400 annual inspections required for the contract from July 1, 2015 until the contract’s end on September 30, 2017. The current contract stipulates that of the 7,400 annual inspections, 75 percent of these inspections must be undercover buys (UB) and 25 percent must be advertising and labeling inspections, equating to 5,550 UB’s and 1,850 advertising and labeling inspections. If DPH does not meet this requirement, FDA can contract with another state agency or local enforcement agency to complete the work.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further review of this proposal.

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

1. Please provide an overview of this issue.

12. Medical Waste Resources (AB 333, 2014)

Budget Issue. DPH requests \$333,000 (Medical Waste Management Fund) in 2015-16 and 2016-17, and three two-year limited-term positions to implement the mandated activities specified in AB 333 (Wieckowski), Chapter 564, Statutes of 2014. This bill provides updates to the Medical Waste Management Act, and ensures public health protection for the proper transportation, temporary storage, and disposal of medical waste.

Background. The Medical Waste Management Program provides oversight of the healthcare and medical waste treatment industries through the use of annual facility compliance inspections that review and evaluate the medical waste management activities of these entities including, but not limited to, the generation, handling, storage, transport, treatment, and disposal of medical waste. These compliance inspections ensure that waste management activities conducted at these facilities are protective of public health and do not inadvertently expose facility personnel or the public to disease causing etiologic agents.

Federal law, through the United States Department of Transportation (USDOT), also governs the transportation of hazardous materials, including medical waste, on public roads and highways. AB 333 is a response to potential conflicts between federal rules and requirements and California law. A major component of AB 333 requires DPH to convene stakeholder meetings to examine the differences between federal and state law, and submit a report to the Legislature by January 1, 2016.

DPH is requesting one two-year, limited-term senior environmental scientist to conduct meetings and develop the report. In addition to the legislative report, AB 333 authorizes DPH to update standards related to the transportation of medical waste through the issuance of guidance documents. AB 333 also authorizes DPH to temporarily waive the transportation requirements of this bill while a federal preemption determination is pending. During this temporary waiver period, or if a federal preemption is found, the federal requirements would be deemed to be the law in California and enforceable by DPH. The requested senior environmental scientist will perform the following duties related to these provisions of the bill:

- Develop guidance documents based on the outcome of the stakeholder meetings and findings of the legislative report.
- Conduct training sessions for local enforcement agencies.
- Develop a process and review temporary waiver requests submitted in accordance with the provisions of AB 333.
- Prepare preemption petition documents as needed and respond to petitions initiated by entities other than DPH.
- Revise guidance documents and training sessions as necessary as a result of temporary waivers and the result of the USDOT petition process.

DPH is also requesting two two-year, limited-term environmental scientist positions. The two environmental scientists will assist the senior environmental scientist in all of the aforementioned duties.

In addition, the environmental scientists will conduct inspections as needed in order to meet the Medical Waste Management Program's statutorily mandated inspection rate.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the need for these positions.

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

1. Please provide an overview of this issue.

13. Inspection of Public Beaches Resources (SB 1395, 2014)

Budget Issue. DPH requests one three-year limited term position and \$384,000 (General Fund) in 2015-16 and \$182,000 (General Fund) in 2016-17 and ongoing to implement the mandated provisions of SB 1395 (Block), Chapter 928, Statutes of 2014. This bill authorizes the department to develop regulations for alternative beach water quality test that would shorten the amount of time required to produce results.

Background. Beach water quality monitoring and strong pollution prevention measures are critical for protecting beachgoers from water-borne diseases. Under the state’s Beach and Bay Water Quality Monitoring Program, county public health departments perform beach water sampling and close beaches or post warning signs if testing indicates water quality is below state standards. Current permissible tests are culture-based, involving a multiple sample standard for three indicators – total coliform, fecal coliform, and enterococcus. Lab results can take up to two days to determine if the beaches are safe.

In 2012, the United States Environmental Protection Agency (EPA) released a new rapid quantitative polymerase chain reaction (qPCR)-based method for detecting enterococcus in recreational water, Method 1611. In 2014, EPA released a second improved qPCR-based method for enterococcus detection in recreational water, Method 1609. These new methods can return results in approximately four hours, rather than the current culture-based methods which take up to two days for test results. When the EPA released these methods, they left it to states to develop guidelines and validation criteria for implementation of these methods.

SB 1395 authorized DPH to allow local environmental health officers to use a DPH approved qPCR Methods 1611 and 1609, as the single test for contamination under specified conditions to determine the level of enterococci bacteria and overall microbiological contamination conditions in all or part of that health officer’s jurisdiction. While qPCR-based testing methods would result in a more rapid result, the testing is site-specific and environmental inhibitors could impact the result of the test. These qPCR-based test methods must be validated at each specific location prior to implementation. The state will need to validate test methods and draft guidelines for performance and acceptance of the site-specific testing.

This proposal would provide the resources for the development of alternative beach water quality tests. DPH’s Drinking Water and Radiation Laboratory Branch (DWRLB) will hire one three-year limited term Research Scientist II (RS II) Microbiological Sciences, and purchase laboratory instruments/equipment, and laboratory supplies. Once the guidance documents have been developed, the department will need to evaluate the future changes required to develop new regulations and training for the testing methodologies.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the need for these positions.

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

1. Please provide an overview of this issue.

14. California Gambling Education and Treatment Services (CalGETS)

Budget Issue. DPH's Office of Problem Gambling (OPG) requests two permanent positions and \$5 million (Indian Gaming Special Distribution Fund) in 2015-16 to make permanent the regional pilot California Gambling Education and Treatment Services (CalGETS) program. Of this request, \$4 million will be allocated to local governments, public universities, and/or community organizations for treatment programs serving problem and pathological gamblers and their families. This proposal includes trailer bill language to delete outdated verbiage related to the program.

Background. As a result of legalized gambling expansion in California, the OPG was created in 2003. OPG's mission is to provide quality, research-driven leadership in prevention, intervention, and treatment for problem and pathological gamblers, their families and communities. Initially, OPG's first priority was its prevention program. In 2008-09, the OPG within the Department of Alcohol and Drug Programs (DADP) initiated a pilot treatment program in four regions (Sacramento, San Francisco, Los Angeles and San Diego) with limited-term funding and two positions. In 2011-12, funding was approved for an additional two years, increasing the term of the pilot to five years. Again in 2013-14, funding was approved for another two years, increasing the term of the pilot to seven years. The 2013 Budget Act transitioned OPG from DADP to DPH effective July 1, 2013. CalGETS expenditure and position authority will end on June 30, 2015.

CalGETS is the only specialized treatment program available to problem gamblers and affected individuals in California. According to DPH, in 2012-13, CalGETS clients reported improvement in their overall health condition, reduction in Diagnostic and Statistical Manual of Mental Disorders IV criteria for pathological gambling and also experienced a decrease in time and money spent gambling after treatment. Data on CalGETS clients indicate a relatively significant percentage are of low socioeconomic status and possess other risky health behaviors.

Over the past five years, an average of 13 individuals called the 1-800-GAMBLER helpline each day seeking assistance with gambling addiction. Currently there are, on average, 150 clients per month entering into CalGETS. To date, CalGETS has helped more than 6,300 clients.

According to DPH, by making the CalGETS program permanent, California will benefit via reduction of social costs. Problem gambling treatment saves money; every \$1 spent on treatment saved more than \$2 in social costs (National Council on Problem Gambling, March 2010). If CalGETS is not funded, other social programs, such as those that serve people with mental health and substance use disorders, could see an increase in utilization.

The current CalGETS awardees are:

Contractor	Amount	Purpose of Contract
UCLA Gambling Studies Program	\$400,000	Training & Research
UCLA Gambling Studies Program	\$3,740,000	Treatment Services
Auersoft	\$257,582	Data Management System
Evalcorp	\$93,827	CalGETS Evaluation
Total	\$4,491,409	

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further review of this proposal.

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

1. Please provide an overview of this issue.

15. Biomonitoring Resources

Budget Issue. DPH requests six, two-year limited-term positions and \$900,000 annually for fiscal years 2015-16 and 2016-17 to support the 16 to support the California Environmental Contaminant Biomonitoring Program (CECBP) including investigating the feasibility of detecting and measuring emerging chemical threats to California. Funding for this request is split between the Toxic Substances Control Account (\$775,000) and the Birth Defects Monitoring Fund (\$125,000).

DPH is the designated lead for Biomonitoring California, coordinating with two CalEPA departments: the Office of Environmental Health Hazard Assessment (OEHHA) and the Department of Toxic Substances Control (DTSC).

Background. SB 1379 (Perata and Ortiz), Chapter 599, Statutes of 2006, established the tri-departmental CECBP. CECBP is a collaborative effort among DPH, OEHHA, and DTSC. CECBP's principal mandates are to measure and report levels of specific environmental chemicals in blood and urine samples from a representative sample of Californians, conduct community-based biomonitoring studies, and help assess the effectiveness of public health and environmental programs in reducing chemical exposures. CECBP provides unique information on the extent to which Californians are exposed to a variety of environmental chemicals and how such exposures may be influenced by factors such as age, gender, ethnicity, diet, occupation, residential location, and use of specific consumer products.

Overall, Biomonitoring California is supported across the three departments by five funds: the Toxic Substances Control Account (TSCA), Air Pollution Control Account, Pesticide Registration Fund, Childhood Lead Poisoning Prevention Fund, and Birth Defects Monitoring Fund (BDMF). Baseline program funding since 2008-09 has been approximately \$2.1 million (\$1.1 million is allocated to DPH) and supports 13 core staff (eight in DPH, three in OEHHA, and two in DTSC). In addition to the baseline state funding, the 2014-15 State budget includes \$700,000 annually for two years, from the TSCA and BDMF allocated equally between DPH and DTSC.

Biomonitoring California's funds have also been augmented by two competitive federal CDC grants. The initial five-year Cooperative Agreement (FFY 2009-14), which ended on August 31, 2014, provided \$2.65 million annually to California and supported up to 17 grant staff. CDC support played a critical role in allowing the program to establish much of its sophisticated laboratory instruments, develop needed methods, initiate multiple community studies, obtain blood and urine samples, and create report-return protocols. A new cooperative agreement with the CDC (FFY 2014-19) was awarded and began on September 1, 2014. Because of CDC's policy to lower the maximum award amount granted to individual states, the amount to California was reduced to \$1 million annually for five years and this amount only supports five grant staff. While this funding enables Biomonitoring California to retain some of its core functions, the overall impact on Biomonitoring California is a 62 percent reduction in supplemental funding. The current CDC cooperative agreement does not support research or development of new analytical methods. These important functions are therefore dependent on state funding.

This proposal requests six new two year limited-term, full-time state positions and \$900,000 annually from the TSCA and BDMF to offset the reduction in supplemental federal funds in 2015-16 and partially offset the reduced federal funds in 2016-17.

This proposal includes a request for \$50,000 in contract funding to recruit targeted Californians to participate in biomonitoring studies and to collect blood and urine specimens. Currently, there are no dedicated funds available from state sources for this purpose. Biomonitoring California is looking into obtaining blood and urine specimens from racially diverse populations around the state to investigate potentially vulnerable populations, like those identified using Cal/EPA's CalEnviroScreen. In addition, to maintain Biomonitoring California's highly specialized analytical instruments, this request includes \$37,500 annually for necessary maintenance service contracts and \$37,500 annually for other laboratory-related costs such as specialized non-reusable supplies.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further review of this proposal.

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

1. Please provide an overview of this issue.
2. Please describe the changes in federal funding for this program over the last couple years.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

**OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, March 5 (Room 4203)**

All items were held open except for Issue 5 under the Department of Public Health:

4265 Department of Public Health (DPH)

5. Infant Botulism Treatment Program: Production Lot 6

- Motion – Approve proposal.
- Vote: 3-0

SENATE CALIFORNIA LEGISLATURE

STATE CAPITOL
SACRAMENTO, CALIFORNIA
95814

**Joint Oversight Hearing
Senate Human Services Committee and
Senate Committee on Budget and Fiscal Review, Subcommittee #3**

**March 10, 2015
1:30 p.m., Room 3191**

Welfare to Work: Oversight of California's CalWORKs Program

Agenda

I. Opening Remarks

- Sen. Mike McGuire, Chair, Senate Human Services Committee
- Sen. Holly J. Mitchell, Chair, Budget and Fiscal Review Subcommittee #3

II. Overview of California's Welfare to Work Program

- Michelle, Welfare to Work client
- Chris Hoene, Executive Director, California Budget & Policy Center
- Will Lightbourne, Director, Department of Social Services
- Ryan Woolsey, Fiscal and Policy Analyst, Legislative Analyst Office

III. Building a Successful Welfare To Work Program

- Liz Schott, Senior Fellow, Center on Budget and Policy Priorities
- Frank Mecca, Executive Director, California Welfare Directors Association
- Phil Ansell, Chief Deputy Director, Los Angeles County Department of Public Social Services
- Elaine Lytle, Division Manager, Yolo County

IV. Perspectives

- Alfonso Quiroz, Ventura County Employment Specialist
- Tia Orr, Senior Government Relations Advocate, Service Employees International Union
- Stephen Goldberg, Senior Attorney, Legal Services of Northern California
- Vivian Louise Thorp, Legal Advocate, Homeless Action Center, Berkeley
- Jessica Bartholow, Legislative Advocate, Western Center on Law and Poverty

V. Public Comment

VI. Closing Remarks

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Joint Oversight Hearing Senate Human Services Committee and Senate Committee on Budget and Fiscal Review, Subcommittee #3

March 10, 2015
1:30 p.m., Room 3191

Welfare to Work: Oversight of California's CalWORKs Program

Background Paper

Summary

California has the highest poverty rate in the nation – nearly one-quarter of the Golden State's residents are poor, living on no more than \$20,090 per year for a family of three. More than one in four children younger than age six exist in poverty in California. During and after the Great Recession, California saw growing rates of childhood deep poverty – those living below 50 percent of the federal poverty line. One of California's most essential anti-poverty strategies is the CalWORKs program, which provides cash assistance to approximately 540,000 families – including more than 1 million children, according to 2014 federal data.

A grant to a family of three in a high-cost California county will go from \$670 per month currently, to \$704 per month in April 2015. The current grant level is 40 percent of the federal poverty threshold (FPL), compared with 81 percent of FPL in 1989 and 55 percent in 1997.

In the past five years, California's CalWORKs benefit has undergone significant grant cuts, the elimination of a Cost of Living Adjustment, and a radical restructuring of the Welfare to Work activities, requirements and time limits. In 2011, the lifetime limit for adults was reduced from 60 to 48 months. Then in 2012, SB 1041 (*Budget and Fiscal Review Committee, Chapter 47, Statutes of 2012*) created a 24-month Welfare to Work time clock, which permits greater program flexibility during the first 24 months, but then imposes far more rigid requirement to remain eligible once the 24-month clock expires. A host of services was legislatively mandated to accompany the shortened clock: Intensive case management and family stabilization services



for those identified as having significant barriers to work; additional subsidized employment slots to give clients the work experience they need; community college, adult education and vocational classes; a more flexible “flow” within the program so that individuals can skip job club and go straight to other paths that may be better suited to their background and skills; and a statewide assessment tool administered at the beginning of the program to help identify barriers.

Based on January estimates by the Department of Social Services (CDSS), more than 7,900 adults will be timing out of the CalWORKs program by the end of June 2015 – roughly three months before the state is expected to bring its assessment tool online. Recent revisions, based on more current data, indicate no clients will time out in the current fiscal year. CDSS predicts that instead, some clients will begin to see grant reduction in July 2015, and that by the end of fiscal year 2015-2016, roughly 2,500 people will have exhausted their 24-month clock.

Meanwhile, implementation of the menu of robust, flexible activities has been chaotic. Notices to require counties to inform clients they are timing out of the Welfare to Work program have overlapped with notices directing counties to implement critical elements of the program. In September 2014, for example, CDSS sent a letter instructing counties how to inform clients that they were nearing the end of their 24-month clock. Three weeks earlier, on September 4, the department had sent instructions and guidance for implementing the Family Stabilization program. CDSS sent updated instructions to counties on January 27, 2015 on how to implement the new WTW flow requirements.

This hearing will seek to resolve questions about the implementation of various elements of the program. It also will evaluate whether the flexibility in service choices and more robust array of services that were promised to clients in conjunction with the loss of time on the program have materialized statewide.

Background

Poverty in California

Even before President Lyndon Johnson declared the war on poverty in July 1964, the federal government had been trying to define an adequate amount of income for survival. Ultimately, an official federal poverty measure was developed based on the estimated price of a low-cost family food plan, as determined by the U.S. Department of Agriculture in 1962, multiplied by three to reflect research showing that food purchases are about one-third of family monthly income. The poverty rate is updated annually to reflect price shifts in food, but the basic formula remains intact. The 2015 poverty threshold for a family of three in the United States is \$20,090 per year.

Soon after the official poverty measure was adopted, it began drawing controversy for what was left out – geographic cost of living differences, an accounting for differentials in family costs based on family composition, child care, transportation, health costs, and others. More than three decades later, in response to those longstanding criticisms, researchers at the National Academy

of Sciences recommended a new poverty threshold that included those costs, as well as the benefit of public aid.¹ In 2013 the Census Bureau published its first “research Supplemental Poverty Measure,” intended to provide a more accurate picture of poverty in the United States. For a number of reasons, the federal poverty measure was kept intact as the official threshold of eligibility for public and other programs.

California’s poverty rate is dramatically different under the supplemental measure, jumping from 16.3 to 23.5 percent - the highest poverty rate in the nation. A more recently developed California Poverty Measure, published by researchers at Stanford University’s Center on Poverty and Inequality and the Public Policy Institute of California (PPIC) attempts to refine California’s data to include geographic and demographic differences throughout the state.²

The California Poverty Measure takes into account costs of living besides food, including transportation, child care, medical out of pocket expenses. It also considers the benefit of social safety net programs such as CalWORKs aid, CalFresh food benefits and others. PPIC researchers calculated that while 22.0 percent of Californians were in poverty in 2011 with safety net resources, without such aid, more than 30 percent of the state’s population would be living in poverty. “For children, the effect is much larger: in the absence of need-based safety net resources, a startling 39.0 percent of California’s children would have been in poverty.”³

2015 Federal Poverty Thresholds	
Persons in family/household	Poverty guideline
1	\$11,770
2	\$15,930
3	\$20,090
4	\$24,250
5	\$28,410
6	\$32,570
7	\$36,730
8	\$40,890
Each additional	\$4,160 per person
<small>Source: US Health and Human Services Agency</small>	

Child poverty

¹ Citro, Constance, et al. “Measuring Poverty: A New Approach,” National Academy Press, 1995

² Wimer, Christopher, et al. “A Portrait of Poverty within California Counties and Demographic Groups,” The Stanford Center on Poverty and Inequality.

³ Bohn, Sara, et al. “The California Poverty Measure: A New Look at the Social Safety Net,” Public Policy Institute of California, October 2013.

Children are disproportionately represented among the poor. The US Census bureau reported⁴ that in 2013, children represented less than a quarter of U.S. residents and more than one-third of all poor people. The nation's overall child poverty rate was 19.9 percent, significantly higher than adults or older adults. Nearly 15 million children live below the poverty level nationally.

In California, no matter which poverty measure you use, the level of need is dramatic. A 2014 Stanford poverty center report found that 26.3 percent of young children – aged 6 or younger - were below poverty under the California Poverty Measure, and 24.9 percent were classified below poverty using the official measure. While California's child poverty rate is well above the national average, there are pockets of poverty within this state where children are especially needy. In Merced County, 2013 research showed a childhood poverty rate of 40.6 percent, while more than one in three children in Fresno, Kern, Tulare, Lake, and Mendocino counties live below the poverty line.⁵

Deep poverty and extreme poverty

Deep poverty is defined as living below half of the federal poverty line: \$10,045 annually for a family of three, or \$12,125 annually for a family of four. Over the past two decades, the proportion of children living in poverty has declined, but the harshest extremes of child poverty have increased, according to a 2014 analysis published by the Center on Budget and Policy Priorities in Washington DC. The center, using federal Census data, estimated the percentage of children across the country living in deep poverty increased from 2.2 percent to 3 percent between 1995 and 2005, and that the number of children living at or below half of the poverty level rose from 1.5 million to 2.2 million.

In California, 7.3 percent of all residents lived below 50 percent of the federal poverty threshold in 2013 or 2.8 million people, according to US Census Bureau data.

California's children, and especially young children, are at the greatest risk of experiencing deep poverty, according to research provided by Stanford University's poverty center, which examined the percentage of young children, older children, working-age adults and elder adults between 1980 and 2013. At 11.2 percent, young children's deep poverty has grown since 2007. The Stanford researchers found that rates of deep poverty grew most steeply among young children during and after the Great Recession.⁶

CalWORKs and TANF

⁴ DeNavas-Walt, Carmen and Bernadette D. Proctor, U.S. Census Bureau, Current Population Reports, P60-249, *Income and Poverty in the United States: 2013*, U.S. Government Printing Office, Washington, DC, 2014.

⁵ Bohn, Sarah and Matt Levin, "Child Poverty in California," Public Policy Institute of California, August 2013.

⁶ Mattingly, Marybeth J., "Trends in California's Deep Poverty Rate 1980-2013"

In 1935, Congress authorized Aid to Families with Dependent Children, the nation's first welfare program, amid the Great Depression to stabilize the families of jobless Americans, which were estimated to be one-quarter of the nation's workforce. Six decades later, the AFDC cash entitlement program was replaced by the Temporary Aid to Needy Families (TANF), which set time limits on receipt of federal benefits, and mandated work participation rates. The federal Personal Responsibility and Work Opportunity Reconciliation Act or PROWORA (42 U.S.C. 601), which established TANF funding, was designed to give states flexibility in setting eligibility and guidelines and was intended to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives. States receive TANF funds through fixed block grants as long as states meet maintenance of effort requirements and adhere to federal work participation requirements. The federal statute permits a recipient to receive aid for up to 60 months.

In California, the CalWORKs program provided TANF cash assistance to approximately 540,000 families in 2014 – including more than 1 million children, according to federal data. A family's grant level is determined by the number of family members and the cost of living in the county where they live.

Welfare to Work Program

Adults eligible for CalWORKs are subject to a lifetime limit of 48 months of assistance under California law. Unless exempt for reasons such as disability or caregiving for an ill family member, adults must participate in work or other allowable activities, including job search, and certain 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 – in a limited number of cases – housing support.

Effective January 1, 2013, clients are under a Welfare to Work 24-month clock, which provides an initial 24 months of flexibility around work requirements, but imposes stricter work requirements to receive assistance after the initial 24 months of flexibility is exhausted. These months do not have to be consecutive, and the initial 24 month flexible clock does not “tick” as long as a participant is engaged in federally allowable work activities.

Work Participation Rate

TANF 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 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, including the practice of denying any credit for a significant number of families who meet partial hourly requirements. Many states, including California, did not meet federal WPR requirements in recent years, and California is appealing its penalties and

has put additional measures into place to bolster the rate in future years. CDSS estimates that the state will meet the federal requirement in FFY 2015 with a 52.64 percent participation rate.

Link between deep poverty and welfare reforms

The impact of federal welfare reform has been lasting. According to numerous researchers, since reforms were enacted in 1996, the poorest families have had reduced access to benefits while working poor families with slightly higher incomes have seen increased access to benefits. A growing body of work links the growth of deep poverty in the United States to welfare reform efforts in 1996 that required adults to work, or lose TANF funding.

One 2014 article written jointly by a professor at University of Michigan and Johns Hopkins University and published by Stanford University's Center on Poverty and Inequality's *Pathways* magazine linked the growth of deep poverty to the PROWRA.

At the same time, in the years since 1996, a new group of American poor has emerged: families with children who are living on virtually no income—\$2 or less per person per day in a given month. These are America's "extreme poor." The U.S. official poverty line for a family of three would equate to roughly \$17 per person per day. What scholars call "deep poverty"—incomes at less than half the poverty line—is about \$8.50 per person per day, over four times higher than our cutoff. This new group of American poor, the extreme poor, are likely experiencing a level of destitution not captured in prior poverty measures, one that few of us knew even existed in such a rich country.⁷

Barriers to employment

Many TANF recipients face multiple barriers to work, including a low educational attainment, lack of work experience, limited English proficiency, mental and physical health challenges, caring for a child with special needs, a history of domestic abuse, homelessness and other challenges. According to research published by the Urban Institute, surveys in five states and the District of Columbia found that four in 10 recipients didn't graduate high school, 20 percent had little work experience, 30 percent cared for a special needs child and at least 20 percent battled physical illness or mental health challenges.⁸

Refocusing the Welfare to Work program

⁷ Schaefer, Luke and Kathryn Edin, "The Rise of Deep Poverty in the United States," *Pathways* magazine, Summer 2014.

⁸ Bloom, Dan, et al, "TANF Recipients with Barriers to Employment," Urban Institute and U.S. Administration for Children and Families Office of Planning, Research and Evaluation, August 2011.

As states struggle to meet and maintain the required work participation program and as researchers document the failure of the WTW program to reach families with barriers, resulting in a growing class of people in extreme poverty, researchers have begun to consider the elements of success in the program.

The American Psychological Association formed a task force to study the challenges to long term success of welfare to work programs out of concern that many women were improperly prepared to succeed. Among the failures it documented was the premise that WTW programs require women to accept the first available job, “regardless of wages, benefits, or flexibility and “family friendliness.”⁹

According to a December 2014 report issued by the U.S. General Accounting Office, the latest in a lengthy series of studies on improving the success of the TANF program, the authors suggested federal incentives are needed to encourage states to promote career pathways from the program. The 62-page report underscores research that shows successful welfare to work outcomes include an assessment for mental health and substance abuse problems followed by appropriate therapy in conjunction with work preparation activities, subsidized employment programs to create work experience for participants, and training for specific types of jobs.

The report also noted that two states used a career pathways approach of combining occupation-specific training with basic skills education and support services even though some states “have a misperception” that the approach is not allowable under TANF rules. The GAO encouraged the federal Health and Human Services agency to clarify its guidelines for education and other support services as a promising approach to welfare to work success.¹⁰

Recent changes to California’s program structure

SB 1041 (*Budget and Fiscal Review Committee, Chapter 47, Statutes of 2012*) made significant changes to CalWORKs’ welfare to work rules. The program restructure, initially proposed by the Governor, was designed to cut program costs as the state struggled with massive recessionary shortfalls. It used a multi-pronged approach, including creating a 24-month Welfare To Work time clock within the state’s 48 month limit to accommodate flexible activities¹¹ needed preparation for work, but limits aid after those 24 months to only those adults who are meeting stricter federal work participation requirements. Essentially, parents who cannot find work after

⁹ Task Force on Women, Poverty, and Public Assistance, “Making Welfare to Work Really Work,” American Psychological Association

¹⁰ US General Accounting Office, Temporary Assistance to Needy Families: Action is Needed to Better Promote Employment-Focused Approaches, November 2014, <http://www.gao.gov/assets/670/667051.pdf>

¹¹ In the first 24 months, the flexible activities could include: employment, vocational education; job search; job readiness; job skills training; adult basic education; secondary school; or barrier removal activities.

the first 24 months are removed from the program.

The bill also ended what had been a broadly applied temporary exemption from welfare-to-work requirements for parents of young children and required the state to re-engage them in job finding and other activities. This was replaced by a one-time exemption for parents with children under 24 months. The bill also conformed state work hour requirements to the number of hours of work participation (20, 30, or 35, depending on family composition) required by federal work requirements.

Statutory language in the bill permits counties to provide extensions of the flexible 24 month clock for up to six months and for as many as 20 percent of participants. Consistent with Legislative intent, CDSS testified before a budget subcommittee in February 2015 that the extender is designed to be a target and not a firm cap, however the department issued a letter to counties on January 9, 2015 estimating the number of extended slots each county would have – 327 statewide by the end of fiscal year 2015.

When the Administration presented its proposal to change the time clock in 2012, it was with the stated intent that the program would include earlier and more meaningful engagement with clients at the front end. However, some members of the Legislature expressed concern that these changes were not adequately reflected within those proposals. The Legislature also expressed concern that the more limited time clock may have a disproportionately negative effect on clients whose lives were especially in crisis and who may need more time to become stable.

As a result, the final language included in SB 1041 included direction for the administration to convene a workgroup to identify the statutory and administrative changes that may be necessary to address these concerns. The timeline for the administration to report back on the results of this work group was designed to be short, to make sure that these meaningful changes would be available to clients as the 24-month clock took effect.

AB 74 (*Budget Committee, Chapter 21, Statutes of 2013*) responded to a list of items developed by the CDSS stakeholder workgroup and added a number of specific elements to the 24 month clock. These supports were designed to help adults with barriers to work be better prepared to enter the workforce and sustain employment. They included:

Subsidized employment

Under the subsidized employment program, wages are partially or fully subsidized for Welfare to Work clients for a limited amount of time through partnerships that counties establish with various employers. The bill expanded subsidized employment by 3,000 slots statewide, although development of those slots is still ongoing, according to CDSS. The state allocated more than \$134 million to 57 counties in the current year budget, and as of February 20, 2015, there were 42 counties participating in the program. A report on subsidized employment efforts is due to the

Legislature on April 1.

Online CalWORKs Appraisal Tool (OCAT)

The bill also required the creation of a standard statewide appraisal tool, which would inform counties what barriers clients faced and result in referrals to appropriate services or to the family stabilization program. The OCAT provides an in-depth assessment of a client's strengths and barriers, including: employment history, interests, and skills; educational history; housing status and stability; language barriers; child health and well-being; and, physical and behavioral health, including, but not limited to, mental health and substance abuse issues. The Governor's proposal initially estimated that the OCAT would be fully deployed to all counties by January 2014, however delays in creating and piloting the tool mean that it still is not available to counties for widespread use. CDSS estimates the OCAT will be available statewide by the end of 2015. Without access to the OCAT, stabilizing services for some clients may not be fully available.

Advocates for the poor and others within the system have noted that this time frame for the OCAT's deployment coincides with the first cohort of clients to time out of the 24 month clock.

Family stabilization

Family stabilization 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 in crisis. Services include intensive case management with a caseworker who has a lowered caseload, coupled with identifying and finding supports to address barriers. Clients must have a "Stabilization Plan" with no minimum hourly participation requirements in the welfare to work program. At any point in a client's 24-month clock, a social worker can refer a client to family stabilization services. A crisis that might warrant a referral to family stabilization program could include homelessness or imminent risk of homelessness, unsafe living conditions due to domestic violence or untreated or undertreated behavioral needs.

Many of the services categorized as part of the family stabilization program are currently available to clients, such as mental health therapy, substance abuse treatment and domestic violence counseling. What distinguishes family stabilization from existing practices and services is the intensive case management and a more robust assessment to identify less visible barriers. For the first time, caseworkers also have the ability to refer other family members for services if their troubles are creating a barrier to employment for the adult CalWORKs participant, for example, a child's untreated behavioral needs. As of December 2014, there were 1,300 family stabilization cases opened statewide, and 40 percent of those receiving services were children.

At least one county, Los Angeles, has interpreted the family stabilization statute and instruction letters to say that the program is triggered by the information on the OCAT tool. Los Angeles has deferred initiating the program until the tool comes online later this year. Early statewide data

indicates that some counties have clients in the program while others are not serving clients.

Welfare To Work flow

Additionally, the bill required that CDSS convene a stakeholder workgroup to examine strategies to make the first 24 months as useful as possible, review the flow of the existing welfare-to-work processes in the early months and identify legislative solutions to those issues. One common difference among counties is the process for deciding when job search is beneficial or when participants should move directly to assessment. The new flow, required as of January 1, 2014, mandates that counties consider multiple paths forward when evaluating a client for the program.

Housing Support Program

SB 855 (*Budget and Fiscal Review, Chapter 29, Statutes of 2014*) established in the budget trailer bill a rapid housing support program for CalWORKs clients who were homeless. Included in the program are rental assistance and security costs as well as caseworker engagement with the clients' landlord, home finding, credit repair, financial literacy. The bill allocated \$20 million for the program to 20 counties. County plans project that more than 3,000 homeless CalWORKs families will be placed in permanent housing through the program.

Outcomes and expectations

Timed out

The Governor's January budget estimates 7,934 cases will experience a grant reduction for not meeting CalWORKs federal standards after exhausting the time on their Welfare to Work 24-Month Clock by the end of FY 2014-15. That estimate was based on preliminary data that has since been updated to reflect a more accurate picture, according to CDSS. The Administration's current projections show no clients will time out in the current fiscal year, but that a small cohort clients will begin to see grant reduction in July 2015, which will continue to grow monthly for a total of 2,500 people who have exhausted their 24 month clock by the end of FY 2015-2016.

Counties may grant extensions for up to twenty percent of those cases and the state assumes that some recipients will begin to meet the CalWORKs federal standards to avoid a grant reduction. The state projects that 1,200 of the timed out cases will receive extensions.

Continued struggles

Despite reforms intended to create stronger pathways out of poverty for families in the CalWORKs program, the numbers of struggling families continues. Data on homelessness reported by Los Angeles County shows the rate of homeless families in the CalWORKs program continues to grow significantly through the recession and into 2014, as demonstrated in the chart below.

	CalWORKs Families	CalWORKs Homeless Families
Jul-06	152,722	5,487
November-14	169,910	15,814
% Increase	11%	188%

Source: Los Angeles County Department of Children and Family Services

Participation in flexible and stabilizing activities

Preliminary data indicates there has been little increase in the activities that were identified as flexible, as well as those that would indicate family stabilization efforts, such as domestic violence and mental health treatment. This data is limited in multiple ways, but it does raise questions about the degree of implementation of various aspects of the program during the time that clients' clocks have been ticking.

For a summary of that outcomes data, please refer to the attached report from the Legislative Analyst's Office.

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Holly J. Mitchell

**Senator Jeff Stone, Pharm. D.
Senator William W. Monning**



**March 12, 2015
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol**

PART A

Consultant: Samantha Lui

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PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. 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. Thank you.

5160 Department of Rehabilitation

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 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 2015-16 budget of \$435.5 million (\$58 million GF) and 1,860 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 (to be discussed below). Overall, federal funding constitutes around 84 percent of the department’s total funding. Below is a chart that provides an overview of the department’s funding since FY 2013-14.

Fund Source	2013-14 Actuals	2014-15*	2015-16
General Fund	\$ 56,974	\$58,390	\$58,429
Traumatic Brain Injury Fund	\$925	\$1,004	\$1,004
Vending Stand Fund	\$908	\$2,361	\$2,361
Federal Trust Fund	\$338,969	\$362,990	\$365,980
Reimbursements	\$5,994	\$7,680	\$7,680
Total Expenditures	\$403,770	\$432,425	\$435,454
Positions	1,783	1,829	1,860

* FY 2014-15 are projected figures

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. The DOR waiting list has been opened and cleared on four occasions since 2011, with the last time on May 2014. Currently, there are 36 individuals with disabilities on the waiting list.

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

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

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

- Assistive Technology (AT). The Assistive Technology Act of 1998 (amended in 2004) funds each state and U.S. territory to provide AT services. California's program, known as the California Assistive Technology System (CATS), is funded by a federal grant through the Rehabilitation Services Administration (RSA). For DOR to provide the required services, DOR contracts with the California Foundation for Independent Living Centers (CFILC) to provide statewide AT services.
- Independent Living Services. DOR funds, administers, and supports 29 independent living centers in communities located throughout California. Each independent living center provides services necessary to assist consumers to live independently and be productive in their communities. Core services consist of information and referral, peer counseling, benefits advocacy, independent living skills development, housing assistance, personal assistance services, and personal and systems change advocacy.
- Traumatic Brain Injury (TBI). In coordination with consumers and their families, seven service providers throughout California provide a coordinated post-acute care service model for persons with TBI, including supported living, community reintegration, and vocational supportive services.

Workforce Innovation and Opportunity Act. On July 22, 2014, President Obama signed the Workforce Innovation and Opportunity Act (WIOA), which seeks to assist job seekers access employment, education, training, and support services to succeed in the labor market, and to match employers with skilled workers. WIOA seeks to improve services to individuals with disabilities, including extensive pre-employment transition services for youth, better employer engagement, and increasing access to high-quality workforce services. The DOR is moving forward to identify strategies to meet the new requirements in the Workforce Innovation and Opportunity Act (WIOA), notwithstanding the federal government's delay in publishing draft regulations, which were due in January 2015.

The DOR has prioritized its efforts by creating eight internal workgroups comprised of policy, program staff, and field staff, under the guidance of the directorate and directed by an executive team member, to determine how to provide services to our consumers, under the new federal requirements, without increasing ongoing resource expenditures, as WIOA does not authorize new funding. DOR has prioritized WIOA implementation, with the goal to have decisions made on most of the changes in effect by October 2015. State regulations will be amended consistent with federal regulations. The department's current activities include:

- Conducting four public forums on specific subject areas impacting the VR program
- Incorporating input from our consumers, community partners, State Rehabilitation Council and advisory bodies, and other stakeholders including government representatives.
- Collaborating with the Employment Development Department, Department of Developmental Services, Department of Education, and the workforce investment boards to identify consistent

practices to better serve individuals with disabilities and increase employment outcomes, with a greater focus on early intervention with youth.

- Evaluating and commenting on federal regulations – now expected in the next month – and encouraging the public to do the same, seeking to maintain the flexibility that is currently reflected in the federal law.

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

Questions

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

2. Oversight: Traumatic Brain Injury (TBI) Program and Funding

Budget Issue. Last year, the budget provided an additional \$500,000 to the Traumatic Brain Injury Fund from the Driver Training Penalty Assessment Fund to augment funding for the services provided by the seven TBI sites. The department notes that the one-time funding allocation has not yet been received from the Driver Training Penalty Assessment Fund and is not likely to be received until June or July 2015 due to specified budget bill language, which lists the TBI Fund as the last of the four possible funds that can receive remaining balances from the Driver Training Penalty Assessment Fund. This oversight item will examine the TBI Program’s funding stability and sustainability.

Background. Generally, traumatic brain injuries are caused by an external force’s impact on the brain, frequently from a fall or motor vehicle accident. Symptoms resulting from TBI can include short and long-term effects that hinder the person’s ability to function.

The Department of Rehabilitation administers the Traumatic Brain Injury (TBI) program, where seven providers deliver statewide services, such as coordinated post-acute care, supported living, community reintegration, and vocational supports, to help impacted individuals lead productive and independent lives. TBI Fund revenues stem from penalties paid for various violations of California’s Vehicle Code, including the seatbelt law. Recent penalty funding and corresponding TBI funds are summarized in the chart below.

**TOTAL STATE PENALTY FUND AND
TBI FUND REVENUE**

State Fiscal Year	State Penalty Fund	TBI Fund
FY 06-07	\$ 167,589,106	\$ 1,105,546
FY 07-08	\$ 167,483,359	\$ 1,104,936
FY 08-09	\$ 162,260,219	\$ 1,070,492
FY 09-10	\$ 157,883,929	\$ 1,041,716
FY 10-11	\$ 165,532,414	\$ 1,091,926
FY 11-12	\$ 137,101,778	\$ 809,181
FY 12-13	\$ 128,975,874	\$ 849,834
FY 13-14	\$ 122,193,411*	\$ 806,739*
FY 14-15	\$ 120,156,040**	\$ 776,000**
FY 15-16 (projected)	\$ 113,273,491**	\$ 752,000**

* Year-to-date revenue as of 8/30/2014

** Estimated Amount

Pursuant to AB 398 (Monning), Chapter 439, Statutes of 2009, the Department of Rehabilitation administers the TBI program since its transfer from the Department of Mental Health. AB 398 also directed DOR to monitor and evaluate the performance of service providers, and to establish requirements and processes for continuing participation in the program.

Annually, DOR funds services for approximately 700 individuals through the seven TBI program sites, as well as 1,300 through the Independent Living Centers. DOR provides direct services to an additional

1,043 individuals with TBI through its Vocational Rehabilitation program. In total, there are around 3,043 consumers served.

For the last four fiscal years, the DOR contracted with the seven TBI sites for a total of \$924,000. In compliance with competitive solicitation requirements in AB 398, the DOR released a request for applications (RFA) on February 24, 2015. New awards will be granted for FY 2015-16, 2016-17, and 2017-18 based on available funding. Applications are due on March 27, 2015 by 3:00 PM. The grants are expected to be effective on July 1, 2015. Seven new grants will be awarded with the amount based on the available funding projected over the three-year cycle.

Fund stability. The DOR is not aware of programs at risk of closure. However, the State Penalty Fund is decreasing. In December 2014, the updated Fund Condition Statement from Department of Finance showed that, despite the one-time augmentation of \$500,000, revenue from the State Penalty Fund will not support the current level of funding over the next three years. The DOR, in collaboration with the community, is seeking additional funding opportunities, such as federal grants, to stabilize the funds available through the RFA process. To date, however, the department has been unsuccessful at identifying a stable funding source for the TBI programs.

TBI Medicaid waiver. On January 16, 2015, the department notified stakeholders that the waiver it developed did not satisfy federal requirement of cost neutrality. In coordination with DHCS, the DOR has identified services currently available to Californians with TBI through the Assisted Living, Nursing Facility/Acute Hospital, Developmentally Disabled, Multi-purpose Senior Service Program, and Community-Based Adult Services waivers. The department notes that these existing waivers contain many or all of the TBI community's preferred services as proposed in the stand-alone waiver. However, there are eligibility restrictions to entry and participants may be enrolled in only one waiver at a time. The department states that it will continue to engage with the DHCS to enhance, expand and include TBI-appropriate services in existing waivers.

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

Questions:

1. Please briefly provide an overview on TBI program funding.
2. How does DOR plan to coordinate with DHCS since the TBI waiver was found to not satisfy federal requirements of cost neutrality?
3. How have the declines in TBI Fund revenues impacted the ability to provide services?
4. What other avenues is the department pursuing to maintain stability of the TBI program funding?

3. Update: California PROMISE Initiative (CaPROMISE) Grant

Budget Issue. In fiscal year 2014-15, the Department of Rehabilitation was awarded a competitive federal grant, entitled Promoting the Readiness of Minors in Supplemental Security Income (or PROMISE). The 2014 Budget Act provided \$10 million in federal budget authority for the California PROMISE Initiative (CaPROMISE) federal grant, which begins October 1, 2013, to September 30, 2019; and authority to hire six permanent, full-time positions. CaPROMISE 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 award is \$10 million per year, with a \$50 million maximum, and is 100 percent federal funds without a state match requirement. This item provides an update on the implementation of the CaPROMISE grant.

Background. The SSI/State Supplemental Payment programs provide cash assistance to around 1.3 million Californians, aged 65 or older (28 percent), who are blind (one percent), or who have disabilities (78 percent), and meet federal income and resources limits. Grants under SSI are 100 percent federally-funded. The maximum grant amount for individuals is \$877.40 per month (\$721 SSI + \$156.40 SSP), which is roughly 90 percent of the federal poverty level (FPL). For couples, the maximum grant amount is \$1,478.20 per month (\$1,082 SSI + \$396.20 SSP), which is equal to 113 percent of FPL. According to the Social Security Administration's (SSA) Office of Retirement and Disability Policy, in December 2012, California had 114,852 individuals under the age of 18 receiving SSI. The department indicates that approximately 60 percent of child SSI recipients will receive SSI as adults.

Since July 2014, the department has filled the requested six permanent, full-time positions for the administrative and program oversight, and to perform mandated accounting, contracting, and data management activities. Federal funding will cover position costs (salary and benefits) and all ancillary costs, such as travel, supplies, operational expenses, and equipment.

As the lead coordinating agency for CaPROMISE, DOR is responsible for statewide leadership, oversight, administration, and coordination of the grant. DOR partners with five other state departments¹ and 21 Local Educational Agencies (LEAs) to coordinate services, direct outreach, recruitment, and involvement of, at a minimum, 3,078 14- to 16-year old SSI recipients and their families.

The 21 participating LEAs include:

- | | |
|--|---------------------------|
| 1. Oakland Unified School District (USD) | Area - San Bernardino |
| 2. Vallejo City USD | 9. Los Angeles USD |
| 3. Solano COE | 10. Centinela Valley UHSD |
| 4. West Contra Costa USD | 11. Compton USD |
| 5. Desert Mountain Special Education
Local Plan Area - San Bernardino | 12. Long Beach USD |
| 6. Riverside COE | 13. Elk Grove USD |
| 7. San Bernardino City USD | 14. Whittier Union HSD |
| 8. West End Special Education Local Plan | 15. Irvine USD |
| | 16. San Diego USD |

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

- 17. Lodi USD
- 18. East Side Union HSD
- 19. Santa Clara USD

- 20. Milpitas USD
- 21. Santa Clara County Office of Education

Service delivery and implementation timeline. Please see chart below with activities and associated benchmarks.

CaPROMISE Activities, Targets, Timelines with Benchmarks

Activities	Targets	Estimated Completion	Update
Career Services Coordinators Receive Basic Training	100% complete training	June 2014	Completed
Career Service Coordinators Receive Cornell Training	100% complete training	September 2014	Completed
Interagency Council Meeting	2 meetings per year	March 2014 (Initial Meeting)	All Meetings conducted to date
Recruitment of Students	At least 3,078 child SSI recipients ages 14-16 and their families	June 2015	Spring 2016 33% complete
Data Collection System Developed	Developed and initiated	June 2014	Completed
Case Management Intervention	100% of students	September 2018	On Track
Benefits Counseling/Financial Planning Intervention	100% of students	September 2018	On Track
Work Experience Intervention	100% of students have at least one volunteer and one paid experience	September 2018	On Track
Parent Training and Information Intervention	100% of families	September 2018	On Track
Employment Preparation Workshops/Soft Skills Training Intervention	100% of students	September 2018	On Track

To date, DOR has completed the following:

- Partnered with five state departments.
- Contracted with 21 Local Education Agencies (LEAs) and one community organization in the coordination of services, direct outreach, recruitment, and involvement of SSI recipients and their families.
- Received the Health and Human Services Institutional Review Board approval and Social Security Administration clearances for 106 program staff.
- Provided training to 65 Career Service Coordinators including Benefits Planning training and Certification from Cornell University.

In addition, partner LEAs have enrolled approximately 1,000 SSI recipients and their families, with a goal of 3,078 enrollees.

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

Questions

1. Please provide an update on the implementation of the proposal, including but not limited, the the enrollment and recruitment process of the 3,078 child SSI recipients and their families and the status of the staff hiring at the department.

4. Statewide Funding of Social Security Beneficiary Work Incentives Planners

Budget Issue. The department requests \$3.11 million in additional federal fund authority and 31 ongoing full-time permanent positions to hire Work Incentives Planners (WIPs). WIPs will provide financial literacy and benefits planning services to eligible consumers who receive Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits. This budget change proposal does not require trailer bill legislation nor any information technology.

The department anticipates that the requested 31 positions will generate the reimbursements needed to fund them, as well as stabilize the \$12.5 million funding provided to the independent living centers with no additional cost to the state. The department projects that the 31 positions will be funded entirely with federal Social Security Reimbursements until at least 2019-20.

The table below is a proposed distribution of WIP positions throughout the State, though no final determination has been made to-date. The positions will be placed in specific offices as demand is further determined.

District	No. of WIPs
Blind Field Services	2
Greater East Bay	3
Greater Los Angeles	2
Inland Empire	3
LA South Bay	2
Northern Sierra	2
Orange/San Gabriel	2
Redwood Empire	2
San Diego	3
San Francisco	2
San Joaquin Valley	2
San Jose	2
Santa Barbara	2
Van Nuys/Foothill	2
Total	31

According to the department, the 31 requested positions will serve approximately 8,000 DOR consumers with SSI/SSDI who require benefits planning and financial literacy services in order to obtain and maintain a job leading to financial self-sufficiency. DOR estimates that there are around 40,000 DOR consumers with SSI/SSDI. The projected 8,000 consumers represents only twenty percent of the total possible eligible population that could benefit from a WIP.

In order to meet this need, each of the 31 WIPs will be required to provide intensive services to over 258 consumers annually on a flow basis.

Because of the complex nature of benefits planning services, it is estimated that 60 WIP positions would allow each WIP to manage approximately 133 cases during the year. DOR consumers would greatly benefit from this smaller WIP-to-consumer ratio.

Background. In 1981, Congress established the Cost Reimbursement Program to encourage state Vocational Rehabilitation Agencies to provide services that would result in gainful employment by SSI/SSDI beneficiaries. Under the Cost Reimbursement Program, the Social Security Administration pays DOR for the reasonable costs of services provided to SSI/SSDI consumers, if those services result in the consumer achieving work at specified earnings level, known as the Substantial Gainful Activity.

Currently, as part of the department's vocational rehabilitation, rehabilitation counselors provide DOR consumers with SSI/SSDI with work incentive planning, and assist consumers navigate a complex set of SSA rules and regulations. Yet, employment outcome rates for SSI/SSDI consumers remained stagnant. According to Public Law 106-170, Section 2(a)(8), less than one-half of 1 percent of all SSI/SSDI recipients return to work. The department notes that common barriers to re-entry into the workforce include: complexity of SSA rules that discourage SSI/SSDI recipients from pursuing work, or fear that employment would have a negative impact on an individual's Medi-Cal/Medicare benefits or SSI/SSDI benefit payments. To increase the employment outcomes and self-sufficiency of DOR consumers receiving SSI/SSDI, the department began a Work Incentives Planning Pilot in September 2013 through August 2015.

Under this pilot program, nine limited-term WIPs (9/1/13 through 8/31/15) in three district offices—Greater East Bay District (4 WIPs), San Diego District (3 WIPs), and Northern Sierra District (2 WIPs – work with the Vocational Rehabilitation Service Delivery Team to provide consumers financial literacy and intensive benefits planning assistance. WIPs also assist consumers by coordinating referrals; providing information regarding benefit status; facilitating referrals to Ticket to Work Employment Networks for ongoing support services after the DOR case closure; and actively encouraging the consumer to achieve their choice of employment.

The pilot seeks to demonstrate the effectiveness of work incentives planning and return on investment through an increase in:

- The number of successful employment outcomes for consumers;
- The number of cases closed with earnings above Substantial Gainful Activity (SGA) (earnings of \$1,090 per month in 2015); and,
- Social Security Cost Reimbursements to DOR.

According to the department, the intensive planning and team approach successfully lead to more individuals going to work and earning higher wages. As of September 2014, nine WIPs enrolled around 1,000 consumers in the pilot. Of those, 170 achieve employment outcomes, and 79 of the 170 are earning wages above the Substantial Gainful Activity (SGA). The average monthly salary for employed enrolled consumers in the WIP pilot is \$1,362, in contrast with \$928 of the 1,000 SSI/SSDI consumers. Overall, the department finds that as a result of this pilot, Social Security Cost Reimbursements have

increased by 51 percent with the 5,181 SSI/SSDI consumers going to work, with 2,108 employed with earnings above the SGA benchmark. The department is currently using temporary help funds to fund the current nine positions for the pilot. It is estimated that it will cost \$900,000 (80% federal funds and 20% other funds) of the department's temporary help budget to fund the nine WIPS for one fiscal year.

Justification. The proposal is aligned with the Governor's Executive Order (S-10-08), which seeks to increase employment in the most integrated setting and independent living for individuals with disabilities, and is also consistent with the department's strategic plan and goals.² According to the department, the proposal would enable comprehensive financial literacy and benefits planning statewide for all DOR consumers who receive SSI/SSDI. Based on the 9 current WIPs, the department estimates that an average of \$166,779 per WIP will be generated from consumers. If 31 positions are funded, Social Security Administration Cost Reimbursements could increase by \$5,186,247 or more annually. The WIP Pilot demonstrates the value of benefits planning, as provided by the WIPs in the Vocational Rehabilitation service delivery team; and the ability to employment with earnings above the substantial gain activity level, which results in more cost reimbursements to DOR.

Advocate concerns. The California Foundation for Independent Living Centers (CFILC) raises concerns with the proposal. Specifically, the department's use of federal Social Security Cost Reimbursements may put ILC funding at risk because if reimbursements fall below projected figures, the department would first pay costs related personnel, superseding funding for ILCs. The department notes that the commitment to fund independent living centers remains and that despite independent living centers and 31 requested positions being financed through a similar mechanism – Social Security Cost Reimbursements – there is no link that could risk ILC funding. The advocates and department note that there is ongoing discussion regarding the matter.

Staff Comment & Recommendation. **Hold open** to allow for further discussion.

Questions

1. Please provide a brief description of the existing the Work Incentives Planning Pilot.
2. How would these work incentive planning services be different than the services currently provided in vocational rehabilitation or at independent living centers?
3. Is it anticipated that the department will utilize all federal Social Security Cost Reimbursements to fund the 31 positions until 2019-2020? What is the contingency plan if the estimated Social Security Cost Reimbursements are lower than projected?

² Strategic plan objectives includes: increase number of individuals with disabilities becoming employed; increase average earnings of a person with disabilities; improve integration of individuals with disabilities in their community.

Senator Holly J. Mitchell, Chair
Senator Jeff Stone, Pharm. D.,
Senator William W. Monning



March 12, 2015
9:30 a.m. or upon adjournment of session
John L. Burton Hearing Room 4203

Part B

Staff: Peggy Collins

4100 State Council on Developmental Disabilities (SCDD)

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PUBLIC TESTIMONY

4300 Department of Developmental Services (DDS)

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PUBLIC TESTIMONY

NOTE: Issues related to the state developmental centers will be heard on Thursday, May 7, 2014.

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the agenda unless otherwise directed by the Chair.

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. Thank you.

4100 State Council on Developmental Services (SCDD)

PANEL

Michael C. Clark, PhD., Interim Executive Director, State Council on Developmental Disabilities
 Aaron Carruthers, Chief Deputy Director, State Council on Developmental Disabilities
 Santi Rogers, Director, Department of Developmental Services
 Lawana Welch, Department of Finance

SCDD Overview

The State Council on Developmental Disabilities (SCDD) is a federally-funded systemic advocacy organization. California's SCDD is one of 56 such councils across the United States and its territories. According to the Administration on Intellectual and Developmental Disabilities (AIDD), which funds and oversees the councils, state councils are "self-governing organization charged with identifying the most pressing needs of people with developmental disabilities in their state or territory" (and) "work to address identified needs by conducting advocacy, systems change, and capacity building efforts that promote self-determination, integration, and inclusion. Key activities include conducting outreach, providing training and technical assistance, removing barriers, developing coalitions, encouraging citizen participation, and keeping policymakers informed about disability issues."

Under federal law, state councils are intended to be autonomous organizations that function without interference from the state, except in that federal law requires that council members be appointed by the governor. Under federal law, more than 60 percent of a council's membership must consist of individuals with developmental disabilities or their family members. Councils develop federally-required five-year plans to address one or more of seven specified goals, and update the plan annually. Councils must spend a minimum of 70 percent of their federal funding to address their plan objectives.

ISSUE 1: BUDGET OVERVIEW – GOVERNOR'S PROPOSAL

The proposed Governor's budget is shown in the following chart:

	2013-14 (actual)	2014-15 (estimated)	2015-16 (proposed)
Federal Trust Fund	\$6,841	\$7,014	\$7,019
Reimbursements	\$3,608	\$4,549	\$4,551
Total	\$10,449	\$11,563	\$11,570

The SCDD uses its federal grant and reimbursements to fund three primary activities, as shown below.

Activity	2013-14	2014-15	2015-16
Planning and Administration	\$1,792	\$2,070	\$2,072
Community Program Development	\$652	\$430	\$430
Regional Offices and Advisory Committees	\$8,005	\$9,063	\$9,068

Planning and Administration: The council is responsible for developing and implementing a state plan containing goals, objectives, activities, and projected outcomes designed to improve and enhance the

availability and quality of services and supports to individuals with developmental disabilities and their families. The appointed council members engage in policy planning and implementation to ensure system coordination, monitoring, and evaluation.

Community Program Development: The council administers grants to community-based organizations that fund new and innovative community program development projects to implement state plan objectives and improve and enhance services and supports for individuals with developmental disabilities and their families.

Regional Offices and Regional Advisory Committees: Thirteen regional offices and advisory committees provide administrative support and assist with advocacy, training, coordination, and implementation of state plan objectives in council regions throughout the state. These offices and advisory committees provide regional information and data to the council to assess regional needs and implementation of the state plan and for inclusion in reports to the federal government and the Legislature.

Questions for the SCDD:

- *Please describe how the activities of the SCDD and its regional office meet state plan objectives.*
- *How does the SCDD adjust to the fluctuation of the state grant from year-to-year, given the high percentage of the grant that is used for personnel who are state employees and subject to state-directed wages, benefits and civil service requirements?*
- *Please describe the process by which SCDD grants are awarded and monitored. How are the outcomes of grant-funded activities used to inform system change? Why was the amount allocated for community program development reduced by 34 percent in the current year?*

Question for DDS:

- *How does DDS, who also funds program development activities, coordinate with the SCDD to ensure both state and federal funds are maximized and fund unmet or under-met needs in the community?*

ISSUE 2: UPDATE ON FEDERAL HIGH RISK DESIGNATION – OVERSIGHT ISSUE

Prior to 2014, state statute established 13 area boards on developmental disabilities and assigned the area boards with tasks related to meeting the objectives of the SCDD state plan. Additionally, under previous state law, the Governor appointed the majority of area board members, appointed some of the council staff, and included additional prescriptive language that was at odds with the federal requirements for autonomy and self-direction of the council.

Since 1994, federal reviewers have expressed concerns with state law that committed a significant portion of the state grant to specific uses; with the authority granted to the Governor to make some staff and area board membership appointments; and with mandated activities and duties. Additional concerns were raised about the council's fiscal management, long-term unfilled vacancies on the council, and activities that have may overlapped with the federally-funded state protection and advocacy organization, Disability Rights California. Federal concerns were communicated to the council and the state in 1994, 2006 and 2013. Although some statutory changes to address federal concerns were made during the ensuing years, in November of 2013 the AIDD designated the council as being at high risk and limited access to its annual state grant by shifting its funding to a monthly reimbursement methodology. Additionally, the AIDD required SCDD submit to additional project monitoring through a correction action plan and monthly program progress reports; technical or management assistance through regular, ongoing assistance from experts and quarterly calls with AIDD staff.

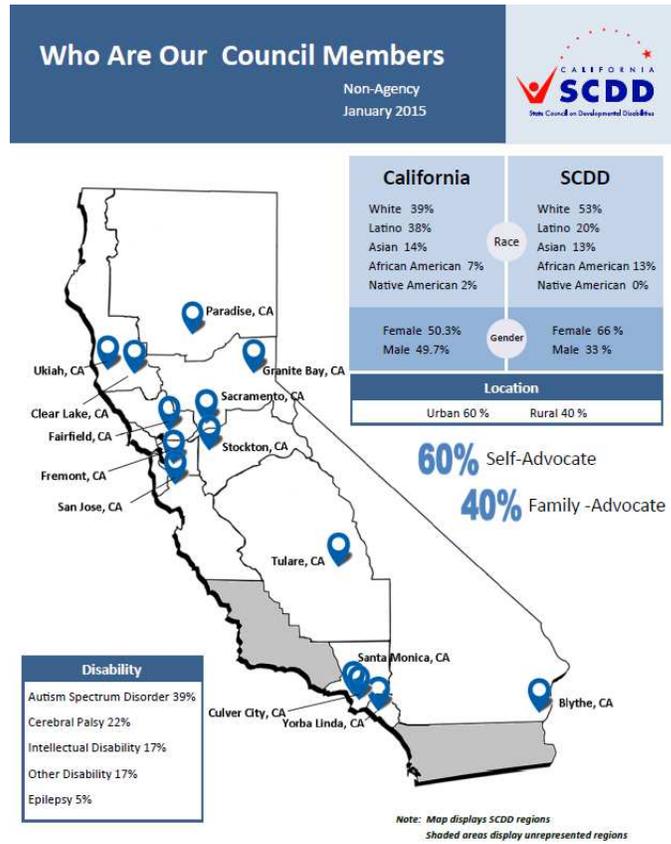
In order to address the structural concerns raised by the AIDD, the council sponsored Assembly Bill 1595 (Chesbro), Chapter 409, Statutes of 2014, to remove state oversight of many of its functions, including the ability of the Governor to appoint regional advisory board directors. Additionally, the legislation eliminated prescriptive language in state statute, including the requirement for a specified number of regional advisory boards.

Questions for SCDD:

- *Please describe the issues that led to the federal high-risk status that the State Council on Developmental Disabilities currently operates under.*
- *What structural and organizational changes have taken place following the passage of AB 1595 and how have these addressed federal concerns?*
- *What additional changes are required to fully comply with federal requirements before the high-risk status is removed and when is the soonest that may occur?*
- *What are the challenges associated with the monthly reimbursement methodology under which the council currently operates?*

ISSUE 3: COUNCIL DIVERSITY – OVERSIGHT ISSUE

Welfare and Institutions Code 4521 sets forth the criteria by which the 31 members of the SCDD are appointed. Prior to making his or her appointments, the Governor is required to “take into account the socioeconomic, ethnic and geographic considerations of the state.” The current regional and ethnic make-up of the council (for non-agency members) is shown in the following graphic provided by the council.



Questions for SCDD:

- *How does the council communicate with the Governor regarding diversity needs of the council?*
- *How does the council recruit potential members for the council or its regional advisory boards to ensure they reflect the diversity of the state and the regions that they serve?*
- *Please describe council activities that address socioeconomic, ethnic and geographic disparities in access to services and supports for persons with developmental disabilities and their families.*

ISSUE 4: STATE CONTRACTS WITH SCDD – OVERSIGHT ISSUE

The Department of Developmental Services (DDS) contracts with the SCDD to provide two activities, as described below. Both of these activities are achieved, in part, through the use of trained volunteers.

Quality Assurance Surveys: Welfare and Institutions Code Section 4571 requires DDS to implement a nationally-validated quality assessment tool that will enable DDS to monitor the performance of California's developmental disabilities services system, and to assess quality and performance among all of the regional centers. DDS chose the National Core Indicators (NCI) survey tool for this purpose. State statute requires DDS to contract with the SCDD to collect data using this assessment tool. The contract provides \$7.4 million (\$5.7 million GF; \$1.7 million other funds) to the SCDD for the period of July 1, 2014 through June 30, 2017, for this purpose.

Clients' Rights/Volunteer Advocacy: Welfare and Institutions Code 4433 requires DDS to provide clients' rights advocacy services for all consumers in its service delivery system. To avoid the potential for, or appearance of, a conflict of interest, DDS is required to contract for these services. DDS contracts with the SCDD to provide these services for residents in the state developmental centers. The contract provides \$9.3 million (\$5.1 million GF) to the SCDD for the period July 1, 2012 through June 30, 2017. DDS contracts with Disability Rights California and its Office of Client Rights Advocacy to provide similar services to consumers living in the community.

Questions for SCDD:

- *Please describe briefly how the requirements of each contract are met, including any challenges you face in meeting the contract goals.*
- *Please describe the process for recruiting, training, and maintaining volunteers. What are the challenges and benefits of using volunteers?*
- *How does SCDD staff interact and share information with Disability Rights California regarding persons who are moving, or have moved, from a developmental center to the community?*

Questions for DDS:

- *How does DDS monitor the performance of the SCDD in meeting the requirements of these contracts?*
- *How is the information collected from the National Core Indicators survey utilized and shared with system stakeholders, the Legislature, and the public. How does this survey inform decision-making by DDS?*
- *Has SCDD staff and/or volunteers played a role in the process related to the closures of Agnews and Lanterman developmental centers? How has the SCDD contract been amended, or their role at the remaining centers changed, once these facilities closed?*

Staff Recommendation: Leave open the State Council on Developmental Disabilities budget pending May Revision.

4300 Department of Developmental Services (DDS)**Department Overview**

The Department of Developmental Services (DDS) oversees the provision of services and supports to approximately 279,709 persons with developmental disabilities and their families, pursuant to the provisions of the Lanterman Developmental Disabilities Services Act, also known as the Lanterman Act, (Division 4.5 of the California Welfare and Institutions Code). The Lanterman Act establishes an entitlement to services and supports for Californians with developmental disabilities.

For the majority of eligible recipients, services and supports are coordinated through 21 private, non-profit corporations, known as regional centers (RCs). The remaining recipients are served in three state-operated institutions, known as developmental centers (DCs) and one state-leased and state-operated community-based facility. Regional centers are anticipated to serve an average caseload of 278,593 individuals in the current year, and 288,317 individuals in the budget year; an increase of 9,724 or 3.5 percent. As of the February 25, 2015 census, developmental centers housed 1,131 residents; the department projects 951 individuals will reside in the centers, a reduction of 180 or 15.9 percent.

Eligibility

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

Governor's Budget

The following summary chart from DDS provides a summary of the proposed 2015-16 budget, the various fund sources, caseload, and authorized positions, as it compares to the proposed revised 2014-15 budget.

DEPARTMENT OF DEVELOPMENTAL SERVICES
November 2014 Estimate

(Dollars in Thousands)

	2014-15	2015-16	Difference
Community Services Program			
Regional Centers	\$4,848,508	\$5,141,657	\$293,149
Totals, Community Services	\$4,848,508	\$5,141,657	\$293,149
General Fund	2,761,388	\$2,991,911	\$230,523
Dev Disabilities PDF	4,071	4,103	32
Developmental Disabilities Svs Acct	150	150	0
Federal Trust Fund	67,172	51,853	-15,319
Reimbursements	2,014,987	2,092,900	77,913
Mental Health Services Fund	740	740	0
Developmental Centers Program			
Personal Services	\$472,632	\$405,608	-\$67,024
Operating Expense & Equipment	90,262	109,605	19,343
Total, Developmental Centers	\$562,894	\$515,213	-\$47,681
General Fund	\$309,648	\$279,839	-\$29,809
Federal Trust Fund	384	285	-99
Lottery Education Fund	367	367	0
Reimbursements	252,495	234,722	-17,773
Headquarters Support			
Personal Services	\$36,290	\$37,334	\$1,044
Operating Expense & Equipment	6,194	\$5,245	-949
Total, Headquarters Support	\$42,484	\$42,579	\$95
General Fund	\$27,043	\$27,070	\$27
Federal Trust Fund	2,560	2,561	1
PDF	325	349	24
Reimbursements	12,116	12,128	12
Mental Health Services Fund	440	471	31
Totals, All Programs	\$5,453,886	\$5,699,449	\$245,563
Total Funding			
General Fund	\$3,098,079	\$3,298,820	\$200,741
Federal Trust Fund	70,116	54,699	-15,417
Lottery Education Fund	367	367	0
Dev Disabilities PDF	4,396	4,452	56
Developmental Disabilities Svs Acct	150	150	0
Reimbursements	2,279,598	2,339,750	60,152
Mental Health Services Fund	1,180	1,211	31
Caseloads			
Developmental Centers	1,116	1,010	-106
Regional Centers	278,593	288,317	9,724
Authorized Positions			
Developmental Centers	4,681.1	4,270.2	-410.9
Headquarters	381.5	381.5	0.0

ISSUE 1: BUDGET YEAR INCREASE – GOVERNOR’S PROPOSAL

DDS Headquarters

The Governor’s budget provides \$42.6 million (\$27.1 million General Fund (GF)) for DDS headquarters. This reflects an increase of \$1.4 million (\$0.9 million GF) increase across the current and budget year related to retirement rate contribution, employee compensation, and other staff benefit increases.

PANEL

Santi Rogers, Director, Department of Developmental Services
Lawana Welch, Department of Finance

Questions for DDS:

- *Please provide an overview of the DDS headquarters budget.*

Staff recommendation: Leave open pending May Revision

ISSUE 2: CURRENT YEAR DEFICIENCY AND BUDGET YEAR INCREASE – GOVERNOR’S PROPOSAL
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Regional Center Operations

The Governor’s budget provides a current year increase of \$6.2 million (-\$2.1 million GF) above the 2014-15 enacted budget for regional center operations, reflecting increases in caseload and utilization in the current year. For the 2015-16 budget year, the Governor’s budget provides an increase of \$30.3 million (\$22.5 million GF) for regional center operations over the 2014-15 enacted budget, reflecting projected increases in caseload and utilization in the budget year. Additionally, the Governor’s budget proposes a \$1.9 million increase (\$1.6 million GF) in regional center operations to adjust the budgeted salaries for account clerks and secretary I positions to reflect the increase in the state minimum wage from \$9.00 to \$10.00 an hour, effective January 1, 2016. These estimates will be updated at the May Revision. The Administration will request current year deficiencies be funded through a supplemental appropriation bill.

PANEL

Santi Rogers, Director, Department of Developmental Services
Lawana Welch, Department of Finance

Questions for DDS: Please present the current and budget year proposals.

Staff recommendation: Leave open pending May Revision.

ISSUE 3: CORE-STAFFING FORMULA - OVERSIGHT ISSUE

A core staffing formula is the primary driver of regional center operations funding. With some exceptions, this formula has not been updated since 1991. As a result, regional centers are provided funding for required positions that are far below what they are actual paying. For example, the core staffing formula provides \$60,938 for a regional center executive director position when, in fact, regional centers are paying between a low of \$130,992 and a high of \$284,352 (excluding benefits, retirement, bonuses, and other allowances). Other examples of core staffing formula allocations for key positions are shown in the following chart:

Position	Core Staffing Formula Allocation
Physician	\$79,271
Behavioral Psychologist	\$54,972
Client Program Coordinator	\$34,032
High-Risk Infant Case Manager	\$40,805
Chief Counselor	\$46,983
Human Resources Manager	\$50,844

Additionally, the complement of staff funded through the core staffing formula does not fully reflect the demands on the regional centers today. For example, the Association of Regional Center Agencies (ARCA) points out that the formula does not provide sufficient middle management positions and support staff for organizations that have grown from an average 2,000 person caseload to about 7,000 person caseload today. Disability Rights California (DRC) argue that regional centers may lack resources to provide the expertise necessary to assist persons with developmental disabilities and their families access to generic services. For example, DRC has requested that regional centers be mandated to employ a dental coordinator to assist consumers to access dental services through Denti-Cal and other community-based dental services.

In addition to the outdated core staffing formula, regional centers have absorbed multiple “unallocated reductions” to their operations budgets and ARCA argues they have absorbed additional case management and administrative workload for which they have not been adequately funded.

The following chart was provided by the Administration at a Developmental Disabilities Task Force meeting and shows the number of regional centers out of compliance with caseload ratio requirements.

Year	Waiver Consumers (1:62)	Under 3 (1:62)	DC Movers Over 12 Months (1:62)	DC Movers Last 12 Months (1:45)	Over 3, Non-Waiver, Non-Mover (1:66)	Total RC's out of Compliance in One or More areas
2004	6	4	-	2	8	12
2005	13	9	3	3	10	16
2006	5	2	1	2	9	11
2007	5	4	-	-	9	9
2008	7	8	1	-	9	11
2009-2010	Regional centers reporting requirements were statutorily suspended in 2009 and 2010.					
2011	15	4	6	1	N/A*	16
2012	17	9	6	1	N/A*	17
2013	13	3	4	-	N/A*	13
2014	14	7	7	-	21	21

*The 1:66 ratio was statutorily lifted from February 1, 2009 to June 30, 2013.

HCBS Waiver Risk

California's first Home and Community-Based Services (HCBS) waiver for Individuals with Developmental Disabilities (waiver) was approved in November 1982. Direct services and regional center case management and other quality assurance activities are eligible for federal funding participation for consumers enrolled under the waiver. In the budget year, DDS projects the state will receive \$175 million in federal funding related to regional center case management and quality assurance activities related to waiver services.

In 1997, the federal Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services (CMS)), conducted a review of California's waiver services and administration and identified significant health and safety deficiencies, as well as significant issues pertaining to program monitoring, quality assurance, and residential care. Due to these concerns, the DDS and Department of Health Services (as the state's Medicaid agency; now the Department of Health Care Services) had to implement extensive program compliance measures relating to consumer health and safety, and had to certify that regional centers were in compliance, on a case-by-case basis. Although waiver participation restrictions were relaxed slowly over the ensuing years, it was not until January 2004 that the enrollment freeze was fully lifted. According to DDS, the cumulative impact of the waiver enrollment freeze was \$933 million.

In a report entitled "Funding the work of California's Regional Centers", published in September of 2013, and as illustrated in the chart above, ARCA argues that a large number of regional centers are again not meeting caseload ratio criteria for waiver participation, and have not done so for multiple years, putting California at risk of losing substantial federal funding.

The 2014-15 state budget adopted by the Legislature included budget bill language to require DDS to work with stakeholders to develop a proposal relative to reforming the regional center core staffing formula. However, the Governor vetoed this language and instead directed the Health and Human Services Agency to convene a work group to review this issue, along with other issues discussed later in this agenda. This issue has been incorporated into the agency's Developmental Services Task Force, which began its work in December of 2014.

PANEL

Eileen Richey, Executive Director, Association of Regional Center Agencies

Santi Rogers, Director, Department of Developmental Services

Joe Meadours, Self-Advocate, People First of California

Catherine Blakemore, Disability Rights California

Questions for ARCA:

- *Please provide a brief summary of your 2013 report "Funding the Work of California's Regional Centers."*

Questions for DDS:

- *How significant is the concern that regional centers' inability to meet caseload ratio requirements could result in the loss of federal funding?*

Questions for Joe Meadours:

- *Please describe your experience getting needed help from your regional center case manager, or other regional center staff, in recent years?*

Questions for DRC:

- *As the organization that provides client rights' advocacy services to persons served by the regional center system, what indicators have you seen that demonstrate the regional center operations may be underfunded?*

ISSUE 4: CURRENT YEAR DEFICIENCY AND BUDGET YEAR INCREASES – GOVERNOR’S PROPOSAL**Regional Center Purchase-Of-Services (POS)**

The Governor’s budget projects a current year increase of \$104.6 million (\$58.1 million GF) in POS, reflecting increases in caseload and utilization. According to DDS, the major increase in POS expenditures reflect an increased utilization of specialized adult residential facilities and increased utilization and costs for supported living services. The current year POS budget also includes an increase of \$44.3 million (GF) to reflect restoration of funding necessary as a result of unrealized savings from SB 946 (Steinberg), Chapter 650, Statutes of 2011, which requires health care insurers to provide coverage for behavioral health treatment (BHT) for pervasive developmental disorder or autism. The current year is also proposed to be adjusted by a \$3.7 million (\$1.9 million GF) increase to implement federal labor regulations regarding overtime payments to some workers in some community-based programs. However, implementation of these federal regulations has stalled, pending the outcome of an appeal of a federal court ruling that negated the overtime requirements.

In the 2015-16 budget year, the Governor proposes additional increases over the enacted 2014-15 budget, related to the same factors:

- Caseload and Utilization: \$278.5 million (\$214.0 million GF) increase
- Unrealized SB 946 Savings: \$44.3 million (GF) increase
- Federal Labor Regulations: \$24.4 million (\$13.1 million GF) increase

These estimates will be updated at the May Revision. The Administration will request current year deficiencies be funded through a supplemental appropriation bill.

LAO Recommendation

The Legislative Analyst’s Office (LAO) finds that the current year community caseload estimate, and the projection for community caseload growth in the budget, appear reasonable, pending an update at May Revision. However, they have identified issues with the department’s estimate of costs associated with greater utilization of services. Specifically, they find that for specialized adult residential facilities and supported living services, the department’s 2015-16 estimated costs proposed for general fund expenditures that do not draw down federal Medicaid matching funds, far outpace recent trends in cost growth.

For community care facilities, the non-matched General Fund expenditures are estimated to increase from \$96 million in 2014-15 to \$152 million in 2015-16, an increase of \$56 million, or 58.6 percent. For support services, the non-matched general fund expenditures are expected to increase from \$81 million in 2014-15 to \$160 million in 2015-16, and increase of \$79 million, or 97.2 percent.

PANEL

Rashi Kesarwani, Legislative Analyst’s Office
Santi Rogers, Director, Department of Developmental Services
Lawana Welch, Department of Finance

Questions for LAO:

- *Please briefly provide your analysis of the current and budget year POS estimate.*

Questions for DDS:

- *Why are non-matched general fund expenditures significantly increasing for community care facilities and support services and far outpacing the cost growth of expenditures that draw down federal matching funds?*

Staff recommendation: Leave open pending May Revision.

ISSUE 5: SICK LEAVE – GOVERNOR’S PROPOSAL

Assembly Bill 1522 (Gonzalez), Chapter 317, Statutes of 2014, enacts the Healthy Workplaces, Healthy Families Act of 2014. This new law requires that, by July 1, 2015, an employee who works in California for 30 days or more in a calendar year, is entitled to paid sick days that will accrue at a rate of no less than one hour for every 30 hours worked, and may be used beginning on the 90th calendar day of employment, with certain limitations.

Governor’s Budget

The Governor’s budget proposes a \$25.3 million increase (\$16.2 million GF) in purchase-of-services to reflect the costs associated with the implementation of AB 1522 for community-based programs that do not currently provide sick leave benefits to employees. The Administration has proposed trailer bill language to implement this provision.

LAO Recommendation

The LAO recommends the Legislature approve the Governor’s proposed augmentation, and adopt supplemental report language to require DDS to provide the actual general fund costs for these proposals.

PANEL

Santi Rogers, Director, Department of Developmental Services
Lawana Welch, Department of Finance
Rashi Kesarwani, Legislative Analyst’s Office

Questions for DDS:

- *Please describe your methodology in developing your estimate. How did you collaborate with providers in developing your estimate?*

Questions for LAO:

- *Please briefly present your analysis of the Governor’s proposal and your recommendation.*

Staff recommendation: Leave open pending May Revision.

ISSUE 6: MINIMUM WAGE INCREASE – GOVERNOR’S PROPOSAL

Assembly Bill 10 (Alejo), Chapter 351, Statutes of 2013, increased the state minimum wage from \$8.00 to \$9.00 per hour, effective July 1, 2104; and increases it again to \$10.00 per hour on January 1, 2016. The 2014 budget act included funding to allow minimum wage adjustments to rates paid to work activity programs, community-based day programs, in-home respite service agencies that can demonstrate to DDS that they employ minimum wage workers, and providers who have a rate negotiated with a regional center if they demonstrate to the regional center that they employ minimum wage workers.

The Legislature also adopted the following supplement report language:

Expenditures for Minimum Wage Increase. No later than May 14, 2015, the department shall provide to the fiscal and policy committees of the Legislature and to the Legislative Analyst’s Office the actual General Fund cost of the rate increases provided to vendors as a result of the state-mandated hourly minimum wage increase to \$9. The department shall report these actual costs by vendor type, including Community Care Facilities, Day Program Services, Habilitation Services, Transportation, Support Services, In-Home Respite, and Out-of-Home Respite.

Governor’s Budget

The Governor’s budget proposes a \$64.2 million increase (\$36.6 million GF) to \$10.00, effective January 1, 2016. The following adjustments are associated with this increase:

- \$1.9 million increase (\$1.6 million GF) in regional center operations to adjust the budgeted salary for Account Clerks and Secretary I positions, which currently are budgeted at salary levels that are below \$10.00 per hour.
- \$62.3 million increase (\$35.0 million GF) in purchase-of-services to reflect the minimum wage increase impact on community-based day programs, work activity programs, respite services, and others, who rely on minimum wage employees.

LAO Recommendation

The LAO recommends the Legislature approve the Governor’s proposed augmentation, and adopt supplemental report language to require DDS to provide the actual general fund costs for these proposals.

Provider Concerns

Last year, provider organizations argued that the Governor’s proposal failed to reflect the real impact of the minimum wage increase on their programs. Specifically, providers argue that some direct and indirect costs, such as retirement and long-term disability insurance, were not included in the minimum wage rate adjustments. Additionally, providers cite California Labor Code Section 515 as requiring certain supervisory staff to be paid twice the minimum wage, under defined circumstances. Providers also argued that a minimum wage increase necessitates increases for staff above the minimum wage to maintain the differentials earned through seniority and promotion within their agency. The Governor’s budget year proposal does not address these issues.

PANEL

Santi Rogers, Director, Department of Developmental Services

Lawana Welch, Department of Finance

Rashi Kesarwani, Legislative Analyst's Office

Will Sanford, Executive Director, Futures Explored

Questions for DDS:

- *Please present your proposal.*
- *Has the number or type of program impacted by this increase changed since last year?*
- *How have you vetted the legitimacy of providers argument about secondary costs associated with the minimum wage increase?*

Questions for LAO:

- *Please briefly present your analysis of the Governor's proposal and your recommendation.*

Question for Will Sanford:

- *Please share your perspective and experience on this issue.*

Staff recommendation: Leave open pending May Revision.

ISSUE 7: STATEWIDE SELF-DETERMINATION PROGRAM – GOVERNOR’S PROPOSAL

SB 468 (Emmerson), Chapter 468, Statutes of 2013, establish a statewide self-determination program (SDP), under which consumers are provided with individual budgets and the ability to purchase the services and supports they choose that are consistent with their individual program plan (IPP) and with the assistance of a financial manager. The SDP program must be consistent with new federal HCBS regulations discussed later in this agenda.

The department has worked collaboratively with system stakeholders to design and submit a federal waiver application to the Centers for Medicare and Medicaid Services (CMS) in late December; however, the application was returned for additional information. It is unknown at this time when federal approval will occur. However, DDS anticipates that more information may be available at the May revision.

The Administration has proposed new provisional budget bill language to allow the transfer of up to \$2,800,000 from local assistance to state operations, once federal approval occurs. This represents the estimated General Fund savings in purchase-of-services associated with the SDS program that would be used to offset the administrative costs incurred by the department, including the costs of required criminal background checks.

PANEL

Santi Rogers, Director, Department of Developmental Services

Lawana Welch, Department of Finance

Marty Omoto, Director/Founder, CDCAN California Disability-Senior Community Action Network

Questions for DDS:

- *Briefly described the SDS program.*
- *Please explain why the federal application was returned and the status for resubmission.*
- *How are General Fund saving achieved through this program?*
- *How are regional centers and community stakeholders, including persons with developmental disabilities and their families, being prepared now to ensure timely implementation once federal approval is secured? How many regional centers have established an advisory committee?*

Questions for DOF:

- *Relative to your proposed provisional language, would you object to 30-day notice being provided to the Joint Legislative Budget Committee prior to your approval of the transfer? Given that the amount of savings, and associated administrative costs, will be tied to the date of approval and the ability of regional centers to implement in a timely manner, the Legislature may want an opportunity to examine the methodology for determining the appropriate amount to transfer.*

Staff recommendation: Leave open pending May Revision.

ISSUE 8: STABILITY OF COMMUNITY-BASED SERVICES AND SUPPORTS SYSTEM - OVERSIGHT ISSUE

Rates paid to community-based providers for services and supports provided to persons with a developmental disability are established through multiple methodologies, as shown below.

Rate Paid to Regional Center Vendors
Department of Developmental Services set statewide rates established pursuant to cost statement, statute, or regulation.
Department of Health Care Services Schedule of Maximum Allowance.
Negotiated Rates: a rate negotiated up to the applicable median rate for the regional center catchment area, or the current statewide median rate, whichever is lower.
Department of Social Services rates.
Standard Rate Schedule, established by the regional center based upon the cost-effectiveness of providing specific transportation services.
Regional Center set mileage reimbursement set at a per mile rate not to exceed the travel rate paid by the regional center to its own employees.
Usual and Customary Rates is a rate regularly charged by a vendor for a service that is used by both regional center consumers and where at least 30 percent of the recipients of the given service are not regional center consumers.

Most community-based service providers have not received a rate increase since 2006. Residential care providers (ARM), day programs, and traditional work programs received a three percent rate reduction in February of 2009, which expired in July of 2012. These providers received an additional rate reduction of 1.25 percent in July 2010, which expired in July 2013. Since 2008, providers whose rate is set through negotiations with individual regional centers have had their rate limited to the median rate for the year 2007. These providers were also subject to the three percent and 1.25 percent rate reductions, and subsequent expiration, discussed above. Supported work providers, whose rate is set in statute, received a 24 percent increase in 2006, but their rate was subsequently reduced by 10 percent in 2008.

Other changes have further skewed the relationship between costs and reimbursement rates, and the relative rationalization of rates paid across programs throughout the state. These include:

- Exceptions to rate freezes and reductions, justified through a “health and welfare” waiver.
- Prohibition on the use of POS for program “start-up” costs.
- Implementation of uniform holiday schedules.
- Implementation of additional administrative functions, including required audits, for providers.

State set standardized rates do not recognize cost differentials between regions of the state, including costs-of-living and local wage requirements. Providers contend that recent and proposed rate adjustments related to increases in the state minimum wage have not fully reflected all the associated costs.

Recent Court Ruling Ends Some State Actions to Reduce Costs

In 2011, The ARC of California and UCP of San Diego filed a lawsuit in federal court claiming the state had violated federal Medicaid law by enacting budget reductions strategies without first seeking federal approval. These included a rate reduction for providers, requiring providers to adhere to a uniform holiday schedule and reimbursing providers based on a half-day billing schedule. In the most recent court ruling in this case, a federal court ruled in favor of the plaintiffs. Since the rate reduction has already been reversed by subsequent legislative action, the ruling only impacts the uniform holiday schedule and half-day billing policies. The department has indicated that it will not pursue further appeal of this ruling and is preparing to notify regional centers that the uniform holiday schedule and half-day billing policies are no longer in effect.

“On the Brink of Collapse, The Consequences of Underfunding California’s Developmental Disabilities System” – a report prepared by the Association of Regional Center Agencies.

Earlier this month, the Association of Regional Center Agencies (ARCA) released a report entitled “On the Brink of Collapse, The Consequences of Underfunding California’s Developmental Disabilities System.” The report illustrates how California’s spending on services and supports compares to investments in other states; how rates paid to providers compares to other states; how cost disparities across regions are not addressed in state-set provider rates and other factors which have resulted in rates that do not support a stable, quality network of services and supports in California; and how the increasing caseloads of regional center case managers have exasperated the challenges of finding and maintaining appropriate services and supports for persons with developmental disabilities in California communities. Additionally, the report shares, for the first time, data relative to program closures and changes in program design that limit choices for individuals. Finally, the report discusses the changes in the system’s landscape that are difficult to meet under the current rate structures, including new federal requirements; state mandating improvements for California workers, such as minimum wage increases, mandated sick leave, and overtime requirements; and increasing diversity among those served.

Senate Human Services Committee Oversight Hearing

At an oversight hearing of the Senate Human Services Committee, held in October of 2014 in Los Angeles, providers from various sectors serving persons with developmental disabilities discussed the impact that suppressed rates of reimbursement have had on the availability and quality of services and supports provided in California communities. Steve Miller, the former executive director of Tierra del Sol, which provides work and day program services to persons with developmental services, conducted an informal poll of 25 providers that produced the following results:

- Respondents reported staff turnover rates between 25-50 percent, and multiple vacancies in ratio required position or key supervisorial or quality assurance positions.
- Agencies reported declining skill competencies in direct support and management staff.
- Agencies have become more restrictive in whom they accept into their programs.
- Agencies report that they are less likely to respond to local regional center requests to expand services.

- Four agencies reported they have, or will, close programs; other report they have downsized programs.

Residential providers report a growing number of regional centers will not place residents in facilities that have more than four beds, a policy consistent with state and federal direction, but continue to rely on funding that assumes revenues from six beds. Intermediate care facilities (ICF) providers have argued that an increasing number of these facilities have closed or converted to another model due to insufficient reimbursement.

Changing State and Federal Direction

Recent federal and state actions have articulated a growing preference for the delivery of services and supports that best promote integration and self-direction for persons with developmental disabilities. The implementation of these new initiatives will require a significant shift in how services and supports are provided in California. These actions include:

- Under new federal home and community-based waiver and state plan regulations, that will fully go into effect in 2019, waiver-funded services must meet certain criteria, including:
 - The setting is integrated and supports full access to the greater community;
 - The setting is selected by the individual from among options that include non-disability-specific settings and an option for a private unit in a residential setting;
 - Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint;
 - Optimizes, but does not regulate, individual initiative, autonomy, and independence in making life choices; and,
 - Facilitates individual choice regarding services and supports, and who provides them.

In California, DDS administers one waiver program and two state plan programs, serving approximately 130,000 persons.

- The U.S. Department of Justice has entered into a settlement agreement with the state of Rhode Island to redirect consumers receiving services in segregated sheltered workshops and facility-based day programs into integrated settings. In California, three state departments, DDS, the Department of Rehabilitation and the Department of Education, have entered into an agreement to develop a blueprint over a six month period to guide California toward a similar outcome.
- AB 1041 (Chesbro), Chapter 677, Statutes of 2013, establishes an “Employment First” policy in the state, requiring the prioritizing of integrated, competitive employment opportunities for working age adults with developmental disabilities.
- SB 468 (Emmerson), Chapter 468, Statutes of 2013, establishes a statewide self-determination program, under which consumers are provided with individual budgets and the ability to purchase the services and supports they choose that are consistent with their IPP and with the assistance of a financial manager.

The Administration's Response

The 2014 budget approved by the Legislature included budget bill language to require DDS to work with stakeholders to develop a proposal relative to rate-setting methodologies for community-based services and supports. However, the Governor vetoed this language and instead directed the Health and Human Services Agency to convene a work group to review this issue, along with the regional center core-staffing formula discussed above. The agency convened its first Developmental Services Work Group meeting in December 2014. The work group will next meet on March 26th to discuss regional center operations and on April 20th to discuss community rates.

Additionally, DDS held its first meeting of their Home and Community-Based Services Advisory Group on February 17, 2015. Working through a small stakeholder steering committee, DDS recently received commitments from 21 identified individuals (consumers, family members, advocates, providers, regional centers, and affected state entities) to serve on a new advisory group to analyze issues, identify steps and processes, and develop policy recommendations involved with implementing federal home and community-based settings requirements, discussed above.

The Lanterman Coalition Recommendation

The Lanterman Coalition, made up of numerous statewide provider and advocacy organizations, has requested the 2015-16 budget be augmented to reflect (1) a 10 percent increase in provider rates and regional center funding, (2) a five percent increase in the 2016-17 budget year, and (3) a longer-term action to repair the rate system.

PANEL

Rashi Kersarwani, Legislative Analyst's Office

Eileen Richey, Executive Director, Association of Regional Center Agencies

Catherine Blakemore, Disability Rights California

Kristopher Kent, Assistant Secretary, Health and Human Services Agency

Santi Rogers, Director, Department of Developmental Services

Ernie Huerta, Self-Advocate

Sue North, Director of Government Affairs, California Disability Services Association

Tony Anderson, Chair, Lanterman Coalition

Questions for LAO:

- *Please provide an overview of the budget actions taken by DDS in previous years to achieve necessary savings that have impacted community-based service providers.*

Questions for ARCA:

- *Please provide a summary of your report as it relates to what you have learned relative to program closures and program modifications that have reduced options for persons with developmental disabilities.*

Questions for DRC:

- *Please discuss the requirements of the new federal regulations and the structural ways that service provision may need to change.*
- *Please discuss your agreement with the Administration relative to employment programs and how it may change the structure of service delivery for employment programs.*

- *What policy changes made to reduce expenditures have had the most significant negative impact on consumers and providers?*

Questions for Agency:

- *Please briefly describe the various collaborative work group and task force efforts to examine the need for long-term change in the regional center and community-based service system.*

Questions for DDS:

- *What indicators does DDS examine when determining if a statewide rate adjustment for a particular service is necessary?*
- *How is DDS monitoring the community service system to ensure it does not collapse while the work on system restructuring being conducted by various Administration-led task forces is done?*
- *Given the significant structural changes that will need to occur to be in compliance with the new federal regulations by 2019, do you think some steps can be taken now (or soon) to stabilize and grow program models that clearly meet federal requirements, and assist those programs that do may need to remodel their program design?*

Question for Sue North:

- *Please provide your perspective on this issue.*

Question for Tony Anderson:

- *Please present the request from the Lanterman Coalition.*

ISSUE 9: DISPARITIES IN SERVICE DELIVERY – OVERSIGHT ISSUE

DDS and regional centers are 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 DDS is required to provide oversight, through their contract agreements with the regional centers, by requiring specified activities and establishing annual performance objectives.

In April of 2012, and following a 2011 Los Angeles Times series that reported significant disparities in access to regional center services based on race and ethnicity, income level and socio-economic community, the Senate Autism and Related Disorders Select Committee held an informational hearing to examine what disparities exist in the provision of services to persons with autism spectrum disorders. Following the hearing, Senate Majority Leader Darrell Steinberg established a 20-member taskforce to make recommendations relative to these issues.

According to the 2011 Los Angeles Times series, in 2010, “For autistic children 3 to 6, a critical period for treating the disorder, the state Department of Developmental Services last year spent an average of \$11,723 per child on whites, compared with \$11,063 on Asians, \$7,634 on Latinos and \$6,593 on blacks.” The series also reported, “Last year, the system served 16,367 autistic children between the critical ages of 3 and 6, spending an average of \$9,751 per case statewide. But spending ranged from an average of \$1,991 per child at the regional center in South Los Angeles to \$18,356 at the one in Orange County.”

Numerous bills were introduced in response to these recommendations, including:

SB 367 (Block), Chapter 682, Statutes of 2013: requires regional centers to include issues related to cultural and linguistic competency in governing board training; improved posting of data on regional center websites; and improved DDS oversight.

SB 555 (Corea), Chapter 685, Statutes of 2013: requires regional centers to communicate and provide written materials in a consumer or a family’s native language, as specified.

SB 1232 (V. Manuel Pérez), Chapter 679, Statutes of 2013: requires the existing DDS quality-assurance instrument to assess the provision of services in a linguistically and culturally competent manner, and include an outcome-based measure on issues of equality and diversity.

SB 1093 (Liu), Chapter 402, Statutes of 2014: requires the above discussed data be collected and reported by residence type and requires data posted for all previous years remain on DDS and regional center websites.

The DDS website provides links to each regional center’s website, where local demographic, expenditure and utilization data is displayed. However, DDS does not provide similar data from a statewide perspective. Raw data collected through the Client Development and Evaluation Report (CDER) is provided on the DDS website however DDS provides no significant analysis of this data as it relates to disparities.

PANEL

Santi Rogers, Director, Department of Developmental Services

Sandra Smith, Council Member, State Council on Developmental Disabilities

Gloria Wong, Executive Director, Eastern Los Angeles Regional Center

Marty Omoto, Director/Founder, CDCAN California Disability-Senior Community Action Network

Catherine Blakemore, Disability Rights California

Questions for DDS:

- *Please describe how DDS uses data to evaluate trends in diversity and access to regional center services.*
- *How does DDS measure the delivery and outcomes of culturally-appropriate services by regional centers?*
- *Please describe how regional center performance contracts address diversity and access issues.*
- *Please describe the types of activities that DDS may require of a regional center to improve access for specific demographic groups.*
- *Please describe how DDS assists regional center in identifying and utilizing best practices in addressing diversity and access issues.*

Questions for SCDD:

- *Please describe your perspective on this issue.*

Questions for ARCA:

- *Please describe how ARCA is working to identify and address issues related to diversity and access.*

Questions for DRC:

- *Please describe the disparities in access to services that your organization has identified, based on the data that RCs provide. What recommendations would you make to improve our understanding of these disparities and how to best address the associated gaps in service access.*

ISSUE 10: EARLY START PROGRAM – OVERSIGHT ISSUE**Background and Previous Budget Actions**

The Early Start Program was established in 1993, in response to federal legislation that intended to ensure that early intervention services to infants and toddlers with disabilities and their families are provided in a coordinated, family-centered system of services that are available statewide. Provided services are based on a child's assessed developmental needs and the family's concerns and priorities, as determined by each child's individualized family service plan (IFSP) team.

In 2009, the Legislature adopted significant changes to the Early Start Program in order to reduce expenditures by \$41.5 million (GF). These changes included:

- Removing “at-risk” infants and toddlers under 24-months from eligibility.
- Requiring toddlers aged 24-months or older to have more significant delays across a larger number of domains in order to be eligible for services.
- Discontinuation of the provision of services that are not required by the federal government, with the exception of durable medical equipment. The services no longer provided are child care, diapers, dentistry, interpreters, translators, genetic counseling, music therapy, and respite services not related to the developmental delay of the infant or toddler.

As part of the changes to the Early Start Program, a prevention program was established for infants and toddlers who are “at risk” but no longer qualify for the Early Start Program. The prevention program provides safety net services (intake, assessment, case management, and referral to generic agencies) for eligible children from birth through 35 months. In 2011, DDS proposed, and the Legislature adopted, additional changes to the prevention program. Specifically, the required functions of the program were limited to information, resource, outreach and referral and the program was transferred from the regional centers to the Family Resource Centers, through a contract with DDS in the amount of \$2.003 million (GF). This same amount is included in the Governor's budget for the 2015-16 fiscal year.

Last year, the Legislature provided an \$8 million General Fund augmentation, and adopted trailer bill language, to restore eligibility for the Early Start Program to the level in place prior to the 2009 state budget, effective January 1, 2015. This was included in the final budget signed into law.

Governor's Budget

The Governor's budget projects the Early Start caseload, estimated as of January 31, 2015, to be 34,944 in the adjusted current year; and, estimates as of January 31, 2016, to be 36,313 in the budget year. This represents a growth of 1,369 or 3.92 percent in the budget year over the adjusted current year. The department estimates the caseload associated with the restoration of Early Start Program eligibility, that became effective on January 1, 2015, will increase to 3,554 in the budget year, or 42.16 percent, the first full year of implementation.

Federal Office of Special Education Programs Determination of Non-Compliance for California's Early Start Program

Each year, states are required to submit an annual performance report (APR) regarding their Early Start Program to the federal Office of Special Education Programs (OSEP). This report includes data on how the state performed in a number of compliance and outcome-based indicators. OSEP uses this data to make an annual determination of compliance for each state. When OSEP determines a state "Needs Intervention" for three or more years, one of five actions must be taken:

- Preparation of a corrective action plan if the correction can occur within one year.
- Require a compliance agreement if OSEP does not believe correction can occur within one year.
- Seek to recover funds.
- Withhold all or a portion of future payments.
- Refer for enforcement action, if appropriate.

For the past four fiscal years, California has received a "Needs Intervention" determination from OSEP. According to DDS, in the first three years of this status, the non-compliance issues revolved around insufficient data provided in the APR, and that this issue has been resolved. However, in the most recent OPR "Needs Intervention" determination issued in June of 2014 for the APR submitted for FY 2012-13, OSEP cited low performance in five out of 12 indicators, including:

- Timely provision of service.
- Timely resolution of complaints.
- Three indicators measuring compliance with requirements for children transition out of Early Start.

DDS has been required to submit correction action plans for the past two years. According to DDS, the APR submitted on February 2, 2015, shows improvement in some areas, with slight decreases in other areas. According to DDS, OSEP has indicated that beginning with the recently submitted APR, determinations will not only be based on performance related to compliance, but also will factor in outcome-based measures.

PANEL

Santi Rogers, Director, Department of Developmental Services

Rick Rollins, Legislative Advisor, Association of Regional Center Agencies

Kelly Young, Executive Director, WarmLine Family Resource Center

Marty Omoto, Director/Founder, CDCAN California Disability-Senior Community Action Network

Questions for DDS:

- *Please discuss what you know to date about the impact of the budget action last year, to restore eligibility, on regional center caseloads and services utilization.*
- *Please discuss the issues that led to the federal “needs intervention” status for this program, the current requirements on the state because of this status, when OSEP will issue its next determination, and what the ramifications may be for California if its status does not improve.*

Question for ARCA:

- *Please present the regional center perspective on this issue.*

Question for Kelly Young:

- *What role do family resource centers play in helping families access needed services and supports?*

ISSUE 11: PARENTAL FEES – OVERSIGHT ISSUE

Some parents are assessed a fee for services provided by the state, under the three programs described below.

Parental Fee Program

Established in the Lanterman Act in 1969 and subsequently amended in the late 1970's, parents with children under the age of 18 with developmental disabilities who live in out-of-home care are assessed a fee, based on their ability to pay. Parents with incomes at or below the federal poverty level (FPL) are not liable to pay the parental fee. Fees are scaled to gross annual family income, the number of persons dependent on the income, and the age of the child in placement.

Although there is no exemption policy, fees can be adjusted for major unusual expenses or if more than one child is in out-of-home placement.

Fees range from \$0 to \$1,877.

Fees collected up to the amount that would be assessed using the fee schedule in effect on June 30, 2009, are deposited into the Program Development Fund to provide resources needed to initiate new programs, consistent with approved priorities for program development in the state plan. Fees collected using the schedule effective July 1, 2009, that are above the amount that would have been assessed using the fee schedule in effect on June 30, 2009, are deposited into the Program Development Fund and are available for expenditure by the department to offset general fund costs.

In 2013-14, there were 641 accounts assessed, 313 families who were assessed a fee, and 129 families who paid fees. DDS estimates for 2013-14, the annual administrative costs for this program were \$572,000 (\$247,000 GF; \$325,000 program development fund (PDF)).

The Family Cost Participation Program (FCPP)

Established in 2005, parents of children who receive three specific regional center services: day care, respite, and/or camping, are required to pay a share-of-cost for those services, if they meet the following criteria:

- The child has a developmental disability or is eligible for services under the California Early Intervention Services Act.
- The child is zero through 17 years of age.
- The child lives in the parents' home.
- The child is not eligible for Medi-Cal.

Legislation was passed in February 2008, to include consumers, age birth through 2, receiving respite, day care, and/or camping under the California Early Intervention Services Act (Early Start Program).

The family assessment is based on a sliding scale, using income and family size, and ranges from 10 percent to 100 percent of the cost of service. Families with a gross annual income below 400 percent of the federal poverty level are excluded from participation in this program. The regional centers pay

the provider up to their authorized cost, regardless of whether the family has paid their share-of-cost for the services. The provider must collect the family's share-of-cost directly.

Families may appeal the determination of their share-of-cost to the executive director of the regional center, based on financial hardship.

In 2013-14, it is estimated that 7,174 families were eligible and 3,128 families were assessed a share-of-cost. DDS estimates for 2013-14, the annual administrative costs for this program in DDS were minimal. The core staffing formula provides 24.22 positions to the regional centers, statewide, at a budgeted cost of \$883,255, to administer this program.

Annual Family Program Fee (AFPF)

Established in 2011, parents whose adjusted gross family income is at or above 400 percent of the FPL, and who are receiving qualifying services through a regional center for their children ages 0-18, are assessed an Annual Family Program Fee (AFPF).

There is one AFPF assessed yearly, per family, regardless of the number of children in the household receiving services. Families who only receive assessment and case management services are not assessed a fee. Families receiving services through the Medi-Cal program are not assessed a fee. Families of children receiving only respite, day care, or camping services from the regional center and who are assessed a cost for participation under the Family Cost Participation Program (FCPP) are not assessed a fee.

Regional centers may grant an exemption to the assessment of an AFPF if the parents demonstrate that an exemption is necessary to maintain the child in the family home, or, the existence of an extraordinary event that impacts the parents' ability to pay the fee or the parents' ability to meet care and supervision needs of the child. Additionally, an exemption may be granted in the instance of a catastrophic loss that temporarily limits the ability of the parents to pay and creates a direct economic impact on the family.

The annual fee is \$150 or 200. Fees collected are deposited in the Program Development Fund.

In 2013-14, it is estimated that 13,881 children met this criteria and 13,644 families were assessed a fee, and 5,242 families paid a fee. DDS estimates for 2013-14, the annual administrative costs for this program was \$212,000 GF.

The chart below estimates the revenue generated by these programs.

	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
Parental Fee	\$1,302,431	\$1,417,599	\$1,420,059	\$1,336,277	\$1,221,746
Family Cost Participation	\$6,169,872	\$6,181,846	\$4,088,440	\$4,539,177	\$4,842,235
Annual Family Program Fee	N/A	N/A	\$486,850	\$872,821	\$966,140

State Auditor Report

In January of 2015, the California State Auditor released a report that found the process for assessing the fees under the Parental Fee Program is “woefully inefficient and inconsistent.” Specifically, the auditor found:

- Assessments do not occur in a timely manner, resulting in delayed billing and lost revenue. The auditor estimates lost revenue related to these delays could range from \$740,000 to \$1.1 million annually.
- Regional centers do not provide required documentation about placements and parental notification letters, resulting in DDS inefficiencies.
- Assessments are applied inconsistently and initial fee assessments lack sufficient documentation to justify the assessment level, or the assessment was calculated incorrectly.
- Required annual redeterminations were not conducted in 61 percent of accounts reviewed.
- Because DDS considers different factors when conducting the initial assessment and when considering an appeal, the vast majority of appeals are granted. For example, initial assessments use a family’s gross income; an appeal uses a net income.
- Appeal documentation contains numerous staff errors, no clear reasoning for adjustments, and inconsistencies that resulted in miscalculations.
- The process for collecting from families is ineffective; 733 accounts reviewed carried an unpaid balance totaling just under \$7.5 million, which is five times higher than the revenue collected annually.

The auditor has made recommendations intended to improve accountability. DDS has accepted some of these, is reviewing statutory and regulatory authority relative to other recommendations, and has modified implementation of others. Notably, DDS does not agree to pursue a fiscal penalty for regional centers who do not provide DDS with the required monthly placement reports and copies of information letters sent to parents.

Association of Regional Center Agencies (ARCA) Recommendation

ARCA recommends that the Annual Family Fee Program be eliminated. They argue that the program is a barrier to services and that they have seen families declining or postponing services that their children need in response to the fee.

PANEL

Rashi Kesarwani, Legislative Analyst's Office

Eileen Richey, Executive Director, Association of Regional Center Agencies

Santi Rogers, Director, Department of Developmental Services

Lawana Welch, Department of Finance

Questions for LAO:

- *Please briefly describe the State Auditor findings regarding the Parental Fee Program.*

Questions for ARCA:

- *Please describe your experience with, and your recommendation for, the Annual Family Fee Program.*
- *Please discuss the impact on the regional center staff and operations budget to administer these three fee programs.*

Questions for DDS:

- *Please describe the actions you have taken, or will take, to comply with recommendations of the state auditor regarding the Parental Fee Program.*
- *What is the rationale for why regional centers have not provided the required placement and notifications of the parents' documents required in the Parental Fee Program and why is a fiscal penalty not appropriate?*
- *Has ARCA shared their concerns about how the Annual Family Fee Program may be resulting in the delay of needed services and what is your response to this concern?*
- *Might the same concerns apply to the Family Cost Participation Program?*

ISSUE 12: INSURANCE CO-PAYS AND DEDUCTIBLES – OVERSIGHT ISSUE

The 2013-14 state budget included trailer bill language to allow regional centers to make health insurance co-pays and co-insurance payments, on behalf of consumers and their families, for the services identified as necessary in an individual program plan (IPP), under defined circumstances. Specifically, these payments may be made when all of the following is met:

- It is necessary to ensure that the consumer receives the service or support.
- When health insurance covers the service in whole or part.
- When the consumer or family has income that does not exceed 400 percent of the federal poverty level (FPL).
- When there is no third party who is liable to pay the cost.

Under extraordinary circumstances, when needed to successfully maintain the child at home or adult consumer in the least-restrictive setting, regional centers may make these payments for individuals and families who exceed the income threshold. At the time of adoption of this policy, DDS estimated that roughly 50 percent of consumers or families have incomes below 400 percent of FPL.

The adopted trailer bill prohibited pay by regional centers of insurance deductibles (the amount the insured must spend on covered services before insurance benefits can be utilized). However, the Legislature removed this prohibition last year, through the adoption of trailer bill (SB 856 (Budget and Fiscal Review Committee), Chapter 30, Statutes of 2014).

The current year budget includes \$9.9 million to cover the POS costs associated with this issue. Actual expenditures to date, are illustrated in the chart below, for all consumers and for consumers only utilizing behavioral health treatment (BHT), based on information provided by the department. The 2014-15 figures reflect services through January, 2015, but may not reflect the total amount that will be claimed for the budget year.

Year	Co-Pay/Co-insurance (all consumers)		Co-Pay/Co-Insurance (BHT only)		Deductibles (all consumers)		Deductibles (BHT only)	
	Claims	Consumers	Claims	Consumers	Claims	Consumers	Claims	Consumers
2013-14	\$3,211,569	2,726	\$2,776,610	1,899	N/A	N/A	N/A	N/A
2014-15	\$838,238	1,453	\$625,424	8	\$4,424	5	\$1,817	2

PANEL

Santi Rogers, Director, Department of Developmental Services

Lawana Welch, Department of Finance

Rick Rollins, Legislative Advisor, Association of Regional Center Agencies

Kristin Jacobson, Executive Director, Autism Deserves Equal Coverage Foundation

Questions for DDS:

- *Please discuss your analysis of the expenditure trend illustrated in the chart above, and how you think that trend may move in future years.*
- *What services, in addition to BHT, are most covered through this program?*
- *What POS savings can reasonable be associated with this program, based on cost avoidance for services that would otherwise be funded in full or part by the General Fund?*

Questions for ARCA:

- *Please describe your perspective and experience on this issue.*

Question for Kristin Jacobson:

- *Please describe your perspective and experience on this issue.*

ISSUE 13: BEHAVIORAL HEALTH TREATMENT – GOVERNOR’S PROPOSAL

SB 946 (Steinberg), Chapter 650, Statutes of 2011, requires insurers and health plans to provide coverage of behavioral health treatment (BHT) for persons with autism spectrum disorders, effective July 1, 2012. The budget assumed General Fund savings of \$80 million, in both the 2012-13 and 2014-13 fiscal years. However, the department now assumes an annual savings of only \$35.7 million General Fund, beginning in 2014-15. The Department of Finance has provided notice to the Joint Legislative Budget Committee of its intent to pursue funding for the current year deficiency in a supplemental deficiency bill. The amount will be updated at the May Revision.

SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014, directed BHT be provided under the Medi-Cal program for individuals under 21 years of age, to the extent it is required by federal law. Once implemented, the retroactive date of this new Medi-Cal service is July 1, 2014. The Governor’s proposed 2015-16 budget assumes a \$2 million decrease (\$1 million GF) over the current year budget to reflect a reduction in POS expenditures for an estimated 292 new consumers who would receive BHT services through the DHCS as a Medi-Cal benefit.

On September 30, 2014, DHCS submitted a state plan amendment to CMS seeking approval for BHT to be added as a Medi-Cal benefit for individuals under the age of 21. It is estimated that 7,700 individuals currently receiving BHT services through a regional center may be eligible to receive these services under the proposed Medi-Cal benefit.

Consistent with DHCS’ interim policy guidance, issued on September 15, 2014, all individuals receiving BHT services on September 14, 2014, through a regional center will continue to receive those services through the regional center until such time that DHCS and DDS develop a transition plan.

PANEL

Santi Rogers, Director, Department of Developmental Services
Lawana Welch, Department of Finance
Rick Rollins, Legislative Advisor, Association of Regional Center Agencies
Kristin Jacobson, Executive Director, Autism Deserves Equal Coverage Foundation

Questions for DDS:

- *Please describe your estimate methodology and whether you can reasonably project expenditure trends that are associated with these policy changes.*
- *Please provide a status update of the Medi-Cal transition plan, including strategies to ensure consumers and families do not “fall between the cracks” or see the quality and quantity of services reduced in the transition to private insurers or Medi-Cal.*

Questions for ARCA:

- *Please describe your perspective and experience on this issue.*

Question for Kristin Jacobson:

- *Please describe your perspective and experience on this issue.*

Staff recommendation: Leave open pending May Revision.

Peggy Collins 651-1891 or 651-4103
Senate Budget and Fiscal Review Committee

OUTCOMES: Senate Subcommittee #3 on Health and Human Services
Thursday, March 12, 2015
Agenda Part B: State Council on Developmental Disabilities
Developmental Services

4100 State Council on Developmental Services (SCDD)

ISSUE 1: BUDGET OVERVIEW – GOVERNOR’S PROPOSAL

- **Leave open pending May Revision.**

ISSUE 2: UPDATE ON FEDERAL HIGH RISK DESIGNATION – OVERSIGHT ISSUE

- **Informational.**

ISSUE 3: COUNCIL DIVERSITY – OVERSIGHT ISSUE

- **Informational.**

ISSUE 4: STATE CONTRACTS WITH SCDD – OVERSIGHT ISSUE

- **Informational.**

4300 Department of Developmental Services (DDS)

ISSUE 1: BUDGET YEAR INCREASE – GOVERNOR’S PROPOSAL

- **Leave open pending May Revision**

ISSUE 2: CURRENT YEAR DEFICIENCY AND BUDGET YEAR INCREASE – GOVERNOR’S PROPOSAL

- **Leave open pending May Revision.**

ISSUE 3: CORE-STAFFING FORMULA - OVERSIGHT ISSUE

- **Informational.**

ISSUE 4: CURRENT YEAR DEFICIENCY AND BUDGET YEAR INCREASES – GOVERNOR’S PROPOSAL

- **Leave open pending May Revision.**

ISSUE 5: SICK LEAVE – GOVERNOR’S PROPOSAL

- **Leave open pending May Revision.**

ISSUE 6: MINIMUM WAGE INCREASE – GOVERNOR’S PROPOSAL

- **Leave open pending May Revision.**

ISSUE 7: STATEWIDE SELF-DETERMINATION PROGRAM – GOVERNOR’S PROPOSAL

- **Leave open pending May Revision.**

ISSUE 8: STABILITY OF COMMUNITY-BASED SERVICES AND SUPPORTS SYSTEM - OVERSIGHT ISSUE

- **Informational.**

ISSUE 9: DISPARITIES IN SERVICE DELIVERY – OVERSIGHT ISSUE

- **Informational.**

ISSUE 10: EARLY START PROGRAM – OVERSIGHT ISSUE

- **Informational.**

ISSUE 11: PARENTAL FEES – OVERSIGHT ISSUE

- **Informational.**

ISSUE 12: INSURANCE CO-PAYS AND DEDUCTIBLES – OVERSIGHT ISSUE

- **Informational**

ISSUE 13: BEHAVIORAL HEALTH TREATMENT – GOVERNOR’S PROPOSAL

- **Leave open pending May Revision.**

Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.



March 19, 2015

9:30 a.m. or Upon Adjournment of Session

Room 4203, State Capitol

Agenda

(Michelle Baass)

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PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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. Thank you.

4150 Department of Managed Health Care

1. Overview

The mission of the Department of Managed Health Care (DMHC) is to regulate, and provide quality-of-care and fiscal oversight for health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

The department achieves this mission by:

- Administering and enforcing the body of statutes collectively known as the Knox-Keene Health Care Service Plan Act of 1975, as amended.
- Operating the 24-hour-a-day Help Center to resolve consumer complaints and problems.
- Licensing and overseeing all HMOs and some PPOs in the state. Overall, the DMHC regulates approximately 90 percent of the commercial health care marketplace in California, including oversight of enrollees in Medi-Cal managed care health plans.
- Conducting medical surveys and financial examinations to ensure health care service plans are complying with the laws and are financially solvent to serve their enrollees.
- Convening the Financial Solvency Standards Board, comprised of people with expertise in the medical, financial, and health plan industries. The board advises DMHC on ways to keep the managed care industry financially healthy and available for the millions of Californians who are currently enrolled in these types of health plans.

Budget Overview. The budget proposes expenditures of \$68.2 million and 417 positions for DMHC. See table below for more information.

Table: DMHC Budget Overview

Fund Source	2013-14	2014-15	2015-16
	Actual	Projected	Proposed
Federal Trust Fund	\$1,584,000	\$518,000	\$0
Reimbursements	\$2,999,000	\$3,157,000	\$2,640,000
Managed Care Fund	\$38,388,000	\$61,984,000	\$6,551,000
Total Expenditures	\$42,971,000	\$65,659,000	\$68,191,000
Positions	299.8	394.8	417.0

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested DMHC respond to the questions below:

1. Please provide a brief overview of DMHC's programs and budget.
2. Please provide an update on DMHC efforts regarding stakeholder engagement.

2. Federal Mental Health Parity Rules

Budget Issue. DMHC requests 11.0 positions (5.5 permanent and 5.5 two-year limited term) to address workload associated with conducting medical surveys of the 45 health plans affected by the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). In addition, two additional positions are requested starting in 2016-17, providing 7.5 permanent positions ongoing.

The requested positions and proposed activities are as follows:

1. Help Center – Division of Plan Surveys - 11.0 positions (5.5 permanent, 5.5 two-year limited term), effective July 1, 2015.

- 3.0 Attorney III (1.5 permanent, 1.5 two-year limited term)
- 1.0 Staff Health Care Service Plan Analyst (permanent)
- 6.0 Assistant Health Care Service Plan Analyst (2.0 permanent, 4.0 two-year limited term)
- 1.0 Office Technician (permanent)

Beginning January 1, 2016, the Help Center's Division of Plan Surveys (DPS) will conduct focused medical surveys of the 45 health plans required to comply with the MHPAEA, scheduled to be completed by December 31, 2016. According to DMHC, due to the complexity of the MHPAEA and its requirements and the large number of focused surveys to be conducted in twelve months, it is imperative that DPS has sufficient resources to efficiently plan and prepare to ensure that all 45 focused surveys are conducted and completed in 2016. Beginning July 1, 2015, DPS will begin the pre-survey planning necessary, including training new staff; drafting focused survey procedures and required documentation; researching outstanding legal, compliance, and regulatory issues; and, reviewing and analyzing health plan filings regarding their methodologies for complying with the MHPAEA.

Once the focused MHPAEA surveys are completed by December 31, 2016, the DPS will be responsible for completing the post-survey workload, including reviewing all final reports and identifying uncorrected deficiencies that warrant referral to the Office of Enforcement (Enforcement); comparing and analyzing all final reports to identify trends or systemic issues that may exist across multiple health plans; and, conducting analysis to identify serious deficiencies for potential non-routine or expedited follow up surveys. All post-survey workload will be completed by June 30, 2017. In addition to the focused surveys and in support of the sustained compliance oversight of the 45 health plans, beginning in 2017-18, the DPS will perform a special and specific review of mental health benefits during each health plan's existing schedule of triennial routine medical surveys, which equates to 15 surveys per fiscal year. These surveys will continue to require the use of highly specialized medical, psychological, medical risk management and other clinical experts that will require the use of consulting services. Results will be reported in the final report for each routine survey.

2. Office of Enforcement - Two positions (permanent), effective July 1, 2016.

- 1.0 Attorney III (permanent)

- 1.0 Senior Legal Analyst (permanent)

Enforcement expects a total of six MHPAEA compliance case referrals annually beginning in 2016-17 and ongoing, three from DPS and three from the Help Center's Division of Legal Affairs, with the DPS referrals being the most time consuming. According to DMHC, the MHPAEA compliance cases will be more complex than typical case referrals and the DMHC anticipates that enforcement of MHPAEA compliance cases will be more aggressive. MHPAEA legal issues are new and unique to the DMHC and the managed care industry and are expected to involve challenging legal matters including federal pre-emption issues.

3. Clinical Consulting - This request also includes \$1.86 million for 2015-16; \$2.22 million for 2016-17; and \$166,000 for 2017-18 and ongoing for clinical consulting services for the medical health plan surveys and for expert witness and deposition costs for enforcement trials.

DMHC currently contracts for the specialized medical and mental health expertise that is required and not available through the civil service system. These consultants support the DPS in evaluating the specific elements related to the requirements of the MHPAEA. Conducting effective MHPAEA focused medical surveys will require the use of highly specialized medical, psychological, medical risk management and other clinical experts that are not available through the civil service system.

Background. In 2008, Congress enacted the MHPAEA, requiring only large group health plans that offer mental health benefits do so in a manner comparable to medical and surgical (medical) benefits. After the enactment of the Affordable Care Act (ACA) in 2010, federal regulations and state statute implementing Essential Health Benefits (EHB) made the MHPAEA also applicable to individual and small group health care and health insurance products. As of July 1, 2014, the rules apply for all group products as employers renew or purchase coverage. For individual products, the rules apply to the new policy years beginning January 1, 2015.

Assessing compliance of health plans with the rules requires an analysis that is significantly different than the analysis the DMHC currently conducts to enforce state mental health parity requirements. The DMHC presently reviews health plans' Evidences of Coverage (EOC) for compliance with state law, generally focusing on whether analogous benefits for specific severe mental illnesses and serious emotional disturbances in children are subject to the same cost-sharing and utilization-management requirements as medical conditions.

In contrast, these rules require analysis of broader benefit classifications. Rather than a comparison of the applicable terms and conditions, the rules require extensive review of the health plans' processes and justifications for classifying benefits into six permissible classifications:

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network
4. Outpatient, Out-of-Network
5. Emergency Care

6. Prescription Drugs

After classifying all benefits into the six categories, health plans must then determine parity for financial requirements (e.g., deductibles, copays, coinsurance); quantitative treatment limitations (QTL) (e.g., number of visits, days of treatment) and nonquantitative treatment limitations. According to DMHC, the analyses of the health plans' methodology for determining compliance requires extensive reviews that are beyond the DMHC's existing capacity and expertise. Moreover, the analyses required under the rules are data-intensive and require information the health plans do not routinely file with DMHC (e.g., methodologies to determine benefit classifications, projected plan payments, and rationale for application of NQTL). As such, implementation and enforcement of health plan compliance with the MHPAEA require the DMHC to undertake both an initial focused analysis and continuing evaluation of a new depth and breadth due to the complexities of this law and the inter-relationship with existing California mental health parity laws and EHB requirements.

2014 Budget Resources for Federal Mental Health Parity. The 2014 budget included a one-time augmentation of \$369,000 (Managed Care Fund) in 2014-15 for clinical consulting services to conduct initial front-end compliance reviews to ensure oversight of California's implementation of the MHPAEA and five positions to enforce these requirements. (The Legislature augmented DMHC's budget by \$4.2 million to add ten positions and consulting services to ensure enforcement of these requirements and the Governor vetoed five of the positions added by the Legislature, resulting in a net augmentation of five positions.)

Findings from DMHC's Initial Front-End Reviews. According to DMHC, it is still early in DMHC's review of the federal mental health parity compliance filings. Each plan is in a different point in the process, so it is not yet possible to make industry-wide assessments of compliance. DMHC has encountered a variety of compliance issues during all stages of the review process, some minor, some significant and/or complex. As an example, there are plans that need to adjust cost-sharing for specific services or refine language in their evidences of coverage to ensure consistency with the law. Further, some plans are still working to submit a complete compliance filing due to the complexity of the requirements. As the review team encounters compliance issues, DMHC's licensing counsel works with the plans to develop corrective actions to bring them in compliance.

As DMHC began developing the specific reporting criteria for the compliance project, DMHC determined that 26 full-service health plans would be required to submit filings. Specialized behavioral health plans under contract with full service health plans are required to include their filing information with the full service plans. While the total number of plans submitting filings is lower than DMHC originally anticipated, the complexity and length of each plan's filings is significant higher. Each plan was required to submit complete information for 15 separate products (to the extent they offer products in each market segment).

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to keep this item open as discussions on this proposal.

Questions. The Subcommittee has requested DMHC to respond to the following questions:

1. Please provide an overview of this proposal.

2. Please explain the findings from the initial front-end reviews that are being conducted.
3. When does DMHC anticipate that health plans will complete the initial front-end review?
4. Please explain how DMHC's recent findings regarding Kaiser's failure to provide patients with appropriate access to mental health care is distinguished from a health plan's compliance with federal mental health parity.

3. Additional Enrollment in Individual Market

Budget Issue. DMHC requests seven permanent positions and \$1,134,000 for 2015-16 and \$1,070,000 for 2016-17 and ongoing to address the increased workload resulting from the revised projected increase in enrollment in the individual market pursuant to SB 2 X1 (Hernandez), Chapter 2, Statutes of 2013-14 of the First Extraordinary Session. This request includes \$208,000 for 2015-16 and ongoing for expert witness and deposition costs for enforcement trials.

The requested positions are:

Program/Classification	Number of Positions
Help Center	
Attorney I	1.0
Nurse Evaluator II	0.5
Associate Governmental Program Analyst	1.0
Consumer Assistance Technician	1.0
Office of Enforcement	
Attorney III	1.0
Legal Secretary	0.5
Office of Administrative Services	
Associate Governmental Program Analyst	1.0
Office of Technology and Innovation	
Associate Information Systems Analyst	1.0
Total Positions	7.0

Background. DMHC is a health care consumer protection organization that helps California consumers resolve problems with their health plans and works to provide a stable and financially solvent managed care system. DMHC regulates health care service plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended.

Existing federal law, the Affordable Care Act (ACA), enacts major health care coverage market reforms that take effect January 1, 2014. With the passage of SB 2 X1, California law now conforms to the ACA requirement that beginning January 1, 2014 health plans that offer health coverage in the individual market accept every individual that applies for that coverage.

As a result, DMHC is now responsible for providing consumer assistance and regulatory oversight to millions of enrollees and new health plans and products offered in Covered California.

In the 2014 budget, DMHC received 13.5 positions effective July 1, 2014, with an additional 5.5 positions effective July 1, 2015, for a total of 19.0 permanent positions for the workload associated with SB 2 X1. As part of the 2014 budget request, DMHC estimated that 90 percent of all new enrollees in individual market plans would be under the jurisdiction of the DMHC with the other ten percent under

the jurisdiction of the California Department of Insurance (CDI). However, in the past year it has been realized that the DMHC has jurisdiction over approximately 98 percent of the enrollees in Covered California individual market plans, with only two percent under the jurisdiction of the CDI. Because of this percentage increase, along with the revised enrollment projections of 1.9 million individuals enrolled in health plans—licensed by DMHC—in the individual market (compared to 1.7 million estimated in May), DMHC requests additional resources.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal. Subcommittee staff notes that seven of the 13.5 positions requested last year remain vacant as DMHC has had difficulty filling these positions. DMHC notes that it has reclassified the difficult-to-fill positions and anticipates filling the vacant positions in the short-term.

Questions. The Subcommittee has requested DMHC to respond to the following questions:

1. Please provide an overview of this proposal and the growth in workload related to the individual market.

4. Large Group Claims Data Exposure (SB 1182, 2014)

Budget Issue. DMHC requests one permanent position (a senior legal analyst), effective January 1, 2016, and \$85,000 for 2015-16 and \$148,000 for 2016-17 and ongoing to address the increased workload resulting from the implementation of SB 1182 (Leno), Chapter 577, Statutes of 2014, regarding large group claims data exposure. This request also includes \$23,000 for 2015-16 and \$45,000 for 2016-17 and ongoing for clinical consulting services to provide methodology and statistical sampling of the claims data provided.

Background. SB 1182 requires a health care services plan or health insurer to annually provide de-identified claims data at no charge to a large group purchaser that requests the information and meets specified conditions. Most health plans already provide some large group purchasers with some level of de-identified claims data about their employee populations. Ensuring that all health plans and insurers are subject to the same disclosure standards promotes a level playing field, enables purchasers to better negotiate rates, and also assist efforts to improve the health of employees in large groups through disease management programs and other mechanisms aimed at improving the health of a large group membership.

The Office of Enforcement expects to see complaints from large group employers regarding a health plan's failure to provide de-identified claims data or failure to provide complete data. As purchasers receive and analyze this information it is expected that disagreements between large group plans and large group purchasers will arise over whether the health plan has satisfactorily provided required information. It is also expected that disagreements will arise between consumer advocacy groups and health plans as to whether the information is sufficiently de-identified so that an employer group cannot identify an employee based off of the claims data provided.

The requested positions would sort, organize, review, and summarize the documents submitted by a health plan and large group purchaser, as well as the documents provided in response to the DMHC's discovery requests. This position would also identify the issues presented and provide a written evaluation to an attorney as to whether a health plan met statutory and regulatory standards regarding provision of de-identified claims data. This evaluation will be necessary for each referral and will require a comparison between established standards and submitted documents as well as identification of deficiencies.

In addition, the requested funding for clinical consulting services would be used to provide methodology and statistical sampling of the claims data provided. The consultant will also be responsible for advising the Office of Enforcement on the sufficiency of the claims data provided and for establishing baselines of what constitutes a sufficient submission of information by a large group plan.

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

Questions. The Subcommittee has requested DMHC to respond to the following questions:

1. Please provide an overview of this proposal.

5. Dental Plans Medical Loss Ratio (AB 1962, 2014)

Budget Issue. DMHC requests 1.5 permanent positions and \$189,000 for 2015-16 and \$173,000 for 2016-17 and ongoing to address the increased workload resulting from the implementation of AB 1962 (Skinner), Chapter 567, Statutes of 2014, regarding dental plan medical loss ratios (MLR).

Background. AB 1962 requires health plans that issue, sell, renew, or offer specialized dental plan contracts to file a report with DMHC that contains the same information required in the federal MLR Annual Reporting Form. This report is due to DMHC on an annual basis beginning no later than September 30, 2015. The bill declares the intent of the Legislature that the data reported pursuant to these provisions be considered in adopting an MLR standard that would take effect no later than January 1, 2018. AB 1962 requires DMHC to make available to the public the MLR data received, and allows DMHC to issue guidance outside the Administrative Procedures Act. Identical provisions apply to health insurers regulated by the California Department of Insurance.

DMHC reviews all health plan filings related to health coverage, including health plan subscriber contracts and evidence of coverage documents, resolves inquiries and complaints from enrollees with health coverage, conducts financial oversight, and takes enforcement action when health plans fail to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended. In addition, the DMHC oversees dental care products both inside and outside California's Health Benefit Exchange (Exchange), Covered California.

DMHC regulates health plans, including specialized health plans such as dental plans, under the KKA. While the KKA historically did not include an MLR requirement for any health plans, Public Health Service Act (PHSA) Section 2718, added by the Affordable Care Act (ACA), requires that individual and small group plans provide an annual rebate to each enrollee if the percent of premium spent on claims and quality improvement activities is less than 80 percent (unless a state determines a higher percentage) of the plan's MLR. AB 51 (Chapter 644, Statutes of 2011) incorporated this requirement into the KKA. However, the ACA's MLR provision does not apply to stand-alone dental plans, which are "excepted benefits" under PHSA Section 2791 (c)(2)(A), and the KKA similarly exempts dental plans from the ACA's MLR requirement.

Existing state law requires a health care service plan or health insurer to comply with specified MLR requirements and requires a plan or insurer to provide an annual rebate to enrollees and insureds if the ratio of the amount of premium revenue expended by the plan or insurer on specified costs to the total amount of premium revenue is less than a certain percentage. Existing law specifies that these requirements do not apply to specialized health care service plan contracts or specialized health insurance policies, such as dental plans.

For 2014, inside the Exchange, five dental plans offered stand-alone dental products in the individual market: Anthem Blue Cross, Blue Shield of California, Delta Dental, Liberty Dental, and Premier Access. Nine plans offered stand-alone dental products in the small group market: Access Dental, Blue Shield of California, Delta Dental, Guardian, Liberty Dental, Managed Dental, MetLife, Premier Access, and SafeGuard. For 2015, Covered California anticipates offering a wider range of dental care products that are overseen by the DMHC: (1) stand-alone dental plans covering pediatric oral care and

family dental plans (covering both pediatric and adult oral care), and Qualified Health Plans (QHPs) that offer 10 Essential Health Benefits (EHBs) inside the Exchange, (2) stand-alone dental plans covering pediatric oral care and family dental plans (covering both pediatric and adult oral care) that are bundled with a QHP that offers ten EHBs, and (3) QHPs with pediatric dental benefits embedded.

The Department of Health Care Services (DHCS) requires a 70 percent MLR for all Medi-Cal Dental Managed Care plans. DHCS currently contracts with three Dental Managed Care plans (Access Dental Plan, Health Net of California, Inc., and Liberty Dental Plan of California, Inc.) and DMHC conducts MLR reviews of these plans on behalf of DHCS. DMHC also conducts MLR reviews of all full-service medical plans, pursuant to Health and Safety Code section 1367.003 and its attendant regulation, California Code of Regulations, Title 28, Rule 1300.67.003.

The requested positions would be used to (1) acquire permission to use the federal MLR reporting form and then implement an MLR reporting form, (2) determine whether the DMHC should adopt federal MLR standards and definitions, or use the KKA's MLR standards and definitions for the new dental MLR annual reports, (3) develop a new examination program and training procedures for dental plan MLR examinations, (4) perform three additional examinations each year to assure the accuracy of the financial reporting, (5) review of 18 additional MLR reports on an annual basis, and (6) potentially assess MLR for dental products embedded in full service plans. DMHC indicates that it is unable to absorb this new workload.

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

Questions. The Subcommittee has requested DMHC to respond to the following questions:

1. Please provide an overview of this proposal.

4260 Department of Health Care Services

1. Overview

The Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering personal health care services to eligible individuals. DHCS's 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.*** The Medi-Cal program 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 12 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, low-income people with specific diseases, and, as of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level.
- ***Children's Medical Services.*** The Children's Medical Services coordinates and directs the delivery of health 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, and it includes: 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, the 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.

See following table for DHCS budget summary information.

Table: DHCS Fund Budget Summary (dollars in thousands)

Fund	Actual	Estimated	Proposed
	2013-14	2014-15	2015-16
General Fund	\$16,692,207,000	\$18,167,875,000	\$19,041,233,000
Federal Trust Fund	32,814,407,000	56,192,246,000	61,364,918,000
Special Funds and Reimbursements	8,636,020,000	14,019,575,000	17,642,975,000
Total Expenditures (All Funds)	\$58,142,634,000	\$88,379,696,000	\$98,049,126,000
Positions	3337.6	3678.2	3720.6

State Auditor – DHCS a High-Risk State Agency. On March 5, 2015, the State Auditor notified the Legislature that DHCS remains a high-risk agency due to its increased responsibility under the Affordable Care Act and the state Mental Health Services Act, as well as outstanding audit recommendations regarding other programs.

Subcommittee Staff Comment—Information Item. This item is for informational purposes.

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

1. Please provide a brief overview of DHCS’s programs and budget.
2. What is DHCS’s response to the State Auditor’s notification that DHCS remains a high-risk agency? What is DHCS doing to address these recommendations?

2. Medi-Cal Estimate and Caseload

DHCS administers the Medi-Cal program (California’s Medicaid health care program). This program pays for a variety of medical services for children and adults with limited income and resources. The Governor proposes total expenditures of \$95.4 billion (\$18.6 billion General Fund) which reflects a General Fund increase of \$770 million above the Budget Act of 2014. Generally, each dollar spent on health care for a Medi-Cal enrollee is matched with one dollar from the federal government. See following table for a summary of the proposed Medi-Cal budget.

Table: Medi-Cal Local Assistance Funding Summary

	2014-15	2015-16	
	Revised	Proposed	Difference
Benefits	\$81,242,000,000	\$91,331,800,000	\$10,089,800,000
County Administration (Eligibility)	\$3,981,500,000	\$3,617,300,000	-\$364,200,000
Fiscal Intermediaries (Claims Processing)	\$524,200,000	\$463,300,000	-\$60,900,000
Total	\$85,747,800,000	\$95,412,400,000	\$9,664,600,000
General Fund	\$17,839,700,000	\$18,610,500,000	\$770,800,000
Federal Funds	\$56,977,500,000	\$61,637,100,000	\$4,659,600,000
Other Funds	\$10,930,500,000	\$15,164,700,000	\$4,234,200,000

Caseload. The Governor’s budget assumes total annual Medi-Cal caseload of 12.2 million for 2015-16. This is a two percent increase over the revised caseload estimate of 12 million for 2014-15.

- **ACA Caseload.** The budget assumes that compared to 2013-14, which reflected the first six months of implementation for ACA-related expansions, the combined annual caseload from the optional and mandatory expansions will have tripled in 2014-15. Following this steep climb, the budget assumes that in 2015-16, the optional and mandatory expansions will remain flat at two million and one million enrollees, respectively. The budget estimates that combined caseload from other ACA-related policies, such as express lane enrollment and hospital presumptive eligibility, will be 250,000 in 2014-15 and 220,000 in 2015-16.
- **Non-ACA Caseload.** The Administration projects that annual Medi-Cal caseload in the base forecast—absent the effects of the ACA—will be 8.8 million in 2014-15 and 8.9 million in 2015-16, a two percent year-over-year increase. Between the two years, the budget also implies that the underlying trend for both seniors and persons with disabilities (SPDs) and families and children is two percent growth.

Uncertainty Regarding CHIP Funding. The ACA-appropriated federal funding for the Children’s Health Insurance Program (CHIP) through federal fiscal year (FFY) 2015, which ends September 30,

2015. In order for states to receive annual CHIP allotments beyond FFY 2015, Congress must appropriate additional funds for the program. The Medi-Cal estimate assumes that the state would continue to receive the same federal matching rate for CHIP as it does today. However, this is dependent on Congress to appropriate additional funds for CHIP. Currently, the federal government provides a 65 percent federal matching rate for CHIP coverage (roughly a two dollar match for every dollar the state spends). Whereas for other Medi-Cal-covered children, California generally receives a 50 percent federal matching rate (a one dollar match for every dollar the state spends). DHCS estimates the state will draw down nearly \$2.1 billion in federal CHIP funding in 2015-16 (most of which is matched with General Fund).

Medi-Cal Caseload Estimate Does Not Reflect Minimum Wage Increase. Additionally, the Medi-Cal estimate does not reflect any adjustments to caseload as a result of the minimum wage increase pursuant to AB 10 (Alejo) Chapter 351, Statutes of 2013. Generally speaking, since eligibility for Medi-Cal is based on income level (among other factors), as wages increase, it is likely that some individuals may no longer qualify for Medi-Cal. It should be noted that the CalWORKs estimate reflects savings of \$11.4 million in 2014-15 and \$20.3 million in 2015-16 as a result of AB 10. The Medi-Cal estimate does reflect increases to provider rates (“add ons”) to account for increases in salaries as a result of AB 10. AB 10 increased the minimum wage from \$8.00 to \$9.00 per hour on or after July 1, 2014 and a second increase (to not less than \$10.00 per hour) will go into effect on January 1, 2016.

LAO Comments on Medi-Cal Caseload Estimate. The LAO has the following comments related to the Medi-Cal caseload estimate:

- ***Senior Trend Raises Questions.*** DHCS projects the senior caseload to increase 5.7 percent in 2014-15, yet only 2.3 percent in 2015-16. The spike has a material impact on spending in 2014-15. Most seniors enrolled in Medi-Cal are dually eligible for Medi-Cal and Medicare. For 2014-15, the budget’s updated estimate of the number of dual eligibles enrolled in the Medicare prescription drug benefit is higher by five percent, leading to a \$95 million increase in General Fund spending compared to the 2014 budget act.

In terms of underlying trends, seniors represent the fastest-growing segment of Medi-Cal caseload, due to the state’s large cohort of baby boomers passing age 65. Over the two-year period, DHCS’s implied annual growth rate for seniors is four percent, which is more in line with our expectations. As suggested by the department, the delay in redeterminations, modified renewal process, or other temporary factors could explain the 2014-15 spike as a one-time anomaly. However, without more current data on enrollment, the LAO cannot rule out the other possibility that the spike could signal an upward shift in the underlying trend for seniors, due to demographic changes or other fundamental factors.

- ***Assumes Underlying Growth for Families and Children, Despite Improving Economy.*** Excluding the caseload associated with the ACA, the budget implies one percent growth in base caseload for families and children in 2014-15, rising to two percent growth in 2015-16. However, Medi-Cal enrollment among families and children has moved countercyclical to the economy. (This means that families enrollment tends to go up during an economic downturn and go down during an economic expansion.) The LAO notes that caseload for California Work Opportunity and Responsibility to Kids (CalWORKs)—a means-tested program that overlaps with Medi-Cal in terms of the families enrolled—has declined steadily since 2011-12.

The LAO expects the *underlying* trend for Medi-Cal’s families caseload (absent ACA impacts) to transition to a slight decline as the economy expands. Historically, there has usually been some lag between the onset of an economic recovery and a turning point in the families caseload for Medi-Cal. However, the economy is well into the sixth year of the current expansion. All else equal, the LAO would have expected the underlying trend for families to be declining—particularly since the trend showed signs of leveling off just prior to the beginning of ACA-related enrollment.

Consequently, the LAO recommends:

- ***Require Administration to Resume Monthly Caseload Reports.*** Prior to 2014, DHCS released monthly reports on Medi-Cal caseload levels and trends. Although these reports came with certain caveats, they were useful for keeping abreast of the overall direction of statewide Medi-Cal enrollment. In March 2014, the department announced the temporary suspension of its monthly caseload reports. The LAO recommends the Legislature require DHCS to report at budget hearings on options for releasing statewide monthly enrollment data, aggregated at the level of families and children, SPDs, and childless adults. Since the LAO’s report, DHCS has resumed posting this information on its website.
- ***Ask Administration About Future Treatment of Mandatory Expansion.*** The LAO recommends DHCS report at budget hearings about its forecasting decision to continue to parse out the ACA “mandatory” expansion population instead of including as part of the base Medi-Cal estimate. The LAO finds that continuing attempts to parse out this segment from the overall caseload estimate seem abstract and potentially misleading, as more data accumulate and any definable distinction between mandatory and nonmandatory caseload fades. This forecasting decision impacts the ability to project the underlying trend in families and children caseload.
- ***In Addition to ACA, Begin Refocusing on Underlying Trends.*** While the ACA has had an important and sudden impact on total Medi-Cal enrollment, the LAO also raises the issue of *underlying* enrollment trends. The LAO recommends the Legislature explore this issue in more depth during budget hearings.

LAO Assessment on CHIP Funding. The LAO finds that the Governor’s approach to budgeting CHIP funding is reasonable since it assumes a “middle-of-the-road scenario.” However, the LAO notes that federal CHIP funds available to California in 2015-16 may be more or less than assumed in the Governor’s budget. Additionally, the LAO indicates that there are also longer-term implications for children’s health coverage given that CHIP may not continue beyond the next several years, even if Congress appropriates funding for CHIP beyond FFY 2015.

Subcommittee Staff Comment and Recommendation. It is recommended to:

- a. **Hold Open Caseload Estimate.** It is recommended to hold the Medi-Cal caseload estimate open as discussions continue and updates are reflected in the May Revision. As noted above, several assumptions included in the Medi-Cal caseload estimate suggest that the Administration has taken a conservative approach to projecting caseload and expenditures. As the LAO notes, caseload estimates are important not only for budgeting purposes, but also to understand access and capacity in the program.

- b. Adopt Placeholder Trailer Bill Language To Eliminate Nonemergency Emergency Room Copay.** It is recommended to adopt placeholder trailer bill language to eliminate the statutory references implementing a nonemergency emergency room copay in Medi-Cal, as this assumption has been removed from the Medi-Cal estimate. As part of the Medi-Cal estimate, the Governor's budget removes the assumption that the state would implement a copayment for nonemergency emergency room usage pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011 and AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012 which was expected to result in about \$34 million (\$17 million General Fund) savings. This copay has never been implemented as it had not received approval from the federal Centers for Medicare and Medicaid. While the budget discontinues this assumption, the Administration did not propose trailer bill language to delete this provision from statute.

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

1. Please provide a brief overview of the Medi-Cal caseload estimate.
2. Please respond to LAO's findings regarding the Medi-Cal caseload estimate.
3. How is DHCS planning for contingencies regarding CHIP funding?
4. Does DHCS conduct or plan to conduct a demographic analysis of Medi-Cal enrollees to identify and report on disparities by managed care plan and region? Does DHCS find that this type of information would help identify quality improvement initiatives aimed at reducing health disparities in the state and potentially reduced Medi-Cal expenditures? Does DHCS plan to make this information public?
5. It is estimated that one million Medi-Cal renewals will be processed every month. Given that the 2015 renewal process includes pre-populated applications and electronic verification, how is DHCS monitoring the processing of Medi-Cal renewals? Are counties reporting this information to DHCS? How does DHCS estimate for the number of individuals that will be discontinued during the annual review process?

3. CalHEERS Oversight

Oversight Issue. Concerns have been raised regarding the processes by which stakeholder input is provided to and considered by the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) project to aid decision-making, coordination, and rollout of system changes.

In February, a 24-month roadmap for CalHEERS changes was released and it appeared that changes to implement requirements of the Affordable Care Act (ACA) and state law regarding Medi-Cal continued to be delayed without any insight or justification for the delays provided to external stakeholders. For example, under the ACA, former foster youth qualify for Medi-Cal coverage until age 26, regardless of their income. This law, which has been in effect since January 1, 2014, is still not programmed accurately into CalHEERS resulting in enrollment delays, enrollment in the wrong affordability program, or denial of Medi-Cal for these former foster youth.

In response to these concerns, on March 13, 2015, DHCS released a revised 24-month roadmap and indicated that the functionality to determine former foster youth eligibility and the functionality to incorporate the Medi-Cal Access Program (formerly Access for Infants and Mothers-AIM) will be included as part of the September 2015 CalHEERS release. Previously, this functionality was projected to be included no sooner than February 2016 (and no date-certain for incorporation of AIM functionality).

The Medi-Cal budget includes \$128.6 million (\$25.7 million General Fund) for CalHEERS development in 2015-16.

24-Month Roadmap. Recently, CalHEERS established a 24-month roadmap of mission-critical automation needs. This roadmap is intended to be a comprehensive plan delineating major CalHEERS system initiatives and related partner's system critical events to enable overarching strategic and tactical planning by each system organization and sponsors. The business goals developed as a guide for roadmap efforts are:

1. Ensure consumers receive accurate and timely eligibility determinations and correct plan enrollment, initially and during any change or renewal event.
2. Ensure business partners are able to receive, exchange, and reconcile appropriate consumer information on a timely basis.
3. Appropriately equip authorized end users with tools necessary to serve consumers effectively and to handle exception situations.
4. Provide consumers and end users with an improved consumer experience.
5. Ensure the technical infrastructure is properly maintained, current, secure, and supports capacity demands and completion of business goals.

Background. The ACA requires a single, accessible, standardized paper, electronic, and telephone application process for insurance affordability programs, which require a joint application for Medi-Cal and Covered California. The joint application is required to be used by all entities authorized to make an

eligibility determination for any of the insurance affordability programs. (Medi-Cal and Covered California with a premium or cost-sharing subsidy are “insurance affordability programs.”)

CalHEERS is the information technology system that is used to support this application process. The primary business objective of CalHEERS is to provide a ‘one-stop shop’ to determine eligibility for California’s health coverage programs offered by the Exchange and the Department of Health Care Services.

The CalHEERS Project is jointly sponsored by the Exchange and the Department of Health Care Services (DHCS). The CalHEERS Project has acquired Accenture, LLP as a prime vendor to develop the CalHEERS solution that will support the implementation of a statewide healthcare exchange.

Required Stakeholder Input Regarding CalHEERS. AB 1296 (Bonilla), Chapter 641, Statutes of 2011 requires DHCS, Covered California and the California Health and Human Services Agency to provide:

a process for receiving and acting on stakeholder suggestions regarding the functionality of [CalHEERS], including the activities of all entities providing eligibility screening to ensure the correct eligibility rules and requirements are being used. This process shall include consumers and their advocates, be conducted no less than quarterly, and include the recording, review, and analysis of potential defects or enhancements of the eligibility systems. The process shall also include regular updates on the work to analyze, prioritize, and implement corrections to confirmed defects and proposed enhancements, and to monitor screening.

Office of Systems Integration Recommendations Regarding CalHEERS Governance. At the March 5, 2015 Subcommittee No. 3 hearing, the issue of the Office of System Integration’s (OSI) role in the CalHEERS project was discussed. Subcommittee staff requested the list of OSI recommendations regarding improvements to the CalHEERS governance structure. These include:

- *Those parties with accountability for the outcomes of the CalHEERS project should retain final authority for making decisions. Other advisory members should be included in the governance structure in non-voting capacities to provide input, insights, and counsel to inform the decisions.*
- *Establish a CalHEERS Project Steering Committee comprised of Deputy Director-level representatives from the Sponsor organizations and corresponding leaders from partner entities to provide counsel, advice, and input for Sponsor decision-making.*

Consider a layered committee structure to garner input while retaining appropriate accountability and authority, for example:

- *Voting members could include designated DHCS and Covered California deputy directors who are accountable for budgets and outcomes related to the Insurance Affordability Program needs of the sponsor organizations.*
- *Advisory members could include designated executives from CDSS, OSI, and CWDA.*

- *There is an opportunity to realign the Program Coordination Committee to retain a focus on refining, reinforcing, and updating the 24-Month Roadmap initiatives including addressing necessary changes, resolving conflicts, and planning for business resource needs to support timely design decisions.*
- *Confirm the Program Coordination Committee includes the appropriate individuals to represent the business, technology, and project needs of DHCS, Covered California, CWDA/Counties, SAWS, and CalHEERS. Representatives should be at a level sufficiently close to program delivery that they have a thorough working knowledge of business execution, and possess the authority to make recommendations on behalf of their organization.*
- *The project team should extend the use of priority-balancing criteria established for the 24-Month Roadmap initiative to help evaluate the timing and relative value of changes proposed for the CalHEERS system.*

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions on this topic continue.

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

1. Please describe the governance structure of CalHEERS and the criteria CalHEERS project sponsors use in establishing the release schedule.
2. Please discuss how the “lessons learned” in 2014 are being applied to CalHEERS planning in 2015. What happened in 2014 that delayed the release of Medi-Cal functionality in CalHEERS?
3. Given that the first business goal related to the 24-month roadmap is “to ensure consumers receive accurate and timely eligibility determinations,” why is functionality related to former foster youth eligibility for Medi-Cal and the Medi-Cal Access Program not expected to be included in CalHEERS until later in 2015?
4. Is DHCS confident that the current workarounds for former foster youth and the Medi-Cal Access Program are ensuring that individuals that qualify under these categories are gaining easy access to the Medi-Cal program?
5. Please explain how the AB 1296 stakeholder workgroup suggestions are considered as part of establishing the release schedule.
6. Has there been an increased workload on the county eligibility workers as a result of some of the functionality problems over the original estimates? If so what accommodations have been made?
7. How is DHCS working with county eligibility workers to solicit feedback on improvements to CalHEERS?

8. Does DHCS commit to including optional demographic questions regarding sexual orientation and gender identity on the paper and online application for 2016 open enrollment for Covered California?

4. CalHEERS Electronic MAGI Determination Trailer Bill Language

Budget Issues. DHCS proposes trailer bill language to remove the sunset provision to allow for continued electronic verification of Medi-Cal eligibility information.

Background. As part of the Affordable Care Act, the Department of Health Care Services (DHCS) and the California Health Benefit Exchange (Covered California) built the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). CalHEERS is the system that assesses an individual's eligibility for insurance affordability programs, including eligibility for modified adjusted gross income (MAGI) Medi-Cal and to purchase health insurance through Covered California.

If an applicant can be determined MAGI Medi-Cal eligible using only electronic verifications, CalHEERS determines MAGI Medi-Cal eligibility and the case information is sent to the applicant's county of residence for ongoing case management services. If an applicant cannot be determined MAGI Medi-Cal eligible using only electronic verifications, CalHEERS electronically sends the case information to the applicant's county of residence for a MAGI Medi-Cal eligibility determination. Upon receiving the MAGI Medi-Cal case, the counties collect necessary information to complete the applicant's MAGI Medi-Cal eligibility determination. This process, codified in Section 14015.5 of the Welfare and Institutions Code, sunsets on July 1, 2015. The purpose of this trailer bill language is to remove the sunset provision.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions on this topic.

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

1. Please provide an overview of this proposal and why a sunset was originally included.

5. Dental Services in Medi-Cal

Budget Issue. The Governor’s budget includes proposals related to dental services in Medi-Cal, these are:

1. **Child Health and Disability Prevention (CHDP) Program Dental Referral** – DHCS proposes trailer bill language requiring CHDP programs and providers to refer all Medi-Cal-eligible children participating in CHDP who are one year of age and older to a dentist participating in the Medi-Cal program, rather than at age three.

The budget assumes annual costs of \$808,000 (\$404,000 General Fund) for additional dental services for children referred to a dentist at one year of age or later.

2. **Allied Dental Professionals Enrollment** – DHCS proposes to include allied dental professions employed by a public health program (registered dental hygienists, registered dental hygienists in extended functions, and registered dental hygienists in alternative practice) in the Medi-Cal dental services program. A State Plan Amendment is under development to implement this change.

The budget assumes annual costs of \$2 million (\$925,000 General Fund) for the increase in dental services as a result of these professionals providing services.

Oversight Issue. A December 2014 California State Auditor (CSA) audit of the Denti-Cal program found that, while the number of active providers statewide appears sufficient to provide services to children, some counties may not have enough providers to meet the dental needs of child beneficiaries. CSA reported five counties may lack active providers, an additional 11 counties had no providers willing to accept new Medi-Cal patients, and 16 other counties appear to have an insufficient number of providers.

CSA found the utilization rate for Medi-Cal dental services by child beneficiaries is low relative to national averages and to the rates of other states. CSA’s analysis of federal data from federal fiscal year 2013 (October 1, 2012 through September 30, 2013) shows that California had the 12th worst utilization rate for Medicaid children receiving dental services among 49 states and the District of Columbia (data from Missouri was unavailable). According to the data, only 43.9 percent of California’s child beneficiaries received dental services in federal fiscal year 2013 while the national average for the 49 states and the District of Columbia was 47.6 percent. Denti-Cal statewide utilization rates for child beneficiaries for 2013 were 41.4 percent.

CSA stated a primary reason for low dental provider participation rates is low reimbursement rates compared to national and regional averages and to the reimbursement rates of other states CSA examined. For example, California’s rates for the 10 dental procedures most frequently authorized for payment within the Medi-Cal program’s FFS delivery system in 2012 averaged \$21.60, which is only 35 percent of the national average of \$61.96 for the same 10 procedures in 2011. DHCS indicates that it is currently assessing reimbursement rate adequacy and plans to complete this by July 2015.

Consequently, CSA recommended the following:

- Establish criteria for assessing and monitoring beneficiary utilization, access to services, and provider participation in the program, and take corrective action on any identified declining trends to ensure that the influx of beneficiaries is able to access services.
- Perform annual reimbursement rate reviews and ensure beneficiaries have reasonable access to dental services and ensure that Delta Dental performs all its contract-required outreach activities to improve participation.
- Establish the provider-to-beneficiary ratio statewide and in each county as a performance measure to evaluate access and availability of dental services and capture needed data about dental services for reporting purposes.

Additionally, CSA found that California’s reimbursement rates for Denti-Cal services were low. These rates were last increased in 2000-01.

CMS Direction on Improving Access to Dental Care for Children. On May 8, 2013, DHCS received a letter from the federal Centers for Medicare and Medicaid Services (CMS) setting forth two goals to improve access to dental care for children. These goals are:

1. Increase by ten percentage points, from federal fiscal year 2011, the percentage of children ages 1-20 enrolled in Medicaid for at least 90 continuous days that received a preventive dental service. The target date for this goal is federal fiscal year 2015 (September 30, 2015). CMS indicates it will assess if the state meets this goal in April 2016 after the data has been reported. CMS identifies the following baseline and target goal percentages:

	California	National
2011 Baseline	37%	42%
2015 Goal	47%	52%

2. Increase by ten percentage points the percentage of children ages 6-9 enrolled in Medicaid for at least 90 continuous days that received a sealant on a permanent molar. Federal fiscal year 2010 is the baseline and federal fiscal year 2015 is the target year.

DHCS Efforts to Increase Utilization of Dental Services. To meet these goals, DHCS indicates that it has taken several steps (in addition to the proposals included as part of the budget). These include:

- DHCS has targeted the use of mobile dentistry vans initially in Alpine, Amador and Calaveras counties. The state’s dental fiscal intermediary (Delta Dental) is currently finalizing a contract with a mobile van and is in negotiations with another mobile van. These initial contracts should be executed in March-April of 2015. According to DHCS, in an effort to maximize the potential for success with these mobile vans, the mobile dentistry van staff will work closely with local entities (First 5, Head Start, schools and stakeholders). DHCS is also looking to expand these efforts into other counties. The mobile vans will service all children (not only Medi-Cal children) and will provide the full range of preventive services and basic restorative services.
- Last year’s budget included \$643,000 (\$190,000 Proposition 10 funds and \$453,000 federal funds) for outreach activities targeted at increasing pediatric dental utilization. DHCS sent a

letter to about 500,000 families who had a child age 0-3 who has not seen a dentist in the last year. DHCS also plans to do follow-up calls with these families and assist in connecting the family to a provider.

Finally, DHCS also notes that as part of the state's 1115 Medicaid waiver renewal, it plans to include proposals regarding providing provider incentives to increase preventive dental services in Denti-Cal. DHCS plans to make public and submit its waiver renewal proposal to the federal Centers for Medicare and Medicaid by the end of March.

Dental Services Provided Under General Anesthesia. In Medi-Cal, dental services provided under general anesthesia are provided via Medi-Cal fee-for-service (FFS) and through Medi-Cal managed care. Concerns have been raised that access to general anesthesia for dental services for FFS Medi-Cal enrollees who are regional center clients is very limited. According to DHCS, it is currently monitoring access to these services through a review of FFS historical claims and consumer calls and it is not aware of any access concerns regarding these services. Additionally, concerns have been raised regarding the differential between general anesthesia and dental anesthesia and that this differential is impeding access to dental anesthesia.

For Medi-Cal managed care, DHCS is in the process of establishing departmental policies and procedures for dental services provided under general anesthesia through Medi-Cal managed care. These policies and procedures are currently in the internal review phase. DHCS indicates it will continue to engage stakeholders to ensure that all members who are in need of hospital dentistry services will have timely access to care, and that the provider and stakeholder communities are educated in the updated policies and procedures upon implementation. Anecdotal access complaints have been received by the Legislature. These include complaints by dental providers in Sacramento and San Diego that there are four or more month waits for operating room or surgery center slots to perform urgent dental procedures.

Background. DHCS delivers dental services to Medi-Cal beneficiaries through two different models: Dental Managed Care (DMC) and Denti-Cal fee-for-service (FFS). DMC is carried out through contracts established between DHCS and dental plans licensed with the Department of Managed Health Care, whereas, Denti-Cal FFS provides services through enrolled providers, who are directly contracted with the program. DMC is offered only in Los Angeles County and Sacramento County. Between these two counties there are approximately 672,000 enrollees received care under DMC.

AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, requires DHCS to provide an annual report to the Legislature on DMC in Sacramento and Los Angeles. On March 14, 2015, this report was due to the Legislature and has not yet been received. Last year's report can be found at:

http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Dental%20Managed%20Care/2014_M-C_Dental_MgdCareReport.pdf

SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014, requires DHCS to monitor Denti-Cal FFS using program metrics and to post this information on the department's website at least on an annual basis. This information can be found at: http://www.denti-cal.ca.gov/provsrvcs/managed_care/FFS_perf_meas_2013.pdf

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions on this topic. The Governor’s budget makes very minor investments in increasing access to Denti-Cal and it is unlikely that these minor investments would have substantive impact on improving utilization of these services.

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

1. Please provide an overview of the budget proposals related to dental services.
2. Please provide an update on the steps DHCS is taking to meet the goals identified by CMS’s to improve access to dental services for children. Will the state meet these goals?
3. How will DHCS measure the impact of the letter outreach campaign?
4. At previous Subcommittee hearings, DHCS has stated it is unclear the degree to which rate increases would increase utilization. Consequently, it has focused on other, less-costly, initiatives (besides rate increases). Given CMS’s direction for a ten percentage point increase in utilization, at what point would DHCS think that rate increases would be part of the solution?
5. How does DHCS ensure that Medi-Cal enrollees have timely access to Denti-Cal?
6. Please provide an update on DHCS’s efforts to address the CSA’s findings:
 - a. Establish criteria for assessing and monitoring beneficiary utilization, access to services, and provider participation in the program, and take corrective action on any identified declining trends to ensure that the influx of beneficiaries is able to access services.
 - b. Perform annual reimbursement rate reviews and ensure beneficiaries have reasonable access to dental services and ensure that Delta Dental performs all its contract-required outreach activities to improve participation.
 - c. Establish the provider-to-beneficiary ratio statewide and in each county as a performance measure to evaluate access and availability of dental services and capture needed data about dental services for reporting purposes.
7. Has DHCS explored the option of using Medi-Cal funding for the California Dental Disease Prevention Program? Is this possible?
8. What is the status of the Dental Managed Care report due to the Legislature on March 15, 2015?

6. Medi-Cal Payment Reductions, Rates, and Access

Budget Issue. The Governor’s budget continues the AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, Medi-Cal payment reductions and assumes total fund savings of \$550 million (\$275 million General Fund). See table below for a summary of the savings the Governor’s budget associates with AB 97.

Table 1: AB 97 Medi-Cal Provider Payment Reduction Summary in January Budget*

AB 97 Payment Reductions								
(Total Fund)								
(dollars in thousands)								
Provider Type	Retroactive Savings Period	Total Retroactive Savings	On-Going Annual Savings	Nov. 2014 Estimated Savings from AB 97 Reduction (1) (2)				Remaining Retro Recoupment
				FY 2014-15		FY 2015-16		
				On Going	Retro	On Going	Retro	
Nursing Facilities - Level A	6/1/11-6/30/12	\$246	\$254	\$254	\$92	\$254	\$0	\$0
ICF/DDs		\$0	\$5,413	\$5,413	\$0	\$5,413	\$0	\$0
FS Pediatric Subacute	Exempt							
AB 1629 Facilities (3)	N/A							
DP/NF-B	6/1/11-9/30/13	\$83,437			\$3,793		\$15,170	\$49,304
Phase 1 Providers (4)	6/1/11-12/20/11	\$21,286	\$44,776	\$38,793	\$0	\$44,776	\$0	\$0
Physician 21 yrs+		\$0	\$49,746	\$49,746	\$0	\$49,746	\$0	\$0
Medical Transportation		\$0	\$14,461	\$14,461	\$0	\$14,461	\$0	\$0
Medical Supplies & DME	6/1/11-10/23/13	\$39,428	\$17,394	\$17,394	\$2,503	\$17,394	\$7,510	\$19,402
Dental		\$0	\$60,458	\$60,458	\$0	\$60,458	\$0	\$0
Clinics		\$0	\$18,512	\$18,512	\$0	\$18,512	\$0	\$0
Pharmacy	6/1/11-2/6/14	\$296,621	\$113,718	\$113,718	\$17,977	\$113,718	\$53,931	\$170,782
Phase 3 Providers		\$0	\$2,414	\$1,811	\$0	\$2,414	\$0	\$0
Managed Care			\$120,261	\$140,980	\$0	\$120,261	\$0	\$0
Grand Total		\$441,018	\$447,407	\$461,540	\$24,365	\$447,407	\$76,611	\$239,488
AB 97 Rate Freeze								
(Total Fund)								
Provider Type	Retroactive Savings Period	Total Retroactive Savings	On-going Annual Savings	Nov. 2014 Estimated Savings from AB 97 Reduction (1) (2)				Remaining Retro Recoupment
				FY 2014-15		FY 2015-16		
				On Going	Retro	On Going	Retro	
DP/NF-B	6/1/11-9/30/13	\$144,229		\$0	\$6,556	0	\$26,223	\$85,227
Note:								
(1) Data Source: Nov 2014 Estimate								
(2) AB 97 injunctions were lifted on 6/25/2013.								
(3) AB 1629 facilities includes Freestanding (FS) NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. The Department paid back the 10% payment reduction to this facility type in December 2012.								
(4) Phase I includes all subject providers, including the Pediatric Day Health Care (PDHC) and Audiology Program, except for the enjoined providers and the Child Health and Disability Prevention (CHDP) program.								

*Please note these numbers will be updated at the May Revision.

The Governor's budget, and this chart, do not correctly reflect the savings associated with ICF/DDs. The corrected AB 97 savings for this provider type is \$11.1 million (this will be reflected in the May Revision).

Primary Care Rate Increase Expired. The ACA required Medi-Cal to increase primary care physician service rates to 100 percent of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The state received 100 percent federal financial participation (FFP or federal funding) for the additional incremental increase in Medi-Cal rates determined using Medi-Cal rates that were in effect as of July 1, 2009. Consequently, on an annual basis, this brought in approximately \$1.6 billion in additional federal funds (to reach the Medicare rate). Also, an additional \$91.5 million (\$45.8 million General Fund) on an annual-basis was budgeted in order to bring Medi-Cal rates to the level in effect as of July 1, 2009 (as required by the ACA).

Background. As a result of the state's fiscal crisis, AB 97 required the Department of Health Care Services (DHCS) to implement a ten percent Medi-Cal provider payment reduction, starting June 1, 2011. This ten percent rate reduction applies to all providers with certain exemptions and variations. Certain exemptions were specified in AB 97 and some are a result of an access and utilization assessment. AB 97 provides DHCS the ability to exempt services and providers if there are concerns about access. DHCS has formally established a process for pharmacy providers to seek exemption from the provider payment reductions.

On October 27, 2011, the federal Centers for Medicare and Medicaid (CMS) approved California's proposal to reduce Medi-Cal provider reimbursement rates. As part of this approval, CMS required DHCS to (1) provide data and metrics that demonstrated that beneficiary access to these services would not be impacted, and (2) develop and implement an ongoing healthcare access monitoring system.

DHCS had been prevented from implementing many of these reductions due to a court injunction. On June 14, 2013, the United States Court of Appeals for the Ninth Circuit denied the plaintiffs' motion for a stay of mandate in this case, allowing the implementation of all of the AB 97 Medi-Cal provider ten percent payment reductions. For the enjoined providers, DHCS began implementation of the retrospective payment reductions on a staggered basis, by provider type, starting in September 2013.

About 80 percent of Medi-Cal enrollees are enrolled in Medi-Cal managed care. The remaining 20 percent receive Medi-Cal through fee-for-service. Generally, those in FFS are persons with limited-scope aid codes, dual eligibles in the non-Coordinated Care Initiative counties, and persons who are exempt from managed care because of a medical exemption request.

Recoupment of Retroactive Savings. DHCS has begun the recoupment of retroactive savings for all affected providers except DP/NFs and Pharmacy. DHCS will give these providers 60 day notice prior to recouping these savings. According to DHCS, each provider will receive a recoupment notice. If the provider contests the amount reflected, they can contact a service center and submit documentation contesting the amounts. While there is no formal appeals process, the provider may also contact DHCS if they do not believe the amount is correct and they do not get resolution at Xerox (the state's fiscal intermediary). If a Medi-Cal provider no longer participates in Medi-Cal or in fee-for-service Medi-Cal, the department's Third Party Liability and Recovery Division will set up an accounts receivable and follow the customary collection procedures.

Managed Care and Actuarial Soundness of Rates. Managed care rates can only be reduced by AB 97 on an actuarial basis and must support the required services. Consequently, as more and more individuals shift into Medi-Cal managed care, the negative impact of these reductions to access of Medi-Cal services is reduced. This is because health plans must meet access standards *and* a health plan's rate must be actuarially sound (i.e., generally, the rate cannot be reduced to a level that does not support the required services). In the Governor's budget, the AB 97 reductions to managed care plans as a percentage of their base rates are 0.62 percent in 2014-15 and 0.45 percent in 2015-16. If the reductions applicable to the elimination of the primary care physician rate increase are considered, then the reductions as a percentage of health plan base rates are 0.76 percent in 2014-15 and 0.71 percent in 2015-16.

The Governor's budget includes a placeholder rate increase for managed care plans of 3.57 percent in 2015-16. This is a net rate increase. Since managed care plan rates must be actuarially sound, although they are reduced by AB 97, on the net, managed care plans generally receive a rate increase every year.

Rate Freezes – ICF/DDs. In addition to the AB 97 payment reductions discussed above, some providers are impacted by rate freezes. For example, rates for intermediate care facilities for the developmentally disabled (ICF/DDs), habilitative (ICF/DD-H), and nursing (ICF/DD-N) are frozen at 2008-09 levels. For ICF/DDs (all types), the budget assumes \$11.1 million (\$5.5 million General Fund) savings from the AB 97 rate reduction and \$49.1 million (\$24.5 million General Fund) from the rate freeze.

Beginning with the 2013-14 rates, effective for dates of service on or after May 27, 2014, ICF/DD, ICF/DD-H, and ICF/DD-N providers will be reimbursed at the facilities' rebased projected cost per day plus five percent, but no higher than the 65th percentile rate established in 2008-09, and no lower than the 65th percentile rate established in 2008-09, reduced by ten percent. DHCS will determine each facility's rebased projected cost by using cost or audited cost reports each year. The department has recently implemented a new rate methodology for these facilities which uses the most current facility-specific data.

Concerns have been raised by these providers that ICF/DDs are closing because of the low Medi-Cal reimbursement rates and transitioning to other types of homes (e.g., negotiated rate homes) overseen by the Department of Developmental Services which have higher reimbursement rates; thereby, resulting in increased costs to the state. According to the Administration, from 2010 to February 2015, 65 ICF/DD-Ns and ICF/DD-Hs have closed and 58 new ICF/DD-Ns and ICF/DD-Hs have opened. Additionally, according to the California Department of Developmental Services (DSS) of the 17 facilities that closed in 2014, DSS found no evidence of them converting to negotiated rate homes.

LAO Findings and Recommendations. Last year, the LAO reviewed DHCS's baseline access analyses and quarterly monitoring reports and came away with numerous concerns about the quality of the data, the soundness of the methodologies, and the assumptions underlying the Administration's findings on access. In the LAO's view, these concerns are sufficient to render the Administration's public reporting of very limited value for the purpose of understanding beneficiary access in the fee-for-service (FFS) system. The LAO also found that much of the debate regarding the Medi-Cal provider payment reductions has focused mainly on FFS while access issues in managed care are gaining more importance

(as a majority of Medi-Cal enrollees are in managed care). Since dental care will remain primarily a FFS benefit for the foreseeable future, the LAO recommends the Legislature create meaningful standards for monitoring Denti-Cal (FFS) access. In addition, the LAO recommends future oversight focus on monitoring the managed care system. The LAO indicates that it plans to produce a more detailed analysis on this topic in the future.

Stakeholder Concerns. Consumer advocates, providers, provider associations, and other stakeholders are concerned that the existing Medi-Cal rates, payment reductions, and rate freezes directly impact an enrollee's ability to access Medi-Cal services. These stakeholders find that the existing payments do not cover the costs to provide services to Medi-Cal enrollees and are not sufficient enough to sustain their operations. On March 4, 2015, the Senate Health Committee and Assembly Health Committee held a joint hearing on the question of whether Medi-Cal rates ensure access to care.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as updated information will be received at the May Revise and discussions continue on this topic.

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

1. Please provide an overview of this issue and a brief discussion of how managed care rates are set.
2. How does DHCS proactively evaluate the impact of the AB 97 reductions to each specific provider type to ensure that access is not compromised? Please explain what data sources and other information the department uses to evaluate access.
3. Please provide a brief overview of the department's Network Adequacy Monitoring Project. What is the timeline of this project? Prior to implementation of this project, how is DHCS comprehensively and proactively monitoring network adequacy?

7. Medi-Cal Annual Open Enrollment Period

Budget Issue. DHCS proposes trailer bill language (TBL) to establish an Annual Health Plan Open Enrollment process for specified Medi-Cal managed care health plan (MCP) beneficiaries who are enrolled in counties that have more than one Medi-Cal managed care health plan (MCP) option. DHCS estimates that this proposal would result in a net General Fund savings of \$1 million (and a total fund savings of \$2 million). This savings comes from the reduction in the number of initial health assessments (IHAs) and reduced mailing costs to implement Annual Health Plan Open Enrollment.

Under this proposal, beneficiaries subject to the Annual Health Plan Open Enrollment process would be allowed to change MCPs only during the Annual Health Plan Open Enrollment period, with a few exceptions. This Annual Health Plan Open Enrollment period would occur each year and would align with the open enrollment period relative to populations applying for health care coverage through the California Health Benefit Exchange (Exchange). This proposal does not prohibit eligible individuals from enrolling into Medi-Cal throughout the year. Enrolling onto the Medi-Cal program will continue to be available at any time during the year for those that are eligible, as it is currently.

The Annual Health Plan Open Enrollment process would only apply to those beneficiaries in affected counties in the Family and Child aid code categories. It would not apply to beneficiaries residing in counties where there is only one managed care plan choice, Seniors and Persons with Disabilities, beneficiaries dually eligible for Medicare and Medi-Cal (Duals), new adult beneficiaries under the Affordable Care Act Medi-Cal expansion, or any other category of mandatorily enrolled beneficiaries that the director of the Department of Health Care Services (DHCS), after receiving stakeholder input, determines should not be subject to the Annual Health Plan Open Enrollment process.

This TBL proposal would provide an exception to the Annual Health Plan Open Enrollment process for the following beneficiaries, who would have the option to change their initially selected MCP, with or without cause, within the first 90 days following enrollment in the MCP:

- A beneficiary that is newly enrolled in Medi-Cal managed care; and
- A beneficiary moving from one county to another.

This TBL proposal would require DHCS to conduct an assessment of the Annual Health Plan Open Enrollment process and report to the Legislature six months after the first calendar year of implementation. If the assessment indicates the Annual Health Plan Open Enrollment process is appropriate for other mandatory populations, the Administration may propose or seek future legislation to extend the Annual Health Plan Open Enrollment process to the additional mandatorily enrolled populations. In addition, the TBL would: 1) allow DHCS to implement the Annual Health Plan Open Enrollment process through expedited contracts and the use of plan letter, plan or provider bulletins, or similar instructions, until such time as final regulations are adopted; and 2) require regulations to be adopted no later than July 1, 2018.

Background. Current practice allows beneficiaries residing in counties with more than one MCP choice to change plans every month. DHCS notes that this current policy is not consistent with overall health care industry practice. Enrollees of Medicare Advantage (MA) and Part D Plans (except Dual-Eligible

Special Needs Plans), commercial, the California Public Employees' Retirement System, and Exchange plans are all subject to Annual Health Plan Open Enrollment periods.

According to DHCS, it submitted this proposal because it finds that frequent MCP enrollment changes can have a detrimental impact on patient care management and limit coordination of care with other programs. Additionally, DHCS argues that frequent changes can also impair quality monitoring and improvement activities because many MCP beneficiaries are not enrolled in an MCP long enough to assess the quality of their care. Lastly, DHCS states that this proposal would reduce the number of health assessments that MCPs must perform each time a beneficiary enrolls in a different MCP.

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature has denied similar proposals in the last few years because it found that it is important to ensure that Medi-Cal enrollees have the ability to change health plans at any time to ensure that his or her health needs are met. Although this proposal includes the ability for someone to switch plans if they have “good cause,” having to demonstrate this and go through this process could be a barrier to ensuring timely treatment. It is recommended to hold this item open as discussions continue on this proposal.

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

1. Please provide an overview of this proposal.

8. Managed Care Organization Tax

Budget Issue. The Administration proposes to create a new managed care organization tax. This tax is projected to generate about \$1.72 billion in revenue and offset \$1.13 billion in General Fund expenditures.

The Administration cites the following goals of this proposal: (1) raise the same amount of non-federal funding for the Medi-Cal program as the current MCO tax (\$1.13 billion), (2) raise an additional \$215.6 million in revenues (to be matched with federal funds) to fully restore the seven percent reduction in IHSS hours, and (3) meet federal broad-based and uniform provisions and no hold harmless requirements for health care-related fees/taxes. The Administration indicates that it will likely seek federal waiver of certain broad-based and uniform requirements in order to have the lowest net financial impact on health plans.

Background. California has had many variations of a tax on Medi-Cal managed care organizations (MCOs) over the last ten years. These include:

- **Managed Care Organization (MCO) Fee.** In 2005, California enacted a quality improvement fee (QIF) on Medi-Cal managed care organizations.¹ Based on federal rules, the fee was assessed on all premiums paid to legal entities providing health coverage to Medi-Cal enrollees. When the fee was established, 75 percent of the revenue generated was matched with federal funds and used for payments to managed care organizations and the remaining 25 percent was retained by the state General Fund. Under this arrangement, the managed care organizations received a rate adjustment and on the net, health plans gained.

Effective October 1, 2007, as part of the implementation of the state's new managed care rate methodology, this arrangement changed and 50 percent of the revenue generated by the QIF was matched with federal funds and used for payments to managed care organizations and the remaining 50 percent was retained by the state General Fund.² Under this allocation, managed care plans were made whole in that they were reimbursed the amount of QIF they paid, but no longer realized a net benefit.

Changes in federal law resulted in this fee sunseting on October 1, 2009, as it no longer complied with federal requirements. New federal law required that provider fees be broad based and uniformly imposed throughout a jurisdiction, meaning that they cannot be levied on a subgroup of providers, such as only those enrolled in Medicaid programs.

- **Gross Premiums Tax (GPT).** Assembly Bill 1422 (Bass), Chapter 157, Statutes of 2009, extended the 2.35 percent premium tax imposed on all types of insurance to include all comprehensive health plans contracting with Medi-Cal. The revenues from this tax were directed to fund health coverage for children through the Healthy Families Program, provide a cost-of-

¹ Assembly Bill 1762 (Committee on Budget), Chapter 230, Statutes of 2003.

² "Financing Medi-Cal's Future: The Growing Role of Health Care-Related Provider Fees and Taxes," California HealthCare Foundation, November 2009.

living increase to health plans participating in Healthy Families, and increase Medi-Cal capitation rates paid to health plans. Under this arrangement, 50 percent of the revenue was matched with federal funds to make health plans whole and 50 percent of the revenue was used to maintain the Healthy Families Program. This tax expired December 31, 2010, and was extended twice until it expired on June 30, 2012.

It should be noted that because the GPT is an existing tax on a broad group of insurers, the overwhelming majority of which are not health care insurers, it can be extended to Medi-Cal managed care plans without being considered a fee under federal law. As such, the state does not have to meet federal requirements for provider fees to obtain federal matching funds, using this source of revenues as the state match.

- **Current MCO Tax.** The state's current MCO tax imposes a sales and use tax rate of 3.9375 percent on Medi-Cal managed care plans' gross receipts effective July 1, 2013 through June 30, 2016. This tax was approved by the federal government as a component of the state's Duals Demonstration Project (Coordinated Care Initiative). The revenues are deposited into the Childrens Health and Human Services Special Fund. Half of the MCO tax revenues are used to draw down federal Medi-Cal funds and then used to pay back Medi-Cal managed care plans in order to "make them whole". The other half of these funds is used to offset General Fund expenditures for Medi-Cal managed care rates for children, seniors and persons with disabilities, and dual eligibles. For 2015-16, the current MCO tax is projected to generate \$1.13 billion in non-federal funding for the Medi-Cal program.

Recent Federal Guidance on Health Care Related Taxes. On July 25, 2014 the federal Centers for Medicare and Medicaid Services (CMS) issued guidance clarifying the treatment of health care-related taxes (provider taxes) and their effect on federal matching funding for Medicaid (Medi-Cal in California) and the Children's Health Insurance Program (CHIP). CMS clarified that provider taxes must:

- **Broad-Based** - Be broadly based, so as not to specifically target one group (must include providers that do not receive Medicaid funding).
- **Uniform** - Be uniformly imposed, meaning levied equally across all providers in that provider type.
- **No Hold Harmless** - Not hold providers harmless from the burden of the tax, meaning that states cannot guarantee taxed dollars will be returned to affected providers.

The provisions of broad-based and uniform requirements can be waived by the federal government if the tax program structure meets the standard to waive these requirements (referred to as the B1/B2 test). The hold harmless requirement cannot be waived.

States that have provider taxes that do not meet these criteria must take action in the state's next legislative session to redesign the tax to meet these requirements. California's current MCO tax does not meet these criteria because it is not broad-based as it applies to only Medi-Cal managed care plans and not all managed care plans in the state.

In-Home Supportive Services (IHSS) Settlement Agreement. As part of a 2013 settlement agreement between the Administration and labor unions and disability rights advocates regarding reductions in IHSS, the Administration is required to submit to the Legislature proposed legislation authorizing an assessment on home care services, including but not limited to home health care and IHSS. The new assessment would be used to offset the seven percent reduction in authorized IHSS service hours, which was authorized by the 2013 settlement agreement. (This settlement agreement was in response to lawsuits regarding IHSS budget reductions in the 2009, 2010, 2011, and 2012 budgets.) This assessment proposal was supposed to be submitted to CMS by October 1, 2014.

On August 28, 2014, the Administration sent a letter to the Legislature indicating that it had worked in good-faith to develop a federally-compliant proposal authorizing an assessment but, given the new federal guidance on health care related taxes, it would not be able to meet the October 1, 2014 deadline. The letter indicated that the Administration would work with all parties on viable legislation early in the 2015-16 Legislative Session.

In January, the Administration indicated that it seeks to enact this proposal by the end of March and submit the request to CMS by April 1 so that it can be implemented on July 1, 2015. See chart below for details on this proposal.

Summary of Managed Care Organization (MCO) Tax Proposal
Effective Date of Tax
<ul style="list-style-type: none"> July 1, 2015 – no sunset
Who is subject to this tax?
<ul style="list-style-type: none"> All full-service managed care plans regulated by the Department of Managed Care (DMHC) and the Department of Health Care Services (DHCS), except two plans that provide international coverage. There are about 45 plans that meet these criteria and would be subject to this tax, of which 22 are Medi-Cal managed care plans.
How would this tax be calculated?
<ul style="list-style-type: none"> The tax would be assessed based on total plan enrollment. Medicare (including D-SNP) and plan-to-plan (for the subcontracted plan) enrollees would be excluded from this assessment of total plan enrollment. It is estimated that this would apply to 277 million member months or about 23 million MCO members. The tax would be assessed based on a tier-structure that is intended to ensure no plan has a disproportionate tax based on its relative size and that targets the tax on plans with higher numbers of Medi-Cal enrollees. <ul style="list-style-type: none"> Taxing Tier 1 – For enrollment up to 125,000 member months at \$3.50 per enrolled member month. Taxing Tier 2 – For enrollment of 125,001 through 275,000 member months at \$25.25 per enrolled member month. Taxing Tier 3 – For enrollment of 275,001 through 1,250,000 member months at \$13.75 per enrolled member month. Taxing Tier 4 – For enrollment of 1,250,001 through 2,500,000 member months at \$5.50 per enrolled member month. Taxing Tier 5 – For enrollment greater than 2,500,001 member months at \$0.75 per enrolled member month.
How much tax revenue would be generated by this tax and how would it be used?
<ul style="list-style-type: none"> \$1.72 billion in MCO tax revenue would be generated and deposited into the Health and Human Services Fund. This revenue would be used: <ul style="list-style-type: none"> \$371 million to pay Medi-Cal MCOs (matched to get an additional \$371 million federal funds). \$215.6 million to restore the IHSS seven percent reduction (matched to get an additional \$215.6 federal funds). \$1.13 billion in General Fund offset in the Medi-Cal program.
Who would administer the tax?
<ul style="list-style-type: none"> DHCS and DMHC.
How would this tax impact MCOs?
<ul style="list-style-type: none"> The Administration estimates that the net impact to MCOs, after accounting for the Medi-Cal reimbursement, is \$658 million (0.48 percent of total plan revenue).

LAO Findings and Recommendation. Generally, the LAO is supportive of this proposal given that the state must restructure its existing MCO tax, but notes that the Legislature should carefully consider its impacts. Additionally, the LAO finds that such a tax should not be authorized on permanent basis.

Subcommittee Staff Comments and Recommendation—Hold Open. Subcommittee staff notes that a permanent extension of this tax would make it difficult to periodically evaluate its effectiveness and its impact on managed care plans in the state. Two of the state’s other provider fees (the skilled nursing facility quality assurance fee and the hospital quality assurance fee) have sunset dates.

It is recommended to hold this item open as discussions continue on this proposal. DHCS notes that it is working with health plans on alternatives.

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

1. Please provide an overview of this proposal.
2. What is the status of the discussions with health plans regarding alternatives? Has DHCS set a timeframe for these discussions?
3. Are there any legal risks if the state does not submit an MCO tax proposal is to CMS by April 1, 2015 (in light of the IHSS settlement agreement)?

9. Eliminate Cost-of-Living Adjustment for County Eligibility Administration

Budget Issue. DHCS proposes trailer bill language to suspend the county administration cost-of-living adjustment (COLA) on a permanent basis. See table below for summary of county administration funding.

Table: Summary of Proposed County Administration Funding

	2014-15		2015-16	
	Total Fund	General Fund	Total Fund	General Fund
Base County Administration	\$1,302,683,000	\$651,341,500	\$1,302,683,000	\$651,341,500
Affordable Care Act Implementation	\$390,000,000	\$195,000,000	\$120,000,000	\$240,000,000
Other	\$447,696,000	\$117,541,300	\$405,142,000	-\$61,762,200
Enhanced Federal Funding		-\$371,022,000		-\$271,693,000
Total	\$2,140,379,000	\$592,860,800	\$1,827,825,000	\$557,886,300

The Administration contends that this proposal is technical clean-up as county administrative funding has been adjusted due to implementation of new Affordable Care Act requirements in 2013-14 and 2014-15 and that the new budget methodology (discussed earlier) will be implemented for 2015-16.

Background. DHCS provides funding for county staff and support costs to perform administrative activities associated with the Medi-Cal eligibility process. Welfare and Institutions Code Section 14154 states the Legislature's intent to provide the counties with an annual COLA. Nevertheless, the COLA was suspended for the following four fiscal years: 2009-10, 2010-11, 2011-12, and 2012-13. Furthermore, AB 12 (Evans) Chapter 12, Statutes of 2009-10, 4th Extraordinary Session, added Government Code Section 11019.10 that prohibits automatic COLAs.

DHCS notes that county administration workload is experiencing multiple changes as part of ACA implementation and the Governor's budget provides significant resources to support county administration work through 2015-16. Once ACA implementation stabilizes, the state and the counties will work collaboratively to develop a new methodology for county administrative funding pursuant to SB 28 (Hernandez and Steinberg), Chapter 442, Statutes of 2013. SB 28 directed DHCS to convene a workgroup to create a new methodology for budgeting and allocating funds for county administration of the Medi-Cal program no sooner than 2015-16.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as updated estimates regarding county administration funding may be included in the May Revise. Additionally, it should be noted that this proposal was included as part of last year's budget and the Legislature adopted trailer bill language to suspend the COLA for the budget year only and not on a permanent basis.

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

1. Please provide an overview of this proposal.
2. Please provide an update related to developing a new methodology for county administrative funding.

10. Financial Audits Workload

Budget Issue. DHCS requests 21 positions (nine permanent and 12.0 two-year limited term) and expenditure authority of \$3,094,000 (\$844,000 General Fund , \$1,544,000 federal funds and \$706,000 reimbursements) to address new audit workload associated with Intermediate Care Facilities for the Developmentally Disabled Nursing/Habilitative (ICF-DDN/H) and AB 959 (Frommer), Chapter 162, Statutes of 2006, public clinics.

Specifically, the new workload stems from the following mandated work:

- **ICF-DDN/H** - Revisions made by State Plan Amendment (SPA) 13-019 which changed the reimbursement methodology for the ICF-DDN/H programs
- **AB 959** - AB 959’s expansion of Welfare & Institutions (W&I) Code, Section 14105.965 to include supplemental Medi-Cal outpatient reimbursement to state veteran homes and clinics operated by the state, a city, a county, the University of California system and public healthcare systems.

The resources will be utilized between three DHCS Divisions/Offices: Audits & Investigations/Financial Audits Branch (FAB), Office of Administrative Hearings and Appeals (OAHA), and Office of Legal Services (OLS). The chart below details the number of positions per division and fund source.

Division/Office	Number of Positions	Total Expenditure Authority	Fund Split*
A&I/FAB	11.0	\$1,486,000	27GF/50FF/23RF
OAHA	6.0	\$988,000	19GF/50FF/31RF
OLS	4.0	\$620,000	40GF/50FF/10RF
Total:	21.0	\$3,094,000	

*GF: General Fund; FF: federal funds; RF: Reimbursements

Background-SPA 13-019 Facility-Specific Reimbursement Rates (ICF DDN/H). Medi-Cal Long-Term Care reimbursement rates are established under the authority of Title XIX of the federal Social Security Act. The specific methodology is described in the State Plan, and when changes to such methodologies are requested, DHCS must submit a SPA for approval by the Centers for Medicare and Medicaid Services.

SPA 13-019, approved by CMS on December, 4, 2013, revised the way ICF-DDNs/Hs are reimbursed. Pursuant to the SPA, DHCS must use facility-specific audited costs to calculate the rates for audited facilities. The ICF/DD-H and the ICF/DD-N programs are now reimbursed by Medi-Cal with a methodology that is based on a per diem basis, also called a “client day.” Prior to SPA 13-019, the facility payment rate per day was established by using the 65th percentile of the facility’s respective peer group. Previously, the number of audits conducted was determined by statistical analysis, which equated to approximately 150 to 200 audits per year.

The new methodology creates facility-specific rates based on reported costs and sets a floor and a ceiling for the Medi-Cal per diem rate. A facility cannot be paid more than or less than the range specified by the established floor and ceiling. Any facility whose costs fall within the established floor and ceiling will have their reimbursement rate set based on the actual audited costs. If a facility's costs fall below the floor, they will receive the established floor rate. If a facility's costs are above the ceiling, they will receive the established ceiling rate. This facility specific methodology has created an increase in the number of audits performed as the new program is implemented, requiring new positions to perform the additional audit oversight and post-audit activities.

Moreover, when audit adjustments are issued, the providers are accorded both informal and formal hearing rights. In the past, reimbursement to ICF-DD-H/N was not based upon audited allowable costs of each specific facility, but rather on an applied statistical analysis that would establish a per diem rate. However, with the changes made to the reimbursement methodology by SPA 13-019, every facility now has a specific and direct interest in ensuring that its cost report is accepted as submitted. Consequently, DHCS anticipates a sharp rise in filed appeals. A conservative estimate is that DHCS will receive 165 informal appeal requests and 85 formal appeal requests.

To implement this methodology change, the number of audits DHCS must complete is expected to increase from approximately 150-200 audits pre-SPA 13-019 to approximately 300-350 audits per year. According to DHCS, the significant increase in the number of audits performed requires new positions to complete the additional audit oversight and post-audit activities.

Background-AB 959 Supplemental Payment Audits (Public Clinics/Veteran Homes). AB 959 expanded Welfare and Institutions Code (WIC) Section 14105.965 to include supplemental Medi-Cal outpatient reimbursement to:

- State veteran homes that provide services to Medi-Cal beneficiaries, and
- Clinics that are operated by the state, a city, a county, the University of California system or public healthcare systems that were enrolled as Medi-Cal providers retroactive to 2006-07.

AB 959 allows state veteran homes and public clinics to obtain increased federal funding reimbursement without the use of state General Funds. Based on current law, supplemental Medi-Cal outpatient payments are made from Medi-Cal federal funds that are available to AB 959 public clinics that provide local funding, referred to as Certified Public Expenditures (CPEs). The federal funds are drawn down by applying the clinic's CPEs. The AB 959 program is funded using 50 percent federal funds and 50 percent CPE. The eligible facilities will reimburse DHCS for the costs of administering the program.

AB 959 requires an eligible facility veteran home or clinic to reimburse DHCS for the cost of administering the expansion of WIC Section 14105.965 as a condition of receiving supplemental reimbursement. In enacting this section, the Legislature intended to provide the supplemental reimbursement described without any expenditure from the General Fund.

This proposal seeks resources related to the implementation of AB 959 regarding public clinics, as the implementation of AB 959 for veteran homes has already occurred. Although AB 959 was enacted in 2006, DHCS did not receive approval from CMS to implement it for public clinics until August 2012 and will be making payments retroactive to 2006. DHCS anticipates that this will result in short-term increase in work load and there is requesting that 12 of the 21 positions be two-year limited-term.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.
2. Please explain the delay in the implementation of AB 959 for public clinics and the department's plan to become current in payments to clinics.

11. Health Care Reform – Workload Extension

Budget Issue. DHCS requests the extension of six limited-term positions and expenditure authority to support the continued implementation of and ongoing work required under the federal Affordable Care Act (ACA), including but not limited to the implementation of enhanced provider screening under the program integrity requirements and the support of the anticipated enhancements to the existing Medi-Cal Eligibility System (MEDS) and its sub-applications in order to meet the business needs of the health insurance-exchange, and county consortia including Electronic Health Information Transfer integration requirements.

The total limited-term expenditure authority request for 2015-16 is \$716,000 (\$129,000 General Fund and \$587,000 federal funds) and for 2016-17 is \$547,000 (\$78,000 General Fund and \$469,000 federal funds). The following chart details the extension of limited-term positions for the CA-Medicaid Management Information Systems (CA-MMIS), Provider Enrollment Division (PED), and Information Technology Services Division (ITSD):

Division/ Office	Classification	# of Positions	Term
CA-MMIS	Associate Information Systems Analyst (Spec)	2.0	7/1/15-6/30/17
CA-MMIS	Data Processing Manager I	1.0	7/1/15-6/30/17
PED	Staff Services Analyst	2.0	7/1/15-6/30/16
ITSD	Sr. Information Systems Analyst (Spec)	1.0	7/1/15-6/30/17

Background. On March 23, 2010, President Obama signed the ACA into law, which impacts every sector of the health care system, including Medi-Cal. The law puts into place comprehensive health insurance reforms that seek to hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.

DHCS contends that these positions are needed to continue the ACA efforts related to:

- 1. California Medicaid Management Information Systems (CA-MMIS)** - Extending the 3.0 limited-term positions will provide the continuity of the identification and development of the business rules of the CA-MMIS changes required or resulting from the ACA:
 - The positions will continue coordination efforts with other DHCS Divisions/Branches, and the fiscal intermediary contractor.
 - Address any anticipated workload activities and system changes associated with rate changes, reporting, increased eligibility, problem statements, and erroneous payment corrections.
 - Provide subject matter insight in their areas of expertise, ensure application and enforcement of the statewide standards for project management and oversight, review and adjudicate contractor invoices, review and adjudicate contractor deliverables, and work with the DHCS Office of Legal Services and state control agencies as needed.
 - Be responsible for reviewing and approving project plans, methodologies, and documentation; participating in and/or overseeing all development, system testing and

acceptance testing, including but not limited to the review of functional, technical, test, implementation, and post-implementation deliverables; conducting analysis of deliverables to ensure conformance to contract requirements, technical design standards, and end-user business objectives; and preparing reports, documents, publications, and presentations.

2. **Provider Enrollment Division (PED)** - The 2.0 requested positions will be required to handle new workload associated with:
 - Processing applications, including reviewing applications for completeness and consistency and identifying and notifying providers of errors.
 - Verifying the licensure and permit status of providers and search background verification database for information on the provider to analyze the data for consistency with the application.
 - Evaluating whether the provider meets statutory and regulatory requirements for participation, recommending approval/denial of the provider's application using known fraud risk factors and making investigation referrals when determined.

3. **Information Technology Services Division (ITSD)** - ITSG is requesting the extension of 1.0 Senior Information Systems Analyst (specialist) position through June 30, 2017, to continue the following activities to ensure compliance with ACA:
 - Interpret the policy guidance and rules on the required Medicaid interfaces, gather business requirements and participate with our Program Areas in any federal, county, and state policy discussions that affect the operational provisions, including the public website that enroll/re-enroll persons directly in to the Exchange.
 - Continue to conduct system analysis, produce technical requirements and design deliverables, develop test plans and scenarios, and oversee the implementation of the system enhancements and interfaces between MEDS, CalHEERS, and the county consortia.
 - Continue to participate as the technical liaison and Subject Matter Expert (SME) for the Program Area for any Statewide Automated Welfare System (SAWS) modifications that will affect MEDS. Ensure the changes are compatible to the existing MEDS interface standards and best practices.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

12. Health Care Reform Financial Reporting Resources

Budget Issue. DHCS requests expenditure authority of \$1,959,000 (\$980,000 General Fund and \$979,000 federal funds) for 2015-16 and \$1,797,000 (\$899,000 General Fund and \$898,000 federal funds) on-going for 18 three-year limited term positions. The resources will address the increases in federal Centers for Medicare and Medicaid Services (CMS) mandated reporting requirements.

As the single state agency which administers the Medicaid program and Children’s Health Insurance Program, DHCS has full fiscal responsibility for CMS federal reporting. The table below illustrates the fiscal changes, specific to the Medi-Cal Program and Children’s Health Insurance Program (CHIP), from 2012-13 to 2014-15.

Table: Medi-Cal and CHIP Funding Summary (dollars in thousands)

Fiscal Year	General Fund	Federal Fund	Other Funds	Total Funds
2012-13	\$14,707,722	\$36,192,651	\$8,787,620	\$59,687,993
2013-14	\$16,235,742	\$42,999,474	\$10,788,402	\$70,023,618
2014-15	\$17,433,680	\$58,907,705	\$14,460,362	\$90,801,747
% of Change for Federal Reporting (2012-13 to 2014-15):		63%		

Background. DHCS is the single state agency which administers the Medi-Cal program. According to DHCS, the new financial reporting requirements associated with the Affordable Care Act (ACA) have expanded the Accounting Section beyond its current capacity. For example:

- New federal reporting requirements have doubled the current workload for Medi-Cal reporting. 8,100 forms were required for the financial reporting of Medi-Cal benefits prior to ACA; 16,200 forms will now be a required when ACA expansion is complete. The CMS-64 quarterly financial claim for March 2013 totaled 1,396 pages compared to March 2014 which totaled 2,122 pages. In a year’s time, the quarterly federal financial claim form for federal funds (CMS-64) has increased by over 700 pages. DHCS expects continued growth due to the new expanded ACA reporting requirements. March 2014 included only the initial phase of ACA which began on January 1, 2014. The current staff of eight will not be able to sustain the level of reporting required by the ACA.
- Reconciliations of the benefit payments will be increased due to the high profile nature of the ACA. This will require additional staff dedicated solely to this project as the guidelines, population and modified adjusted gross income (MAGI) information are unique from the normal Medi-Cal benefit payments.
- The Governor’s budget for local assistance in 2013-14 was \$52,905,467,000 while 2014-15 is \$72,233,221,000. This is an increase of \$19.3 billion in benefit payments. For one DHCS program, eleven accounts payable staff currently receives an average of 800 monthly invoices. ACA doubles the workload to 1,600 monthly invoices while holding staff to the same deadlines.

- Reconciliations for drug rebates, overpayment collections, and False Claims Act for the new ACA population will increase the workload for accounting and the corresponding programs due to the complexity of the federal requirements. The current workload is being performed by two staff which will need to be increased to meet the new ACA requirements. The impact of not meeting the federal reporting requirements for these reconciliations can affect the receipt of the quarterly federal grant award for Medi-Cal, interest payments to the federal government for the collections of overpayments, drug rebates and settlements not meeting Code of Federal Regulations requirements, and failing to be in compliance with federal requirements.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

13. Hospital Quality Assurance Fee Resources

Budget Issue. DHCS requests extending 9.5 limited-term positions and expenditure authority, set to expire on December 31, 2015, to December 31, 2018. DHCS also requests \$350,000 in additional limited-term expenditure authority for two contracts to calculate and actuarially certify increased capitation rates as well as for high level counsel and assistance for federal submissions associated with the Hospital Quality Assurance Fee (HQAF) program.

The HQAF program has been statutorily extended through December 31, 2016, with the option of extending the program another three years. The positions requested are necessary to facilitate the program. The total cost is \$983,000 (\$492,000 HQAF Fund and \$491,000 federal funds) for 2015-16; \$1,416,000 (\$708,000 HQAF Fund and \$708,000 federal funds) annually for 2016-17 and 2017-18; and \$983,000 (\$492,000 HQAF Fund and \$491,000 federal funds) for 2018-19.

The previous HQAF programs covered the periods between April 1, 2009 and December 31, 2013, and provided supplemental payments in the amount of \$23.4 billion to California hospitals. DHCS requests the extension of these positions due to the renewal of the program and to complete administrative duties that continue beyond the duration of the HQAF program on December 31, 2016.

Background. California's Medi-Cal program provides access to health care services to individuals with low income and limited resources under Title XIX of the federal Social Security Act.

In 2010, the department implemented California's first hospital provider fee and supplemental payment program under AB 1383 (Jones), Chapter 627, Statutes of 2009, for the period of April 1, 2009 through December 31, 2010. The program resulted in fee collections of \$3.046 billion, hospital payments of \$5.63 billion, and \$560 million retained for health care coverage for children. This program requires most California's general acute hospitals (except county and UC general acute hospitals) to participate. However, the provider fee program requires only private hospitals that were not considered small and rural to pay the fee. Approximately 405 hospitals participated in this program, 318 were private hospitals. Both public and private hospitals received payments from this program. The program was extended under SB 90 (Steinberg), Chapter 19, Statutes of 2011, an additional six months for the period of January 1, 2011 through June 30, 2011.

In 2011, SB 335 (Hernandez), Chapter 286, Statutes of 2011, extended the HQAF program from July 1, 2011 through December 30, 2013 to draw down additional federal funds and increase supplemental payments to hospitals participating in the Medi-Cal program.

SB 239 (Hernandez) Chapter 657, Statutes of 2013, extended the HQAF program, and establishes the framework for a second phase and permanent continuation of the program under future legislation or a constitutional amendment. The first phase, January 1, 2014 through December 31, 2016, is estimated to generate \$13.3 billion in funds from hospitals during the program period, of which approximately \$12.5 billion would be used to draw down an equal amount in federal funds and used to increase Medi-Cal payments to hospitals. Generating these funds pay out an estimated \$23 billion to the hospital community and \$2.4 billion for health care coverage for children, a savings to the general fund. The

department resubmitted State Plan Amendments (SPA) 14-001 and 14-002 formally to the Centers for Medicare and Medicaid Services (CMS) on November 21, 2014, for CMS approvals.

According to DHCS, continuation of the HQAF program requires significant workload for DHCS, which is distributed to staff in limited-term positions in the Safety Net Financing Division (SNFD), Third Party Liability and Recovery Division (TPLRD), Capitated Rates Development Division (CRDD), and the Office of Legal Services (OLS). Additional actuarial contract resources are needed to continue support for the program and rate build through the new period of the HQAF. In addition, while the first phase of the program payment period ends December 31, 2016, the HQAF program workload extends further to December 31, 2018. There are significant work activities needed to settle HQAF program payments that extend after the HQAF program payment period, such as, obtaining CMS necessary approvals for capitation HQAF payments, collecting delinquent fees, and necessary reconciliations.

SNFD is responsible for significant workload involving negotiations with CMS for approval of the HQAF model, the upper payment limit (UPL) models, the SPAs, and the amendment to the hospital financing waiver (all required to implement the program). In addition to this workload, SNFD is responsible for calculating the HQAF, notifying the hospitals of the HQAF amounts owed, and issuing the grant payments. This work requires the implementation and maintenance of program structures, processes and procedures, and databases for tracking status correspondence, and communications with the hospitals and external stakeholders. DHCS also has to monitor and ensure the integrity of the Hospital Quality Assurance Revenue Fund.

In order to maintain the program, TPLRD performs administrative activities relating to accounting, monitoring, processing payments as well as collecting the HQAF. In addition TPLRD monitors for delinquent payments, and the requisite administrative remedies that will continue past the end of the program. TPLRD is also responsible for a system of checks and balances to ensure the integrity of the Fund.

CRDD validates timely and accurate distribution of funds to hospitals by reviewing the plans' records. The HQAF funds are built into the plans' capitation rates for the purpose of providing additional funding to the hospitals. Each separate QAF program requires new capitation rates. Ensuring that the plans receive the appropriate funding under this program and that the plans are appropriately disbursing funds to the hospitals is a critical and substantial ongoing workload.

OLS attorneys will be required to help draft the SPAs and related public notices, as well as assist with preparing responses to CMS' Request for Additional Information which routinely accompany the SPAs. OLS attorneys will also be required to participate in discussions with the participating hospitals regarding the implementation and ongoing administration of the Program. This is especially true given the nature of the fee model and the necessity of its compliance with federal regulations. Redirection of existing staff resources is not feasible.

In addition, DHCS requests funding for the following contracts:

- Covington and Burling Contract - Provide high level advice and counsel regarding development of quality assurance fees, SPAs, fee models, UPL calculation, the federal B1/B2 test, and conformance with federal regulations.

- Mercer Contract - Calculate and actuarially certify increased capitation rates that would be paid to managed care plans.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

14. Martin Luther King Jr. Hospital Resources

Budget Issue. DHCS requests two full-time permanent positions and \$745,000 (\$373,000 Federal Fund and \$372,000 Reimbursement) including annual contract funding of \$500,000. This request is needed to meet the department's workload requirements related to Welfare and Institutions Code (WIC) Section 14165.50 to facilitate the financial viability of a new private nonprofit hospital that will serve the population of South Los Angeles. This population was formerly served by the Los Angeles County Martin Luther King, Jr. – Harbor Hospital.

Statute requires reimbursement to this new hospital based on one hundred percent of Medi-Cal projected costs for inpatient services in fee for service (FFS) and managed care, subject to a variety of requirements outlined in the law. The statute provides for the County of Los Angeles to reimburse the state for the nonfederal share of staffing and administrative costs directly related to implementation of its provisions.

Background. Currently, Medi-Cal reimburses hospitals for acute inpatient services using a Diagnosis Related Group (DRG) methodology. The DRG payment system operates on a reimbursement related to the recipient's assigned diagnosis or diagnoses. The diagnoses and procedures must be documented in the patient's medical record. The information is then coded in the claim. The coding process is extremely important since it essentially determines what DRG and reimbursement will be assigned for a patient. Each DRG category is designed to be "clinically coherent", and all patients assigned to a specific DRG are deemed to have a similar clinical condition requiring similar interventions and the same number of days of inpatient stay. The payment system is based on paying the average cost for treating patients in the same DRG. This reimburses hospitals for actual services and resources utilized based on the acuity level of a patient.

Pursuant to WIC Section 14165.50, the cost-based reimbursement methodology for FFS and managed care Medi-Cal payments to the new MLK hospital will provide compensation at a minimum of 100 percent of the projected costs for each fiscal year, contingent upon federal approvals and availability of county funding.

Under the statute, the State General Fund (GF) is obligated to provide each fiscal year through fiscal year 2016-17 a guaranteed level of 77 percent of the projected Medi-Cal cost for inpatient hospital services. Managed care rates must be adjusted to reflect the actuarial equivalent of those costs, subject to specified requirements. If current Medi-Cal private hospital reimbursement methods result in funding that is less than 77 percent of projected Medi-Cal costs, GF appropriations are required to fund the non-federal share of the additional payments up to the 77 percent of costs.

Beginning in fiscal year 2017-18, and subsequent fiscal years, this GF obligation is reduced to 72 percent of projected Medi-Cal costs. If current Medi-Cal private hospital reimbursement methods results in funding that is less than 72 percent of projected Medi-Cal costs, the GF will be required to fund the non-federal share of the additional payments up to 72 percent of the costs.

In order to enable reimbursement for the new MLK hospital to reach 100 percent of projected costs, the remaining non-federal share amounts may be transferred by the County of Los Angeles via voluntary

intergovernmental transfers (IGTs). Any public funds transferred shall be expended solely for the non-federal share of the supplemental payment. Additionally, the department shall seek further federal approval to enable MLK to receive Medi-Cal supplemental payments to the extent necessary to meet minimum funding requirements. Further reimbursement exceeding the 100 percent minimum funding requirement may be sought through additional supplemental programs upon federal approval.

The requested staff would be responsible for policy development and implementation of the FFS interim rate setting process for MLK, verification and acceptance of the projected costs submitted by the county on a yearly basis, as well as detailed monitoring to ensure funding requirements are met. These activities are vital so that the amount of funding from the GF is kept to a minimum. Additionally, the proposed staff would be responsible for the development of managed care policy as it relates to rate setting, and will be required to oversee the development of the methodology, data gathering process, and consultation with stakeholders, to ensure the appropriate cost methodology is captured and used for rate development purposes. The proposed contracted actuaries will be responsible for the development and adjustment of the rates to ensure compliance with the statute.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

15. MEDS and Securing Medi-Cal Eligibility Information Resources

Budget Issue. DHCS requests the conversion of ten limited-term positions to permanent and two-year extension of one limited-term position. The expenditure authority requested for the 11 positions is \$1,497,000 (\$714,000 General Fund and \$783,000 federal funds). The resources are necessary to perform 1) the ongoing workload of managing, protecting, and securing confidential Medi-Cal eligibility information, 2) ensuring compliance with requirements of the federal Social Security Administration (SSA), and 3) monitoring access to the Medi-Cal Eligibility Data System (MEDS). The 11.0 limited-term positions are scheduled to expire on June 30, 2015.

Background. DHCS is the single state agency which administers the Medi-Cal program, and as such, has interagency agreements in place with other departments to administer select components of the program. DHCS must authorize access to and monitor MEDS access by other departments and agencies. MEDS is a robust database containing over 25 million records which include SSA data, personal health information, and other confidential data. MEDS provides eligibility information to agencies including county welfare departments and other health and welfare agencies throughout the state. DHCS must ensure that no user has authorized access to MEDS or SSA data unless they have a verified and justifiable need directly related to the administration of the Medi-Cal program in compliance with SSA access requirements. DHCS' Information Security Office has investigated where unauthorized access either has occurred and where there was the potential for unauthorized access. Since MEDS is a key data repository for DHCS in terms of SSA data, the required SSA compliance review demonstrate we have high standards for tracking and monitoring MEDS access. MEDS is one of the most critical applications supporting Medi-Cal and numerous other public assistance programs. Many organizations, including other state departments and all 58 counties, require access to MEDS.

To obtain access to data from the SSA, DHCS must enter into a data-sharing agreement with the SSA and comply with all SSA requirements. In 2007, as a result of directives from the federal Office of Management and Budget (OMB), the SSA made substantial changes in the data-sharing agreement. This agreement focused on limiting access to SSA data to only authorized employees who need it to perform their official duties and the security procedures relating to protecting the privacy of SSA personally identifiable information.

Since 2008-09, DHCS has received staffing authority to establish limit-term positions to perform the activities necessary to maintain compliance with the SSA agreement and retain access to SSA data. With this proposal, DHCS requests the conversion of ten limited-term positions to permanent, and the extension of one limited-term position for two years effective July 1, 2015. According to DHCS, the resources will ensure the privacy and security of Medi-Cal eligibility information and MEDS data. This work is ongoing and permanent in nature.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.

16. Intergovernmental Transfer Program Resources

Budget Issue. DHCS requests two new permanent positions, the conversion of three limited-term positions to permanent, and \$467,000 expenditure authority (\$120,000 federal funds and \$347,000 reimbursements). The requested staffing resources would address the additional and ongoing workloads from Medi-Cal managed care expansion and mandated statutory requirements to implement SB 208 (Steinberg) Chapter 714, Statutes of 2010. The three limited-term positions are set to expire on October 31, 2015. Starting in 2016-17, and on-going, the requested expenditure authority would be \$540,000 (\$164,000 federal funds and \$376,000 reimbursements).

Background. DHCS is responsible for calculating and setting the capitation rates for managed care organizations, and ensuring certification that capitation rates for managed care health plans are determined in compliance with federal requirements. Managed care serves more than eight million Medi-Cal beneficiaries in 58 counties, which is more than 70 percent of the total Medi-Cal population. In California, there are six models of managed care: 1) County Organized Health Systems (COHS); 2) Two-Plan Model (TPM); 3) Geographic Managed Care (GMC); 4) Regional Model; 5) San Benito and 6) Imperial. There are currently more than 12 million Medi-Cal members.

Background - Intergovernmental Transfer (IGT) Program. According to DHCS, the rate range intergovernmental transfer (IGT) program, authorized by Welfare and Institutions (W&I) Code 14164 and 14301.4, has grown significantly as more health plans and eligible providers (also known as funding entities) have decided to participate in this voluntary program. An IGT is a transfer of funds from an eligible governmental entity such as a public hospital or county clinic to the DHCS for the purpose of providing the non-federal share of Medi-Cal payments. Federal law generally authorizes the use of IGTs. IGTs are currently used by the Medi-Cal program in a variety of areas, including the Disproportionate Share Hospital (DSH) program, and to finance portions of Medi-Cal managed care payments. The actuarially sound health plan capitation rates are developed with lower to upper bound rates known as the rate range. Generally, the health plan rates are paid at the lower bound. IGTs are then used to enhance the health plan rates up to, but not exceeding the upper bound of the range. Technical agreements between a health plan and the funding entity, as well as DHCS and the funding entity, are required for this purpose including supporting documentation that requires significant DHCS review. The rate range IGT program has substantially increased over the years as more health plans and funding entities have chosen to participate in an increasing number of counties. DHCS charges an administrative fee authorized by W&I Code 14301.4 to support program operations. The fee is 20 percent of the IGT contribution from the funding entity. The fee is expected to generate approximately \$70 million in General Fund savings in 2014-15, for plan services in the 2012-13 rate year.

This IGT rate range program has grown significantly over time. When the program first began in 2006-07, only two health plans and two providers participated. Due to increased interest, DHCS expanded health plan participation to Geographic Managed Care (GMC) county plans and providers for the 2011-12 rate year. Today, a number of health plans and providers now participate. For example, the number of rate range IGT related plan-provider agreements from Two-Plan Models, increased from 17 for rate year 2010-11 to 35 for rate year 2011-12 (the last year for which complete IGT participation data).

DHCS anticipates continued growth in this program generally in existing participating counties as well as a result of managed care expansion in rural areas.

As a result of the growth of this program, DHCS requests two new permanent associate governmental program analysts who will review financial information to ensure appropriateness of reimbursement and reconciliations of contributions to outgoing capitation payments; conduct high level analysis of IGT transactions, provide technical assistance and policy review; and process submissions for federal approvals.

Background - SB 208 IGT Program. SB 208 authorized components of the state's 1115 Medicaid Bridge to Reform Waiver and many Medi-Cal programmatic changes including mandatory enrollment of seniors and persons with disabilities (SPDs) into managed care and a related IGT program. This SB 208 IGT program enables Medi-Cal health plans to compensate Designated Public Hospitals in amounts no less than what they would have received for providing services to beneficiaries under fee-for-service (FFS). Since the non-federal share of the funding related to the SPD population historically was financed through Certified Public Expenditures (CPEs), the IGT program was created to avoid a significant General Fund impact due to the transition of this population into managed care. Specifically, SB 208 permits IGTs to provide financial support of the non-federal share of risk-based payments to managed care health plans to enable those health plans to sufficiently compensate DPHs. DHCS staff continues to work on reconciling the IGT transactions, review the flow of funds between the plans and hospitals, ensure the accuracy of transactions, and respond to and collaborate with stakeholders regarding this complex program.

Three limited term positions were originally authorized for this IGT workload associated with implementation of SB 208 in 2011-12 and were extended in 2013-14 to align with the timing of the Bridge to Reform waiver. However, this is permanent workload required by statute that does not sunset with the waiver. Therefore, DHCS requests to make these positions permanent.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this proposal.
2. Can the department identify areas where this opportunity could be more fully utilized?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

**OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, March 19 (Room 4203)**

All items were held open except for Issue 2 under the Department of Health Care Services:

4260 Department of Health Care Services

2. Medi-Cal Estimate and Caseload

- **Motion: To approve staff recommendation (b):**
 - b. Adopt Placeholder Trailer Bill Language To Eliminate Nonemergency Emergency Room Copay.** It is recommended to adopt placeholder trailer bill language to eliminate the statutory references implementing a nonemergency emergency room copay in Medi-Cal, as this assumption has been removed from the Medi-Cal estimate. As part of the Medi-Cal estimate, the Governor's budget removes the assumption that the state would implement a copayment for nonemergency emergency room usage pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011 and AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012 which was expected to result in about \$34 million (\$17 million General Fund) savings. This copay has never been implemented as it had not received approval from the federal Centers for Medicare and Medicaid. While the budget discontinues this assumption, the Administration did not propose trailer bill language to delete this provision from statute.

- **Vote: 2-1 (Senator Stone voting no.)**

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Holly J. Mitchell

**Senator Jeff Stone, Pharm. D.
Senator William W. Monning**



**March 26, 2015
9:30 a.m. or Upon Adjournment of Session
Room 4203**

Consultant: Samantha Lui

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PLEASE NOTE: Only items contained in the agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the Agenda, unless otherwise directed by the Chair. 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.

4185 California Senior Legislature**1. Trailer Bill: [606] Successor Fund Designation**

Budget Issue. The Administration provides trailer bill language that establishes the California Senior Legislature Fund as the successor fund of the California Fund for Senior Citizens.

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 assemblymembers, who are elected by their peers in elections supervised by the Advisory Councils in 33 Planning and Services Areas. The CSL's mission is to gather ideas for state and federal legislation and to present these proposals to members of the Legislature and/or Congress. Each October, the CSL convenes a model legislative session in Sacramento, participating in hearing up to 120 legislative proposals.

State law allows taxpayers to contribute money to voluntary contribution funds (VCFs) by checking a box on their state income tax returns. Contributions made through so-called "check-offs" to be made from tax-payers' own resources and not from their tax liabilities, as is possible on federal tax returns. Check-off amounts may be claimed as charitable contributions on taxpayers' tax returns in the subsequent year.

With a few exceptions, VCFs remain on the tax form until they are repealed by a sunset date or fail to generate a minimum contribution amount. For most VCFs, the minimum contribution amount is \$250,000, beginning in the fund's second year. By September 1st of each year, the Franchise Tax Board (FTB) must determine the minimum contribution amount required for each VCF to remain on the form for the following calendar year, and estimate whether contributions to each VCF meet that amount. If FTB estimates that a VCF will fail to meet its minimum contribution amount, that VCF is repealed for the following calendar year.

The California Fund for Senior Citizens first appeared on the 1983 personal income tax return. Donations to the California Fund for Senior Citizens supports the ongoing work of the CSL. In 2014, the California Fund of Senior Citizens received \$229,522 in voluntary contributions. Because it did not meet the minimum contribution amount of \$250,000, it fell off the tax check-off for the 2014 tax return.

Justification. As of March 3, 2015, there is \$343,000 in the Surplus Money Investment Fund. Below is a look-back of how many contributions were provided to CSL. CSL members felt that there may have been confusion amongst the senior population, as to which senior fund to donate, creating the decline in donations. The Administration proposes establishing and renaming the successor fund with a title that is identifiable with the organization's name.

**FRANCHISE TAX BOARD
STATUS REPORT - VOLUNTARY CONTRIBUTION FUNDS
CALIFORNIA FUND FOR SENIOR CITIZENS**

	2014 Minimum contribution requirement \$250,000		2013 Minimum contribution requirement \$250,000		2012 Minimum contribution requirement \$250,000		2011 Minimum contribution requirement \$250,000		2010 Minimum contribution requirement \$250,000	
	Items Processed	Valid Contributions								
Totals	20,912	\$229,522	21,666	\$234,247	24,042	\$272,742	25,895	\$308,763	25,442	\$296,144
January	912	\$6,307	541	\$3,922	1,373	\$10,751	956	\$6,615	769	\$5,941
February	3,704	\$33,739	3,910	\$34,664	4,078	\$40,653	4,150	\$42,922	4,367	\$44,166
March	3,631	\$42,135	4,098	\$43,174	4,290	\$45,448	4,410	\$51,364	4,650	\$54,204
April	6,310	\$78,769	6,884	\$86,422	6,913	\$89,472	7,889	\$104,763	6,564	\$85,550
May	2,543	\$24,850	2,557	\$27,029	4881	\$51,125	4,687	\$46,915	3,684	\$35,840
June	2,264	\$23,437	2,125	\$19,646	1000	\$9,656	1,621	\$21,553	3,753	\$39,686
July	274	\$2,282	262	\$2,031	199	\$3,396	591	\$5,795	238	\$2,138
August	159	\$1,285	165	\$1,446	204	\$2,523	337	\$4,113	198	\$2,029
September	160	\$2,313	165	\$3,025	141	\$1,283	188	\$2,109	183	\$3,418
October	482	\$8,778	509	\$7,606	471	\$12,819	579	\$10,416	469	\$6,419
November	368	\$5,030	378	\$5,151	370	\$3,781	441	\$11,835	471	\$16,196
December	105	\$597	72	\$131	122	\$1,835	46	\$363	96	\$557

The table below shows the current funding level of the California Senior Legislature Fund.

	2015 No Minimum Requirement	
	Items Processed	Valid Contributions
Totals	2,076	\$9,658
January	378	\$1,446
February	1,698	\$8,212
March		
April		
May		
June		
July		
August		
September		
October		
November		
December		

Staff Comment & Recommendation. Approve. Staff recommends adopting placeholder trailer bill language.

Questions

1. Please briefly summarize the trailer bill language and proposal.

5180 Department of Social Services, Adult Protective Services (APS)**1. Overview**

Background. Each of California's 58 counties has an Adult Protective Services (APS) agency to help adults aged 65 years and older and dependent adults when adults 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 who live in private homes, apartments, hotels or hospitals, and health clinics when the alleged abuser is not at staff member. APS social workers evaluate abuse cases and arranges for services such as advocacy, counseling, money management, out-of-home placement, or conservatorship. APS social workers conduct in-person investigations on complex cases, often coordinating with local law enforcement, and assist elder adults and their families navigate systems such as conservatorships and local aging programs for in-home services. These efforts often enable elder adults and dependent adults to remain safely in their homes and communities, avoiding costly institutional placements, like nursing homes.

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

Budget 2014. The 2014 Budget Act included \$150,000 in funding for one staffing position within the Department of Social Services to assist with APS coordination and training.

Staff Comment. No action. Item included for information and discussion purposes.

Question.

1. Please briefly summarize the program and services. Please provide an update on the hiring of the one staff position.

¹ AB 118, (Budget Committee), Chapter 40, Statutes of 2011, and AB 16 x 1 (Budget Committee), 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.

2. Proposal for Investment

Budget Issue. The California Commission on Aging, California Justice Coalition, and California Welfare Directors Association request an increase of \$5 million General Fund to create a statewide Adult Protective Services (APS) training program for all new APS staff, for supervisor training, and for advance training related to new policy and emerging trends. Advocates note that the level of funding would ensure access to mandated training for mandated reporters, such as physicians and public safety personnel, and training coordination with public guardians, conservators, and administrators.

Background. DSS currently contracts with local universities to deliver training. Currently, \$176,000 (\$88,000 General Fund) is allocated to the Department of Social Services (DSS) for statewide APS training. According to the California Welfare Directors Association, APS funding levels have not been increased for the past 10 years, despite APS caseload increasing by 35 percent between 2001 and 2013 throughout California.

Staff Comment & Recommendation. **Hold open.** Staff recommends holding this issue open.

Question.

1. Please briefly summarize the proposal and request.

5180 Department of Social Services, Supplemental Security Income/State Supplemental Payment (SSI/SSP)**1. Overview**

The SSI/SSP programs provide cash assistance to around 1.3 million Californians, who are aged 65 or older (28 percent), are blind (one percent), or have disabilities (71 percent), and meet federal income and resources limits. Grants under SSI are 100 percent federally funded. The state pays SSP, which augments the federal benefit.

Funding. The budget proposes \$10.2 billion total funds (\$2.8 billion General Fund) for SSI/SSP. The state pays administration costs for SSP, around \$188 million for the budget year. From 2014-15 to budget year, the budget is projected to increase by \$23.6 million GF due to a projected average monthly caseload growth and increase in the average grant.

Total spending for SSI/SSP grants—including General Fund and federal expenditures (which are not passed through the state budget)—has increased by about \$1.1 billion— or 12 percent—between 2007–08 and 2015–16. As this spending is less than the rate of inflation over this time period (roughly 14 percent), total spending has decreased slightly in real terms. Costs for SSI/SSP include the California Veterans Case Benefit Program and the Cash Assistance Program for Immigrants (to be discussed below).

Cash Assistance Program for Immigrants (CAPI). In 1998, CAPI was established as a state-only program to serve some of those aged, blind, and disabled legal non-citizens. After 1996 federal law changes, most entering immigrants were ineligible for SSI. Refugees are limited to seven years of SSI. CAPI benefits are equivalent to SSI/SSP program benefits, less \$10 per individual and \$20 per couple. The CAPI recipients in the base program include 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 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 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 2014-15, the estimated monthly average caseload was 13,093 cases.

California Veterans Cash Benefit Program (CVCB) Program. The CVCB program is linked to the federal Special Veterans Benefit (SVB) Program, which was signed into law in 1999 and provides benefits for some World War II veterans. The SVB application also serves as the CVCB application, and both payments (issued by SSA) are combined. 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. The department estimates that the caseload is around 608 cases. Grant levels are identical as the SSP portion for individuals.

Caseload. In the period from 2007–08 to the budget proposed for 2015–16, the SSI/SSP caseload has grown from 1,235,932 individuals to an estimated 1,310,977 individuals, or an increase of 6.1 percent.

Cost-of-Living Adjustment (COLA). Under current law, both the federal and state grant payments for SSI/SSP recipients are adjusted for inflation each January through Cost-of-Living Adjustments (COLAs). Federal law provides an annual SSI COLA based on the Consumer Price Index, and state law provides an annual SSP COLA based on the California Necessities Index. A 2009 human services budget trailer bill (SB 6 X3) eliminated the statutory requirement to provide a state COLA for SSI/SSP grants.

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

Grant Levels. The chart below displays the maximum monthly SSI/SSP grant for individuals and couples in 2007–08, as compared to proposed grant levels for 2015–16. Reflecting SSP grant reductions and the suspension of the state COLA, the combined SSI/SSP maximum monthly grant for individuals and couples has declined as a percentage of FPL over the nine-year period.

SSI/SSP Maximum Monthly Grants Pre- and Post-Recession		
	2007-08	2015-16 (as proposed)
Maximum Grant—Individuals		
SSI	\$637	\$744
SSP	233	156
Totals	\$870	\$900
Percent of FPL	102.3%	91.8%
Maximum Grant—Couples		
SSI	\$956	\$1,116
SSP	568	396
Totals	\$1,524	\$1,512
Percent of FPL	133.6%	113.9%

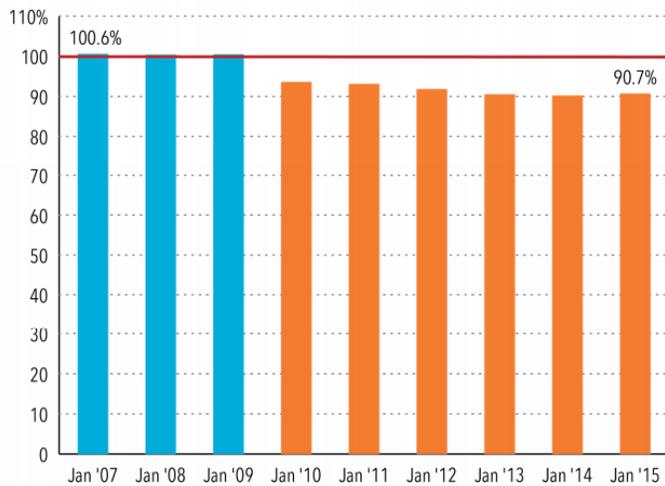
FPL = federal poverty level

According to the LAO, after adjusting for inflation, the maximum combined SSI/SSP grant proposed for 2015–16 (1) for individuals represents roughly \$76 (8.7 percent) less purchasing power than was provided in 2007–08 and (2) for couples represents roughly \$190 (12.4 percent) less purchasing power than was provided in 2007–08. According to the California Budget and Policy Center, fair market rent for a studio apartment exceeds one-half of the SSI/SSP grant for an individual in all 58 counties and is actually higher than the entire grant for 15 counties.² The charts below compares an individual’s SSI maximum grant amount as a percentage of the federal poverty level and demonstrates its loss of purchasing power since 1989.

² <http://calbudgetcenter.org/wp-content/uploads/Fact-Sheet-3.11.15-Due-to-State-Cuts-SSI-SSP-Grants-Lose-Ground-to-Housing-Costs.pdf>

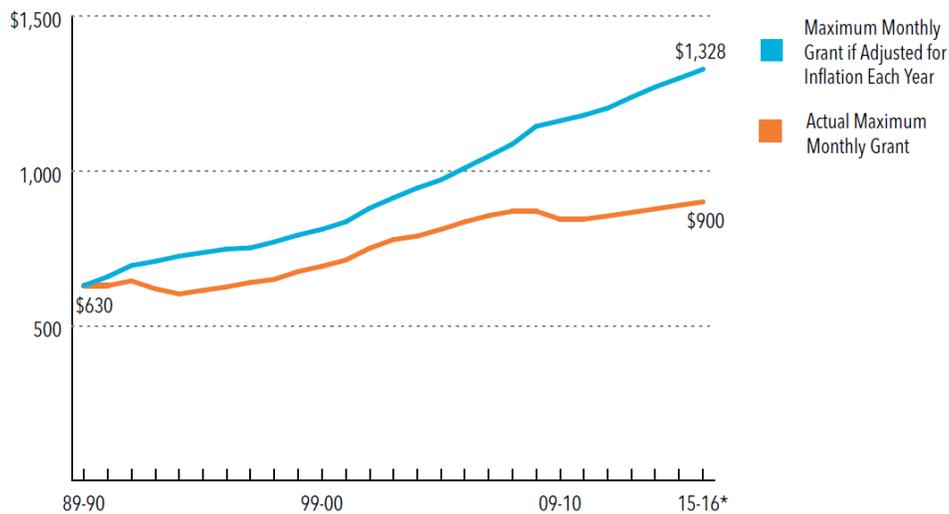
SSI/SSP Grants for Individuals No Longer Lift Seniors and People With Disabilities Out of Poverty

Maximum Monthly Grant for Individuals as a Percentage of the Federal Poverty Line



SSI/SSP Grants Have Lost Nearly One-Third of Their Purchasing Power Since 1989-90

Maximum Monthly SSI/SSP Grant for Individuals Who Are Elderly or Have Disabilities



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

Staff Comment & Recommendation. This is an informational item, and included for discussion. No action is required.

Question

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

2. Proposal for Investment

Budget Issue. Advocates request restoration on the SSP grant cuts and the cost-of-living adjustment (COLA).

Background. Currently, the individual SSI/SSP grant is worth 90.2 percent of the federal poverty level. If grant cuts had not occurred, and the COLA were applied annually, the SSI/SSP grant level for individuals would be 106.7 percent of the FPL.

Staff Comment & Recommendation. **Hold open.** Staff recommends holding the item open.

5180 Department of Social Services, In-Home Supportive Services (IHSS)**1. Overview**

The IHSS program provides personal care services to approximately 420,000 qualified low-income individuals who are aged (over 65), blind, or who have disabilities. Services include tasks like feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services frequently help program recipients to avoid or delay more expensive and less desirable institutional care settings. The average annual cost of services per IHSS client is estimated to be around \$14,217 (\$1,185 per client per month) for 2015-16.

Budget Issue. The budget proposes \$8.2 billion (\$2.4 billion GF) for services and administration. The budget also includes \$300 million (\$152 million GF) for IHSS Basic Services, an overall increase due to a 3.7 percent caseload growth, and higher cost per hour, due to the increase in the hourly minimum wage from \$8 to \$9, effective July 1, 2016. In addition, the budget includes a net increase of \$307 million (\$134 million GF) to reflect the annualized cost of complying with federal labor regulations. To offset the above increases, the budget assumes reduced funding for CMIPS II, specifically, \$53 million (\$27 million GF) due to completion of system enhancements for IHSS recipients who are blind or visually impaired; software upgrades and training; and one-time system changes related to the assumed implementation of federal labor regulations.

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

As of March 2015, IHSS providers' combined hourly wages and health benefits vary by county, and range from \$9.00 to \$12.81 per hour. Prior to July 1, 2012, county public authorities or nonprofit consortia were designated as "employers of record" for collective bargaining purposes on a statewide basis, while the state administered payroll and benefits. Pursuant to 2012-13 trailer bill language, however, collective bargaining responsibilities in the counties participating in Coordinated Care Initiative (CCI) will shift to an IHSS Authority administered by the state.

Program Funding. The program is funded with federal, state, and county resources. Federal funding is provided by Title XIX of the Social Security Act. Prior to July 1, 2012, the state and counties split the non-federal share of IHSS funding at 65 and 35 percent, respectively. A 2012-13 budget trailer bill changed this structure as of July 1, 2012, to base county IHSS costs on a maintenance of effort (MOE) requirement. The change was related to enactment of the CCI, also called the Duals Demonstration project.

Recent policies. Several recent policies have impacted the IHSS program³, including:

- **Reductions in IHSS recipient hours.** The federal court enjoined some proposed reductions to the IHSS program, including:

Policy	Lawsuit that enjoined policy from taking effect
Loss of eligibility for individuals with assessed needs below specified thresholds.	<i>Oster (V.L.) v. Lightbourne, et al. (Oster I)</i>
Across-the-board cut of 20% of authorized hours, with exceptions (impacts about 300,000 recipients).	<i>Oster (V.L.) v. Lightbourne, et al. (Oster II)</i>
Reduction in state participation in provider wages (from maximum of \$12.10 to \$10.10 per hour).	<i>Dominguez v. Schwarzenegger, et al.</i>

In March 2013, the Administration and plaintiffs (labor unions and disability rights advocates) announced their comprehensive settlement agreement from *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*-- an eight percent across-the-board reduction to authorized service hours, effective July 1, 2013, and a seven percent across-the-board reduction to service hours July 1, 2014. The settlement agreement includes a provision to “trigger off” the ongoing reduction of up to seven percent—in whole or in part—as a result of enhanced federal funding received pursuant to an “assessment” on home health care services, including IHSS. The Department of Health Care Services (DHCS) must submit a proposal for its implementation to the federal government by October 2014.

On August 28, 2014, the Administration sent a letter to the Legislature indicating that it had worked in good-faith to develop a federally-compliant proposal authorizing an assessment but, given the new federal guidance on health care related taxes, it would not be able to meet the October 1, 2014 deadline. The letter indicated that the Administration would work with all parties on viable legislation early in the 2015-16 Legislative Session. The Governor’s budget includes a proposal to create a new managed care organization (MCO) tax, which is projected to raise an additional \$215.6 million GF in revenues (to be matched with federal funds) to fully restore the seven percent reduction in IHSS hours.

- **Fair Labor Standards Act – Overtime Regulations.** In September 2013, the U.S. Department of Labor’s Fair Labor Standards Act (FLSA) established a Final Rule, which requires overtime pay for domestic workers and payment for activities not previously eligible for compensation, 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

3. Some policies, including the “share-of-cost,” remain in effect. An individual pays a share-of-cost for IHSS services, if they have income above SSI/SSP grant level.

must pay at least the federal minimum wage (\$7.25) and overtime pay at one and a half times the regular pay if a provider works over 40 hours per work week.

The Budget Act of 2014 recognized these new regulations, thought to be effective January 1, 2015, and provided \$405.6 million (\$183.6 million GF) to cover implementation of federal requirements, including the creation of a new workweek system, automation changes for the Case Management Information and Payrolling System II (CMIPS II), and payment for overtime, travel time between two clients, and medical accompaniment wait time. On December 31, 2014, a federal district court determined that a portion of the regulations exceeded the Department of Labor's authority and delayed implementation of the regulations. California's implementation of FLSA, such as limiting providers to a 61-hour workweek (66-hour workweek minus the current seven-percent reduction in service hours), is delayed pending further action by the federal court.

The Administration notes that if the court blocks federal regulations, IHSS providers will be compensated the same way as in 2014. However, if the court allows all, or a portion of, new regulations to be implemented, the budget includes funding for these purposes, specifically, \$712 million (\$316.6 million GF). In addition, the budget assumes the following provisions related to the implementation of overtime:

- 87 percent of recipients will have a provider accompany them to medical visits, spending an estimated three hours per month waiting for recipients to complete appointments.
- 18 percent of providers service multiple recipients and may spend an average of ten hours per month traveling between recipients.
- To allow parent providers who provide services for multiple IHSS recipients within their home, the state is pursuing a 1915(i) option to allow them to exceed workweek limits without noncompliance violations.⁴

LAO Comments. The Legislative Analyst's Office (LAO) makes the following recommendations and comments related to FLSA:

- What happens to funding appropriated in 2014-15 Budget? The Legislature may wish to consider enacting legislation that reverts around \$184 million GF to be made available for legislative priorities, or departments could spend some or all of these funds on other purposes. SB 855(Budget and Fiscal Review), Chapter 29, Statutes of 2014, language requires that funding appropriated for FLSA-related activities must remain within the IHSS budget.
- Report on the CMIPS II. The state has complete most of the CMIPS II system changes needed to process overtime compensation, provide wait and commute time payments, and to enforce overtime-related rules. The LAO recommends that DSS report on the following specific issues related to CMIPS II:

⁴ DSS estimates around 740 cases in FY 2014-15 and 760 cases in budget year fall under the category of a provider providing services for multiple IHSS recipients in their home (e.g., adult caring for two parents; a person caring for sister and her father; provider caring for two or more minor dependent children). The budget assumes that the allowance for a provider to perform tasks in excess of the workweek restrictions, as in the aforementioned circumstances, is contingent upon federal approval of the 1915(i) option.

- Can CMIPS II changes lie dormant while the validity of the regulations is being challenged in courts?
- What is the fiscal impact to the CMIPS II budget if federal labor regulations were to remain invalidated upon resolution of the court case? What is the associated cost with reversing FLSA-related system changes?
- What is the anticipated fiscal impact to the CMIPS II budget if federal labor regulations are upheld? What additional changes in CMIPS II need to occur?

Staff Comment & Recommendation. Hold open. Last week, this subcommittee heard the MCO tax proposal, which would, in part, restore the seven percent cut to IHSS service hours. For that item, and for the state's policy on overtime, staff recommends keeping the item open for further discussion.

Questions

1. Please provide an overview for the IHSS program, including caseload and funding levels.
2. What is the current status of FLSA? When will opening arguments of the appeal be heard?
3. How is the Administration planning to use the current year's appropriation for implementing FLSA related activities? Can this amount be carried over?
4. Please summarize which policies and changes have been implemented (e.g., workweek agreements, CMIPS II), assuming the Jan. 1, 2015 effective date of FLSA. Are there overtime policies that were mid-implementation and were suspended following the December 2014 district court ruling?
5. Please respond to the questions raised by the LAO related to CMIPS II system changes and impacts.

2. BCP #1: IHSS CMIPS II and Overtime Implementation for FLSA

Budget Issue. To support the development of policies and requirements to implement the proposed workweek limitations for IHSS providers, as specified in SB 855, the department requests \$1 million (\$513,000 GF) for associated operating expenses and for four new positions, which include:

- One associate governmental program analyst (AGPA);
- Two research analysts; and,
- One attorney for the Legal Division.

The department is also seeking a two-year extension of the following four existing limited-term positions:

- One staff services manager;
- Two AGPAs; and,
- One attorney for the Legal Division.

These limited-term positions were assigned to support the Case Management, Information and Payrolling System II through the maintenance and operation phase.

Background. In January 2014, the CMIPS II project began its maintenance and operations (M&O) phase. According to the department, “it has become evident in the months since that the workload will continue to increase.” Examples of increased workload include the new mandated program changes related to the Coordinated Care Initiative, quality assurance of the Community First Choice Option, and the development and application of the Fair Labor Standards Act (FLSA) into CMIPS II. The department also notes that there is also a backlog of CMIPS II service requests from counties that require DSS to perform special system transactions. These backlogs and additional workload related to FLSA activities, such as incorporating workweek limitations and payment for providers who travel between two recipients in the CMIPS II system, have placed “some of the normal operational activities on hold and has resulted in time-consuming tasks for staff to research and identify the issues.”

Justification. According to the department, the justification for the positions are as follows:

- One AGPA will work on policy development to maintain statutory and regulatory requirements, and to implement procedures that counties will use to adhere to the workweek limitation.
- One research analyst will conduct oversight of the 24-month study to evaluate the implementation of SB 855, including overtime restrictions, travel time and wait time allowances.
- One research analyst will develop voluntary in-class provider training pursuant to state law.
- One attorney will represent the department and work with the U.S. Department of Labor, California Department of Industrial Relations Wage and Hour Division, and Department of Human Resources.
- One attorney will draft legislation and provide legal analysis of the implementation of overtime
- One attorney will conduct research, draft legal opinions, and provide legal advice.

- The extension of existing CMIPS II limited-term staff will address the existing backlog and ongoing workload, including stakeholder communication, county support, and data resource and analysis. In addition, these positions will produce guidelines and instructions; conduct county outreach; and Timesheet Processing Facility oversight.

Staff Comment and Recommendation. Hold open. Given that the state is not currently implementing overtime, the request for staff to implement a policy will need further discussion.

Questions

1. Given the uncertainty about the federal appeals process, what are the department's thoughts on the timing of the requested positions?
2. Will the request for the extension of four existing LT positions mean that these positions will be publicly noticed and go through the regular application/interview/hiring process? Or, will current staff in those positions simply be extended?
3. Will these positions be entirely dedicated to FLSA implementation, or will they also monitor the minimum wage system increases, recipient service hour adjustments, and CCI-related activities?
4. Please provide an update on the existing backlog of CMIPS II service requests.
5. What is the average length of time it takes to resolve a special transaction? Do these special transactions delay payment? If so, by how long?

5180 Department of Social Services - CalWORKs**1. Overview**

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. In the last several years, CalWORKs has sustained very significant reductions (summarized below), as well as programmatic restructuring. Total CalWORKs expenditures are \$6.9 billion (all funds, State General Fund is \$504 million) in 2014-15. The amount budgeted includes \$5.3 billion for CalWORKs program expenditures (including grants, services, and child care) and \$1.6 billion in non-CalWORKs programs. California receives an annual \$3.7 billion TANF federal block grant. To receive TANF funds, California must provide an MOE of \$2.9 billion annually. State-only programs funded with state General Fund are countable towards the MOE requirement.

Budget Issue. The budget includes \$5.6 billion in federal, state, and local funds for the program, and estimates an average monthly caseload of 533,000 families. The budget reflects full year cost (\$174.6 million) of the five-percent restoration to the Maximum Aid Payment (MAP) grant levels, effective April 1, 2015. These costs will be funded by 1991 Realignment growth funds in the Child Poverty and Family Supplemental Support Subaccount (\$101.3 million) and a \$73.3 million General Fund augmentation. Future grant increases will be based on subsequent revenue analysis and caseload estimates.

Demographics of CalWORKs Recipients⁵. Around three-quarters of all CalWORKs recipients are children. Nearly half of those children are under the age of six. 92 percent of heads of CalWORKs recipient households are women. Two-thirds are single and have never married. Nearly half have an 11th grade or less level of education, and ten to 28 percent are estimated to have learning disabilities. Around 80 percent of these adults report experiencing domestic abuse at some point.

Caseload and Spending Trends. Prior to federal welfare reform in the mid-1990s, California's welfare program aided more than 900,000 families. By 2000, the caseload had declined to 500,000 families. During the recent recession the caseload grew; but at an estimated 563,500 families in 2012-13, it is not anywhere close to the levels of the early 1990s. Most recently, the caseload declined 1.8 percent in 2011-12, and from there is expected to increase slightly in 2012-13 and 2013-14 (to a projected 572,000 families). According to the California Budget Project, welfare assistance represented 6.8 percent of the state's overall budget (including federal, state, and local resources) in 1996-97, compared with 2.9 percent in 2011-12.

According to the Department of Social Services (DSS), over one million children in 551,000 families are served. During federal fiscal year 2013, nearly 50 percent of the children living in poverty were served.

⁵ Context information comes from sample data collected by the Department of Social Services (DSS) and from studies in single or multiple counties, as summarized in *Understanding CalWORKs: A Primer for Service Providers and Policymakers*, by Kate Karpilow and Diane Reed. Published in April 2010; available online.

Welfare-to-Work Program. Adults eligible for CalWORKs are subject to a lifetime limit of 48 months of assistance. Unless exempt for reasons such as disability or caregiving for an ill family member, adults must participate in work and other welfare-to-work (e.g., educational) activities. Depending on family composition, these activities are required for 20, 30, or 35 hours per week. The program also offers supportive services, such as childcare and housing support. Effective January 1, 2013, clients are under the WTW 24-month clock, which provides 24 months of additional flexibility around how to meet work requirements, but then after the initial 24-months, imposes stricter work requirements to receive assistance and a limit on the number who can.

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 the Department of Social Services (DSS).
- Stage 2. Once counties deem the family “stable,” CalWORKs families move to this program. Families remain in Stage 2 until they have not received assistance for two years. The California Department of Education (CDE) administers this program.
- Stage 3. Families transition to this program after Stage 2. CDE also administers this program.

Stages 1 and 2’s services are considered entitlements, whereas Stage 3’s 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.

Major program changes. 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 activities⁶ before the time limit has been reached and stricter requirements afterward (up to 48 total months).
- A two-year phase-out of temporary exemptions from welfare-to-work requirements for parents of one child from 12 to 24 months old or 2 or more children under age 6, along with a new, once in a lifetime exemption for parents with children under 24 months.

⁶ In the first 24 months, the flexible activities could include: employment, vocational education; job search; job readiness; job skills training; adult basic education; secondary school; or barrier removal activities.

- 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. DSS estimates that approximately 6, 200 cases have some month used of their 24-month clock, and by the end of the budget year, around 1,000 cases may reach the end of the 24-month clock.

Early engagement. SB 1041 required DSS to convene stakeholder workgroups to inform the implementation of the above changes, as well three strategies intended to help recipients engage with the WTW component, particularly given the new time limits and rule changes, specifically:

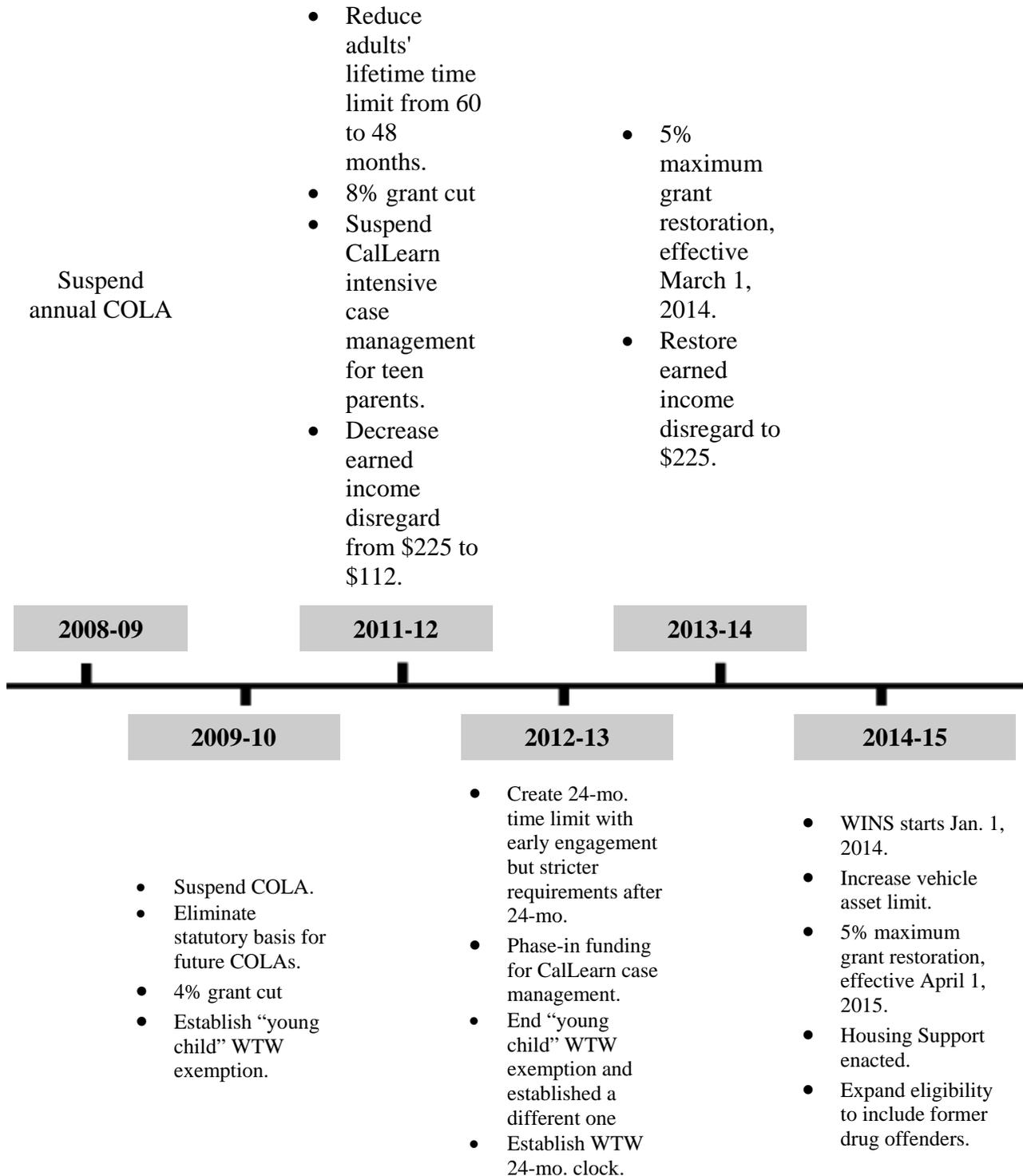
1. Expansion of subsidized employment. Under subsidized employment, counties form partnerships with employers, non-profits, and public agencies. Wages are fully or partially subsidized. \$134 million was allocated to 57 counties in FY 2014-15, and DSS projects that around 8,000 new jobs were anticipated for the same time period. From December 2013 to June 2014, around \$14.7 million of the \$39.3 million allocation was spent, or approximately 37.39 percent.
2. Online CalWORKs Appraisal Tool (OCAT). OCAT is a standardized statewide WTW appraisal tool that provides an in-depth assessment of a client's strengths and barriers, including: employment history, interests, and skills; educational history; housing status and stability; language barriers; child health and well-being; and, physical and behavioral health, including, but not limited to, mental health and substance abuse issues. The department estimated that OCAT would be available statewide September 2014 but roll-out has been delayed. OCAT is expected to reach all counties by the end of 2015.
3. Family stabilization (FS). FS is intended to increase client success during the flexible WTW 24-Month Time Clock period by ensuring a basic level of stability for clients who are especially in crisis, including: intensive case management and barrier removal services. Clients must have a "Stabilization Plan" with no minimum hourly participation requirements. Six months of clock-stopping is available, if good cause is determined. In September 2014, 1,398 individuals were served, and 40 percent of those receiving services were children. According to a joint Senate Human Services and Senate Budget Subcommittee #3 background paper⁷, at least one county, Los Angeles, has interpreted the family stabilization statute and instruction letters to say that the program is triggered by the information on the OCAT tool. Although Los Angeles has deferred fully implementing the program until the tool comes online later this year, clients, who received an OCAT appraisal as part of the pilot, have received FS. The department acknowledges that there has been a delay in full program implementation for a number of counties. According to the department, "A variety of numerous large program changes for counties statewide in 2014 proved difficult for them to implement all concurrently." From March 2014 to June 2014, approximately \$6 million of the \$10.8 million allocation was spent, or approximately 55 percent.

Monitoring results and outcomes. RAND Corporation will evaluate the enacted changes and provide the Legislature a report by October 1, 2017. In the interim, the Department of Social Services (DSS)

⁷ <http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/03102015Sub3JtHearingSenateHHS.pdf>

must annually update the Legislature regarding implementation of the enacted changes related to the 24-month clock.

**Summary of Major CalWORKs Changes
2008-2015**



Federal Context and Work Participation Rate. Federal funding for CalWORKs is part of the Temporary Assistance for Needy Families (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, they do not give credit for a significant number of families who are partially, but not fully, meeting hourly requirements.

California did not meet its federal WPR requirements for 2007, 2008, 2009, 2010, and 2011. The Administration for Children and Families accepted California's Corrective Compliance Plans to address the TANF WPR penalty for federal fiscal years 2008, 2009, and 2010. Penalty relief for all three years is contingent upon WPR compliance for FFY 2015. California has submitted a reasonable cause claim, which is currently pending, to address the \$246.1 million WPR penalty for FFY 2011.

DSS estimates that the state's participation rate for FFY 2015 may be between 48.9 to 52.6 percent.⁸ Below is a chart summarizing WPR requirements and associated penalties.

Summary of WPR Requirements and TANF Penalties

FFY:	2008	2009	2010	2011
Required Rate: All Families	50%	50%	50%	50%
Caseload Reduction Credit¹	21%	21%	21%	21%
Adjusted WPR target	29%	29%	29%	29%
California Actual WPR	25.1%	26.8%	26.2%	27.8%
Potential Penalty Amount	\$47.7 million	\$113.6 million	\$179.7 million	\$246.1 million

^{1/} Due to the American Recovery and Reinvestment Act, California received the 2008 Caseload Reduction Credit for FFYs 2009, 2010, and 2011.

At a joint Senate Human Services and Budget Subcommittee #3 hearing on March 10, 2014, an expert from the Center on Budget and Policy Priorities testified that no other state has ever been required to pay such penalties.

Policy considerations. The Legislature is also faced with other policy considerations in the CalWORKs programs:

- **Grant levels.** In 1996-97, a maximum grant for a family of 3 was \$594, or 55 percent of federal poverty level (FPL). By comparison, in 2015-16, a maximum grant for a family of three is projected to be \$704 or 42 percent of FPL. If maximum grant levels remained at 55 percent of

⁸ The Work Incentive Nutritional Supplement (WINS) program, which provides a state-funded monthly benefit of \$10 to families receiving CalFresh who are meeting TANF work requirement, began on June 1, 2014. Because those state funds are counted toward the TANF maintenance-of-effort requirement, the CalFresh/WINS cases are included in the WPR calculation, and is expected to help improve the state's FFY 2015 WPR.

FPL (using 1996-97 as the base year), the 2015-16 maximum grant level would be \$920. Using 1996-97 as the base year, if grants had received no cuts or increases in the intervening years and received previously applicable cost-of-living adjustments (COLAs), the 2015-16 maximum grant level would be \$1,050 or 63 percent of FPL.

- Earned income disregard. Since 1997, CalWORKs has allowed families to keep the first \$225 of their pre-tax earnings, without an impact on reducing the CalWORKs grant amount. Advocates have noted that this amount has not been increase since its inception.
- Maximum family grant (MFG) stipulates that a family's maximum aid payment will not be increased for any child born into a family that has received CalWORKs for ten months prior to the birth of a child. There is proposed legislation in the current session seeking to amend the MFG.
- Impact of the 24-month clock. The Administration projects that no clients will time out in the current fiscal year, but that a small cohort clients will begin to see grant reductions in July 2015, which will continue to grow monthly for a total of 2,500 people who have exhausted their 24 month clock by the end of FY 2015-2016.

Budget 2014. Last year, SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, enacted several changes to the program, including:

- Eligibility for individuals with previous felony drug convictions. This policy, which expands eligibility for adults who were previously ineligible for benefits due to a prior felony drug conviction, implements on April 1, 2015. The department estimates that approximately 400 persons with a prior felony drug conviction will be added to an existing CalFresh household, and approximately 1,100 households will become newly eligible for CalFresh. In addition, DSS estimates that around 3,900 CalWORKs child-only cases per month are anticipated to include an adult with a previous felony drug conviction that will become eligible for CalWORKs. The 2015-16 budget provides \$23.4 million (\$1 million General Fund) for this policy.
- Establish the CalWORKs Housing Support Program. \$20 million (\$12 million General Fund) was awarded to 20 counties to provide evidence-based interventions to families receiving CalWORKs who are at risk for homeless or are homeless. Services could include landlord outreach, housing search and placement, legal services, and housing barrier assessment.

Staff Comment. The Legislature may wish to consider the following:

- Impacts of recent reductions and program restructuring. The CalWORKs program sustained a volume of grant reductions and program restructuring—such as reduced time limits and different work participation rules—in a time of significantly high caseloads during the Great Recession. In the last two years, two maximum aid payment restorations⁹ have been approved and will go into effect. As the economy recovers, the Legislature may wish to review how the CalWORKs

⁹ A 10 percent MAP increase to a 12 percent grant cut.

restructure, which occurred during a period of economic distress, has impacted client outcomes, and to consider opportunities for future refinement.

- Evaluating the “work first” approach. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, P.L. 104-193), signed on August 22, 1996, reshaped food and assistance programs, emphasizing a “work first” approach to welfare reform. Nearly twenty years after welfare reform, the Legislature may wish to evaluate whether the existing “work-first” approach successfully removes barriers and provides long-term, positive outcomes for recipients; or, if additional discussion regarding alternative approaches that include the blending of services, supports, and investment in human capital (e.g., skills based training, education) may also create long-term, high-wage employment and mobility out of poverty.
- Tackling poverty. In 2011, the U.S. Census Bureau and the Bureau of Labor Statistics released its 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; Supplemental Nutrition Assistance Program (SNAP); necessary expenses that may affect family resources, such as commuting costs, out-of-pocket medical expenses, and childcare costs; and, geographic differences in housing costs.¹⁰ According to the 2011 U.S. Census Bureau figure, California’s current official poverty measure is 16.5 percent; under the SPM, its poverty rate over 2009-2011 averaged 23.8 percent – the highest of any state in the nation. The Legislature may wish to discuss how the CalWORKs program, including strategies for subsidized employment and integration with the federal Workforce Innovation and Opportunity Act (WIOA), can be better leveraged to reduce poverty.

Staff Recommendation. This item is informational, and no action is required at this time.

Question

1. Please briefly summarize the CalWORKs program, including average grant amounts, recent legislative and policy changes, and caseload trends.
2. How is the department working with other agencies to develop WIOA plans and encourage workforce development and participation?

¹⁰ Kathleen Short. "The Research Supplemental Poverty Measure: 2011." *U.S. Census Bureau, Economics and Statistics Administration*. November 2012.

<http://www.census.gov/hhes/povmeas/methodology/supplemental/research/Short_ResearchSPM2011.pdf>

2. Oversight: Cal-Learn

Budget Issue. Cal-Learn costs are 100 percent federally funded through TANF, except for grants and services for the sanctioned caseload and recent noncitizen entrant (RNE) caseload. Specifically, the budget includes \$915,000 federal funds for Cal-Learn bonuses, \$681,000 for grants for the sanctioned caseload; and \$23.4 million (\$628,000 GF) for intensive case management.

Background. In 1998, the Cal-Learn program, which is a statewide program for pregnant and parenting teens in the CalWORKs program, became permanent. The program provides intensive case management, supportive services (e.g, child care, transportation, school supplies); and financial incentives to eligible teen recipients who are pregnant or parenting. The department estimates that around 13 percent of the caseload will utilize transportation services, and 3.2 percent will utilize ancillary services.

In the 2011-12 budget, the Cal-Learn program was suspended, except for bonuses paid for satisfactory progress and high school graduation. The program was restored beginning July 1, 2012.

Key Dates
❖ July 1, 2011: Suspension of Cal-Learn begins.
❖ June 30, 2012: End of suspension of Cal-Learn.
❖ April 1, 2013: Cal-Learn fully restored.

Caseload. DSS estimates an average monthly caseload of 6,996 cases in FY 2014-15 and 6,347 cases for the budget year. There are around 106 RNE cases for FY 2014-15 and 96 cases for the budget year.

Trends. The department notes a declining trend in Cal-Learn caseload, and associates this decline with the corresponding downward trend in the state’s teen birth rate and the overall CalWORKs caseload decline. Sanctions in 2013-14 were the lowest in four years at 1.9 percent. Satisfactory progress bonuses increased to 5.2 percent compared to 4.2 percent in FY 2012-13. Graduation bonuses remained consistent as a percent of the caseload over the four-year period.

**Cal-Learn Average Monthly Participation and Outcomes
2010-11 Through 2013-14**

	2010-11	2011-12	2012-13	2013-14
Total Monthly Participants	11,018	10,324	9,315	7,756
Satisfactory Progress Bonuses	677 ¹	471	393	405
Graduation Bonuses	158	144	129	106
Sanctions	343	226	307	149
Exemptions, Deferrals and Good Cause	38	119	52	38
Repeat Pregnancies	N/A	N/A	51 ²	48

Data Source: STAT 45 monthly reports

¹ FY 2010-11 Satisfactory Progress Bonuses total has been corrected from 648 as reported in 2014 reports.

² Data collected for FY 2012-13 Repeat Pregnancies included April through December 2013 only.

Staff Comment & Recommendation. Hold open. Although this item is included for discussion and informational purposes, staff recommends that this item remains open for further discussion and review.

Question

1. Please provide an overview of the program and services.

3. Oversight: Welfare to Work Program

As discussed in the overview section above, SB 1041 (Budget and Fiscal Review Committee), Chapter 47, Statutes of 2012, made significant changes to CalWORKs welfare-to-work rules and created a differentiation between welfare-to-work participation rules that apply before expiration of a 24-month time limit. SB 1041 also allows for extensions of up to six months, after a review at least every six months, of the more flexible rules for up to 20 percent of participants. Recognizing the significant program changes, AB 74 also established several early engagement strategies, such as subsidized employment, family stabilization, and online CalWORKs appraisal tool.

Budget 2014 Action. The Department of Social Services (DSS) requested eight positions and \$980,000 to support the county peer review process, quality control reviews for the Temporary Assistance to Needy Families (TANF) program, and field monitoring visits to monitor the implementation of recent CalWORKs changes.. Specifically, the eight positions are as follows:

- Two staff services managers;
- Two research analysts; and,
- Four associate governmental program analysts in CalWORKs Employment Bureau.

Staff Comment & Recommendations. Hold open. During a March 10, 2014 hearing, the subcommittee considered several issues related to California’s existing welfare-to-work plan, including its implementation of early engagement strategies. The subcommittee considered testimony related to housing support and family stabilizations. In addition, the subcommittee may wish to consider the following:

- Has the utilization of supportive services, like child care, increased? As more work-eligible individuals participate in re-engagement¹¹ and re-enter the workforce, there should be a corresponding increase in child care. However, we have not seen a significant impact driving utilization for any of CalWORKs child care stages. Instead, there has been decrease in Stage 1 and 2 slots from 2012-13 to 2013-14, with only slight upticks in Stages 1 and 3 in the last two years. The Legislature may wish to investigate why the utilization of supportive services appears to not have significantly increased.
- Has there been an anticipated increase in participation for education-related activities? Under the 24-month clock, the state removed the “core” and “non-core”¹² distinction in activities, assuming an increased participation in non-core activities during the flexible 24-month clock (e.g., vocational training, mental health treatment, or adult education). Also, as related to the 24-month clock, there may have been anticipated increases in the number of enrollments at community colleges or adult educations, given the new flexibility for educational pursuits. Instead, the number of clients receiving CalWORKs who are also participating in community colleges decreased by fourteen percent in the last three years. Further, the department indicates that

¹¹ Re-engagement refers to the process by which DSS re-engaged parents in approximately 15,000 families whose young-child exemptions ended over the last two years.

¹² “Core” activities mean that they can count toward any hours of work participation for an individual.

current data is unable to identify which activities a client participated in during their 24-month clock. This inability to longitudinally track activity pre-dates the establishment of the 24-month clock.

According to the LAO, based on DSS data, the data show a decline in the rate of participation in education activities from 2010 and 2012 to 2014, but also show that the rate of participation in education activities in 2014 was actually slightly higher than prior to the recession (in 2006 and 2007), with the rate of participation in education activities peaking during the recession.

Participation in Various CalWORKs Welfare-to-Work Activities						
	<u>2010 Monthly Average</u>		<u>2012 Monthly Average</u>		<u>2014 Monthly Average</u>	
	Number of Participants	Share of Participants	Number of Participants	Share of Participants	Number of Participants	Share of Participants
Unsubsidized employment	68,672	49%	58,588	49%	64,382	53%
Vocational education	27,455	20%	21,104	18%	19,322	16%
Adult basic education	7,552	5%	6,586	6%	5,565	5%
Job skills training directly related to employment	4,754	3%	5,660	5%	5,474	4%
Education directly related to employment	5,248	4%	4,429	4%	3,702	3%
On-the-job training	80	0%	88	0%	209	0%
Satisfactory progress in a secondary school	500	0%	455	0%	179	0%
Grant-based on-the-job training	42	0%	11	0%	5	0%
All education activities	45,630	33%	38,334	32%	34,455	28%

a. Some individuals may be participating in more than one education activity at any given point in time. As a result, the sum of participants in all education activities may be overstated.

Year	Estimated share of WTW Participants in Any Educational Activity
2006	26%
2007	26%
2008	29%
2009	33%
2010	33%
2011	34%
2012	32%
2013	30%
2014	28%

Questions.

1. Please provide an overview of the key changes enacted by SB 1041 and how the department is monitoring and implementing those changes.
2. What is the effect of the 24-month limit on families in WTW for budget year and BY +1?
3. What metrics or program elements may provide insight as to how the change in flexibility have impacted a client's experience on-the-ground?
4. How will the state ensure that students can pursue their desired WTW activities, education or otherwise, to maximize the flexibility of the 24-month clock?

4. Proposals for Investment

The subcommittee has received the following advocate requests related to the CalWORKs program.

4A. Maximum Family Grant

Budget Issue. Advocates request to repeal the Maximum Family Grant (MFG).

Background. AB 473 (Brulte), Chapter 196, Statutes of 1994, prohibits an increase in CalWORKs aid based on an increase in the number of needy persons in a family due to the birth of an additional child, if the family has received aid continuously for the ten months prior to the birth of the child, as specified, or for longer than the gestational period of the new baby. If the family is not receiving aid for two or more months during the ten-month period preceding the birth of the child, the new child becomes eligible for aid in the CalWORKs benefit calculation. Additionally, the MFG rule does not apply if a family returns to CalWORKs after a break of two or more years during which the family did not receive any aid, provided aided children are still younger than 18 years old.

Based on information provided by the Department of Social Services (DSS) from data collected from the county consortia, 13.3 percent of total children in CalWORKs families are currently subject to the MFG rule, or approximately 131,400 children. Approximately 58.2 percent of those children are under the age of six.

Staff Comment and Recommendation. **Hold open.** Staff recommends the item remain open for further discussion.

4B. Housing Support Program

Budget Issue. California Welfare Directors Association and Housing California request an increase the CalWORKs Housing Support Program by \$30 million General Fund, noting that the augmentation would serve an additional 10,350 children in 4,500 families.

Background. SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, allocated \$20 million for a new Housing Support Program (HSP) for eligible CalWORKs recipients. Twenty counties were awarded HSP funds in September 2014, which must be used before June 30, 2015. Counties were given the flexibility to design their own county specific HSP plan to serve the needs of their community. Please see page 23 of the agenda for additional background on the Housing Support Program.

Staff Comment and Recommendation. **Hold open.** Staff recommends the item remain open for further discussion.

4C. California Partnership to End Domestic Violence

Budget Issue. Advocates request trailer bill language that includes the following provisions:

- Requires counties to waive any program requirement – except for income, resource, and deprivation requirements – for an applicant, relative caretaker, or recipient who has been identified as a past or present victim of abuse, as defined in state law, when the requirement would encourage the individual to return to the abuser, or would be detrimental to or penalize the individual, or his or her family.
- Requires a county to waive the welfare-to-work requirements for an applicant or participant when good cause has been determined.
- Requires that waivers be re-evaluated during annual and semi-annual county eligibility determinations.
- Requires the Department of Social Services (DSS), in consultation with specified individuals, to develop a standard, statewide notice to inform all CalWORKs applicants and recipients that victims of abuse have a right to request a waiver of program requirements.
- Sets forth information of what the notice to CalWORKs recipients should include.
- Prohibits DSS from approving a county's notice unless the notice contains specified information.
- Authorizes that an applicant, or recipient, is not required to disclose his or her status, or the status of another member in the assistance unit, as a victim of abuse.
- Prohibits a county from treating a recipient's request for a domestic violence waiver with prejudice, if the recipient does not immediately disclose abuse.

Background. Under the Social Security Act¹³, a state may implement a special program, within its Temporary Assistance for Needy Families (TANF) program, to serve victims of domestic violence and to waive program requirements for such individuals. Federal regulations grant states broad flexibility to grant program waivers to victims of domestic violence. The 1996 federal welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), provided states with the option, commonly known as the Family Violence Option (FVO), to enact provisions to address barriers for victims of domestic violence. California elected to include the Family Violence Option (FVO) in the CalWORKs program in AB 1542 (Ducheny), Chapter 270, Statutes of 1997.

Staff Comment and Recommendation. **Hold open.** On January 8, 2015, plaintiffs filed a writ of mandate and complaint for declaratory relief in Alameda County against the Department of Social Services. The court case is pending. Staff recommends the item remain open for further discussion.

¹³ Section 402(a)(7)

4D. Additional CalWORKs proposals

Budget Issue. Advocates have also raised the following CalWORKs issues:

- Increase CalWORKs grants;
- Restore the CalWORKs cost-of-living adjustment;
- Restore the value of the Earned Income Disregard and index it to inflation;
- Require Department of Social Services to develop options for reducing sanctions in consultation with stakeholders, with a report to the Legislature in 2016;
- Suspend all transfers to the TANF 24-month-clock; and,
- Require the Department of Social Services to develop alternatives to the TANF 24 month clock to result in fewer sanctions.

Staff Comment and Recommendation. **Hold open.** Staff recommends the above item remain open.

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Holly J. Mitchell

**Senator Jeff Stone, Pharm. D.
Senator William W. Monning**



**March 26, 2015
9:30 a.m. or Upon Adjournment of Session
Room 4203**

Consultant: Samantha Lui

<u>Item</u>	<u>Department</u>	<u>Action</u>
4185	California Senior Legislature 1. Trailer Bill: Successor Fund Designation	Hold open.
5180	Department of Social Services, Adult Protective Services 1. Overview 2. Proposal for Investment	Informational. Hold open.
5180	Department of Social Services, Supplemental Security Income/State Supplemental Payment (SSI/SSP) 1. Overview 2. Proposal for Investment	Informational. Hold open.
5180	Department of Social Services, In-Home Supportive Services (IHSS) 1. Overview a. Governor's Proposal: Restoration of the Seven Percent Across-the-Board Reduction to Service Hours b. Update: Federal Fair Labor Standards Act (FLSA) c. Case Management, Information, and Payrolling System II (CMIPS II) 2. BCP #1: IHSS CMIPS II and Overtime Implementation for FLSA	Informational. Hold open. Hold open. Hold open. Hold open.
5180	Department of Social Services, CalWORKs 1. Overview 2. Oversight: Cal-Learn 3. Oversight: Welfare-to-Work Program 4. Proposals for Investments	Informational. Hold open. Hold open. Hold open.

Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.



April 9, 2015

9:30 a.m. or Upon Adjournment of Session

Room 4203, State Capitol

Part A Agenda
(Michelle Baass)

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PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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. Thank you.

0977 California Health Facilities Financing Authority (CHFFA)

1. Investment in Mental Health Wellness Act of 2013

Oversight Issue. SB 82 (Committee of Budget and Fiscal Review), Chapter 34, Statutes of 2013, enacted the Investment in Mental Health Wellness Act of 2013 that appropriated \$149.8 million to CHFFA as follows:

- Crisis Residential Treatment Beds – \$125 million one-time General Fund to provide grants to expand existing capacity by at least 2,000 crisis residential treatment beds over two years. These funds are to be used to leverage other private and public funds.
- Mobile Crisis Teams - \$2.5 million one-time (\$2 million General Fund and \$500,000 Mental Health Services Act Fund State Administration) to purchase vehicles to be used for mobile crisis teams and \$6.8 million ongoing (\$4 million Mental Health Services Act Fund State Administration and \$2.8 million federal funds) to support mobile crisis support team personnel.
- Crisis Stabilization Units - \$15 million one-time General Fund to provide grants to increase the number of crisis stabilization units.
- \$500,000 in one-time General Fund for CHFFA to develop the above-specified grant programs.

Additionally, SB 82 required CHFFA to submit to the Legislature, on or before May 1, 2015, a report on the progress of the implementation of these grant programs.

Implementation Status. CHFFA has awarded two rounds of funding totaling \$85.3 million to counties to establish 866 crisis residential treatment beds, 43 vehicles for mobile crisis teams, and 58.5 mobile crisis staff. Pursuant to program regulations, each county grantee has reporting requirements in the form of status reports. These reports are due to CHFFA at least twice per year and at each time a disbursement is requested, at a minimum. The status reports include: a description of activities performed to date, the population served, costs and expenditures incurred, a summary of preliminary available evaluation results related to all outcomes identified in the application, a summary of other funding sources, and a description of remaining work to be completed.

CHFFA tracks the number of beds, vehicles, and staff that were awarded and any variances through the status reports and ongoing updates, from and communications, with the counties. The counties have, across the board, encountered significant delays in getting their programs implemented, especially for crisis residential and crisis stabilization. As such, there were not many outcomes counties could report on in the latest status reports submitted in August 2014. CHFFA is currently reviewing the status reports that were due on February 15. So far, for the mobile crisis support teams, the counties have purchased 30 out of the 43 approved vehicles and have hired 29.75 of the 58.25 approved staff individuals. As of February, there are no new beds for either the crisis residential or crisis stabilization programs yet in operation, but they are in various stages of design and construction. As the projects get further along CHFFA expects there will be more results to report.

Remaining Funding Available. As shown in the table below, about \$61.2 million, of the \$149.3 million, remains to be awarded. Applications for the third round of funding are due to CHFFA on March 30, 2015.

Table: SB 82 Funds Remaining after First and Second Funding Round

Purpose	Amount
Crisis Residential Capital	\$60,638,777.03
Crisis Stabilization Capital	\$184,210.52
Mobile Crisis Capital	\$356,340.14
Subtotal - Capital	\$61,179,327.69
Mobile Crisis Personnel	\$1,057.02
Total Remaining	\$61,180,384.71

At the February 26, 2015 CHFFA board meeting, the board discussed the merits of pursuing a re-allocation of dollars from crisis residential to crisis stabilization versus allowing the allocations to stay in place for January 1, 2016. At this time, a statewide competition (as opposed to the existing regional competitions) will be developed for any and all remaining funds. The board also entertained suggestions from stakeholders who were present at the meeting. Stakeholders suggested the board consider extending eligibility to peer respite programs in order to potentially prompt small county interest (because of an increased likelihood in sustainability) in some of the remaining crisis residential funding.

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested CHFFA to respond to the following questions:

1. Please provide an overview and update on this item.
2. Why are counties experiencing difficulties in getting their crisis residential and crisis stabilization programs implemented?
3. What is the timeline for the discussion regarding re-allocating crisis residential funding to other purposes? What criteria will the CHFFA board use to make this decision?

4560 Mental Health Services Oversight and Accountability Commission

1. Overview

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. 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. Among other things, the role of the MHSOAC is to:

- Ensure that services provided, pursuant to the MHSA, are cost effective and provided in accordance with best practices;
- Ensure that the perspective and participation of members and others with severe mental illness and their family members are significant factors in all of its decisions and recommendations; and,
- Recommend policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the MHSA.

Overview of MHSOAC Evaluation Efforts. On March 28, 2013 the MHSOAC approved an Evaluation Master Plan which prioritizes possibilities for evaluation investments and activities over a five year course of action. The MHSOAC five-year Evaluation Master Plan (July 2013 – June 2018) describes seven activities related to performance monitoring, ten evaluation projects, and eight exploratory/developmental work efforts. The 2013 budget provided resources for six positions to implement the Evaluation Master Plan. A listing of the current MHSOAC Evaluation Contracts and Deliverables can be found at:

http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2015/March/OAC/OAC_032615_1C_EvalDash.pdf

Improving Community Mental Health Data. Current mental health data collection and reporting systems do not provide timely data that allows the MHSOAC to evaluate all aspects of the MHSA and broader public community-based mental health systems. Consequently, the MHSOAC has contracted with an outside vendor to prepare an advanced planning document and/or a feasibility study report to improve the data systems at the Department of Health Care Services (DHCS) to fully address the data needs of the MSHOAC and DHCS. This contract will identify the MHSOAC's current data and reporting needs, compare them to what is available via current data systems, and draw conclusions regarding data elements that are missing and not available.

Subcommittee Staff Comment. This is an informational item. The Subcommittee is in receipt of advocate requests to use MHSA Funds (State Administration) to:

1. CAYEN - Augment an existing MHSOAC contract with the California Youth Empowerment Network (CAYEN) by \$300,000 to allow more youth to participate and to get better responses to survey strategies. This program brings transition age (16-25) perspective to development of mental health services and policies.
2. REMHDCO – Transfer the REMHDCO (Racial and Ethnic Mental Health Disparities Coalition) contract from the Department of Public Health’s (DPH) Office of Health Equity to the MHSOAC, as the contract with DPH expires February 29, 2016. The three month cost of this contract (April – June) is about \$187,000 and a full year cost is \$560,000. REMHDCO is a statewide coalition of individuals from non-profit state-wide and local organizations whose mission is to work to reduce mental health disparities through advocacy for racial and ethnic communities.

As noted later in the agenda under Issue 1 of the Department of Health Care Services, the State Administration Cap for the MHSA Fund is estimated to be overprescribed by about \$8 million. Consequently, there is no available room in the State Administration Cap for these two requests.

Questions. The Subcommittee has requested MHSOAC to respond to the following questions:

1. Please provide a brief overview of the MHSOAC.
2. Please explain how the MHSOAC ensures that services provided, pursuant to the MHSA, are cost effective and consistent with the MHSA. Does it make the findings from these reviews public?
3. Please provide a review of the MHSOAC’s evaluation efforts and activities.
4. Please discuss the MHSOAC’s efforts regarding improving community mental health data.

2. Investment in Mental Health Wellness Act of 2013 – Triage Personnel

Oversight Issue. SB 82 (Committee of Budget and Fiscal Review), Chapter 34, Statutes of 2013, enacted the Investment in Mental Health Wellness Act of 2013 which appropriated \$54.4 million to the MHSOAC as follows:

- \$54 million (\$32 million Mental Health Services Act [MHSA] State Administration and \$22 million federal) in ongoing funding to add 600 mental health triage personnel in select rural, urban, and suburban regions. Also required the MHSOAC to provide a status report to the Legislature on the progress of allocating the triage personnel funding. This report was submitted to the Legislature on February 28, 2014.

To conduct a competitive grant process for this funding, the MHSOAC developed Request for Applications guidelines for submitting grant proposals. In this process, MHSOAC gathered subject matter experts to advise staff on the grant criteria. Additionally, the MHSOAC used the five regional designations utilized by the California Mental Health Directors Association to ensure that grants would be funded statewide in rural, suburban, and urban areas. As such, the \$32 million of MHSA funds available annually was divided between the following regions:

Southern	\$10,848,000
Los Angeles	\$9,152,000
Central	\$4,576,000
Bay Area	\$6,208,000
Superior	\$1,216,000
Total	\$32,000,000

Grants cover four fiscal years, with grant funds allocated annually for 2013-14 (for five months), 2014-15, 2015-16, and 2016-17.

A total of 47 grant applications were submitted to the MHSOAC. Twenty-four counties were awarded grant funding. The MHSOAC approved 24 triage grants and allocated funds for 491 triage positions. As of March 16, 2015 counties have hired 86 triage staff and continue to expand the number of mental health personnel available to provide crisis support services that include crisis triage, targeted case management and linkage to services for individuals with mental health illness who require a crisis intervention. These personnel will be located in hospitals, emergency rooms, jails, shelters, high schools, crisis stabilization and wellness centers, and other community locations where they can engage with persons needing crisis services. According to the MHSOAC, counties are having extreme difficulty in hiring due to workforce shortages in the selected classification. The MHSOAC is continuing to work with counties to evaluate these hiring issues. See table below for award details.

Table: Investment in Mental Health Wellness – Triage Personnel Grant Awards

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FTE's as of 3-16-15	
Amount Allocated	\$32,000,000	\$32,000,000	\$32,000,000	\$32,000,000		
	Approved	Approved	Approved	Approved	FTE's	
Southern Region	\$10,848,000	\$10,848,000	\$10,848,000	\$10,848,000		
Ventura	\$840,259	\$2,126,827	\$2,242,542	\$2,364,043	23.0	14.0
Riverside	\$488,257	\$2,134,233	\$2,307,808	\$2,510,844	32.3	1.0
Santa Barbara	\$933,135	\$2,352,536	\$2,468,608	\$2,594,250	23.5	8.5
Orange	\$1,250,000	\$3,000,000	\$3,000,000	\$3,000,000	28.0	0.0
San Bernardino*	\$7,174,512	\$0	\$0	\$0	25.0	0.0
Region Total	\$10,686,163	\$9,613,596	\$10,018,958	\$10,469,137	106.8	23.5
Los Angeles	\$9,152,000	\$9,152,000	\$9,152,000	\$9,152,000		
Los Angeles	\$3,802,000	\$9,125,000	\$9,125,000	\$9,125,000	183.0	0.0
Region Total	\$3,802,000	\$9,125,000	\$9,125,000	\$9,125,000	183.0	0.0
Central	\$4,576,000	\$4,576,000	\$4,576,000	\$4,576,000		
Yolo	\$221,736	\$505,786	\$496,247	\$504,465	8.3	3.0
Calaveras	\$41,982	\$73,568	\$73,568	\$73,568	1.0	0.0
Tuolumne	\$74,886	\$132,705	\$135,394	\$135,518	3.0	2.0
Sacramento	\$545,721	\$1,309,729	\$1,309,729	\$1,309,729	20.8	0.0
Mariposa	\$88,972	\$196,336	\$203,327	\$210,793	4.3	0.0
Placer	\$402,798	\$750,304	\$667,827	\$688,417	13.6	8.0
Madera	\$163,951	\$389,823	\$410,792	\$396,030	4.2	3.2
Merced	\$359,066	\$868,427	\$882,550	\$893,026	8.0	1.0
Region Total	\$1,899,112	\$4,226,678	\$4,179,434	\$4,211,546	63.2	17.2
Bay Area	\$6,208,000	\$6,208,000	\$6,208,000	\$6,208,000		
Sonoma	\$351,672	\$871,522	\$897,281	\$923,888	8.0	1.0
Napa	\$126,102	\$411,555	\$403,665	\$382,313	6.0	0.0
San Francisco	\$1,751,827	\$4,204,394	\$4,204,394	\$4,204,394	63.7	21.5
Marin	\$137,065	\$315,738	\$320,373	\$326,746	3.0	0.0
Alameda	\$311,220	\$765,811	\$785,074	\$804,692	11.6	1.0
Fresno*	\$2,697,000	\$0	\$0	\$0	11.5	0.0
Region Total	\$5,374,886	\$6,569,020	\$6,610,787	\$6,642,033	103.8	23.5
Superior	\$1,216,000	\$1,216,000	\$1,216,000	\$1,216,000		
Butte	\$358,519	\$514,079	\$199,195	\$3,277	18.0	13.5
Lake	\$26,394	\$52,800	\$52,800	\$52,800	1.0	1.0
Trinity	\$60,697	\$145,672	\$145,672		2.5	2.5
Nevada	\$289,260	\$694,169	\$728,878	\$765,321	11.8	4.8
Region Total	\$734,870	\$1,406,720	\$1,126,545	\$821,398	33.3	21.8
Total	\$22,497,031	\$30,941,014	\$31,060,724	\$31,269,114	490.1	85.9
Balance	\$9,502,969.16	\$1,058,985.62	\$939,275.51	\$730,886.16		
Golden Gate Bridge, Highway & Transportation District**	\$7,000,000	\$0	\$0	\$0		
Remaining Balance	\$2,502,969.16					

*Reappropriated \$19.3 million of the Fiscal Year 2013-14 funds. The OAC funded two additional county Triage programs (San Bernardino and Fresno).

**Redirected \$7 million of the reappropriation for suicide prevention efforts.

In 2013-14 and rolled over to the current year, \$2.5 million in these MHSA grant funds have not yet been awarded. The Administration is considering options for the use of this funding.

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested MHSOAC to respond to the following questions:

1. Please provide an overview of this item.
2. How is MHSOAC monitoring counties' implementation of these grants? Why have counties established only 85 of the 490 positions?
3. What options is the Administration considering regarding the \$2.5 million that has yet to be awarded?

4260 Department of Health Care Services**1. Community Mental Health Overview**

Background. California has a decentralized public mental health system with most direct services provided through the county mental health system. Counties (i.e., county mental health plans) have the primary funding and programmatic responsibility for the majority of local mental health programs. See table below for a summary of county community mental health funding.

Table: Community Mental Health Funding Summary

Fund Source	2013-14	2014-15	2015-16
	Total	Total	Total
1991 Realignment			
Mental Health Subaccount (base and growth)*	\$41,690,000	\$64,636,000	\$125,386,000
2011 Realignment			
Mental Subaccount Health Account (base and growth)*	\$1,129,700,000	\$1,136,400,000	\$1,134,700,000
Behavioral Health Subaccount (base)**	\$992,363,000	\$1,051,375,000	\$1,198,071,000
Behavioral Health Growth Account	\$60,149,000	\$146,696,000	\$140,885,000
Realignment Total	\$2,223,902,000	\$2,399,107,000	\$2,599,042,000
Medi-Cal Specialty Mental Health Federal Funds	\$1,425,814,863	\$2,153,244,000	\$2,772,568,000
Medi-Cal Specialty Mental Health General Fund	\$5,803,134	\$117,209,000	\$138,004,000
Mental Health Services Act Local Expenditures	\$1,246,741,000	\$1,392,014,000	\$1,362,650,000
Total Funds	\$3,476,446,134	\$6,061,574,000	\$6,872,264,000

*2011 Realignment changed the distribution of 1991 Realignment funds in that the funds that would have been deposited into the 1991 Realignment Mental Health Subaccount, a maximum of \$1.12 billion, is now deposited into the 1991 Realignment CalWORKs MOE Subaccount. Consequently, 2011 Realignment deposits \$1.12 billion into the 2011 Realignment Mental Health Account.

**Reflects \$5.1 million allocation to Women and Children's Residential Treatment Services. Includes Drug Medi-Cal.

Medi-Cal Mental Health. As of January 1, 2014, there are three systems that provide mental health services to Medi-Cal beneficiaries:

- 1. County Mental Health Plans (MHPs)** - California provides Medi-Cal “specialty” mental health services under a waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children’s specialty mental health services are provided

under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21. County mental health plans are the responsible entity that ensures specialty mental health services are provided. Medi-Cal enrollees must obtain their specialty mental health services through the county.

California's Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2015. See issue two of this agenda for discussion of the renewal of this waiver.

2. **Managed Care Plans (MCPs)** - Effective January 1, 2014, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session expanded the scope of Medi-Cal mental health benefits and required these services to be provided by the Medi-Cal Managed Care Plans (MCP) excluding those benefits provided by county mental health plans under the SMHS Waiver. Generally these are mental health services to those with mild to moderate levels of impairment. The mental health services provided by the MCPs 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 (FFS system)** - Effective January 1, 2014 the mental health services listed below are also available through the Fee-For-Service/Medi-Cal 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

Behavioral Health Realignment Funding. SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012, created the permanent structure for 2011 Realignment. SB 1020 codified the Behavioral Health Subaccount which funds Medi-Cal Specialty Mental Health Services (for children and adults), Drug Medi-Cal, residential perinatal drug services and treatment, drug court operations, and other non-Drug Medi-Cal programs. Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs and counties have a responsibility to provide for these entitlement programs.

Government Code Section 30026.5(k) specifies that Medi-Cal Specialty Mental Health Services shall be funded from the Behavioral Health Subaccount, the Behavioral Health Growth Special Account, the Mental Health Subaccount (1991 Realignment), the Mental Health Account (1991 Realignment), and to the extent permissible under the Mental Health Services Act, the Mental Health Services Fund. Government Code Section 30026.5(g) requires counties to exhaust both 2011 and 1991 Realignment funds before county General Fund is used for entitlements. A county board of supervisors also has the ability to establish a reserve using five percent of the yearly allocation to the Behavioral Health Subaccount that can be used in the same manner as their yearly Behavioral Health allocation, pursuant Government Code Section 30025(f).

Consistent with practices established in 1991 Realignment, up to 10 percent of the amount deposited in the fund from the immediately preceding fiscal year can be shifted between subaccounts in the Support Services Account with notice to the Board of Supervisors, pursuant to Government Code Section 30025(f). This shift can be done on a one-time basis and does not change base funding. In addition, there is not a restriction for the shifting of funds within a subaccount, but any elimination of a program, or reduction of 10 percent in one year or 25 percent over three years, must be duly noticed in an open session as an action item by the Board of Supervisors, pursuant to Government Code Section 30026.5(f). Government Code Section 30026.5(e) also requires 2011 Realignment funds to be used in a manner to maintain eligibility for federal matching funds.

DHCS issued Mental Health Services Division Information Notice 13-01 on January 30, 2013, to inform counties that 2011 Realignment did not abrogate or diminish the responsibility that, “they must provide, or arrange for the provision of, Medi-Cal specialty mental health services, including specialty mental health services under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit.” As noted above, Government Code Section 30026.5(k) specifies fund sources for Medi-Cal Specialty Mental Health Services. The Administration continues to work with the California State Association of Counties and the California Behavioral Health Directors Association to ensure all counties are aware of these entitlement programs and clients cannot be denied services.

On May 19, 2014, DHCS issued Mental Health and Substance Use Disorder Services Information Notice 14-017 indicating that first priority of the Behavioral Health Growth Account funding would be given to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health EPSDT and Drug Medi-Cal. Specifically, this allocation provided additional funding to eight counties in which the approved claims for EPSDT and Drug Medi-Cal services in 2012-13 were greater than the funding they received in 2012-13 from the Behavioral Health Subaccount. The remaining balance of this growth account would then be distributed using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount. The Administration indicates that it plans to follow the same allocation formula for the \$60.1 million in 2013-14 Behavioral Health Growth Account funds that will be distributed later this spring. As displayed on the previous table, the projected 2014-15 Behavioral Health Growth Account is \$146.7 million and the projected 2015-16 Behavioral Health Growth Account is \$140.9 million.

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 of the act’s funding is to be expended by county mental health departments for mental health services consistent with their approved local plans (three-year plans with annual updates) and the

required five components, as contained in the MHSA. The following is a brief description of the five components:

- **Community Services and Supports for Adult and Children’s Systems of Care.** This component funds the existing adult and children’s systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through its stakeholder process, a listing of programs for which these funds would be used. Of total annual revenues, 80 percent is allocated to this component.
- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.
- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded from five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.
- **Workforce Education and Training.** The component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of \$460.8 million. Counties have 10 years to spend these funds.
- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of \$460.8 million. Counties have 10 years to spend these funds.

Counties are required to submit annual expenditure and revenue reports to the DHCS (and the MHSOAC). DHCS monitors county’s use of MHS funds to ensure that the county meets the MHSA and MHS Fund requirements.

Table: 2015-16 Governor's Budget and March Annual Accrual Adjustment Mental Health Services Fund Administrative Cap (dollars in thousands)

<u>Fiscal Year</u>	<u>Monthly Cash Transfers</u>	<u>Accruals</u>	<u>Interest</u>	<u>Total Revenue</u>	<u>Admin Cap</u>	<u>Expenditures/ Approps</u>	<u>Available Cap</u>	<u>Comments</u>
A	B	C	D	E	F	G		
			(A+B+C)	(D/.035 or .05)		(E-F)		
2012-13*	\$1,204,000	\$480,000	\$721	\$1,684,721	\$58,965	\$31,572	\$27,393	Item 4265-001-3085 (\$15m appropriated w ithout regard to fiscal year in 2012 Budget Act). Item 6440-001-3085 (\$12.3m appropriated in 2014 Budget Act).
2013-14	\$1,187,000	\$94,000	\$548	\$1,281,548	\$64,077	\$49,804	\$14,273	Item 4265-001-3085 (\$15m appropriated w ithout regard to fiscal year in 2013 Budget Act).
2014-15 /e	\$1,289,000	\$513,000	\$564	\$1,802,564	\$90,128	\$116,034	(\$25,906)	2014 Budget Act appropriations: Item 4265-001-3085 (\$15m appropriated w ithout regard to fiscal year), and Items 4560-491 and 6440-001-3085 (subject to available funds through June 30, 2017).
2015-16 /e	\$1,353,000	\$422,000	\$564	\$1,775,564	\$88,778	\$112,674	(\$23,896)	2015 Governor's Budget: Item 4265-001-3085 (\$15m appropriated w ithout regard to fiscal year). The expenditures Include \$45m for the California Reducing Disparities Project.
TOTALS:					\$301,949	\$310,084	(\$8,135)	
e/ = estimate								
*The administrative cap applicable in 2011-12 and 2012-13 was 3.5 percent. The cap was restored to 5 percent in 2013-14.								
Departments Funded in 2015-16: Judicial Branch (0250), State Controller-21st Century HRMS (0840), State Treasurer-California Health Facilities Financing Authority (0977), Office of Statewide Health Planning & Development (4140), Department of Health Care Services (4260), Department of Public Health (4265), Department of Developmental Services (4300), Mental Health Oversight and Accountability Commission (4560), Department of Education (6110), University of California (6440), Financial Information Systems for California (8880), Department of the Military (8940), Department of Veterans Affairs (8955) and Statewide General Administrative Expenses (9900).								

As noted in the chart above, the State Administrative Cap is overprescribed by about \$8 million. In March, the Legislature was notified that the annual adjustment amount for fiscal year 2013-14 was \$154 million less than what was estimated in the Governor's January Budget (\$94 million instead of the estimated \$249 million in the January budget).

Subcommittee Staff Comments. This is an informational item.

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

1. Please provide an overview of community mental health programs overseen by DHCS.
2. Please explain DHCS's activities related to oversight and monitoring of the Proposition 63 funds distributed to counties (e.g., audits, cost reporting analysis). If deficiencies are found, what tools does DHCS have to remediate the problems?
3. Please provide an update on counties reporting Proposition 63 revenues and expenditures for 2012-13 (the most current information available). When was this information due? How many counties have reported this information? How does DHCS work with counties that have not submitted this information?

2. Specialty Mental Health Waiver Renewal

Oversight Issue. The state's Specialty Mental Health Services Waiver expires on June 30, 2015. DHCS submitted an application to renew this waiver on March 30, 2015. DHCS is requesting a five-year renewal.

Background. DHCS administers a Section 1915(b) Freedom of Choice federal waiver to provide Specialty Mental Health Services (SMHS) using a managed care model of service delivery. The SMHS waiver program has been in effect since 1995. The proposed waiver term (July 1, 2015 through June 30, 2020) represents the ninth waiver renewal period. DHCS operates and oversees this waiver.

The SMHS waiver program is administered locally by each county's mental health plan (MHP) and each MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries. It is the responsibility of each MHP to either provide the services directly or contract with providers to provide these services at the local level. The SMHS waiver population is all Medi-Cal beneficiaries. Therefore, all Medi-Cal beneficiaries have access to waiver services if they meet medical necessity criteria.

SMHS provided through the SMHS waiver:

- a. Rehabilitative mental health services including:
 - (1) Mental health services
 - (2) Medication support services
 - (3) Day treatment intensive
 - (4) Day rehabilitation
 - (5) Crisis intervention
 - (6) Crisis stabilization
 - (7) Adult residential treatment services
 - (8) Crisis residential treatment services
 - (9) Psychiatric health facility services
- b. Psychiatric inpatient hospital services
- c. Targeted case management services
- d. Early and Periodic Screening, Diagnosis and Treatment specialty mental health services (i.e., Therapeutic Behavioral Services) for children up to 21 years of age.

The SMHS waiver renewal request was submitted to the Centers for Medicare and Medicaid Services (CMS) for their review on March 30, 2015. The effective date of this waiver renewal will be July 1, 2015.

CMS Concerns with Existing SMHS Waiver. During monthly CMS monitoring calls and in ongoing communications, CMS has asked questions on specific areas of the SMHS waiver. CMS reviews MHP triennial and External Quality Review Organization (EQRO) reports and raised concern about the findings and continued non-compliance with specific waiver requirements. CMS believes that significant improvement is needed in identified areas and expects the state to closely monitor, ensure and provide evidence of compliance. The following are the identified areas of focus:

- **24/7 telephone line with appropriate language access** - Regulations for Medi-Cal Specialty Mental Health Services in Title 9, Section 1810.405(c) and (d) require that MHPs provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries in the county. Focus will be on ensuring the toll free line is always answered and has adequate linguistic capacity with no excessive wait times 24/7 and not just during business hours.
- **System in place to track timeliness of access across the plan** - The MHPs must have an organized system to track the timeliness of beneficiary access to services across the MHP, specifically the time between an initial request for services to the time services are actually provided to the beneficiary. The goal is to produce uniform statewide standards specific to access of SMHS.
- **TARs adjudicated in 14 days** - Title 9, Section 1820.220 requires the MHP to approve or deny a Treatment Authorization Request (TAR) within 14 calendar days. The goal is to establish a specific metric for TAR adjudication as one of the statewide standards.
- **System in place to log grievances and appeals, name, date, and issue** - Title 9, Section 1850.205(d)(1) requires that MHPs maintain a grievance and appeal log that contains the beneficiary's name, date, and nature of the problem. This standard is also reviewed in the triennial system review.
- **System in place to ensure providers are certified and recertified** – Certification and recertification of Medi-Cal providers must be completed accurately and on time to ensure beneficiaries are provided with specialty mental health services that meet program requirements and that providers are qualified to provide services.
- **Disallowance rates** - CMS has expressed concern about the ongoing elevated inpatient and outpatient disallowance rates resulting from chart reviews (i.e., claims not allowable under the Medi-Cal program).

CMS has requested that DHCS explore establishing a process to enact fines, sanctions and penalties, or corrective actions as a way to ensure compliance.

2014 Budget Resources to Improve Monitoring of These Services. The 2014 budget included seven positions and \$1,145,000 (\$314,000 General Fund and \$831,000 federal funds) to increase the scope, frequency, and intensity of monitoring and oversight by DHCS of County Mental Health Plans (MHPs). This budget request was in direct response to CMS's concerns noted above. DHCS has had difficulty filling these positions because of challenges in recruiting psychologist and nurse consultant positions. DHCS indicates that it is currently reviewing its mental health personnel classifications and will be working with the California Department of Human Resources on options.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide an overview of the SMHS waiver renewal application.
2. How does the renewal application address CMS's concerns noted in the agenda?
3. Please provide an update on DHCS's efforts to establish timely access standards for SMHS. What is the timeline to establish these standards? How will the waiver renewal account for these standards?
4. What steps is DHCS taking to fill the positions approved in the 2014 budget to improve oversight of county mental health plans?
5. How has DHCS responded to CMS suggestions to establish a process to enact fines, sanctions and penalties, or corrective actions as a way to ensure compliance?

3. Performance Outcomes System for EPSDT Medi-Cal Specialty Mental Health Services

Budget Issue. DHCS requests three full-time permanent positions at a cost of \$377,000 (\$189,000 General Fund and \$188,000 Federal Trust Fund) to support the program management, coordination with counties and other partners, data collection and interpretation and research needs of the Performance Outcomes System project as required by SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012 and AB 82 (Committee on Budget), Chapter 34, Statutes of 2013.

The purpose of the Performance Outcome System is to provide the capability to understand the statewide outcomes of specialty mental health services provided, in order to best ensure compliance with the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirement. Although the non-federal share of funding for the Medi-Cal Specialty Mental Health program has been realigned to the counties, the state maintains a responsibility for ensuring access to the federal entitlement for the Medi-Cal Specialty Mental Health program. For children and youth up to age 21 in this program, federal law further requires EPSDT to ensure access to medically necessary specialty mental health services. The Performance Outcomes System will measure individual outcomes as clients receive managed care or specialty mental health services.

To carry out and support the objectives for the Performance Outcomes System, DHCS requests the following three positions:

- **Two Research Analysts II (RA II)**
 - Provide support in producing reports, gathering, compiling, analyzing, and applying statistical methods to data.
 - Work as a liaison with county information technology (IT) staff to clean the data and resolve any system issues.
 - Monitor county data submissions and provide training to counties on data interpretation and utilization.
 - Format reports and product.
- **One Associate Information Systems Analyst (AISA)**
 - Supports the more complex IT functions for the Performance Outcomes System and maintains the research analytics data requirements, including system connectivity and database design.
 - Leads the technology activities associated with data systems, Electronic Health Record Systems, and Health Information Exchange systems, to provide data reporting solutions for the 56 county mental health systems.
 - Assists with complex data analysis and writes complex programming logic to extract and compile data for analysis.
 - Provides recommendations for report development.
 - Performs system testing.

Background. SB 1009 requires DHCS to develop a Performance Outcomes System for Medi-Cal Specialty Mental Health Services for children and youth. Consistent with statute, DHCS has produced a Performance Outcomes System Implementation Plan. DHCS released the Performance Outcomes

System Implementation Plan with the 2014-15 Governor’s budget, and a budget change proposal with initial resources (four staff) to begin to implement and operate this system.

In 2013, SB 1009 was amended through AB 82, to add the requirement for mental health screening of children/youth as part of Medi-Cal managed care. The legislation also required the development of measures for screening and referring Medi-Cal beneficiaries to mental health services and supports, making recommendations regarding performance and outcome measures, and providing an updated Performance Outcomes System plan to the fiscal and appropriate policy committees of the Legislature by October 1, 2014. The amendment also requires the department to propose how to implement the updated Performance Outcomes System plan by January 10, 2015. The Legislature has not yet received this updated system plan.

Table A. Timeline to Build the Performance Outcomes System

Milestones	Date
System Implementation Plan	
Draft System Implementation Plan	November 2013
Obtain input on the final draft Implementation Plan from the Performance Outcomes System Stakeholder Advisory Committee	December 2013
Deliverable: System Implementation Plan	January 2014
Establish Performance Outcomes System Methodology	
Facilitate stakeholder input on a performance outcomes system evaluation methodology (including standardized data sources and data collection tools used for the system, frequency of administration, etc.)	December 2014
Obtain Input on the Performance Outcomes System methodology protocol from the Performance Outcomes System Stakeholder Advisory Committee	February 2015
Deliverable: Performance Outcomes System Protocol	March 2015
Initial Performance Outcomes Reporting: Existing DHCS Databases	
Identify performance outcomes data elements in existing DHCS databases	May 2014
Assess data integrity	July 2014
Develop county data quality improvement reports	December 2014
Counties remedy data quality issues	Ongoing Beginning in January 2015
Develop performance outcomes report templates	December 2014
Obtain input on the report templates from the Performance Outcomes System Stakeholder Advisory Committee	February 2015

Milestones	Date
Deliverable: Statewide and County Reports on Initial Performance Outcomes Using Data from Existing DHCS Databases	Ongoing Beginning in February 2015
Continuum of Care: Screenings and Referrals	
Convene Performance Outcomes System Stakeholder Advisory Committee to discuss Continuum of Care	December 2013
Obtain input on screening and referral information needed for the Performance Outcomes System from the Stakeholder Advisory Committee	April 2014
Deliverable: Performance Outcomes System Plan Update	January 2015
Deliverable: Performance Outcomes System Implementation Plan Update	February 2015
Comprehensive Performance Outcomes Reporting: Expanded Data Collection	
The activities associated with this task are dependent on the number and scope of additional data elements adopted as part of the Performance Outcomes System methodology.	2014-15
Obtain input on the report templates from the Performance Outcomes System Stakeholder Advisory Committee	Fall 2015
Deliverable: Statewide and County Reports on Comprehensive Performance Outcomes Using Existing and Expanded Data	2016-2017
Continuous Quality Improvement Using Performance Outcomes Reports	
Develop trainings to support interpretation of the performance outcomes reports (initial and comprehensive)	Ongoing Beginning in April 2015
Develop quality improvement plan process	Ongoing Beginning in May 2015
Obtain input on the quality improvement plan process from the Performance Outcomes System Stakeholder Advisory Committee	Spring 2015
Deliverable: Quality Improvement Plan Process	Summer 2015
Support and monitoring of quality improvement	Ongoing

DHCS indicates that it has experienced unanticipated delays in implementing the Performance Outcomes System and has determined that additional resources are needed. According to DHCS, these ongoing challenges include:

- The work to identify the reporting metrics was more labor-intensive than originally anticipated, and is expected to be an ongoing and changing process as different data reporting needs are

identified by the Subject Matter Expert Workgroup, the larger System Stakeholder Advisory Committee, DHCS and its partners (e.g., counties, other state agencies).

- The incorporation of the Katie A. data reporting requirements into the system, which involves continuous collaboration with the California Department of Social Services staff. (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 services by both the child protective system and the mental health system in California. See Part B of this agenda for more information on Katie A.)
- The continuous nature of working with counties to improve the quality of the data submitted to DHCS, which are critical and more labor-intensive than originally anticipated.

Initial Performance Outcomes System Statewide Reports. On March 24, 2015, DHCS posted initial performance outcomes system statewide reports:

<http://www.dhcs.ca.gov/individuals/Pages/POSReports.aspx>.

The first reports focus on the demographics of the children and youth under 21 who are receiving Specialty Mental Health Services, based on approved claims for Medi-Cal eligible beneficiaries. The statewide reports establish a foundation for ongoing reporting and will be updated every six months.

Three reports will be provided: statewide aggregated data (which was released on March 24th); county groups; and county-specific data. Additionally, in the future, DHCS indicates that foster care information will be delineated in these reports.

Subcommittee Staff Comment and Recommendations—Hold Open. It is recommended to hold this item open as DHCS not yet provided an updated system plan or implementation plan.

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

1. Please provide an overview of this proposal and the timeline to develop this Performance Outcome System.
2. When will the Legislature receive the Performance Outcomes System Plan Update (due October 2014) and the Performance Outcomes System Implementation Plan Update (due January 2015)?
3. How is DHCS preparing for the incorporation of Medi-Cal managed care referrals to county mental health plans into the POS?
4. How does DHCS plan to analyze the data included in the POS to identify issues and make system improvements?

4. Drug Medi-Cal Overview

Budget Issue. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. The proposed budget includes \$401.8 million for DMC in 2015-16. See the following table for DMC funding summary.

Table: Drug Medi-Cal Program Funding Summary (dollars in thousands)

Service Description	2014-15				2015-16			
	GF	County Funds	FF	TF	GF	County Funds	FF	TF
Narcotic Treatment Program		\$59,580	\$72,494	\$132,074		\$60,655	\$77,949	\$138,604
Residential Substance Use Services*		\$5,704	\$5,792	\$11,496	\$19,610	\$7,738	\$44,277	\$71,625
Outpatient Drug Free Treatment Services		\$30,564	\$33,512	\$64,076		\$25,205	\$36,657	\$61,862
Intensive Outpatient Services**	\$24,400	\$10,482	\$56,519	\$91,401	\$32,811	\$10,938	\$72,846	\$116,595
Provider Fraud Impact		-\$27,850	-\$27,850	-\$55,700		-\$27,850	-\$27,850	-\$55,700
Drug Medi-Cal Program Cost Settlement		\$393	\$3,036	\$3,429		\$393	\$3,036	\$3,429
Annual Rate Adjustment					\$793	\$2,409	\$4,605	\$7,807
County Administration	\$1,617	\$7,005	\$13,465	\$22,087	\$2,113	\$6,553	\$15,629	\$24,295
County Utilization Review and Quality Assurance		\$4,990	\$9,268	\$14,258		\$11,644	\$21,626	\$33,270
3rd Party Validation of Providers	\$125		\$125	\$250				
Total	\$26,142	\$90,868	\$166,361	\$283,371	\$55,327	\$97,685	\$248,775	\$401,787

*Previously named “Perinatal Residential Substance Abuse Services”

**Previously name “Day Care Rehabilitative Services”

Background. In 2011, funding for the DMC program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS as part of the Public Safety Realignment initiated by AB 109 (Committee on Budget), Chapter 15, Statutes of 2011. Prior to the realignment of the DMC program, DMC was funded with General Fund and federal funds. Enactment of the 2011 Public Safety Realignment marked a significant shift in the state’s role in administering programs and functions related to substance use disorder (SUD). Realignment also redirected funding for DMC and discretionary substance use disorder programs to the counties. Consequently, counties are responsible for providing the non-federal match used to draw down federal Medicaid funds for DMC services as they existed in 2011 and for individuals eligible for DMC under 2011 Medi-Cal eligibility rules (pre-health care reform).

Additionally, the enactment of 2012-13 and 2013-14 state budgets transferred the responsibility for the SUD programs including DMC, from the former DADP to DHCS.

Current regulations create requirements for oversight of DMC providers at both the state and county levels. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for DMC services directly, or contract with DHCS, which then directly contracts with DMC providers to deliver DMC services. Counties that elect to contract with DHCS to provide DMC 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. As of November 2013, DHCS contracts with 44 counties for DMC services. Another county has direct provider contracts thus resulting in DMC services being offered in 45 total counties. DHCS also has 15 direct provider contracts for DMC services in five counties (Imperial, Orange, San Diego, Solano, and Yuba-Sutter).

Health Care Reform Expansion of SUD Benefits. The federal Affordable Care Act (ACA) requires states electing to enact the Act’s Medicaid expansion to provide all components of the “essential health benefits” (EHB) as defined within the state’s chosen alternative benefit package to the Medicaid expansion population. The ACA included mental health and substance use disorder services as part of the EHB standard, and because California adopted the alternative benefit package it was required to cover such services for the expansion population.

SB 1 X1 (Hernandez and Steinberg), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, required Medi-Cal to provide the same mental health and substance use disorder services for its enrollees that they could receive if they bought a particular Kaiser small group health plan product designated in state law as the EHB benchmark plan for individual and small group health plan products. SB 1X 1 required this benefit expansion for both the expansion population and the pre-ACA Medi-Cal population. Consequently, those individuals previously and newly-eligible for Medi-Cal will have access to the same set of services.

For SUD-related services, SB 1 X1:

- Expanded residential substance use services to all populations (previously these benefits were only available to pregnant and postpartum women);

- Expanded intensive outpatient services to all populations (previously these benefits were only available to pregnant women and postpartum women and children and youth under 21); and
- Provided medically necessary voluntary inpatient detoxification (previously this benefit was covered only when medically necessary for physical health reasons).

DHCS received approval from CMS to expand intensive outpatient services to all populations and to provide medically necessary voluntary inpatient detoxification in general acute hospital settings. However, CMS asked the state to remove the expansion of residential substance use services to all populations and the provision of inpatient voluntary detoxification in other settings in its state plan amendment (SPA) because of the Institutions for Mental Disease (IMD) payment exclusion, which is discussed in greater detail later.

Medi-Cal Substance Use Disorder Services. Substance use disorder services are provided through both the Drug Medi-Cal program and also through Medi-Cal managed care and fee-for-service.

Drug Medi-Cal program services include:

- **Narcotic Treatment Services** – An outpatient service that utilizes methadone to help persons with opioid dependency and substance use disorder diagnoses detoxify and stabilize. 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.
- **Residential Treatment Services** – These services provide rehabilitation services to persons with substance use disorder diagnosis in a non-institutional, non-medical residential setting. (Room and board is not reimbursed through the Medi-Cal program.) Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women. Although, SB 1 X1 expanded this benefit to the general population, it is only currently being provided to pregnant and postpartum women as the state has not yet received federal approval to expand this benefit due to the IMD payment exclusion.
- **Outpatient Drug Free Treatment Services** – These outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Services include individual and group counseling, crisis intervention, and treatment planning.
- **Intensive Outpatient Treatment Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week. Prior to SB 1 X1 this benefit was only available to pregnant and postpartum women and children and youth under 21.

Other Medi-Cal SUD benefits, that are not included in DMC, 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 FFS, 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 FFS.
- **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. This service is provided via Medi-Cal managed care or Medi-Cal FFS, depending on which delivery system the patient is enrolled.

Proposed Drug Medi-Cal Waiver. DHCS is pursuing a DMC Organized Delivery System Waiver as an amendment to the current Section 1115 Bridge to Reform Demonstration Waiver. DHCS proposes that this amendment would demonstrate how organized substance use disorder care increases successful outcomes for DMC beneficiaries. The state’s proposal is currently under federal CMS review. DHCS anticipates hearing back from CMS by the end of April.

DHCS states the waiver will give state and county officials more authority to select quality providers to meet drug treatment needs. DHCS indicates the waiver will support coordination and integration across systems, increase monitoring of provider delivery of services, and strengthen county oversight of network adequacy, service access, and standardize practices in provider selection.

Key elements of the proposed waiver amendment include:

- **Continuum of Care:** Participating counties will be required to provide a continuum of care of services available to address substance use, including: early intervention, physician consultation, outpatient treatment, case management, medication assisted treatment, recovery services, recovery residence, withdrawal management, and residential treatment.
- **Assessment Tool:** Establishing the American Society of Addiction Medicine (ASAM) assessment tool to determine the most appropriate level of care so that clients can enter the system at the appropriate level and step up or step down in intensive services, based on their response to treatment.
- **Case Management and Residency:** Case management services to ensure that the client is moving through the continuum of care, and requiring counties to coordinate care for those residing within the county.
- **Selective Provider Contracting:** Giving counties more authority to select quality providers. Safeguards include providing that counties cannot discriminate against providers, that beneficiaries will have choice within a service area, and that a county cannot limit access.
- **Provider Appeals Process:** Creating a provider contract appeal process where providers can appeal to the county and then the State. State appeals will focus solely on ensuring network adequacy.
- **Provider Certification:** Partnering with counties to certify DMC providers, with counties conducting application reviews and on-site reviews and issuing provisional certification, and the State cross-checking the provider against its databases for final approval.
- **Clear State and County Roles:** Counties will be responsible for oversight and monitoring of providers as specified in their county contract.

- **Coordination:** Supporting coordination and integration across systems, such as requiring counties enter into memoranda of understanding (MOUs) with Medi-Cal managed care health plans for referrals and coordination and that county substance use programs collaborate with criminal justice partners.
- **Authorization and Utilization Management:** Providing that counties authorize services and ensuring Utilization Management.
- **Workforce:** Expanding the pool of Medi-Cal eligible service providers to include licensed practitioners of the healing arts for the assessment of beneficiaries, and other services within their scope of practice.
- **Program Improvement:** Promoting consumer-focused evidence-based practices including medication-assisted treatment services and increasing system capacity for youth services.

This proposed waiver will only be operational in counties that elect to opt into this organized delivery system. However, DHCS has stated that the early phases are considered demonstration projects but the goal is for the model to be eventually implemented statewide. Counties that opt into this waiver will be required to meet specified requirements, including implementing selective provider contracting (selecting which providers participate in the program), providing all DMC benefits, monitoring providers based on performance criteria, ensuring beneficiary access to services and an adequate provider network, using a single-point of access for beneficiary assessment and service referrals, and data collection and reporting. In a county that does not opt-in, there will be no change in services from the current delivery system.

DHCS proposes a phasing-in of this waiver, and anticipates that Phase 1 will be the Bay Area counties and would occur April – June of 2015.

Potential Relief from IMD Payment Exclusion. DHCS has also indicated that it has received informal approval from CMS that under this waiver proposal, the Institutions for Mental Disease (IMD) payment exclusion would not apply for counties that opt-into this demonstration. Consequently, federal funds would be available to provide residential treatment services to all eligible adults and inpatient voluntary detox in chemical dependency treatment facilities and freestanding psychiatric facilities. (See below for background information on the IMD exclusion.)

On October 21, 2014, the Senate Budget and Fiscal Review Committee and the Senate Health Committee held a joint oversight hearing on this proposed Drug Medi-Cal waiver. For more information on the wavier and the Drug Medi-Cal program, please see:

<http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/10212014SBFRHearingAgernda.pdf>

Background - Institutions for Mental Disease (IMD) Exclusion. In preparing to implement the newly expanded residential DMC benefit for all adults, as required by SB 1 X1, DHCS encountered an issue with the Institutions for Mental Disease (IMD) federal Medicaid payment exclusion. IMDs are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness.

The IMD exclusion prohibits federal financial participation (FFP) from being available for any medical assistance under federal Medical law for services provided to any individual who is under age 65 who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. The IMD exclusion was designed to ensure that states, rather than the federal government, continue to

have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group. The IMD exclusion is unusual in that it is one of the very few instances in which federal Medicaid law prohibits FFP for care provided to enrolled beneficiaries.

Based on CMS current interpretation of the IMD exclusion, DHCS is prohibited from using federal funds to reimburse for any Medi-Cal service when a Medi-Cal beneficiary is receiving SUD services in residential facilities larger than 16 beds. In February 2014, DHCS indicated that there are 783 licensed SUD residential treatment facilities in California, with a total statewide licensed capacity of 18,155 beds. However, because of the federal IMD exclusion, DHCS estimates that only 1,825 beds (of the 18,155 licensed beds) are reimbursable under Medi-Cal.

Additionally, federal funding is not available for facilities that provide inpatient voluntary detoxification that are chemical dependency treatment facilities or freestanding psychiatric facilities, as the IMD payment exclusion applies to these facilities.

DHCS requested that CMS employ a different interpretation of the IMD exclusion that recognized California's unique market. However, CMS did not approve the request. Consequently, the residential benefit has not yet been expanded and voluntary detoxification can only be provided in general acute hospitals.

Drug Medi-Cal Program Integrity. In July 2013, an investigation by the Center for Investigative Reporting (CIR) and CNN uncovered allegations of widespread fraud in California's Drug Medi-Cal (DMC) program. Most of the examples of alleged fraud occurred in Los Angeles County and ranged from incentivizing patients with cash, food, or cigarettes to attend sessions, to billing for clients who were either in prison or dead. Most of the providers that were the focus of the investigation primarily offered counseling services and rely on Medi-Cal as the sole payer for services. The reports suggested that the state's oversight and enforcement bodies were not working well in tandem: county audits of providers identified a number of serious deficiencies, but failed to terminate contracts or prevent the problems from continuing.

As of March 27, 2015, this review has resulted in a total of 79 temporary provider suspensions (at 217 sites). Many of these cases (96) have been referred to the California Department of Justice for criminal investigation and prosecution.

Subcommittee Staff Comment. This is an informational item.

Questions. The Subcommittee has requested DHCS to respond to the following questions.

1. Please provide an overview of the Drug Medi-Cal program and budget.
2. Please provide a brief overview of the proposed Drug Medi-Cal waiver.

5. Drug Medi-Cal Provider Enrollment

Oversight Issue. Concerns have been raised that the process to certify and recertify Drug Medi-Cal (DMC) providers is cumbersome and unreasonable and will prove to be an impediment to the success of the proposed Drug Medi-Cal waiver as there will be an insufficient number of Drug Medi-Cal providers (particularly residential treatment providers) available to provide these services. Providers are reporting it taking over one year to complete this application process. Currently new providers who are attempting to become certified to be Medi-Cal providers and existing providers who make changes such as moving locations or adding new sites must submit applications manually to the Provider Enrollment Division (PED).

As a result of the expanded DMC benefit, the allegations of fraud that have come to light, and new requirements under the Affordable Care Act, there is a temporary, but substantial increase in the PED work load. Existing providers must be recertified and/or more closely scrutinized and new providers are needed to meet the increased demand for services.

As noted in the table below, of the 427 new applications/changes to existing certification, 204 (47 percent) have been processed and only 77 (or 18 percent) have been approved. Additionally, of the 306 non-continued certification applications (see below for definition of these applications) submitted to PED after January 1, 2014, 111 (36 percent) have been processed and only 25 (or eight percent) have been approved.

Table: Provider Enrollment Division – Drug Medi-Cal Applications (as of March 20, 2015)

		1. Inventory	2. Total Sites Targeted	3. Decertified	4. Apps Received for processing	5. Hold	6. Apps Assigned to Analyst for Review	7. Deficient	8. Awaiting Remediation Submittal	9. Remediation Submitted	10. Approved	11. Decertified/ Denied	12. Terminated App Review	13. % Total Apps Assigned/Deficient
Non-Targeted Inventory	Backlog	N/A	N/A	121	3	0	120	0	25	52	13	28	99.17%	
	Non-Continued Cert.	N/A	N/A	306	26	29	231	34	82	25	76	10	84.97%	
	TOTAL	0	0	427	29	29	351	34	107	77	89	38	88.99%	
Phased Targeted Inventory	1	337	139	198	28	1	197	16	105	35	15	0	100.00%	
	2	226	49	177	0	41	130	26	91	8	5	0	96.61%	
	3	243	49	194	4	19	117	21	49	4	43	0	70.10%	
	TOTAL	806	237	569	32	61	444	63	245	47	63	0	88.75%	
Pending Targeted Inventory	4 (NTP)	131	0	48	1	1	4	1	3	24	0	0	10.42%	
	Reconciliation	55	0	2	0	0	1	1	0	0	0	0	50.00%	
	TOTAL	186	0	50	1	1	5	2	3	24	0	0	12.00%	

Note - Definition of Categories:

- Non-Targeted Inventory: Backlog applications include new entities/sites/modalities/changes to existing certifications that were submitted to Substance Use Disorder Services Division (SUDS) prior to 1/1/2014 and reassigned to PED for review/processing on 4/3/2014. Non-continued certification applications are decertification appeals, new entities/sites/changes to existing certifications submitted directly to PED after 1/1/2014. These two buckets contain duplicate applications requesting different actions that have been counted separately.
- Phased Targeted Inventory: Phases 1-3 are continued recertifications of existing providers. Per the Affordable Care Act, Medi-Cal providers must be recertified on a regular-basis.
- Pending Targeted Inventory: Phase 4 (Narcotic Treatment Providers (NTP) and reconciliation has not yet been conducted.
- Phased targeted and pending targeted providers are certified providers in good standing with DHCS, able to provide services and bill. Non-Targeted providers also include some providers that are in good standing with DHCS, able to provide services and bill and are in this category solely due to a change that requires a full application.

Budget Issue. PED requests to extend 11 limited term positions that expire June 30, 2015 for one more year for work associated with certifying and recertifying Drug Medi-Cal providers. According to DHCS, these requested positions are essential to address provider fraud, waste, and abuse in the DMC program by certifying only providers meeting standards of participation in Medi-Cal, and decertifying fraudulent providers by conducting a thorough screening including collecting disclosure statements, performing monitoring checks, and making referrals to the DHCS Audits and Investigations Division for onsite reviews. In addition, DHCS has internally redirected six positions for this workload.

According to DHCS, the new workload related to DMC provider certification requirements includes:

- Requiring the enrollment of medical licensed staff. Current DMC program certification standards state that each substance abuse clinic must have a licensed physician designated as the medical director and that the medical director assumes medical responsibility of all of its patients.
- Requiring the submission of provider agreements. Although it is a federal requirement to have provider agreements from participating Medi-Cal providers, most DMC providers had not signed a provider agreement. The provider agreement serves as the contract between the provider and DHCS and is mandatory for participation or continued participation as a provider in the Medi-Cal program pursuant state and federal law.
- Requiring the submission of fingerprinting and criminal background checks. DHCS has designated new DMC certification applicants and DMC providers applying for recertification at the high categorical risk level. Providers designated at the high-risk categorical level must submit to fingerprinting and are subject to a criminal background check. PED will be required to review conviction information and work with the Office of Legal Services in determining the eligibility of the applicants to participate in the DMC program if a conviction is identified through the criminal background process.
- Timely reporting of changes that affect certification, such as ownership changes.

Additionally, database checks will be performed on a monthly basis to determine if DMC providers and their managing employees, owners, agents, or those with a control interest appear on the List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), Medicaid and Children's Health Insurance Program, CHIP, State Information Sharing System (MCSIS), and Social Security Death Match databases. A test sample of over 2,700 DMC providers run against these databases showed as many as 55 percent had matches.

Provide Application and Validation for Enrollment (PAVE). PED is automating its enrollment processes. PAVE will transform provider enrollment from a manual paper-based process to a web-based portal that providers can use to complete and submit their application, verifications, and to report changes. In the spring of 2014, DHCS indicated that PAVE would be up-and-running in September 2014 and that this system would help facilitate the workload to certify Drug Medi-Cal providers. However, implementation of PAVE has been delayed until at least September 2015.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal and the certification of Drug Medi-Cal providers.

Questions. The Subcommittee has requested DHCS to respond to the following questions.

1. Please provide an overview of the Drug Medi-Cal provider certification and re-certification process.
2. Please describe the efforts DHCS has undertaken to assist providers in certification, such as provider call lines and training webinars.
3. Does PED have timeframes (e.g., 60 days) by which it must process applications? If not, why not?
4. Has PED considered expediting applications from providers who already certified for a different location or service? If not, why not? What is the risk in expediting these applications?
5. Has DHCS identified particular services or regions that have severe access inadequacies that could be remedied with a speedier certification process?
6. Why was the implementation of PAVE delayed?
7. What steps is PED taking to ensure that providers in counties opting-into the Drug Medi-Cal waiver are prioritized in the PED certification process?

6. Drug Medi-Cal Provider Monitoring

Budget Issue. DHCS requests 10 positions in its Substance Use Disorder Prevention, Treatment, and Recovery Services Division for workload associated with monitoring Drug Medi-Cal (DMC) providers.

According to DHCS, these positions would be used to increase program integrity within the program and mitigate the risk of fraud, waste, and abuse. For example, these positions would review the on-site operations of every DMC provider at least once every five years (approximately 133 sites annually) and be responsible for follow up with DMC providers on all corrective action plans to ensure any deficiencies DHCS identifies are rectified by the DMC providers.

Additionally, these positions would be used to design and implement a DMC system monitoring protocol similar to the department’s “Program Oversight and Compliance Annual Review Protocol for Consolidated Mental Health Services and Other Funded Services.” This protocol includes monitoring for access; authorization; beneficiary protection; funding, reporting, and contracting requirements; provider relations; program integrity; quality improvement; and chart review. (This protocol can be found at:

http://www.dhcs.ca.gov/formsandpubs/Documents/14_027_Encl_1.pdf)

Background. Upon the transfer of the administration of the DMC program and applicable Medicaid functions to DHCS (from the former Department of Alcohol and Drug Programs) in June 2012, DHCS began a review of the DMC program. Based on issues it identified, DHCS initiated a complete review of the DMC program in an effort to address fraud, waste, and abuse allegations. One of the findings from this review was that monitoring of DMC providers was not occurring.

According to DHCS, identified health and safety issues would be avoided in the future with the implementation of on-site monitoring of the operations of DMC providers. Some of the issues recently identified with DMC providers that would be rectified with a DMC monitoring program are: DMC providers who should not be operating due to their status on federal excluded lists; medical directors with suspended or other action against their license; non-qualified staff providing services; beneficiary health and safety at risk due to unsanitary facilities; providers operating facilities out of compliance with local use permit requirements; inaccessible facilities; inadequate or no policies and procedures to guide operations; lack of adequate staffing to provide services; non-treatment services being provided; etc. Additionally, this monitoring function would strengthen the department’s ability to ensure DMC providers are in compliance with specific requirements related to operating a DMC program on a school site, as well as ensuring the students’ ability to receive treatment services safely and confidentially.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal. While the goal of program integrity and developing a DMC system-wide monitoring system is worthwhile, discussions continue on the level of staff necessary for these purposes.

Questions. The Subcommittee has requested DHCS respond to the following questions.

1. Please provide an overview of this request.

2. For a county that opts-into the Drug Medi-Cal waiver, what are its responsibilities in regard to monitoring DMC providers? How do these responsibilities differ from the proposed activities outlined in this proposal?
3. Please explain how this process will improve program integrity and prevent recurrences of prior problems?

7. Substance Abuse – Recovery and Treatment Services (AB 2374, 2014)

Budget Issue. DHCS requests to establish two permanent, full-time positions at a cost of \$246,000 (General Fund) due to the enactment of AB 2374 (Mansoor), Chapter 815, Statutes of 2014.

AB 2374 requires a counselor certifying organization (CO), prior to registering or certifying a counselor, to contact DHCS-approved COs to determine whether a counselor has previously had a certification or registration revoked. The requested positions would be used to address this new workload.

AB 2374 also requires licensed residential treatment facilities to report resident deaths to DHCS by phone and in writing. The report requires the inclusion of specific information, including a description of the follow-up action that is planned, including, but not limited to, steps taken to prevent a future death. The death reporting requirements of AB 2374 closely align and expand upon the requirements that currently exist in the California Code of Regulations Title 9 § 10561 and DHCS's internal death investigation policy. For this reason, DHCS requests no resources for this component of AB 2374.

Background. Prior to the approval of AB 2374, DHCS only had the authority to ensure that COs maintained a business office in California and remained accredited with the National Commission for Certifying Agencies (NCCA). Once approved, DHCS had no authority to monitor, suspend or revoke approval of a CO unless they lost their NCCA accreditation. Ten COs were originally approved in regulations to register and certify individuals providing AOD counseling in California's licensed and/or certified AOD facilities. DHCS currently recognizes four approved counselor COs. The other six COs lost their accreditation with the NCCA, thereby, losing approval from DHCS. Those four organizations have approximately 28,000 SUD counselors, of which roughly half are certified and half are registered while working towards certification.

AB 2374 establishes new requirements for DHCS' oversight of COs. This new oversight authority includes periodic reviews of the COs and administrative tasks related to periodic reviews to properly monitor the approved COs' adherence to state requirements. DHCS will develop regulations to clarify the CO provisions in AB 2374. DHCS currently has no staff devoted to CO oversight and no funding intended for that purpose. According to DHCS, the anticipated workload associated with AB 2374 is beyond DHCS's ability to absorb and continue to provide the levels of service that existing mandates require.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal.

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

1. Please provide an overview of this budget request.

Michelle Baass & Sam Lui 651-4103
Senate Budget & Fiscal Review Committee

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, April 9 (Room 4203)
Agenda Part A and Part B

All items were informational or held open; no votes were taken.

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Holly J. Mitchell

**Senator Jeff Stone, Pharm. D.
Senator William W. Monning**



**April 9, 2015
9:30 a.m. or Upon Adjournment of Session
Room 4203**

Consultant: Samantha Lui and Michelle Baass

Part B

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PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order noted in the Agenda unless otherwise directed by the Chair. 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. Thank you.

5180 Department of Social Services – Child Welfare Services (CWS)**1. Overview**

The CWS system includes child abuse prevention, emergency response to allegations of abuse and neglect, supports for family maintenance and reunification, and out-of-home foster care. The total proposed budget for the realigned CWS and Adoptions programs is \$5.1 billion (\$2.4 billion federal funds, \$1.6 billion 2011 realignment funds, and \$1.1 billion county funds). In general, around half of child welfare funds support counties to administer or provide the programs; and half support payments to care providers.

The core of child welfare services (CWS) is made up of four components:

- **Emergency Response:** Investigations of cases where there is sufficient evidence to suspect that a child is being abused or neglected.
- **Family Maintenance:** A child remains in the home, and social workers provide services to prevent or remedy abuse or neglect.
- **Family Reunification:** A child is placed in foster care, and services are provided to the family with the goal of ultimately returning the child to the home.
- **Other Placements:** provides permanency services to a child who is unable to return home and offers an alternative family structure, such as legal guardianship or independent living.

Caseload trends.¹ In 2000, there were approximately 107,998 children in foster care in California. In 2013, the figure dropped to around 53,112 children, not including children under probation department supervision who reside in foster care placements. The department attributes part of the caseload decline to prevention efforts for out-of-home care and back-end efforts for permanency placements.

Demographics of children in foster care. Research documents how children and youth, who experience foster care and those who emancipate from care, are at risk for challenges related to education, health, and mental health. As of January 1, 2015, of the 66,969 children currently in care, around forty percent have been in care less than a year; around 23 percent have been in care for nearly two years; and roughly fifteen percent have been in care for longer than five years.

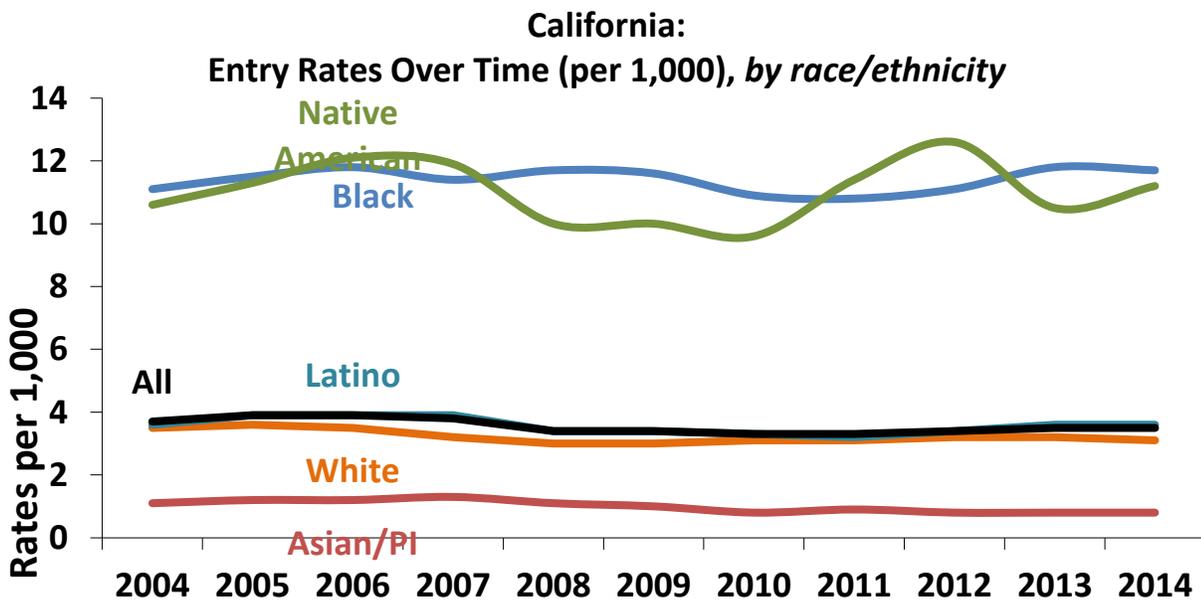
The following table, based on October 2014 data, displays the percentage of ethnic or racial representation of a child in foster care by placement type.

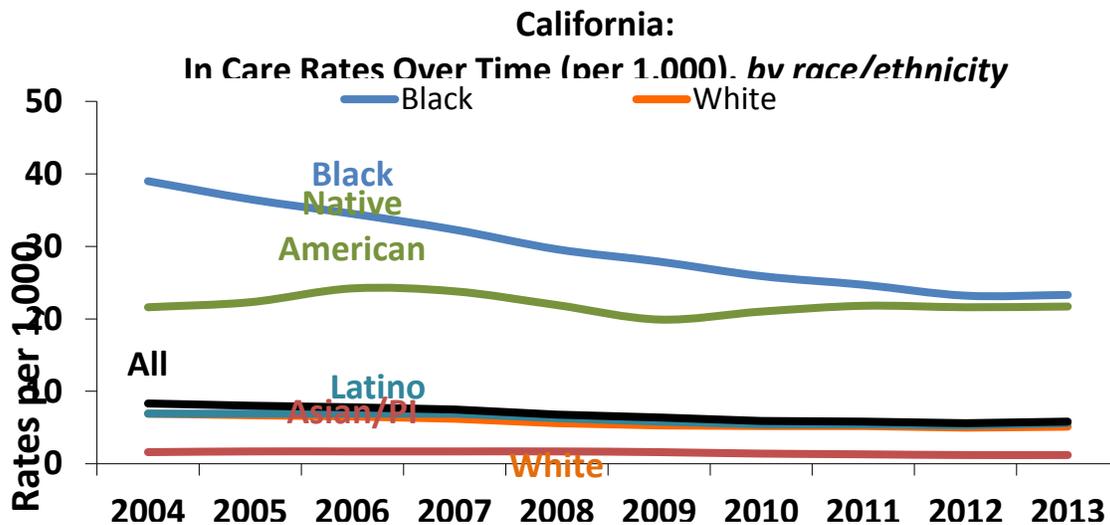
Placement Type	Black	White	Latino	Asian/Pacific Islander	Native American
Pre-Adopt	20.4	22.3	54.8	1.7	0.8
Kinship	19.9	21.5	55.1	2.0	1.5
Foster Home	21.8	27.5	47	2.6	1

¹ Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Putnam-Hornstein, E., King, B., Morris, Z., Sandoval, A., Yee, H., Mason, F., Benton, C., & Pixton, E. (2015). *CCWIP reports*. Retrieved 4/5/2015, from University of California at Berkeley California Child Welfare Indicators Project website. URL: <http://cssr.berkeley.edu/ucb_childwelfare>

FFA	18.1	24.2	54.7	2.1	0.9
Court Specified	22.4	28.1	44.6	3.4	1.5
Group Home	28.9	23.9	44.1	2.0	1
Shelter	12.9	37.9	45.7	1.4	2.1
Non-FC	33.7	23.8	39.5	1.9	1.1
Transitional Housing	37	25.7	33.7	2.5	1
Guardian Dependent	40.8	14.2	42.2	1.6	1.2
Guardian Other	30.9	25.2	38.5	2.7	2.7
Runaway	26.8	18.7	51.8	1.5	1.1
Trial Home Visit	18.3	23.4	53.6	4.4	0.3
Supervised Independent Living Placement	26.7	22.8	45.4	3.8	1.2
Other	25.1	23.1	46.7	2.6	2.5

The following graphs display the entry rates over time and in-care rates by a child’s race or ethnicity.





Placement options. There are four major temporary placement types — kinship care, foster family home (FFH), foster family agency (FFA), or group home:

- Kinship care refers to when a foster child is placed with a relative for care and supervision, known as the least restrictive and most family-like option (45 percent of children in foster care are placed with kin).
- Foster family homes (FFHs) are licensed residences that provide for care up to six children (represents about 11 percent of children in foster care).
- Foster family agencies (FFAs) are private, nonprofit corporations intended to provide treatment and certify placement homes for children with higher level treatment needs (around 30 percent of children in foster care).
- Group homes (GH) are licensed to provide 24-hour non-medical residential care in a group setting to foster youth from both the dependency and delinquency jurisdictions (about 13 percent of children in foster care).

Placement costs. Group home placements constitute 13 percent of foster care placement and represent nearly 46 percent of total foster care costs. Group home rates are based on the level of care and services provided, ranging from \$2,332 to \$9,879 per month.

Table 1: 2015-16 Governor’s Budget: Average Monthly Grants

Group Home	\$8,300
Foster Family Agency ²	\$2,075
Adoption Assistance	\$972
Foster Family Home	\$916
Federal Guardian Assistance	\$790
Kinship Guardian Assistance	\$751

² Includes four components: the basic rate, the child increment (both for care and supervision), the administration rate, and the social worker rate.

Length of stay. According to the department's 2014 CWS Realignment Report, for the largest age group category, 13-17 years old, of the 4,737 children, the majority (45 percent) move out of group home placements in less than 12 months, longer stays (12-36 or more months) comprise the remaining 55 percent (2,619). From 2009 to 2013, the total number of children and youth placed in group homes for the same population dropped from 7,033 to 6,188. DSS estimates that more than two-thirds of children placed in group homes remain there longer for two years. Specifically, around 3,000 children and youth are in group homes for more than one year; of these, 1,000 have been in group home for more than five years.

Licensing and regulations. 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. Ultimately, DSS must visit all facilities at least once every five years, which is less frequent than required in most states. In addition, there is a "trigger" by which annually required inspections increase if citations increase by 10 percent from one year to the next. The Governor's budget includes \$3 million General Fund and staff to address a backlog of complaint cases and to expand training and technical assistance. The budget also provides a plan for how CCL intends to increase inspection frequency over three years.

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. ACF performed its most recent CFSR in California in 2008. The state did not achieve substantial conformity (compliance in 95 percent of cases) with any outcome measures, but did achieve substantial conformity with three of seven systemic factors. According to ACF, challenges included: high caseloads and turnover of social workers; insufficient foster homes; a lack of caregiver support and training; and, a lack of needed services (e.g., mental health and substance abuse). In response, DSS developed a Program Improvement Plan (PIP). The department indicates that the state has now met all of the PIP targets and been released from any potential penalties resulting from the 2008 review.

The Child Welfare System Improvement and Accountability Act also created a statewide accountability system that became effective in 2004. It includes 14 performance indicators monitored at the county-specific level and a process for counties to develop System Improvement Plans (SIPs).

Realignment. The 2011 public safety realignment and subsequent related legislation realigned child welfare services and adoptions programs to the counties, transferring nonfederal funding responsibility for foster care to the counties. In addition, over the last several years, the state increased monthly care and supervision rates paid to group homes, foster family homes, and foster family agency-certified homes, as a result of litigation. The 2011 realignment funding reflects state GF costs for the following programs, which may also receive other matching funds.

Prior to the 2011 realignment, DSS estimated the costs associated with meeting federal and state requirements for the estimated numbers of children and families to be served as part of the annual budget process. Under the 2011 realignment, the total funding for CWS is instead determined by the

amount available from designated funding sources (a specified percent of the state sales and use tax and established growth allocations) that are directed to the counties and corresponding matching funds. Both before and after realignment, certain CWS expenditures, including payment rates for care providers that are statutorily established, are provided on an entitlement basis.

Trailer bill provisions in 2012-13 additionally established programmatic flexibility that allows counties, through action by boards of supervisors after publicly-noticed discussion, to discontinue some programs or services that were previously funded with only General Fund, including, clothing allowance and specialized care increments added to provider rates and Kinship Support Services programs.

Roles of the state and counties. DSS is responsible for oversight, statewide policy and regulation development, technical assistance, and ensuring federal compliance. Prior to realignment, the state was also at risk for the full costs of any federally imposed penalties stemming from federal Child and Family Service Reviews. 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 APS program realignment. Reports must also be posted on the department's website. The 2014 Child Welfare Services Realignment Report³ found the following:

- Data for immediate and ten-day responses for child investigations is used to assess performance for state and federal standards and for monitoring. Immediate response referrals receive a timely response above 97 percent between 2009 and 2013, while ten-day response referrals have been hovering above 91 percent during the same time period.
- Placement stability, defined as the percentage of children who have been in foster care at least eight days and less than 12 months, and who have had no more than two placements, has improved from 84.9 percent in 2008 to 87.6 percent in 2013. The national standard is 86 percent.
- Since 2009, the percentage of children for whom their first placement is with kin has increased from 16 percent to 24 percent, while the proportion of children placed in group homes from 2009 to 2013 has decreased from 18 percent to 13 percent. Over the past four years, Foster Family Agencies (FFAs) have accounted for approximately 40 percent of initial placements.
- For children entering care between 2008 and 2012, there has been a moderate decrease in the proportion of children who reunified within 12 months from 43.5 percent in 2008 to 38 percent in 2012. The proportion of children re-entering foster care within a year has increased from 11.1 percent in 2008 to 12.7 percent in 2012.

Recent policy and budget actions. Several policies and budget actions lay the groundwork for child welfare reform, including:

³ The full report can be accessed here: <http://www.cdss.ca.gov/cdssweb/entres/pdf/CWRealignmentReport2014.pdf>

- **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.
- **Title IV-E Waiver.** Title IV-E is the major federal funding source for child welfare and related probation services. These funds, which were previously restricted to pay for board-and-care costs and child welfare administration, can be used to provide direct services and supports under the waiver extension. Since Title IV-E funding is based solely on actual cost of care, if a county’s preventative services are effective and fewer children enter or stay in the foster care system, the county’s Title IV-E funding is reduced. Thus, the county is penalized for reducing foster care placements, even though such a reduction is the most desirable outcome. Last year’s budget authorized the waiver extension for five years, beginning October 1, 2014. The seven participating counties include: Alameda, Butte, Lake, Los Angeles, Sacramento, San Diego, San Francisco, Santa Clara, and Sonoma.
- **Commercial Sexual Exploitation of Children Program.** SB 855 (Budget and Fiscal Review Committee), Chapter 29, Statutes of 2014 provided \$5 million, and \$14 million General Fund ongoing, to enable county child welfare agencies to provide services to child victims of commercial sexual exploitation to enable county child welfare agencies to serve victims of commercial sexual exploitation.
- **Relative Caregiver Funding.** Effective January 1, 2015, counties, who opt-in to the Approved Relative Caregiver Funding Program, must pay an approved relative caregiver a per child, per month rate, in return for the care and supervision of a federally ineligible Aid to Families with Dependent Children-Foster Care (AFDC-FC) child placed with the relative caregiver, equal to the base rate paid to foster care providers for a federally-eligible AFDC-FC child.

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

Questions

1. DSS: What are some factors that may contribute to the declining foster care caseload? What are some expected caseload trends for the future?
2. DSS: How is the department mitigating disparities across racial and ethnic characteristics of children and youth involved in the child welfare system, of placement types, and of length of time in the child welfare system?

4260 Department of Health Care Services**5180 Department of Social Services – Child Welfare Services****1. Oversight: Out-of-County Placements**

Oversight Issue. Concerns have been raised regarding a longstanding issue of access to mental health services for foster children and youth placed out of county. When these children are placed out of county, they are at risk of experiencing prolonged delays or denials in accessing mental health services as counties dispute the authorization of, and payment for, services and the responsibility for coordinating these services.

In 2010, the Child Welfare Council approved an action plan to resolve this problem. However, this action plan was not implemented. In early 2015, the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) released a “concept paper” outlining a solution to this longstanding problem and anticipate meeting in early April with county stakeholders to discuss next steps to finalize the policy.

Background. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is an entitlement under federal law for all Medi-Cal-eligible children including children placed into foster care. Specialty mental health is a covered EPSDT benefit for children who meet “medical necessity” criteria for such care.

County mental health plans are the responsible entity that ensures Medi-Cal specialty mental health services are provided. Each county mental health plan contracts with local private mental health service providers or uses county mental health staff to deliver services.

It is estimated that 20 percent of foster children and youth are placed out of county. They are placed out of county for various reasons, such as placement with a relative that may live in another county or placement in a short-term residential placement. In these situations, counties can (1) keep the child enrolled in Medi-Cal in the home county or (2) transfer the child’s Medi-Cal case to the host county. There is no statewide policy regarding this choice as each child’s situation may be different (and each county may have a different policy).

Pursuant to Welfare and Institution Code (WIC) Section 5777.6, DHCS is required to collect and keep data to enable “the department to compare access to outpatient specialty mental health services by foster children placed in their county of adjudication with access to outpatient specialty mental health services by foster children placed outside of their county of adjudication.”

Staff Comment & Recommendation. DHCS and DSS indicate that they are close to developing a solution for this longstanding issue; however, these departments have been “working” for years to address this issue.

Subcommittee staff has requested data pursuant to WIC Section 5777.6 regarding DHCS’ comparison of access to outpatient specialty mental health services by foster children in their county of adjudication to foster children placed outside of their county of adjudication. DHCS has not yet provided this information.

This item is informational and is included for discussion. No action is required.

Questions

1. DHCS and DSS: Please provide an overview of this issue.
2. DHCS and DSS: Please provide a brief overview of the policies contained in the draft “concept paper.”
3. DHCS and DSS: When are you meeting with stakeholders to finalize the policy solution and establish a timeline for implementation?
4. DHCS: What statistics does DHCS collect and keep that enable “the department to compare access to outpatient specialty mental health services by foster children placed in their county of adjudication with access to outpatient specialty mental health services by foster children placed outside of their county of adjudication?” (pursuant to WIC Section 5777.6) How does DHCS use this information to ensure that foster care children placed out of county receive timely access to services? When was the last time the department completed this analysis? When will this requested information be submitted to the Subcommittee?

2. Oversight: *Katie A./Child Welfare and Mental Health Coordination and Monitoring*

Oversight Issue. The court jurisdiction over the *Katie A.* lawsuit expired on December 1, 2014. Despite the end of this court jurisdiction, it is important that DSS and DHCS continue to support, assist, and guide county child welfare and mental health agencies as they continue to build their infrastructures and increase service deliveries.

Background. 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 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.

On December 2, 2011, Federal District Court Judge A. Howard Matz issued an order approving a proposed settlement of the case. According to the Department of Health Care Services, “The settlement agreement seeks to accomplish systemic change for mental health services to children and youth within the class by promoting, adopting, and endorsing three new service array approaches for existing Medicaid covered services, consistent with a Core Practice Model (CPM) that creates a coherent and all-inclusive approach to service planning and delivery.” The settlement agreement also specifies that all children and youth who meet subclass criteria are eligible to receive Intensive Care Coordination (ICC),⁴ Intensive Home-Based Services (IHBS)⁵, and Therapeutic Foster Care (TFC). County mental health plans (MHPs) are required to provide ICC and IHBS services to subclass members. MHPs provide ICC and IHBS and claim federal reimbursement through the Short-Doyle/Medi-Cal (SDMC) claiming system.

The Department of Social Services and Department of Health Care Services worked together with the federal court appointed Special Master, the plaintiffs’ counsel, and other stakeholders to develop and implement a plan to accomplish the terms of the settlement agreement.

On December 1, 2014, court jurisdiction over the *Katie A.* lawsuit expired. Pursuant to the *Katie A.* settlement agreement, the court retained jurisdiction over the lawsuit for 36 months after court approval of the agreement which occurred on December 1, 2011. The final status conference was held on November 24, 2014 and focused on post-jurisdiction collaboration and activities.

State Plan Amendment for TFC. On March 27, 2014, DHCS submitted a State Plan Amendment to the Centers for Medicare and Medicaid Services to include TFC services as a rehabilitative mental health service. If approved by the federal government, TFC would then be available to eligible Medi-Cal children and youth, up to age 21, with intensive or complex emotional and behavioral needs. DHCS is awaiting federal notification.

⁴ Intensive Care Coordination (ICC) is a service that is responsible for facilitating assessment, care planning, and coordination of services, including urgent services (for children/youth who meet the *Katie A.* Subclass criteria).

⁵ Intensive Home-Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child’s functioning. IHBS are delivered according to an individualized treatment plan developed by the Child and Family Team (CFT). The CFT develops goals and objectives for all life domains in which the child’s mental health condition produces impaired functioning, including family life, community life, education, vocation, and independent living, and identifies the specific interventions that will be implemented to meet those goals and objectives.

Staff Comment & Recommendation. It appears that the *Katie A.* settlement led to increased collaboration between DHCS, DSS, and counties. It will be important to ensure that this increased collaboration and commitment continue when considering solutions to assist children placed in foster care.

This item is informational and is included for discussion. No action is required.

Questions

1. DHCS and DSS: Please briefly describe the *Katie A.* settlement agreement. What has changed since court jurisdiction of this settlement agreement has ended?
2. DHCS and DSS: How are you supporting counties as they continue to build their infrastructures and increase service deliveries?
3. DHCS and DSS: How are you working with the three counties (Stanislaus, Sutter, and Trinity) that are not yet providing ICC and IHBS services to subclass members?
4. DHCS: Has the department received any updates from CMS about the proposed State Plan Amendment?

3. Oversight: Psychotropic Medications

Oversight Issue. Recent news articles have highlighted the growing concern that psychotropic medications have been over-prescribed to children in the foster care system. Advocates raise concerns that these drugs may be administered for non-medical reasons: as chemical restraints, for the convenience of caretakers, and as punishments for being unpleasant or troublesome.

On February 24, 2015, the Senate Committee on Human Services and Select Committee on Mental Health held a joint oversight hearing on this subject.

Background. Studies have shown that age, gender, and placement type impacts the prevalence of psychotropic drug use.⁶ According to the U.S. Department of Health and Human Services – Administration on Youth and Families (ACYF),⁷ children in foster care are more likely to be prescribed psychotropic medications as they grow older, with 3.6 percent of two- to five- year olds taking psychotropic medication at a given time. This increases to 16.4 percent of six- to eleven-year-olds and 21.6 percent of twelve to sixteen year olds. The likelihood that a child will be prescribed multiple psychotropic medications also increases with age. In addition, males in foster care are more likely to be receiving psychotropic medications (19.6 percent) than their female counterparts (7.7 percent). Pertaining to placement type, ACYF finds that children in the most restrictive placement setting are the most likely to receive psychotropic medications, or multiple medications. In group or residential homes, nearly half of the young people are taking at least one psychotropic drug.

In 2012, the Department of Health Care Services and Department of Social Services initiated a collaborative called the Foster Care Quality Improvement project (“QIP”) for psychotropic drugs in foster care. Workgroups include:

- **Clinical Workgroup** – The Clinical Workgroup’s focus is to develop tools to assist prescribers, pharmacists, and the juvenile courts improve their roles in the provision of psychotropic medications.
- **Data and Technology Workgroup** – The Data and Technology Workgroup’s focus is to conduct analysis of child welfare and managed care and fee-for-service pharmacy claims data.
- **Youth, Family, and Education Workgroup** – The Youth, Family, and Education Workgroup’s focus is to develop and disseminate training materials and information about psychotropic medications for youth, parents, caregivers, social workers, juvenile court staff, and other figures supporting the foster care population.

Global Data-Sharing Agreement. DHCS, DSS, and the counties are in the process of developing a global data-sharing agreement that would allow these entities to share data concerning foster care children (including placement data and Medi-Cal claims data) without having to identify each particular data element that might be shared. This agreement would more easily allow these entities to conduct population-level analysis for foster care children and identify concerning trends or outliers.

⁶ Raghavan, R; Zima, BT; Anderson, RM; Leibowitz, AA; Schuster, MA; & Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. *Journal of child and adolescent psychopharmacology*. 15(1):97.

⁷ Administration for Children and Families Information Memo: “Promoting the Safe, Appropriate, and Effective Use of Psychotropic Medication for Children in Foster Care (2012)”. <http://www.acf.hhs.gov/sites/default/files/cb/im1203.pdf>

Treatment Authorization Request. On October 1, 2014, DHCS implemented a treatment authorization request (TAR) requirement for any antipsychotic medication prescribed to a Medi-Cal beneficiary under the age of 18, including foster children covered by Medi-Cal. The purpose of the TAR requirement is to provide DHCS with greater oversight and monitoring of the use of antipsychotic medications for children. According to DHCS, initially there were implementation issues as the new process was not clear to providers. However, DHCS indicates that these issues have been addressed and it is not aware of any systematic issues with this TAR process. Additionally, DHCS notes that this TAR requirement has improved its ability to track off-label use of drugs for children. According to DHCS, existing regulations already require a TAR for off-label use; however, it appears that some prescribers of these medications for youth were unaware of this requirement.

Medical Board Request for Data. In the fall of 2014, the Medical Board requested information from DHCS to investigate physicians who prescribed three or more psychotropic drugs to foster care children for a period of 90 days or more. DHCS has not yet provided this information and indicates that it is still in the process of finalizing a data use agreement with the Medical Board. In mid-March, Senate President pro Tempore De León and Senators Beall, McGuire, Mitchell, and Monning sent a letter to the director of DHCS inquiring about data requests by the Medical Board.

Staff Comment & Recommendation. This item is informational and is included for discussion. No action is required.

DHCS and DSS have taken steps to tackle this issue; however, important steps remain to be taken. Finalizing the data-sharing agreements, systematically reviewing the data, and identifying courses of action based on this data will be key to ensuring that foster children are not inappropriately medicated and are provided the appropriate continuums of placement, care and service.

Questions

1. DSS and DHCS: Please provide an overview of this item and the activities of the Foster Care Quality Improvement Project.
2. DSS and DHCS: What is the status of the global data-sharing agreement? What is the timeline for executing this agreement?
3. DSS and DHCS: How are the departments using the data that is being compiled to strengthen their oversight of prescribing physicians and of group homes to ensure that appropriate alternative services and programming is made available to foster and probation youth?
4. DHCS: Is there a work plan coming from the Youth, Family, and Education Workgroup to ensure that foster youth receive needed Medi-Cal mental health services and other social support services as well as decreased reliance on psychotropic medications?
5. DSS and DHCS: What tools can either department identify to that could help determine if foster youth are receiving appropriate mental health services that may prevent overuse of psychotropic medications? What would it take to compile it in a way that would be useful to better understand mental health care utilization in foster care?

6. DHCS: Does DHCS have any plans to further education Medi-Cal prescribing providers regarding appropriate use of psychotropic medications for this population?
7. DHCS: What is the status of providing physician data to the Medical Board? Why has it taken DHCS so long to share this data? What is the status of matching Medi-Cal prescribing data with facilities (e.g., group homes) and by county?
8. DSS and DHCS: How will the departments measure improvements and milestones; and evaluate the strategies being developed to address this problem?

5180 Department of Social Services – Child Welfare Services**1. Continuum of Care Reform (CCR)**

Budget Issue. The budget includes \$9.6 million (\$7 million General Fund) to fund two of the 19 recommendations outlined in the Continuum of Care Reform Report: increase foster parent recruitment, retention, and training efforts (\$3.8 million [\$2.8 million GF]); and increase foster family agency social worker rates (\$5.8 million [\$4.2 million GF]) by fifteen percent.

Background. SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, authorized the Continuum of Care Reform (CCR) effort to develop recommendations related to the state's current rate setting system, and to services and programs that serve children and families in the continuum of Aid to Families with Dependent Children-Foster Care (AFDC-FC) eligible placement settings. In particular, the Legislature expressed its intent for recommended reforms, including reforms related to the use of group homes, changes to the rate systems, and changes to the assessment of children's needs, and to outcome measurement, to promote positive outcomes for children and families.

According to the department's 2014 CWS Realignment Report, for the largest age group category, 13-17 years old, of the 4,737 children, the majority (45 percent) move out of group home placements in less than 12 months, longer stays (12-36 or more months) comprise the remaining 55 percent (2,619). From 2009 to 2013, the total number of children and youth placed in group homes for the same population dropped from 7,033 to 6,188.

On January 9, 2015, DSS released the report⁸ concurrently with the release of the Governor's budget. The report provided 19 recommendations with the expressed goal to:

Reduce reliance on group homes as a long-term placement setting by narrowly defining the purpose of group care, and by increasing the capacity of home-based family care to better address the individual needs of all children, youth, and caregivers.

According to the department, the recommendations "represent a paradigm shift from traditional group homes as a long-term placement to Short-Term Residential Treatment Centers (STRTC) as an intervention." The list of 19 recommendations seeks to improve assessment of child and families to make more appropriate initial placement decisions; emphasize home-based family care; support placement with available services; change the goals for group home care placement; and, increase transparency for child outcomes. Some of the recommendations include:

- **Accreditation.** Require STRTCs and Foster Family Agencies to be accredited by a national body, as a condition of receiving a foster care rate.
- **Foster Family Agencies (FFA).** Allow public agencies to be licensed to operate an FFA. Strengthen resource family recruitment (such as relative caregivers and foster and adoptive families), training, and retention strategies.

⁸ Please see http://www.cdss.ca.gov/cdssweb/entres/pdf/CCR_LegislativeReport.pdf for the full legislative report and list of recommendations.

- Short Term Residential Treatment Centers (STRTCs). STRTC programs will provide services and support for children and youth who need short-term, intensive treatment. Placements must be reviewed at six-month intervals or less.
- Rate structures. Replace the group home Rate Classification Level system with a statewide residential rate for all STRTCs. Revise the FFA rate structure to account for two types of FFAs – those that provide core services, and those that function as home-finding agencies.
- Residential treatment. Phase-out county-operated children’s shelters. Educationally-based boarding schools for foster youth must adapt and align their programs to meet CCR goals.
- Performance and outcomes. Use a client satisfaction survey to capture children and their families’ perceptions regarding services received from STRTC and FFA treatment providers. Develop a method to increase transparency of a provider’s performance.

Outcomes associated with group homes. Most children served by a child welfare agency are placed with families. However, approximately 3,000 children and youth have been in group homes for more than one year, and probation departments often use group home settings in lieu of locked settings. Significant research documents the poor outcomes of children and youth in group homes. For example, children who leave group care to reunification have higher re-entry rates into foster care. In addition, students in group homes were the least likely to graduate (35 percent), whereas students in kinship (64 percent) and guardianship placements (71 percent) were the most like of 12th grade students in foster care to graduate from high school. Further, group home placement is also associated with increased risk of arrest. While some youth residing in group homes may have already had more complex needs at the time of their placement, research also indicates that congregate care settings themselves, and the long-term use of residential shift care instead of family-based settings, may create or exacerbate their challenges.

LAO Comments. In the “2015-16: Analysis of the Human Services Budget,” the LAO finds:

- Recommendations broadly consistent but lacks details. The CCR report’s recommendations provide little detail on specifically how the rates for STRTCs and FFAs would be structured to achieve CCR objectives.
- Appropriate to focus on building capacity in home-based settings. Given the concerns about insufficient amount of county foster homes, it is important to ensure that there are enough family-based placements available for children transitioning from group home placements, and that these placements have access to the services and supports to meet a child’s needs.
- Unclear how proposed funding will achieve CCR objectives. The Administration does not specify how the \$3.8 million for foster parent outreach, recruitment and support would be used, and what outcomes would be expected. It is unclear how the funding is to be distributed and whether all counties have access to these funds. It is difficult to assess whether the amount proposed in the budget is appropriate to meet CCR objectives.

Further, the proposed increase in the FFA social worker rate appears to allow FFAs meet existing expectations under current law, not tied to new FFA responsibilities or services as envisioned in the CCR recommendations.

Staff Comment. Hold open. Staff recommends holding the item open for further discussion.

Questions

1. DSS: Please provide an overview of the Administration's proposal. Why were these two items selected as priorities above other CCR recommendations?
2. DSS: Please provide further detail about how funding for the county foster parent recruitment and support will be allocated and used.
3. DSS: How will the department ensure this funding is consistent with timelines with the concurrent legislation? Or, does the department view this funding as separate and distinct from the legislation?

2. Trailer Bill [602]: Approved Relative Caregiver Funding Options Program Clean-Up

Budget Issue. The Administration proposes the following language to “administratively streamline the application process for grant payments, maximize federal funding, and ensure that families do not experience a break in services or payment”:

1. Foster children and non-minor dependents (NMDs), who are eligible to receive an approved relative caregiver (ARC) payment will be placed into a separate assistance unit.
2. The CalWORKs portion of the payment will be the exempt maximum aid payment for an assistance unit of one.
3. If the approved relative caregiver is needy, his or her assistance unit size will include the number of ARC children, or NMDs, only for purposes of determining program income and eligibility of the CalWORKs assistance unit. For purposes of calculating the grant amount for the needy caregiver, the ARC child and NMD is excluded.
4. Foster care resource limits will be used to determine eligibility of an ARC child and NMD.
5. Overpayments will be collected pursuant to existing foster care program requirements.
6. County of court jurisdiction has payment responsibility for ARC children and NMDs.
7. An approved relative caregiver is exempt from Statewide Fingerprint Imaging Systems, reporting, immunization, and other CalWORKs requirements.
8. The General Fund (GF) appropriation must be increased annually by an amount greater than the CNI to ensure that the caregiver payments get a full California Necessities Index (CNI) adjustment.
9. The GF portion of the ARC payment may be countable towards maintenance-of-effort (MOE), only if the GF is not counted as MOE for another purpose.

The Department of Social Services does not anticipate the trailer bill language to have a fiscal impact. In addition to the \$30 million GF for the budget year, the department also estimated \$3.9 million for programming changes to the automation system, Statewide Automated Welfare System for the current fiscal year.

Background. Senate Bill 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, established the Approved Relative Caregiver Option Program and provided an ongoing annual appropriation of \$30 million GF, to be adjusted annually by CNI. Prior to the ARC Program, funding associated for a placement with a relative caregiver depended on a child’s eligibility for federal Aid to Families with Dependent Children-Foster Care (AFDC-FC). If a child was not eligible for AFDC-FC, the relative caregiver could apply for, and receive, a CalWORKs benefit, in lieu of AFDC-FC. Unlike AFDC-FC, generally, CalWORKs grants are based on the entire family size, not per-child, and are less than half of the AFDC-FC rate.

Under the ARC program, relative caregivers receive an applicable regional per-child CalWORKs grant, plus the GF portion in an amount that provides a rate equal to the basic foster family home rate (based on the age of the child).

Participating counties are provided GF, based on the a county’s maximum number of eligible approved relative caregiver placements in the county as of July 1, 2014. If the county-specific ARC caseload exceeds the baseline caseload of July 1, 2014, then the county must be responsible for making the full ARC payments. Counties must also be responsible for the county-share of the CalWORKs payment.

As of March 2014, 30 counties⁹ have opted to participate in the program.

Staff Comment & Recommendation. Hold open. Staff recommends holding the item open.

Questions

1. DSS: Please provide an overview of the ARC Option Program and the need for the trailer bill.
2. DSS: What are some factors that may have contributed to counties not participating in the first year? How is the department conducting outreach to ensure that counties, who are interested in participating, are receiving technical assistance?

⁹ Alameda, Amador, Calaveras, Colusa, Contra Costa, Fresno, Inyo, Kings, Lake, Los Angeles, Madera, Marin, Mariposa, Mendocino, Mono, Monterey, Orange, Placer, Plumas, San Benito, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Shasta, Solano, Sonoma, Stanislaus, Ventura and Yolo.

3. Trailer Bill [608]: Child Near Fatality Public Disclosure

Budget Issue. The Administration proposes trailer bill language that contains the following provisions:

1. Clarifies that the county child welfare agency must, upon request, and within five business days of learning that a child fatality has occurred in the county and that there is reasonable suspicion that the fatality was caused by abuse or neglect, release whether the child resided in foster care.
2. Adds “reports, investigations, results of investigations, and cause and circumstance of the child’s death” to the list of documents from the juvenile case file to be released, upon completion of the child abuse or neglect investigation into the child’s death.
3. Adds “a description of child protective or other services provided, including dates of reports, investigations, and services rendered; and actions taken by the child welfare agency, if any, that are pertinent to the child abuse or neglect that resulted in the fatality” to the list of documents that must be disclosed for cases in which a child’s death occurred while living with a parent or guardian.
4. Clarifies that juvenile case files that are not subject to disclosure pursuant to the proposed section of law, must be disclosed upon a juvenile court order.
5. Provides that the definition of “child abuse and neglect” is identical to the definition provided in federal law.
6. Defines “substantiated” to mean a:
Report determined by the investigator who conducted the investigation to constitute child abuse or neglect, as defined in federal law, based upon evidence that makes it more likely than not that child abuse or neglect occurred. A substantiated report must not include a report where the investigator who conducted the investigation found the report to be false, inherently improbable, to involve an accidental injury, or to not constitute child abuse or neglect, as defined in federal law.
7. Provides that nothing in the state law authorizes information to be disclosed that would reveal a person’s identity who provided information related to the suspected abuse, neglective, or maltreatment of a child.
8. Requires that all cases, in which abuse or neglect results in a child’s near fatality, as proposed to be defined in state law, must be subject to disclosures set forth in state law.
9. Defines “near fatality” as the identical meaning in federal law, except that near fatalities must not include children with injuries or symptoms, however severe, that do not result in the child’s overall condition of serious or critical.
10. Defines a “near fatality case” as one that meets all of the following conditions:
 - a. A licensed physician determines that the child is in serious or critical condition.
 - b. A child’s condition is the result of abuse or neglect, as defined in federal law.

11. Establishes that abuse or neglect is determined to have resulted in a child's near fatality if one of the following conditions is met:
 - a. A law enforcement investigation concludes that child abuse or neglect occurred.
 - b. A county child welfare services agency determines that the child abuse or neglect was substantiated.
12. Requires that findings or information disclosed regarding child near fatalities, upon request, must consist of a written report that includes all of the following information:
 - a. A child's age and gender;
 - b. The date, if known, when the abuse or neglect occurred that resulted in the near fatality;
 - c. The date, if known, when a licensed physician determined the child victim to be in serious or critical medical condition;
 - d. Whether the child resided in foster care, or in the home of his/her parent or guardian at the time of the near fatality;
 - e. The cause and circumstances regarding the near fatality;
 - f. A description of reports received, child protective or other services provided, and actions taken by the county child welfare services agency regarding all of the following:
 - i. Suspected abuse or neglect of the child near fatality victim.
 - ii. Suspected abuse or neglect of other children pertinent to the abuse or neglect.
 - iii. A written narrative that includes the dates of reports; investigations; services rendered; actions taken; and, the investigative disposition for each report.
13. Requires a county welfare department or agency to disclose to the public, upon request, all written assessment of a child's safety in the home and the child's future risk of harm by abuse or neglect prepared by the county child welfare services agency.
14. Requires a county welfare department or agency to release all required findings and information to the public, if disclosure is requested, within 30 calendar days of either the request or the disposition of the investigation, whichever is later.
15. Prohibits the following information and records to be disclosed:
 - a. Names, address, telephone numbers, ethnicity, religion, or any other identifying information of any person or institution, other than the county or the Department of Social Services.
 - b. Any information that would jeopardize a criminal investigation or proceeding.
 - c. Any psychiatric, psychological, therapeutic evaluations, clinical or medical reports, evaluations or similar materials or information pertaining to the child or the child's family.
16. Requires the county welfare department or agency to notify and provide a copy of the request
17. Juvenile case file records that are not subject to the disclosure must only be disclosed upon order of the juvenile court pursuant to state law.
18. Authorizes the Department of Social Services (DSS) or county welfare department to comment on the case once documents have been released. If a county welfare department or agency comments on the case, the social worker on the case may also comment publicly about the case.

19. Requires each county child welfare services agency to notify DSS of every child near fatality that has occurred within its jurisdiction that was a result of child abuse or neglect.
20. Provides that a person disclosing juvenile case file information, as required, must not be subject to civil or criminal proceedings for complying with the law.
21. Establishes that this law shall only apply to near fatalities that occur on, or after, July 1, 2015.
22. Provides that a county child welfare department or agency is not required to retain documents beyond any date otherwise required by law.
23. Clarifies that nothing in this section of law requires a county welfare department or agency to obtain documents not in the case file.
24. Clarifies that nothing in this section of law authorizes the disclosure of information that would reveal the a person's identity who provided information related to suspected abuse, neglect, or maltreatment of the child.
25. Authorizes Department of Social Services to implement changes, including those regarding child near fatalities procedures, through all county letters or similar instructions.

Funding for this proposal includes \$263,000 (\$105,000 GF) for Fiscal Year (FY) 2014-15, which represents a half year of funding. For 2015-16, the budget includes \$529,000 (\$210,000 GF) is budgeted for a full year of costs in FY 2015-16. The budgeted amounts reflects the costs associated with compiling and publishing reports, and disclosing information on all near fatalities caused by suspected child abuse or neglect as required by federal CAPTA.

Background. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states receiving funds under CAPTA must disclose to the public findings and information about child abuse and neglect cases that result in fatalities or near fatalities. After being deemed out of compliance, the Department of Social Services (DSS) issued All County Letter 06-24 on July 21, 2006, as part of its corrective action plan, noting its approach to provide the public a case-specific summary, as prepared by DSS and the county child welfare agencies (child welfare and probation). A September 15, 2008, letter from the federal Department of Health and Human Services, Administration on Children, Youth, and Families found that the state's disclosure practice for fatalities is more extensive than that released for near fatalities. Federal guidance was issued in September 2012, related to disclosing information on these cases and the federal Administration for Children, Youth, and Families (ACYF) has directed states to provide a plan to ensure compliance. The federal Child Welfare Policy Manual (CWPM) clarifies that states must develop procedures for the release of information including, but not limited to, the following items:

- Cause of and circumstances regarding the fatality or near fatality;
- Age and gender of the child;
- Information describing any previous reports of child abuse and/or neglect investigations; that are pertinent to the child abuse and/or neglect that led to the fatality or near fatality;
- Result of any such investigations; and,
- Services provided by and actions of the state on behalf of the child pertinent to the child abuse and/or neglect that led to the fatality or near fatality.

Senate Bill 39 (Migden), Chapter 468, Statutes of 2007, requires that once the cause of death from abuse or neglect has been substantiated, the child welfare agency must, within five days of a request, release specified records (age, gender, date of death of the child; whether an investigation is being conducted; whether the child was in foster care or in the home of his/her parent or guardian), subject to redaction of confidential information. The bill did not make any provision for the release of information for cases of near fatalities.

According to the department, this proposal “will align California statute with the federal Child Abuse Prevention and Treatment Act (CAPTA) regarding the disclosure of findings and information in child fatality and near fatality cases. California must comply with the requirements of CAPTA concerning the disclosure of findings and information in child fatality and near fatality cases.

The CAPTA grant averages slightly more than \$3 million annually. The funds are currently obligated for the following purposes:

- Support of a statewide network to provide technical assistance and training to non-profit prevention and early intervention providers
- A tool to track service provision and outcomes of those served by community-based providers
- Support for parent leadership development
- Funds the California Evidenced-based Clearing House for Child Welfare

Advocate concerns. Some advocates are concerned that the proposed language represents a retreat from or complicates existing practice regarding fatalities, and does not mirror existing language and practice established by SB 39 (Migden). Some concerns include:

- Existing law requires specified information to be released for cases in a child fatality, including emergency response referral information, health care records, cross reports, risk and safety assessments; and copies of policy reports about the person against whom the abuse or neglect was substantiated. Proposed law adds the following to the list of information that must be disclosed: a narrative of child protective or other services provided and actions taken by the child welfare agency; reports; investigations and the results of those investigations. Would this additional information delay agencies’ ability to comply within the 10 day release of information to the public?
- Existing Penal Code defines “child abuse or neglect” as “physical injury or death inflicted by other than accidental means upon a child by another person, sexual abuse, neglect, the willful harming or injuring of a child or the endangering of the person or health of a child, and unlawful corporal punishment or injury.” The proposed definition of child abuse and neglect, which mirrors the federal definition, appears to limit child abuse and neglect to acts by “a parent or caretaker” instead of the Penal Code definition, which includes acts by another person.
- Existing law requires county welfare departments to release juvenile case file information to the public within 10 business days of the request or the disposition of the investigation into a child’s death. For child near fatalities, proposed language requires that information related to a child’s near fatality be released within 30 calendar days, not 10 business days.

- As part of the definition of a “near fatality”, proposed language requires a licensed physician to determine that the child is in serious or critical condition. The language creates a narrow reporting window, as it does not take into account cumulative impact of neglect, or whether the child recently was in serious or critical condition as a result of abuse or neglect.

The department notes that it is currently working with the County Welfare Directors Association, Child Advocacy Institute, NYCL, and the California Newspaper Publishers Association on this trailer bill language.

Staff Comment & Recommendation. Hold open. Staff recommends the item remain open to allow further discussion between the department and the advocates.

Questions

1. DSS: Please provide a brief overview of the issue and a summary of the trailer bill language.
2. DSS: How long has the state been out of compliance with CAPTA? During those years, what did the state do as part of its corrective action plan? What are the repercussions, fiscal or otherwise, for being out-of-compliance with CAPTA?

4. BCP #50: AB 1978 Child Welfare Social Worker Empowerment and Foster Child Protection Act

Budget Issue. The Administration requests one staff services manager and associated operating expenses and equipment to implement a confidential process whereby child welfare social workers can inform the Department of Social Services (DSS) of local policies, procedures, or practices that endanger a child's welfare. Within the department, social worker disclosures are received, evaluated against established criteria, investigated, and reported.

Background. Assembly Bill 1978 (Jones-Sawyer), Chapter 768, Statutes of 2014, requires DSS to collaborate with labor unions and the County Welfare Directors Association to develop a process where county child welfare social workers can notify the department, without fear of reprisal, of a county practice, policy, or procedure that could endanger a child's health and safety.

Justification. According to the department, this position is "needed due to the confidential nature of these investigations; the sensitivity involved with working with high-level county child welfare administrators to obtain the information necessary to conduct and complete the investigations; to work with legal staff; and to develop any corrective or administrative plans for correction." Although the request is for only one position, the department notes that this workload is not-absorbable because it is a new activity and workload for the department. This proposal fulfills the mandate of oversight of the child welfare services system.

As of April, the department has received two calls. DSS anticipates an increase in call volume once the process is publicized.

Staff Comment & Recommendation. Hold open for further review.

Questions

1. DSS: Please provide a brief summary of the proposal.
2. DSS: Please provide a timeline on the implementation of the process, if it is to be fully in place by January 1, 2016. What are the key benchmarks?

5. Interagency Child Abuse and Neglect Reporting (ICAN) Mandate

Budget Issue. The Administration includes a \$4 million grant program to fund county welfare and probation departments' ICAN activities, for counties that choose to participate.

Background. In 1980, the Legislature enacted the Child Abuse and Neglect Reporting Act, which requires mandated reporters to report child abuse and neglect to local law enforcement agencies or county welfare or probation departments. These agencies must forward information to the Department of Justice for entry into a central statewide reporting system, known as the Child Abuse Central Index (CACI).

In December 2007, the Commission on State Mandates found that provisions of the ICAN imposed a state reimburseable mandate on local governments, for requiring them to:

- Distribute the report to mandated reporters;
- Cross-report all reports of child abuse and neglect to other child protective agencies;
- Investigate child abuse and neglect reports to determine if they are substantiated or inconclusive, and therefore, should be submitted to the Department of Justice; and,
- Notify suspected child abusers when they are reported to CACI.

The state owes around \$1.9 billion for unpaid mandate claims. The Interagency Child Abuse and Neglect Reporting (ICAN) mandate includes \$90.4 million in claims from 1999-2013. For more information about mandates and the Governor's associated proposal to suspend the ICAN mandate, please see agendas for Subcommittee No. #4 on State Administration and General Government.

LAO Comments. The Legislative Analyst's Office makes the following comments:

- Governor's proposed grant program has merit but some limitations. Because cost information is limited, some counties may consider the grant amounts to be less than their ICAN mandate costs. In addition, the proposed grant program does not provide any resources to local law enforcement agencies to offset their ICAN mandate costs. Lastly, the proposal adds \$90.4 million on top of the existing post-2004 mandate backlog.
- Link law enforcement Proposition 172 funding to ICAN implementation to possibly increase compliance. In 1993, recognizing the impact of Educational Revenues Augmentation Fund (ERAF) on cities, counties, and special districts, California voters enacted Proposition 172, which established a statewide half-cent sales tax for city and county public safety services. About one quarter of cities, mostly those that incorporated after 1978, do not receive Proposition 172 funds. The LAO recommends requiring cities and counties, as a condition of receiving Proposition 172 funds, to carry out ICAN mandate activities.

LAO Recommendations. The LAO recommends the Legislature work with counties to determine the funding level that would sufficiently encourage full county participation; require city and county law enforcement agencies carry out ICAN activities as a condition of receiving Proposition 172 funds; and, work with the Administration to develop a plan to pay off the post-2004 mandate backlog, including the ICAN mandate.

Staff Comment & Recommendation. Hold open. Staff notes the importance of cross-reporting as a function of the state's oversight role in child welfare, as well as the value of CACI in providing due process for those who may be listed on CACI incorrectly. According to the department, the amount of the grant (\$4 million) is based on claims currently received by the State Controller's Office. For CWS agencies, the department will continue to monitor and evaluate the appropriate level of funding still needed for ICAN activities throughout the budget process.

Staff recommends holding the item open for further review.

Questions

1. DSS: Please provide an overview of the proposal.
2. DSS: What existing mechanisms are in place to ensure communication across child protective services and law enforcement?

6. April Letter - BCP #83: Implementing Child Victims of Human Trafficking

Budget Issue. The Administration requests two permanent associate governmental program analysts to support the implementation of the Commercially Sexually Exploited Children (CSEC) program and the federal Preventing Sex Trafficking and Strengthening Families Act (PL 113-183). These two positions will engage nonprofits, service providers, social service agencies, law enforcement, and health and mental health agencies in the development of state policies and program guidelines for services to children and youth at risk of, or victimized by, commercial sexual exploitation. The requested positions will also support county programs to provide prevention activities, intervention activities, and services to children who are victims, or at risk of becoming victims, of commercial sexual exploitation.

Background. Between 2010 and 2012, 1,277 victims of commercial sexual exploitation were identified within California. Common barriers to intervention and prevention services include the challenges of having to navigate multiple systems, including foster care and the juvenile justice system. SB 855 (Budget and Fiscal Review Committee), Chapter 29, Statutes of 2014, created the CSEC Program and clarified that child trafficked victims fell under the jurisdiction of child welfare, not juvenile justice, when a parent, or guardian, failed to, or was unable to, protect them from trafficking. The Preventing Sex Trafficking and Strengthening Families Act of 2014, amended foster care and adoption assistance IV-E Social Security Act funding to, among other things, require state IV-E agencies to develop and implement policies and procedures to identify, document, report, and serve children and youth in care who are, or are at-risk of becoming, victims of sex trafficking. One of the federal requirements are for IV-E agencies to report cases of CSE to law enforcement no later than 24 hours after identifying a victim of CSE, and to report to law enforcement within 24 hours any time a child in care goes missing that is identified as, or at risk of becoming, a victim of CSE.

Justification. Implementation of SB 855, PL 113-183, and other legislative mandates related to trafficking of children and youth in California has created ongoing workload that cannot be absorbed by current personnel. According to the department, without the additional staff, the Child Welfare Policy and Program Development Bureau within the department would not be able to implement its Strategic Plan for 2015-2018, which focuses on prevention of child abuse and neglect through implementation of public awareness campaigns, development and maintenance of a statewide prevention network, and measuring outcomes and data analytics.

Staff Comment & Recommendation. Hold open for further review.

Questions

1. DSS: Please provide an overview of the proposal.

7. Proposals for Investment

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

7A. Bringing Families Home

Budget Issue. The Corporation for Supportive Housing and Housing California are requesting \$10 million to establish a county matching grant program for child-welfare involved families that may be experiencing homelessness.

Through a competitive application process, DSS would choose select counties to receive matching funds. Counties would use up to 10 percent of the funds to begin a process of data-sharing, meet reporting requirements and hire a liaison, a social worker dedicated to bridge child welfare and homeless systems, and to connect families to an existing assessment of a homeless family's housing needs. DSS would require counties to have functioning coordinated assessment and entry systems in place. Based on assessed needs, counties would use remaining grant funds to offer two types of assistance to families: (1) "rapid re-housing" for about 350-400 families, which helps families quickly exit homelessness and return to permanent housing, offering up to 18 months of rent and move-in assistance to cover move-in costs and case management, among other services, and (2) "supportive housing" for about 135-140 families to stabilize families with disabilities who have been homeless for at least a year or at least four times within the last three years, as well as families facing significant barriers to housing stability.

Background. The rapid re-housing model moves a family, or individual, experiencing homelessness into permanent, stable housing as quickly as possible. Since federal rapid re-housing funds have become available, communities nationwide use this model as a response to homelessness, with results that demonstrate lower rates of return to homelessness and better employment outcomes. Program components include housing identification (e.g, recruiting landlords to provide housing opportunities), or rental or move-in assistance.

Staff Comment & Recommendation. Hold open.

7B. Relative and Foster Parent Recruitment, Retention, and Support

Budget Issue. The County Welfare Directors Association of California requests \$30.2 million increase to support county Foster Parent and Kinship Care Recruitment, Retention and Support activities.

Background. According to CWDA, the proposed \$30.2 million investment would enable counties to: (1) target recruitment and support efforts to better match foster families and foster children; (2) direct services and supports to foster and kin caregivers; (3) and intensive family finding, engagement and support.

Staff Comment & Recommendation. Hold open.

7C. Support to Children and Families Provided by Foster Family Agency Social Workers

Budget Issue. As part of a broader coalition, the California Alliance of Child and Family Services requests \$18.9 million General Fund to fund the Foster Family Agency (FFA) social worker rate. According to the Alliance, the allocation would increase the social work component of the FFA rate by \$200/month, thereby raising the funded hourly wage for a Foster Family Agency social worker to \$24.47.

Background. Foster family agencies (FFAs) receive a monthly rate that consists of different components, including an administration rate, a social worker rate, a child increment rate, and the basic rate. The basic rate is adjusted annually to reflect changes in cost-of-living. The other components of the FFA rate were reduced by 10 percent in 2009 in order to achieve General Fund savings and have not been increased since then. Typically, the social work and administration components of the FFA rate are retained by the FFA to provide services and treatment to certified foster families.

Staff Comment & Recommendation. Hold open.

7D. Transitional Housing Program-Plus (THP+) for Nonminor Dependents Aging Out of Care and to Homeless Youth

Budget Issue. A coalition of organizations, including the John Burton Foundation and the California Coalition for Youth, request \$30 million to expand THP+ for non-minor dependents aging out of care and for homeless youth. Under this proposal, the eligibility criteria for THP+ would be modified to allow homeless youth, ages 18 to 24, to participate in the program. It is anticipated that the program expansion could allow the provision of safe, affordable housing and supportive services to 1,100 youth annually. The requested budget augmentation would be divided equally among the two populations to be served.

Background. In 2001, the Legislature established THP+s to provide safe, affordable housing and supportive services to youth who turned 18 years old, while in foster care or juvenile probation systems. Currently, THP+ is administered by 50 county child welfare agencies and operated by 79 non-profit organizations.

Staff Comment & Recommendation. Hold open.

SUBCOMMITTEES No. 1 and 3

Education and Health & Human Services

Chair, Senator Marty Block

Senator John M.W. Moorlach
Senator Benjamin Allen



Chair, Senator Holly J. Mitchell

Senator Jeff Stone, Pharm.D.
Senator William W. Monning

April 16, 2015
9:30 a.m. or Upon Adjournment of Session
Room 4203, State Capitol

AGENDA

Consultant: Samantha Lui

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PLEASE NOTE. Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. 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. Thank you.

OVERVIEW OF CALIFORNIA'S CHILD CARE AND EARLY LEARNING SYSTEM

The period from birth through age five is a critical time for a child to develop physical, emotional, social, and cognitive skills.¹ Early childhood interventions have demonstrated consistent positive effects for a child's long-term health and well-being, including better health outcomes, higher cognitive skills, higher school attainment, and lower rates of delinquency and crime.² Some academic literature finds that investing in quality early childhood education can produce future budget saving. For example, James Heckman, a University of Chicago Nobel Laureate economist, found that quality preschool investments generate seven to ten cents per year on every dollar invested.³ To provide context for the subcommittees' consideration of the Governor's budget regarding, and oversight of, child care and early childhood education issues, the following sections will: (1) present the impact of poverty on child development; (2) discuss infrastructural factors that impact the delivery of California's child care and early learning programs; and (3) consider possible proposals of investment.

Eligibility and access. Programs in the early care and education system, generally, have two objectives: to support parental work participation and to support child development. To be eligible for subsidized child care, families' incomes must be below 70 percent of the state median income (\$42,000 for a family of three); parents must be working or participating in an education or training program; and children must be under the age of 13. California has, traditionally, guaranteed subsidized child care through a variety of programs, including child care for families currently participating in the California Work Opportunity and Responsibility to Kids (CalWORKs) program. The state subsidizes child care for several years, with Stage 1 care provided for families seeking employment; Stage 2 for families who have been deemed "stable" by a county or are transitioning off of cash assistance; and Stage 3, for families who have been off cash assistance for at least two years.

Summary of California's Child Care and Development Programs

Program	Description	2014 Budget Act Slots	Proposed Slots for 2015-16	Percent Change
CalWORKs (based on estimated caseload)				
Stage 1	Provides cash aid and services to eligible families. Begins when a participant enters the CalWORKs program.	38,363	40,847	6%
Stage 2	When the county deems a family "stable." Participation in Stage 1 and/or Stage 2 is limited to two years after an adult transitions off cash aid.	51,956	46,968	-10%
Stage 3	When a family expends time limit in Stage 2, and as long as family remains otherwise eligible.	34,563	35,908	4%
Subtotals for CalWORKs child care		124,882	123,723	-1%

¹ U.S. Department of Health and Human Services (2003, June). *Strengthening Head Start: What the evidence shows* <http://aspe.hhs.gov/hsp/StrengthenHeadStart03/index.htm>

² A. Reynolds, J. Temple, S. Ou, D. Robertson, J. Mersky, J. Topitzes, and M. Niles (2007) *Effects of a School-Based, Early Childhood Intervention on Adult Health and Well-being: A 19-year follow-up of low-income families*. *ArchPediatrics Adolescent Med/Vol. 161* (No. 8), pp.730-739.

³ J. Heckman (2011). "The Economic of Inequality: The value of early childhood education." *American Educator*, pp.31-47.

Non-CalWORKs (based on proposed number of slots to be funded)				
General Child Care	State and federally funded care for low-income working families not affiliated with CalWORKs program. Serves children from birth to 12 years old.	51,287	53,323	4%
Alternative Payment	State and federally funded care for low-income working families not affiliated with CalWORKs program. Helps families arrange and make payment for services directly to child care provider, as selected by family.	26,554	27,146	2%
Migrant Child Care	Serves children of agricultural workers while parents work.	2,505	2,609	4%
Severely Handicapped Program	Provides supervision, therapy, and parental counseling for eligible children and young adults until 21 years old.	145	146	1%
State Preschool	Part-day and full-day care for 3 and 4-year old children from low-income families.	148,588	153,177	3%
Total		353,961	360,124	2%

How are programs funded? California provides child care and development programs through vouchers and contracts.

- Vouchers.** The three stages of CalWORKs child care and the Alternative Payment Program are reimbursed through vouchers. Parents are offered vouchers to purchase care from licensed or license-exempt caregivers, such as friends or relatives who provide in-home care. Families can use these vouchers at any licensed child care provider in the state, and the value of child care vouchers is capped. The state will only pay up to the Regional Market Rate (RMR) — a different amount in each county and based on regional surveys of the cost of child care. The RMR is currently set to the 85th percentile of the RMR survey conducted in 2009, minus 10.11 percent. If a family chooses a child care provider who charges more than the maximum amount of the voucher, then a family must pay the difference, called a co-payment. Typically, a Title 22 program – referring to the state Title 22 health and safety regulations that a licensed provider must meet — serves families who receive vouchers. The Department of Social Services (DSS) funds CalWORKs Stage 1, and county welfare departments locally administer the program. The California Department of Education (CDE) funds the remaining voucher programs, which are administered locally by 76 Alternative Payment (AP) agencies statewide. Alternative Payment Agencies (APs), which issue vouchers to eligible families, are paid through the “administrative rate,” which provides them with 17.5 percent of total contract amounts. As the state cut the number of child care slots, APs issued fewer vouchers, which generated less funding for programs.
- Contracts.** Providers of General Child Care, Migrant Child Care, and State Preschool – known as Title 5 programs for their compliance with Title 5 of the California Code of Regulations — must meet additional requirements, such as development assessments for children, rating scales, and staff development. Title 5 programs contract with, and receive payments directly from, CDE. These programs receive the same reimbursement rate (depending on the age of the child), no matter where in the state the program is located. Since 2007, the standard reimbursement rate (SRR) was \$34.38 per child per day of enrollment, and increased to \$36.67 following a five percent increase in last year’s budget. Over the past few years, some small and medium-sized

providers have been absorbed by larger providers that have greater economies of scale. This is one indication that the SRR may not be sufficient for them to operate.

For license-exempt care, reimbursement rates remain at sixty percent of the regional reimbursement rate established for family child care homes.

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

Subsidized child care programs are funded by a combination of non-Proposition 98 state General Fund and federal funds. Until the 2011-12 fiscal year, the majority of these programs were funded from within the Proposition 98 guarantee for K-14 education. In 2012, funding for CSPP and the General Child Care Programs were consolidated; all funding for the part-day/part-year CSPP is now budgeted under the State Preschool program, which is funded from within the Proposition 98 guarantee. The remaining funding in the General Child Care program supports the wrap-around care required for working parents.

California also receives funding from the federal Child Care and Development Fund (CCDF), which is comprised of federal funding for child care under the Child Care and Development Block Grant (CCDBG) Act and the Social Security Act. Four percent of the federal block grant must be spent on improving the quality of child care.

Other early learning and child care programs and funding support. Programs, such as Head Start and California First 5, and other funding sources, such as the Race to the Top grant, local school districts, and community college districts, also support child development and early education programs.

Head Start. Head Start is a national program, administered by the U.S. Department of Health and Human Services Administration on Children, Youth, and Families, that serves preschool-age children and their families around the state. Many Head Start programs also provide Early Head Start, which serves infants, toddlers, pregnant women, and their families who have incomes below the federal poverty level. Programs may be based in:

- Centers or schools that children attend for part-day or full-day services;
- Family child care homes; and/or,
- Children's own homes, where a staff person visits once a week to provide services to the child and family. Children and families who receive home-based services gather periodically with other enrolled families for a group learning experience facilitated by Head Start staff.

According to CDE, in 2012, over 111,000 children were served by Head Start with a program budget of over \$965 million. California's Head Start programs are administered through a system of 74 grantees and 88 delegate agencies. A majority of these agencies also have contracts with the CDE to administer general child care and/or State Preschool programs. CDE indicates that it has over 1,316 contracts, through approximately 718 public and private agencies, providing services to approximately 400,000 children.

California First 5 and County First 5 Commissions. In 1998, voters approved Proposition 10, the California Children and Families First Act, which created the California Children and Families Program, also known as First 5. There are 58 county First 5 commissions, as well as the State California and Families Commission (State Commission), which provide and direct early development programs for children through age five. A cigarette tax (50 cent per pack) is the primary funding mechanism, of which about 80 percent is allocated to the county commissions and 20 percent is allocated to the State Commission. According to the Legislative Analyst's Office, the tax generates approximately \$400 million annually. In fiscal year 2013-14, the state and commission invested more than \$195 million to improve access and quality for early learning, including professional development for teachers and classroom support, like family specialists. First 5 can also provide developmental screenings.

After School Education and Safety Program. In 2002, California voters approved Proposition 49, which expanded and renamed the "Before and After School Learning and Safe Neighborhood Partnerships Program" to the "After School Education and Safety (ASES) Program." The ASES Program funds after school education and enrichment programs, created in partnerships between schools and community resources for students in kindergarten through ninth grade. After school programs must have (1) an educational and literacy element, such as tutoring and/or homework assistance, and (2) an educational enrichment element, such as music, performing arts, or community-service learning. ASES grantees must operate programs a minimum of 15 hours a week, and at least until 6:00 p.m. every regular school day during the regular school year. Currently, the ASES program is funded at \$550 million.

Race to the Top -- Early Learning Challenge (RTT-ELC).⁴ In 2012, California was one of nine states awarded a Race to the Top -- Early Learning Challenge grant, which aims to improve the quality of early learning programs and to close the achievement gap for children from birth to age five. California's grant totals \$52.6 million over four years (January 2012 to December 2015). State agencies, including the State Board of Education, DSS, Department of Public Health, Department of Developmental Services, and First 5 California, work with a voluntary network of 17 Regional Leadership Consortia (Consortia)⁵ to operate or develop a local Quality Rating and Improvement System (QRIS). The grant is also making one-time investments in state capacity, such as teacher/provider training and professional development, kindergarten readiness, home visitation, and developmental screenings. Around 74 percent of California's grant is spent in 16 counties⁶ to support a voluntary network of early learning programs. CDE estimates that nearly 1.9 million children, or 70 percent of children under five, can benefit from this grant.

Local School Districts. Local school districts also make considerable investments in early childhood education. Many elementary schools have preschool programs and child care programs on-site, such as Head Start, First 5 funded programs, or State Preschool. However, some programs are funded directly by school districts using other funds, including local property taxes and parent fees. School districts

⁴ For more information on California's Race to the Top -- Early Learning Challenge Grant, please see the May 2013 Report to the Governor, the Legislature, and the Legislative Analyst's Office at <http://www.cde.ca.gov/sp/cd/rt/documents/rttelc2012legrpt.pdf>

⁵ The Consortia includes the counties of Alameda, Contra Costa, El Dorado, Fresno, Los Angeles, Merced, Orange, Sacramento, San Diego, San Francisco, San Joaquin, Santa Barbara, Santa Clara, Santa Cruz, Ventura, and Yolo.

⁶ The Consortia includes 17 members in the counties of Alameda, Contra Costa, El Dorado, Fresno, Los Angeles, Merced, Orange, Sacramento, San Diego, San Francisco, San Joaquin, Santa Barbara, Santa Clara, Santa Cruz, Ventura, and Yolo.

have the flexibility to use their funding streams on early childhood education. There are various funding mechanisms include:

- Title I federal funding, which is dedicated to improving the academic achievement of the disadvantaged;
- Federal special education funding; and,
- California School Age Families Education (CalSAFE) that provided money specifically for child care and other supports for parenting students. This program was added to categorical flexibility in 2008-09, and the funds allocated to districts are no longer restricted to the CalSAFE program.

Community College Districts. There is also a small amount of funding allocated to the Community College districts to support subsidized child care for students. The budget includes funding for the following programs:

- CalWORKs \$9.2 million for subsidized child care for children of CalWORKs recipients.
- Cooperative Agencies Resources for Education (CARE) - Administered by the state Chancellor's Office, CARE uses Proposition 98 funds to operate 113 CARE programs. For fiscal year 2013-14, the program was allocated \$9.3 million to provide eligible students with supplemental support services designed to assist low-income single parents to succeed in college.⁷
- Child Care Tax Bailout - This program was first established in 1978 to mitigate the effect of Proposition 13 on 25 community colleges that had previously dedicated local taxes to child care and development centers. This program was included in the categorical flex item with funding of \$3.4 million in the 2009-10 budget, but there has been no change to this program since that time.

RECENT TRENDS

Some families, despite similar characteristics, are provided different funding and educational opportunities. The Legislature may wish to examine how child care services and early education programs are currently administered and delivered, so as to maximize available funding, deliver quality services, and meet the diverse needs of California's families. This section will review reductions made during the Great Recession and examine current issues and trends, pertaining to the following: (1) access to child care and early learning programs; (2) reimbursement rates; and (3) quality measures.

From 2009-2013, overall funding for child care and preschool programs decreased by \$984 million; and approximately 110,000 slots, across all programs, were eliminated. The following chart by the Legislative Analyst's Office outlines the funding, slot, and caseload reductions made to child care and preschool programs.

⁷ The Chancellor's Office temporarily suspended the Board of Governors-approved CARE allocations' funding formula, so each CARE program is awarded the same allocation received in the past four years. For more information about CARE's final allocations, please see <http://extranet.cccco.edu/Divisions/StudentServices/CARE/Allocations.aspx>

Recent Funding and Slot/Caseload Reductions to Child Care and Preschool Programs	
<i>(Dollars in Millions)</i>	
Year Change	Reductions
2009-10	
Exemptions for Stage 1 families	\$69
Eliminate Latchkey after school program	27
Technical/caseload adjustments	-14 ^a
Total Funding Reduction	\$82
Total Slot/Caseload Reduction	10,400
2010-11	
Cap Title 5 provider reserves at 5 percent	\$83
Reduce CalWORKs Stage 3 (Governor's veto)	70 ^b
Reduce license-exempt rates from 90 percent to 80 percent of licensed rates	31
Reduce administrative payments from 19 percent to 17.5 percent of total contract amounts	17
Reduce some quality improvement activities	6
Technical/caseload adjustments	83
Total Funding Reduction	\$290
Total Slot/Caseload Reduction	35,200^c
2011-12	
Across-the-board cut of 11 percent ^d	\$177
Reduce license-exempt rates from 80 percent to 60 percent of licensed rates	68
Lower income eligibility from 75 percent to 70 percent of state median income	28
Reduce or eliminate some quality improvement activities	16
Eliminate Centralized Eligibility List	8
Additional across-the-board cut of 4 percent ^d (midyear trigger cut)	23
Technical/caseload adjustments	107
Total Funding Reduction	\$427
Total Slot/Caseload Reduction	37,100
2012-13	
Across-the-board cut of 9 percent ^{d,e}	\$130
Institute family fees for part-day preschool	3
Technical/caseload adjustments	52
Total Funding Reduction	\$185
Total Slot/Caseload Reduction	27,300
Total Funding Reduction	\$984
Total Slot/Caseload Reduction	110,000

^a Reflects net increase in funding, not reduction.
^b Governor originally vetoed \$256 million in CalWORKs Stage 3 funding. Legislature restored \$186 million.
^c Reductions primarily due to CalWORKs Stage 3 families not returning to the program after the veto.
^d Except for CalWORKs Stage 1 and Stage 2.
^e Alternate Payment Program was reduced by 18 percent.

How did the Recession impact child care and early learning access? According to data from CDE, the aggregate number of children served by program type has fluctuated annually. The table below provides more specific numbers of children by program type.

Aggregate Number of Children Served by Program Type (2008-09 to 2013-14)

	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
General Child Care	145,353	71,004	68,386	60,317	55,563	54,461
CalWORKs Stage 2	115,242	107,505	109,495	110,033	104,890	91,967
CalWORKs Stage 3	81,035	76,247	67,128	40,391	42,332	44,929
Alternative Payment	54,678	58,226	56,937	51,000	39,768	39,727
California State Preschool Program*	N/A	201,630	213,931	200,426	181,052	180,295
General Migrant Care	4,906	4,393	4,845	4,474	4,069	3,935
Severely Handicapped	178	229	235	245	235	193

* Part-day and Full-day Preschool Programs, and Pre-K Literacy Part-day and Full-day Programs were incorporated into CSPP, pursuant to AB 2759 (Jones), Chapter 308, Statutes of 2007.

Source: CD-801A Monthly Child Care Report. Data summarized represent unduplicated count of children by program type who received subsidized child care and developmental services any time during fiscal year. A child may be counted more than once if he or she receives services within multiple program types during the year.

Increasing demand for subsidized child care remains constant. Families often contact contractors directly to request being placed on waiting lists. In the past, the statewide centralized eligibility list (CEL) consolidated waiting lists for subsidized child care programs. Functionally, the CEL organized and prioritized enrollment of eligible and needy children; it also demonstrated the need for subsidized child care and funding by county and statewide. Due to the budget deficit, Senate Bill 87 (Budget and Fiscal Review Committee), Chapter 33, Statutes of 2011, eliminated funding for CEL. At the time of its elimination, around 240,000 children were waiting for a subsidized child care slot. Since then, some counties have maintained their own CEL with existing local funds. According to data from January 2014, from fifteen Northern California counties, around 24,278 children were on the wait list. As of February 2015, 25,126 income eligible children in the Alternative Payment program (not including center-based care) were on waiting lists in North Los Angeles and San Bernardino counties. Extrapolating from the Los Angeles and San Bernardino county figures, which typically represents ten percent of the state's child care population, a rough estimate would be that more than 251,000 children are currently on waiting lists.

According to the Department of Social Services, between February 2013 and June 2014, California lost 2,305 licensed facilities. A number of factors may contribute to a facility closing, including the increased cost of care per child (especially for infants and toddlers), inability for certain a provider to absorb the impact of, or provide for, minimum wage increases, and stagnant reimbursement rates.

The Department of Education has initiated several initiatives to outreach to families whose first language is not English; for families with children with disabilities; and for infant-toddler care.

Language availabilities. CDE provides key documents in multiple languages. Confidential Application for Child Development Services, Emergency Identification and Information, Notification and Certification, and Statement of Incapacity are available in Chinese (simplified), Chinese (traditional), Hmong, Korean, Pilipino (Tagalog), Spanish and Vietnamese. The Resource and Referral agencies, under contract with the CDE, are required to make every effort to reach all parents within their defined geographic area, including, but not limited to toll-free telephone lines, office space convenient to parents, and referrals with staff proficient in the languages which are spoken in the community.

For families with children with disabilities. CDE is the lead fiscal agency for the Race to the Top-Early Learning Challenge (RTT-ELC) grant, which seeks to improve the quality of early learning programs and close the achievement gap for children who are low-income, English learners, and children with disabilities or developmental delays. California is taking a unique approach that builds upon the state's local and statewide successes. For more information about RTT-ELC, please see page 6 of the agenda.

The Office of Head Start and the Child Care Bureau, Administration for Children and Families, U.S. Department of Health and Human Services funds the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) to provide training and technical assistance to California; and to expand opportunities for inclusion of children with disabilities and other

exceptional needs in child care settings. CSEFEL facilitates a collaborative effort to expand opportunities for children with disabilities and support integration. Resources are available to providers to include children with special needs into child care settings and participating CSEFEL sites. Coordination with the Map to Inclusive Child Care Project (Map Project) began in state fiscal year 1998–99. Stakeholders in the Map Project include representatives from early childhood programs, Head Start, CDE’s Special Education Division, key state agencies such as the California Departments of Developmental Services, Social Services, and Mental Health, and professional organizations providing support services for children with disabilities and their families.

For infant and toddler care. Other resources include the Inclusion and Behavior Consultation Network, which provides consultation, on-site training, and technical assistance to programs serving children with disabilities and special needs, including challenging behaviors through direct support to care providers. The Program for Infant Toddler Care (PITC), Inclusion of Infants and Toddlers with Disabilities provides training of trainers institutes for college instructors and PITC graduates. Local capacity to serve infants and toddlers with disabilities is increased by training provided by 100 to 130 PITC-certified trainers and interventionists.

Rates. The state reimburses child care providers using two rate structures—the regional market rate (RMR) and the standard reimbursement rate (SRR)—depending on the child care program. Families also pay fees for services based on their income.

- Regional Market Rate. For child care, CDE conducts its RMR survey every two years, but state law does not require that California adopt the rate. Over the past few years, providers increasingly have been charging the maximum of what the state will pay for vouchers. In some counties, this is more pronounced than in others. If child care providers charge too high a price, families may be unwilling or unable to pay. In communities with large numbers of low-income families who do not receive subsidies, the families’ ability to pay may be more limited than what the providers could otherwise charge if all families had subsidies. However, if most families were subsidized, the provider could charge closer to the RMR cap without affecting the families’ ability to pay.
- Standard Reimbursement Rate. Since 2007, the standard reimbursement rate (SRR) was \$34.38 per child per day of enrollment, and increased to \$36.67 following a five percent increase in last year’s budget. Over the past few years, some small and medium-sized providers have been absorbed by larger providers that have greater economies of scale. This is one indication that the SRR may not be sufficient for them to operate.

Quality.⁸ The state funds a number of activities to improving quality in child care and early learning settings. For example, four percent of the Child Care and Development Block Grant (CCDBG) must be spent on improving the quality of child care. The Child Care and Development Fund (CCDF), which is comprised of federal funding for child care under the CCDBG Act and the Social Security Act. Examples of uses for quality funds include technical assistance and training, Resource & Referral services, and grants and loans to providers for start-up costs. In 2012-13, the state budgeted \$72 million

⁸ Every three years, California must prepare and submit to the federal government a plan detailing how its CCDF funds are allocated and expended. <http://www.cde.ca.gov/sp/cd/re/stateplan.asp>

for 27 distinct projects, including professional development, stipends for providers, and activities related to health and safety. Another example includes the establishment of the Quality Rating Improvement System for state preschool, which will be further discussed on pg. 15 of the agenda. Additionally, Assembly Bill 212 (Aroner), Chapter 547, Statutes of 2000, provides \$15 million annually to Local Child Care and Development Planning Councils (LPCs)

The subcommittees invited the following panelists to provide their perspective on the value of investing in early childhood education and the possible challenges in the field.

Panelists:

Lourdes Alarcon, Parent Voices
Doris Russell, SEIU Local 99
Cristina Alvarado, Child Care Alliance of LA

5180 Department of Social Services
6100 Department of Education

1. Governor's Budget and TBL #300: Education Trailer Bill Master

Panelists: Jessica Holmes, Department of Finance
 Brandon Nunes, Department of Finance
 Carolyn Chu, Legislative Analyst's Office

Budget Issue. The Governor's budget provides \$2.5 billion total funds (\$899 million federal funds; \$657 million Proposition 98 General Fund; and \$941 million non-Proposition 98 General Fund) for child care and early education programs. The budget reflects an overall increase in child care funding of \$101 million, attributed to changes in the cost of care in the CalWORKs programs, increases to the Regional Market Rate (RMR), and the inclusion of statutory growth and a cost-of-living adjustment (COLA) for specified programs. The table below provides the allocation amounts by program.

Program	Governor's Budget (dollars in millions)
CalWORKs Child Care	
Stage 1	\$362
Stage 2	\$349
Stage 3	\$264
Subtotal	\$974
Non-CalWORKs Programs	
General Child Care	\$574
Alternative Payment	\$190
Other	\$30
State Preschool	\$657
Totals	\$2,497

In addition, the budget includes the following:

- Full-year funding for 4,000 full-day State Preschool slots. The budget includes \$16 million in ongoing Proposition 98 to support a full year of additional full-day State Preschool slots⁹ and \$9.2 million in Proposition 98 to provide COLA for some child care programs. Also, the budget maintains ongoing \$50 million quality grants for State Preschool, which are allocated on a competitive basis to local education agencies.
- Full-year Regional Market Rate increase. The 2014 Budget Act provided \$19.1 million to increase the RMR for the Alternative Payment Program and all three CalWORKs stages, starting

⁹ SB 852 (Budget and Fiscal Review Committee), Chapter 25, Statutes of 2014; SB 858 (Budget and Fiscal Review Committee), Chapter 32, Statutes of 2014; and SB 876 (Budget and Fiscal Review), Chapter 687, Statutes of 2014, enacted several restoration and reinvestment augmentations for State Preschool, General Child Care, and Alternative Payment slots.

January 1, 2015. The new RMR sets the maximum reimbursement rate at the 85th percentile of the 2009 regional market survey reduced by 10.11 percent. The budget annualizes the increase in reimbursement rates and provides \$27.7 million.

- Growth and statutory COLA for the Alternative Payment, General Child Care, State Preschool, Migrant, and Handicapped Programs. The Governor's budget includes an increase of \$9.2 million Proposition 98 General Fund and \$12.3 non-Proposition 98 General Fund to resume the COLA, which was suspended for programs from 2008-09 through 2014-15. The Governor's budget provides a 0.57 percent growth adjustment and a 1.58 percent COLA. For the Alternative Payment Program, the COLA increase is applied to the program's appropriation, but its use is unspecified (traditionally this increase has supported additional slots). Programs using the Standard Reimbursement Rate (General Child Care, State Preschool, Handicapped and some Migrant programs), are increased by the COLA.
- Adjustments for CalWORKs Stage 2 and Stage 3. The budget includes an overall year-to-year decrease of \$11.6 million for Stage 2 due to a decrease in caseload (4,988 fewer slots). Stage 3 funding increases \$38.6 million year-to-year due to increases in the average cost of care (independent from the RMR increase) and a slightly higher caseload (1,345 additional slots).
- \$50 million for quality grants. The Governor's proposal maintains the ongoing \$50 million quality grants for State Preschool, which are allocated on a competitive basis to local education agencies.
- Federal Child Care and Development Funds. The budget includes a decrease of \$14.9 million federal funds to reflect a reduction in carryover funds.

The budget includes trailer bill language, which contains the following provisions:

- Establishes income eligibility limits for subsidized child care to be 70 percent of the state median income in use for the 2007-08 year, adjusted for family size.
- Uncodified language that requires the Department of Education to convene two working groups (one for contractors that provide state preschool and other subsidized child care/Title 5 providers; and another for CalWORKs Stage 2, Stage 3, and alternative payment programs) to review the administrative requirements of the two types of programs. The working groups would identify ways to reduce program administration workload, identify efficiencies in program implementation, and provide its recommendations to the Legislature, Department of Finance, and CDE, no later than April 1, 2016.

Staff Comments and Recommendation. Hold open. Staff recommends keeping the proposed budget and trailer bill language open for further discussion and review.

Question

1. To DOF: Please present the Governor's budget and proposed trailer bill language.

2. Oversight: Implementation of Budget Act of 2014

Panelists: Monique Ramos, Director of Government Affairs, California Department of Education
Debra McMannis, Director of Early Education and Support Division, CDE
Jessica Holmes, Department of Finance

Budget Issue. Last year's budget and trailer bills¹⁰ enacted an early care and education package, which includes quality enhancements, restoration and expansion of preschool access, increased reimbursement rates, and increased slots; including:

- **Increase Regional Market Rate (RMR) and the Standard Reimbursement Rate (SRR).** The regional market rate is the maximum rate the state will pay to reimburse child care providers accepting vouchers. The Budget Act of 2014 allocated \$19.1 million to increase the RMR to the 85th percentile of the 2009 survey, reduced by 10.11 percent. Language also increased the SRR by five percent, effective July 1, 2014.
- **California State Preschool Program.** The Budget Act of 2014 established 4,000 additional full-day State Preschool slots for part of the year. In addition, the 2014 Budget repealed CSPP family fees.
- **One-Time Professional Development.** \$15 million of the funding provided in SB 852 must be allocated to the Department of Education to fund professional development stipends for teachers, to be administered by local planning councils. Further, SB 852 established priorities for the use of those funds, including first priority for transitional kindergarten (TK) teachers and second priority for teachers in the California state preschool program. Language also provided a one-time allocation of \$35 million for facility and improvement and professional development.
- **Ongoing Quality Improvement Grants.** The 2014 Budget also provided an ongoing \$50 million to Quality Rating and Improvement System (QRIS) block grants to support State Preschool.

Background. According to the Department of Education, all available funding has been awarded. Anecdotally, contractors have notified the Early Education and Support Division within the department of possible challenges for expending the award amounts, such as an inability to rapidly and fully enroll enough children, a shortage of facilities, and challenges obtaining additional licenses in time to begin expending contracts.

The following charts detail the slots requests, by county, and amount of slots available.

¹⁰ SB 852 (Budget and Fiscal Review Committee), Chapter 25, Statutes of 2014; SB 858 (Budget and Fiscal Review Committee), Chapter 32, Statutes of 2014; SB 876 (Budget and Fiscal Review), Chapter 687, Statutes of 2014.

FY 2014-15 CCTR Restoration					
Slots Requested					Slots Funded
County Name	Infant Slots (0-17 months)	Toddler Slots (18-36 months)	School Age Slots	Other Eligible Slots ¹	Infant/Toddler Slots ²
Alameda	35	90	15	0	125
Colusa	3	3	0	0	6
Contra Costa	0	108	0	0	48
Del Norte	8	2	0	0	10
Fresno	34	99	44	0	133
Humboldt	1	20	0	0	5
Imperial	7	8	0	0	15
Kern	0	13	0	0	13
Los Angeles	168	411	68	32	351
Mono	0	0	6	0	0
Monterey	9	7	7	0	10
Nevada	10	8	15	0	18
Orange	12	24	22	0	36
Riverside	42	60	12	0	102
Sacramento	15	58	60	60	73
San Bernardino	0	15	0	0	0
San Diego	2	38	0	0	25
San Francisco	10	114	0	0	108
San Joaquin	5	5	0	0	10
San Luis Obispo	8	0	28	28	8
San Mateo	10	12	13	13	22
Santa Barbara	4	4	0	0	8
Santa Clara	65	81	373	116	63
Santa Cruz	25	44	20	16	69
Solano	0	0	10	0	0
Stanislaus	11	32	8	3	43
Tulare	10	9	0	0	19
Yolo	6	20	0	16	26
Total	500	1,270	701	284	1,346

¹ Includes 3 and 4 year olds being served in FCCHEM.
Priority given Infant/Toddler slot requests, funded in Start Date priority.

²

State Preschool Restoration Slots Requested. All requested slots were funded.

County Name	Full-day/Full-year Slot Totals	Part-day/Part-year Slot Totals
Alameda	460	87
Butte	54	0
Colusa	24	0
Contra Costa	75	12
Del Norte	0	40
El Dorado	29	0
Fresno	1023	365
Humboldt	8	20
Imperial	40	10
Kern	40	10
Lake	12	48
Los Angeles	1578	346
Madera	8	16
Marin	36	24
Merced	34	24
Monterey	43	22
Orange	103	948
Plumas	0	36
Riverside	340	212
Sacramento	312	309
San Benito	0	136
San Bernardino	43	72
San Diego	333	268
San Francisco	443	0
San Joaquin	50	163
San Mateo	130	112
Santa Barbara	57	24
Santa Clara	693	221
Santa Cruz	0	88
Shasta	48	8
Siskiyou	0	1
Solano	10	0
Sonoma	21	48
Stanislaus	0	16
Sutter	0	24
Tehama	0	48
Tulare	32	48
Tuolumne	0	10
Ventura	12	248
Yolo	94	20
Yuba	0	28
Total	6,185	4,112

State Preschool Expansion			
County Name	Full-Day Total Per County	Part-Day Total Per County	Total Combined Per County
Alameda	141	0	141
Butte	24	16	40
Colusa	0	24	24
Contra Costa	76	0	76
Del Norte	0	0	0
Fresno	286	0	286
Imperial	0	120	120
Kern	20	24	44
Lassen	0	27	27
Los Angeles	2,027	1,064	3,091
Madera	0	19	19
Marin	24	63	87
Merced	48	40	88
Mono	0	42	42
Monterey	42	0	42
Napa	64	0	64
Orange	472	1,046	1,518
Placer	120	0	120
Plumas	16	0	16
Riverside	462	176	638
Sacramento	522	80	602
San Bernardino	162	96	258
San Diego	762	106	868
San Francisco	46	0	46
San Joaquin	460	96	556
Santa Barbara	26	48	74
Santa Clara	213	68	281
Santa Cruz	20	96	116
Solano	48	0	48
Sonoma	48	0	48
Stanislaus	0	32	32
Sutter	98	24	122
Tehama	0	47	47
Tulare	0	145	145
Ventura	84	160	244
Total	6,311	3,659	9,970

According to data as of April 2, 2015, the following counties did not receive a rate increase under the 2009 RMR Survey with the 10.11 percent deficit factor.

**Counties That Did Not Receive a Rate Increase Under
2009 RMR Survey with 10.11 Percent Deficit Factor, Hold Harmless**

The list below includes the counties that have been held harmless for one or more age groups. This analysis only looks at the Monthly Full Time, Weekly Part Time and Hourly rate categories. It does not include an analysis of the Daily, Weekly Full Time or Monthly Part Time rate categories.

Monthly Full Time Child Care Centers	Monthly Full Time Family Child Care Homes	Weekly Part Time Child Care Centers	Weekly Part Time Family Child Care Homes
ALAMEDA	ALAMEDA	AMADOR	ALAMEDA
CONTRA COSTA	AMADOR	COLUSA	AMADOR
EL DORADO	BUTTE	DEL NORTE	CALAVERAS
FRESNO	CALAVERAS	GLENN	CONTRA COSTA
HUMBOLDT	COLUSA	IMPERIAL	LOS ANGELES
KERN	CONTRA COSTA	INYO	MENDOCINO
MONO	EL DORADO	LASSEN	MONO
NAPA	FRESNO	MADERA	NAPA
NEVADA	GLENN	MARIPOSA	NEVADA
ORANGE	HUMBOLDT	MENDOCINO	ORANGE
PLACER	INYO	MERCED	PLACER
RIVERSIDE	KERN	MODOC	SACRAMENTO
SACRAMENTO	KINGS	PLUMAS	SAN BENITO
SAN BENITO	LAKE	SHASTA	SAN BERNARDINO
SOLANO	LASSEN	SIERRA	SAN LUIS OBISPO
SONOMA	LOS ANGELES	SISKIYOU	SANTA BARBARA
VENTURA	MADERA	STANISLAUS	SONOMA
	MARIN	SUTTER	VENTURA
17 COUNTIES	MARIPOSA	TEHAMA	
	MENDOCINO	TRINITY	18 COUNTIES
	MERCED	TULARE	
	MODOC	TUOLUMNE	
	MONTEREY	YUBA	
	NAPA		
	ORANGE	23 COUNTIES	
	PLACER		
	PLUMAS		
	RIVERSIDE		
	SACRAMENTO		
	SAN BERNARDINO		
	SAN DIEGO		
	SAN FRANCISCO		
	SAN JOAQUIN		
	SAN LUIS OBISPO		
	SAN MATEO		
	SANTA BARBARA		
	SANTA CLARA		
	SANTA CRUZ		
	SHASTA		
	SIERRA		
	SISKIYOU		
	SOLANO		
	SONOMA		
	STANISLAUS		
	TRINITY		
	TULARE		
	TUOLUMNE		
	VENTURA		
	YOLO		
	YUBA		
	50 COUNTIES		

Staff Comment and Recommendation. The item is included for discussion, and no action is needed at this time.

Questions

1. To CDE: Please present how last year’s budget actions have been implemented, including expansion and restoration of slots and the rate increases.

3. Oversight: CalWORKs Child Care and Alternative Payment Program

Panelists: Todd Bland, Deputy Director of the Welfare to Work Division, Department of Social Services
 Kim Johnson, Branch Chief of the Child Care and Refugee Program, DSS
 Legislative Analyst's Office

Background. To ensure an adequate supply of child care resources to recipients and those transitioning off welfare-to-work, AB 1542 (Ducheny), Chapter 270, Statutes of 1997, eliminated seven former welfare-related childcare programs and consolidated them into the three-stage CalWORKs child care programs. 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 2 and 3 are administered by Alternative Payment Program (APP) agencies under contract with the California Department of Education (CDE). The three stages of CalWORKs child care are defined as follows:

- Stage 1 begins with a family's entry into the CalWORKs program. Clients leave Stage One after six months or when their situation is "stable," and when there is a slot available in Stage Two or Three.
- Stage 2 begins after six months or after a recipient's work or work activity has stabilized, or when the family is transitioning off of aid. Clients may continue to receive child care in Stage Two up to two years after they are no longer eligible for aid.
- Stage 3 begins when a funded space is available and when the client has acquired the 24 months of child care, after transitioning off of aid (for former CalWORKs recipients).

Historically, caseload projections have generally been funded for Stages 1, 2, and 3 in their entirety – even though Stage 3 is not technically an entitlement or caseload-driven program. There has been considerable turmoil in the Stage 3 program since Governor Schwarzenegger first vetoed all of its funding in 2010. In 2011, the program was effectively capped and the California Department of Education (CDE) was required to provide instructions to the field on how to dis-enroll families.

During the March 10 and March 26 hearings, the Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services considered several issues related to California's existing welfare-to-work plan, including the Department of Social Services' (DSS) implementation of early engagement strategies and how DSS has re-engaged families. The subcommittee conducted oversight to determine whether the utilization of supportive services, like child care, has increased, in light of significant CalWORKs program changes, such as the end of the young-child exemption and differentiation between welfare-to-work participation rules that apply before expiration of a 24-month time limit.

Issues to consider.

- Uptake rate. Historically, the uptake rate for CalWORKs child care and alternative payment programs appears low. Yet, as more work-eligible individuals participate in re-engagement¹¹ and

¹¹ Re-engagement refers to the process by which DSS re-engaged parents in approximately 15,000 families whose young-child exemptions ended over the last two years.

re-enter the workforce, and more individuals participate in variable work schedules and non-traditional hours, there should be a corresponding increase in child care. However, there has not been a significant impact driving utilization for any of CalWORKs child care stages. Instead, there has been decrease in Stage 1 and 2 slots from 2012-13 to 2013-14, with only slight upticks in Stages 1 and 3 in the last two years.

Advocates find that parents, who receive CalWORKs assistance, may not be adequately assessed for child care needs, or are not told of its availability. Providers in the field also note that many families, who are currently receiving CalWORKs assistance, are on local child care alternative payment waiting lists, suggesting the inadequacy of the needs assessment or inappropriate referral for child care.

- Transfers and sanctions. Another challenge regarding CalWORKs is an apparent misunderstanding about whether families, who have a sanctioned adult in the assistance unit, are eligible for child care. According to legal services, some sanctioned families are still being denied care or transfer. Many alternative payment agencies report that high numbers of families are self-referring into Stage 2, instead of from county referrals. Also, for families who had the young-child exemption under the CalWORKs program, they may not have been told of the availability of child care assistance when re-engaged. In legal services, many clients generally report difficulty being referred to Stage 2 services when they stabilize.
- License-exempt reimbursement ceilings. Some advocates note that the level of payment for license-exempt care has impacted the availability of providers. The Legislature may wish to review whether these reimbursement ceilings, which may function as wages to a provider, is a level comparable to other types of care or work provided in another setting.
- Reviewing “stability” for CalWORKs. Before a family moves from CalWORKs Child Care Stage 1 to Stage 2, a county must determine the family to be in “stable” condition. However, there is no statewide definition of what constitutes “stable.” Because funding for these programs rely heavily on caseload projections and estimates, unpredictable shifts from Stage 1 to Stage 2 could undermine the ability for resources to be allocated accordingly. The Legislature may wish to examine how various counties define “stable” for purposes of determining eligibility for transfer from Stage 1 to Stage 2 of CalWORKs Child Care.
- Characteristics study. The Department of Social Services and California Department of Education are conducting a Subsidized Child Care and Development Characteristics Study, which will generate data from the state’s subsidized child care programs regarding the characteristics of service providers and children and the families receiving these services. The data collected will inform decision-makers on how to improve child care services for families in need. Approximately \$2 million of existing funds from the CDSS’ research budget will fund the study over the next two years. The CDSS and the CDE meet monthly with the Technical Advisory Group (TAG). It is unclear when the complete product will be released.

Staff Recommendation. This item is informational and included for discussion. No action is required at this time.

Questions

1. To DSS: Please provide an update on actions needed to meet child care needs of the re-engaged CalWORKs population. What is currently being done to meet the child care needs of those who are re-engaged, but are no longer eligible for the current young child exemption?
2. To DSS: What actions are being taken to ensure that supportive services include the assessment and provision of child care?

4. Federal Child Care and Development Block Grant (CCDBG)

Panelists. Monique Ramos, Director of Government Affairs, CDE
Debra McMannis, Director of Early Education and Support Division, CDE
Carolyn Chu, Legislative Analyst's Office
Jessica Holmes, Department of Finance

Background. The Child Care and Development Block Grant (CCDBG) is the primary source of federal funding used in California to support subsidized child care programs, direct service, and alternative payment contract types, including CalWORKs Stage 3 and General Child Care. On November 19, 2014, the President reauthorized the CCDBG, which includes new requirements, such as annualizing licensing inspections; providing health and safety inspections for non-family license-exempt providers, allowing extended income eligibility; providing funding for child care quality activities; and, restructuring professional development for child care providers and staff. Some of the provisions of the reauthorized Block Grant include annual monitoring inspections of both licensed and license-exempt providers, implementing 12-month eligibility for children in subsidized child care, increasing the Regional Market Rate to the reimbursement ceilings identified in the most recent Market Rate Study, increasing opportunities for professional development, adding topics to health and safety trainings, and creating a disaster preparedness plan. Most, but not all of the provisions became effective when the reauthorization was signed.

Although the state may have several years to implement these changes, some policies and practices must be in place by March 2016. The Office of Child Care (OCC) is formally extending the submission of the 2016-18 CCDF State Plan until March 1, 2016 – an extension from the original due date of June 30, 2015. Pursuant to the reauthorization of CCDBG, the state must also document its level of compliance, and plans for compliance, with new federal requirements. There is question whether the federal block grant funds will be sufficient to meet new requirements and to maintain current service levels.

State Plan. Each state must complete a triennial CCDF State Plan which describes the extent to which requirements are met, or the process through which states plan to meet the requirements. Traditionally, the State Plan is due to the Federal Government by June 30 every other year. Given the unique circumstances of this reauthorization year, the federal government has granted all states a nine-month extension to March 1, 2016. A first draft of the 2016-18 State Plan will be posted on the California Department of Education's (CDE) Web site in late 2015 when the preprint or template form becomes available from the Office of Child Care. In order to gather stakeholder and public input on the 2016-18 CCDF State Plan, a public hearing was held on January 9, 2015. A stakeholder input process was initiated in February 2015 to obtain feedback from the field of child care providers, contractors and advocates as to how they would like the implementation to take shape, and what structures exist to support implementation in an efficient and cost-effective manner. Topical input sessions related to the major areas of implantation (annual licensing inspections, professional development, etc.) were hosted at the California Department of Education to solicit information and feedback.

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

- **Regional Market Rate (RMR) Survey.** All states must conduct a statistically valid and reliable survey of the market rates for child care services every two years that reflects variations in the

cost of child care services by geographic area, type of provider, and age of child. States must demonstrate how they will set payment rates for child care services in accordance with the results of the market rate survey. Assembly Trailer Bill 1476 (Chapter 663 of the Statutes of 2014), beginning January 1, 2015, requires the California Department of Education to implement ceilings at the 85th percentile of the 2009 Regional Market Rate Survey, reduced by 10.11 percent. If a calculated ceiling is less than the ceiling provided before January 1, 2015, then the ceiling from the 2005 Regional Market Survey will be used. The licensed-exempt child care provider ceilings will be 60 percent of the Family Child Care Home ceilings. Guidance from the Office of Child Care (OCC), dated March 25, 2015, suggests that states must use the most current market rate survey to set rates.

- Annual Monitoring Inspections. In California, the Department of Social Services Community Care Licensing (DSS CCL) issues licenses for child care facilities. Many providers in California supported by CCDF are license-exempt, such as relatives of a child/children, or an arrangement providing care for children of only one family in addition to the operator's own children.

The CCDBG reauthorization requires that licensed providers and facilities paid for with CCDF funds must receive at least one pre-licensure inspection for compliance with health, safety, and fire standards, as well as annual unannounced inspections of each child care provider and facility in the state for compliance with all child care licensing standards. License-exempt providers and facilities must have at least one annual inspection (Section 658E(c)(2)(K)(i)). Currently, DSS CCL must visit a facility at least once every five years – a frequency that does not meet the new federal requirement. Additionally, according to CDE, there is not a state agency charged with monitoring license-exempt providers.

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

Existing state law¹² allows for 12-month eligibility for child care services. Section 18102 of the Title 5 Regulations requires contractors to inform families of the family's responsibility to notify the contractor within five calendar days of any changes in family income, family size, or the need for services. There is some question as to whether California's current eligibility provisions will meet the new federal requirement. Federal guidance provides:

Under the law, states may not terminate CCDF assistance during the 12-month period if a family has an increase in income that exceeds the State's income eligibility threshold, but not the federal threshold of 85 percent of SMI.

¹² California Education Code Section 8263(b)(1)(C)

In addition, the state may not terminate assistance prior to the end of the 12 month period if a family experiences a temporary job loss or temporary change in participation in a training or education activity. In addition to temporary job loss, other examples of temporary changes include, but are not limited to: absence from employment due to extended medical leave or changes in seasonal work schedule, or if a parent enrolled in training or educational program is temporarily not attending class between semesters.

Staff Comment and Recommendation. In light of significant federal changes, the Legislature may wish to consider how families' access to child care and early education may be impacted, and how the state will respond in next year's State Plan. The item is included for discussion purposes, and no action is needed at this time.

Questions

1. To CDE: Please provide a background on the Child Care and Development Block Grant, including recent changes and revised timelines.
2. To CDE: Is it the department's interpretation that the state must update quality measures in advance of the state plan being in effect by next June 2016?

5. Oversight: State Preschool

Panelists. Monique Ramos, Director of Government Affairs, CDE
Debra McMannis, Director of Early Education and Support Division, CDE

Background. AB 2759 (Jones), Chapter 308, Statutes of 2008, consolidated funding for State Preschool, Pre-kindergarten and Family Literacy, and General Child Care center-based programs to create the California State Preschool Program (CSPP). CSPP provides both child care and early education, and serves eligible three- and four-year old children, with priority given to four-year olds who meet one of the following criteria:

- The family is on aid,
- The family is income eligible (family income may not exceed 70 percent of the state median income, as adjusted for family size),
- The family is homeless, or
- The child is a recipient of protective services or has been identified as being abused, neglected, or exploited, or at risk of being abused, neglected, or exploited.

CSPP may also serve families that have incomes up to 15 percent above the eligibility threshold. Parents do not have to be working to enroll their child in part-day preschool. State Preschool can be offered at a child care center, family child care network home, school district, or county office of education. Around 324 local education agencies (LEAs) serve approximately two-thirds of all children enrolled in State Preschool.

According to 2014 data from CDE, families participate in CSPP for different reasons, such as vocational or college training or employment.

Reasons for Extended Care			
REASON FOR CHILD CARE	Care		
	Full Day	Part Day	Total
CPS	402	83	485
Incapacity of Parent	666	6	672
Employment	31,525	174	31,699
Vocational or College Training/Education	2,859	30	2,889
Both Employment and Training/Education	2,070	24	2,094
Seeking Employment	1,622	25	1,647
Homeless or Seeking Housing	82	14	96
None (Child Attends State Preschool)	0	92,608	92,608
Total	39,226	92,964	132,190

Around 51 percent (67,515 families) of all 132,190 families in CSPP have identified a primary language other than English. Specifically, 17,593 families of 39,226 families (44.9 percent) in full-day CSPP, and

40,398 families of 92,964 families (43.5 percent) in part-day CSPP, identified Spanish as their primary language. Vietnamese (1,650 families), Armenian (1,598 families), and Cantonese (1,467 families) were the next highest languages indicated.

Administration. CSPP, which is administered by Local Educational Agencies (LEAs), colleges, community-action agencies, and private nonprofits, provides both part-day and full-day services with developmentally appropriate curriculum. The Department of Education (CDE) administers CSPP through direct state contracts with local providers. Often, program slots are bundled with other programs to allow for extended or full-day care.

Funding. According to CDE, state preschool programs with no child care costs are around \$21.22 per child per day, approximately \$3,820 per pupil for a 180-day program. For full-day state preschool programs with child care, the average cost is \$34.48 per child per day, or \$8,595 per pupil for 250 days. AB 2759 (Jones), Chapter 308, Statutes of 2008, authorizes contractors to blend state part-day preschool funds and General Child Care programs to provide three- and four-year-olds with State Preschool and wrap-around child care needed to help support working parents.

Capacity. According to CDE, the amounts requested for expansion funding exceeded the allocation, and finds it reasonable to expect that much of the field of contractors and providers are prepared to accommodate additional funding. The department is waiting until it receives more contractor fiscal reports from the third quarter, due April 20, to determine whether part-day funds, restoration, and expansion funding will be fully expended in the current year.

Preschool Expansion Grant. California submitted an application in October 2014 to the United States Department of Education for \$140 million (approximately \$35 million per year for four years) to support development of high-quality, inclusive state preschool programs. In December 2014, California was notified that their application was not accepted. If awarded, the funding would have supported California to provide over 3,700 new and improved preschool spaces for children.

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

Questions

1. To CDE: Please provide an overview of the CSPP program and information about the department's efforts to secure the federal Preschool Expansion Grant.

6. Early Head Start Partnership Grant

Panelists. Monique Ramos, Director of Government Affairs, California Department of Education
Debra McMannis, Director of Early Education and Support Division, CDE

Background. California's Early Head Start-Child Care Partnership (EHS-CCP) grant funds Early Education and Support Division to provide intensive on-site training and technical assistance and grant oversight/monitoring to ensure high-quality early learning development outcomes for infants and toddlers. Specifically, the grant:

- Expands the number of high-quality slots for 260 at-risk infants and toddlers in 11 rural northern California counties.¹³
- Provides financial support to implement the comprehensive services required to reach goals outlined in California's Early Learning Plan.
- Includes Partnering Agencies that did not participate in the Race to the Top-Early Learning Challenge grant (RTT-ELC).
- Bridges the current resource gap needed to reach the high level of quality as defined in the RTT-ELC Quality Rating and Improvement System, California's locally implemented Early Childhood Rating Matrix.

Through the Early Head Start Partnership Grant, services are available for low-income children birth to 36 months in center-based settings, and children up to 48 months in family child care settings

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

Questions

1. Please provide an overview of the grant.

¹³ Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Mendocino, Plumas, Sutter, Trinity, and Yuba counties.

7. Proposals for Investment

The subcommittees received the following budget requests for consideration.

7A. Legislative Women's Caucus

Panelist: Senator Hannah Beth Jackson, District 19

Budget request. The Legislative Women's Caucus requests \$600 million (\$300 million for slots and \$300 million for rates) to improve access and quality of child care and early learning.

7B. Quality Early Education Funding

Panelist: Erin Gabel, Deputy Director, External & Government Affairs, First 5 California

Budget request. Advance Project, Bay Area Council, Children Now, Early Edge California, First 5 Association of California, First 5 California, First 5 LA, and Los Angeles Area Chamber of Commerce request the following:

- Expand to include 10,500 preschool slots, starting June 2015, and enact budget bill language with legislative intent to fund the remaining 10,500 slots.
- Expand to include 10,500 infant and toddler slots.
- Increase the Standard Reimbursement Rate; increase the infant multiplier from 1.7 to 2.3, and increase the toddler multiplier from 1.4 to 1.8.
- Increase and extend the QRIS block grant to infant and toddler providers.
- Create an Early Care and Education professional development community college workgroup to support colleges in strengthening the quality and alignment of their Child Care and Development programs.
- Fund California Child Care and Development Block Grant compliance activities through General Fund, not as part of the Child Care and Development Fund quality dollars.

7C. San Francisco Child Care Pilot Project

Panelist: Graham Dobson, Administrative Analyst, Office of Early Care and Education, City and County of San Francisco

Budget request. Repeal sunset of San Francisco Child Care Pilot.

7D. Trailer Bill: License-Exempt Care Rates
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Panelist: California Child Care Alliance of Los Angeles

Budget request.

- Adopt trailer bill language to require CDE and DSS to ensure that the part-time hourly rate for license exempt care and all other rates for license exempt care align with the statutory requirements.
- Increase the percentage from 60 percent of the Licensed Family Child Care rate.

7E. Proposition 98 Funds for Technology Grants for Child Care and Development Contractors
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Panelist: California Child Care Alliance of Los Angeles

Budget request. \$20 million Proposition 98 to fund one-time information systems and technology updates for all Early Education and Support Division contractors.

7F. Trailer Bill: Increase Alternative Payment Contract Administration Rates

Panelist: Northern Directors Group

Budget request. Increase the alternative payment agencies' contract administration rate with the following trailer bill language:

Education Code 8223. The reimbursement for alternative payment programs shall include the cost of child care paid to child care providers plus an amount not to exceed 19.5 percent of the total contract amount for administration and direct support services. Up to 10 percent may be used for administration and up to 15 percent for direct support services ~~the administrative and support services costs of the alternative payment program. The total cost for administration and support services shall not exceed an amount equal to 17.5 percent of the total contract amount.~~ The administrative costs shall not exceed the costs allowable for administration under federal requirements.

7G. State Median Income

Panelist: Parent Voices

Budget request. Update the state median income based on the most recent data.

7H. Trailer Bill: Child Care Law Center

Panelist: Anna Levine, California Child Care Law Center

Budget request. Amend Senate Bill 69, 6100-194-0001, Provision 8:

Notwithstanding any other provision of law, the funds in Schedule (6) are reserved exclusively for ~~continuing~~ child care for the following: (a) former CalWORKs families who ~~are working,~~ have left cash aid, and ~~have exhausted their two-year eligibility for transitional services in either Stage 1 or Stage 2 pursuant to subdivision (c) of Section 8351 or Section 8353 of the Education Code, respectively, but~~ still meet eligibility requirements for receipt of subsidized child care services, and (b) families who received lump-sum diversion payments or diversion services under Section 11266.5 of the Welfare and Institutions Code and ~~have spent two years in Stage 2 off of cash aid, but still~~ meet eligibility requirements for receipt of subsidized child care services.

Staff Comment and Recommendation. **Hold open** all above proposals for further review and consideration.

Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.



April 23, 2015

9:30 a.m. or Upon Adjournment of Session

Room 4203, State Capitol

Agenda

Part A

(Michelle Baass)

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PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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. Thank you.

4265 Department of Public Health

1. Oral Health Program

Oversight Issue. The 2014 budget included \$474,000 (\$250,000 General Fund and \$224,000 in reimbursements, federal funds from the Department of Health Care Services) to establish a State Dental Director, add an epidemiologist, and provide related consulting services to re-establish a statewide oral health program.

With these resources, DPH proposed to develop a Dental Burden of Disease Report which would help identify dental health issues, disease burden, facts and figures of dental disease, and capacity to address the burden. The report would be the foundation for the development of the State Dental Plan (plan). The plan would serve as the roadmap for California's short-term, intermediate, and long-term priorities, goals, and objectives to address dental disease burden and prevention.

DPH notes the following activities have been accomplished since approval of the 2014 budget request:

- The Oral Health Program (OHP) website was developed.
- The Oral Disease Burden Report is under development.
- Program staff has been meeting with the consultant to plan the first advisory committee meetings. A tentative meeting date is scheduled for June 2015.
- Research on other states oral health plans and determining best practices has been initiated.
- Research on current state and other states dental policy strategies, evidence-based community prevention and care systems was initiated.
- Research on basic elements of a state oral health surveillance system, logic models, and evaluation measures has been conducted.

Despite these activities, DPH is behind in accomplishing the goals set forth in last year's proposal. For example, DPH is projecting that it will complete the State Dental Plan in June 2016 instead of June 2015. See below for updated program timeline with originally proposed dates and projected new dates.

Table: Updated Oral Health Program Timeline

Objectives and Activities	Original Date	New Date
Program Leadership		
Recruit, hire and orient Dental Director	10/2014	06/30/2015
Recruit, hire and orient Epidemiologist		Complete
Develop and execute two contracts (Cal EIS Fellow, California State University Sacramento)		Complete
Orient Cal EIS Fellow		Complete
Oversee administrative and fiscal activities		Ongoing
Partnerships and Coalition		
Convene Dental Program Advisory Committee	12/2014	6/30/2015*
Participate in Chronic Disease Branch Communications, Health Care Systems/Community Prevention Workgroups		Ongoing
Participate in Chronic Disease Branch Evaluation, Surveillance and Epidemiology Workgroups		Ongoing
Convene first Coalition Meeting		09/30/2015
Convene an ongoing Coalition Workgroup to develop the State Dental Plan		09/30/2015
Convene second Coalition Meeting		02/29/2016
Develop and implement a Dental Program Communications Strategy		09/30/2015
Capacity Assessment		
Assess current resources and strategies in dental policy, care systems, community prevention and communications		Ongoing
Assess current resources and strategies in dental surveillance/epidemiology		Complete
Create Dental Program website, with information resources	12/2014	Complete
Finalize Capacity Report (result of assessments)		09/30/2015
State Dental Plan		
In conjunction with Coalition members, develop a Dental State Plan Framework		09/30/2015
In conjunction with Coalition members, develop a Draft Dental State Plan		02/29/2016
Finalize Dental State Plan	6/2015	06/30/2016
Implement plan, including benchmarks and evaluation measures		Ongoing
Surveillance/Epidemiology		
Assess current data sets		Complete
Analyze data and write narrative		Complete
Develop a Draft Dental Burden of Disease Report		Complete
Finalize Dental Burden of Disease Report	3/2015	06/30/2015
Evaluation		
Develop a Dental Program Logic Model		04/30/2015
Develop Dental Program Performance Measures		04/30/2015
Track Dental Program Performance Measures and write Report		Ongoing
Report on Dental Program Performance Measures		6/30/2016 & Ongoing

*Could be moved to July 2015 if Dental Director is not hired in June.

Subcommittee Staff Comment and Recommendation—Informational Item. As noted above, the core activities of this program have been delayed. This means that the implementation of innovative policies and strategies to improve the state’s oral health condition are postponed.

Additionally, given the concerns raised by the recent State Auditor Report on the Denti-Cal program, as discussed at this Subcommittee’s hearing on March 19, 2015, proactive collaboration between the Oral Health Program and Denti-Cal should be a high priority. For example, DPH’s Oral Disease Burden Report that is expected to be completed by June should contain delineated information about the Medi-Cal program, so that the state can understand how Medi-Cal enrollees’ oral health conditions compare to the other California residents.

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

1. Please provide an update on the Oral Health Program and highlight key accomplishments in the last year.
2. What are the reasons for the delays in activities regarding this program?
3. Is DPH’s Oral Health Program working with the Department of Health Care Services to identify dental health issues, disease burden, facts and figures of dental disease, and capacity to address the burden related to the Medi-Cal program? Please explain.

2. Office of Health Equity

Background. AB 1467 (Committee on Budget), Chapter 23, Statutes of 2013 created the Office of Health Equity (OHE) at DPH. The OHE was created by consolidating the following entities:

- Office of Multicultural Health at DPH
- Office of Women’s Health at the Department of Health Care Services (DHCS)
- Office of Multicultural Services at the Department of Mental Health (this department was eliminated in 2012)
- Health in All Policies Task Force at DPH
- Healthy Places Team at DPH

OHE was tasked to accomplish all of the following:

- 1) Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically-isolated communities;
- 2) Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;
- 3) Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically-competent health and mental health care and services; and
- 4) Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.

OHE Budget. See following table for a summary of OHE’s budget.

Table: Office of Health Equity’s Budget Summary

Fund	2014-15	2015-16
General Fund	\$362,000	\$362,000
Air Pollution Control Fund	\$111,000	\$112,000
Cigarette and Tobacco Surtax Fund, Unallocated Account	\$222,000	\$221,000
Federal Trust Fund	\$315,000	\$191,000
Mental Health Services Fund	\$18,557,000	\$50,072,000
Cost of Implementation Account, Air Pollution	\$211,000	\$210,000
Grand Total	\$19, 776,000	\$51,167,000

Overdue Report. OHE is required to develop a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities in collaboration with external and internal stakeholders. The strategies and recommendations developed will take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan will establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. OHE will seek input from the public on the plan through an inclusive public stakeholder process.

This report was due by July 1, 2014 but has not yet been finalized. DPH indicates that the review and approval process is underway for the draft document, "Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity."

California Reducing Disparities Project (CRDP). One of OHE's responsibilities is the CRDP. The CRDP is a statewide policy initiative (funded with Mental Health Services Act Funds—Proposition 63) to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system.

The project focuses on five populations: African-American; Latino; Native American; Asian and Pacific Islander; and Lesbian, Gay, Bisexual, Transgender, and Questioning individuals. These groups produced population-specific reports that formed the basis of a statewide comprehensive strategic plan on reducing disparities.

All of the five population reports have been approved and posted on the DPH website. Recommendations from these reports will be incorporated into a comprehensive draft strategic plan. Once finalized, the California Reducing Disparities (CRD) Strategic Plan will be used as a guide to identify new service delivery approaches from multicultural communities using community-defined evidence to improve outcomes and reduce disparities. Furthermore, the strategic plan will serve as a blueprint to implement these strategies at the local level.

In early May of 2015, DPH anticipates the release of multi-component solicitations for the California Reducing Disparities Project (CRDP), Phase II. Phase II will provide four years of funding, totaling \$60 million to implement the practices and strategies identified in the CRDP Strategic Plan. The focus of Phase II will be on demonstrating the effectiveness of community-defined evidence in reducing mental health disparities. The CDPH plans to fund selected approaches across the five CRDP-targeted populations: Native Americans, Latinos, Asian/Pacific Islanders, African Americans, and Lesbian, Gay, Bisexual, Transgender, and Questioning with strong evaluation, technical assistance, and infrastructure support components.

There will be approximately five solicitations released under the CRDP Phase II, beginning in early May 2015. CDPH will fund the following:

- One Statewide Evaluator (SWE) contract (award 8/2015);
- Five Technical Assistance Provider (TAP) contracts (award 8/2015);
- Fifteen Capacity Building Pilot Projects (CBPP) grants (award 9/2015);
- Twenty Implementation Pilot Projects (IPP) grants (award 9/2015); and
- The Education, Outreach and Awareness solicitation is still in development.

Table: CRDP Funding Projections for Phase I and Phase II

	2012-13	2013-14	2014-15	2015-16
Phase I				
Appropriated	\$2,349,000	\$2,201,000	\$3,557,000	\$3,557,000
Expenditures	2,280,000	1,510,000	*\$3,557,000	\$3,557,000
Balance	\$69,000	\$691,000	-	-
Phase II				
Carryover	-	\$15,000,000	\$30,000,000	\$45,000,000
Appropriated	\$15,000,000	\$15,000,000	\$15,000,000	\$15,000,000
Expenditures	-	\$0	\$0	**\$15,000,000
Balance	\$15,000,000	\$30,000,000	\$45,000,000	\$45,000,000

* Expenditure report as of February 28, 2015 is \$1,626,000.

**It is anticipated that \$15 million of MHSA funds will be expended in 2015-16, however DPH indicates that there is a possibility that a small portion of the fund may need to be carried over into 2016-17 should there be delays in issuing the final solicitation (Education, Outreach and Awareness).

Subcommittee Staff Comment and Recommendation—Informational Item. The 2012 budget provided DPH with \$60 million in Proposition 63 funding to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system. DPH has not yet awarded any of these funds. While DPH has been complimented by various stakeholders on conducting an inclusive and thoughtful process regarding the California Reducing Disparities Project, the delay in awarding these funds has postponed the ability of these funds to make any impact on the improvement of the public mental health system.

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

1. Please provide an update on the activities of the Office of Health Equity.
2. Please provide an update on the status of the California Reducing Disparities Project. Please explain why it has taken DPH so long to make progress on this effort.
3. Please provide an update on the overdue report (due July 2014) regarding OHE’s strategic plan to eliminate health and mental health disparities and inequities. Why isn’t this report completed? When does DPH expect to submit this report to the Legislature?

3. Richmond Laboratory – Capital Outlay

Budget Issue. DPH requests a capital outlay appropriation in the amount of \$4,333,000 General Fund to fund a construction project at the Viral and Rickettsial Diseases Laboratory (VRDL) in Richmond, California to meet current guidelines for Bio-safety Level 3 (BSL-3) laboratory requirements as determined by the United States, Centers for Disease Control (CDC) and the National Institutes for Health (NIH).

According to DPH, compliance of the CDC and NIH guidelines is essential for the DPH to maintain its BSL-3 certifications of the VRDL. Enhancements will require design and construction to modify VRDL areas such as: Unidirectional shower-out capacity, hands free faucets, pass-through autoclave sterilizer, an equipment decontamination area, High-Efficiency Particulate Absorption (HEPA) filtration of exhaust side of Heating Ventilation and Air Conditioner (HVAC) system, positive sealing dampers on HVAC system and through-wall ports for the safe gaseous decontamination of the laboratory, and electronic monitoring systems within the HVAC system.

Background. DPH's Richmond Campus is a multi-use laboratory/office complex located at 850 Marina Bay Parkway in Richmond, California. The secured campus has six laboratories, approximately 400,000 square feet of offices, a warehouse, and an animal care facility. The six laboratories are used by various CDPH programs involved in the review and analysis of agents from communicable diseases to environmental toxins.

The VRDL is a BSL-3 certified laboratory and serves as the state's reference laboratory to handle BSL-3 select agent and viruses. Select agent viruses that require BSL-3 facilities include but are not limited to, hantavirus, poxviruses, novel influenza (e.g. avian influenza viruses), Middle East Respiratory System (MERS)-CoV, Severe Acute Respiratory System (SARS), Chikungunya virus, Japanese encephalitis virus and West Nile virus. DPH finds that an operational BSL-3 laboratory is needed to be able to identify these viruses for the important public health mission preparing for and responding to deadly emerging viral diseases.

At the time of construction (2000), the Richmond Campus VRDL laboratory was designed to meet the existing BSL-3 requirements as determined by CDC and NIH. However in 2006, the CDC/NIH implemented an enhanced BSL-3 requirement for BSL-3 laboratories. The CDC/NIH BSL-3 enhancement was in response to reports in 2003 and 2004 from the World Health Organization (WHO) that the Avian flu was spreading from Asia to Europe and Africa.

In response to the enhanced BSL-3 requirement, in 2006-07 DPH through the Department of General Services (DGS) contracted with the engineering firm of CUH2A to conduct an evaluation of the VRDL laboratory and identify the upgrades needed to meet the enhanced BSL-3 requirements. CUH2A evaluated the VRDL laboratory and identified that to meet the new enhanced BSL-3 requirements the VRDL laboratory would need retrofits to the existing infrastructure to provide the following capabilities:

- Unidirectional shower with in/out capabilities.
- Pass-through autoclave sterilizer.
- An equipment decontamination area.

- Upgraded high-efficiency particulate absorption (HEPA) filtration of the exhaust side of the heating ventilation and air conditioner (HVAC) system.
- Positive sealing dampers on the HVAC system and through-wall ports for the safe gaseous decontamination of the laboratory.
- Electronic monitoring systems within the HVAC system.
- Mechanical/Valve Room changes to support the laboratory.

To accommodate the above requirements, CUH2A determined that the following infrastructure changes would be needed to the VRDL laboratory:

- Expand the VRDL BSL-3 suite from 1,210 to approximately 2,000 square feet.
- Modify the laboratory's HVAC mechanical and other related building operating systems to provide enhanced filtering capabilities
- Deconstruct some existing wall(s).
- Construction of new walls to create new containment area(s).

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal, no issues have been raised.

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

1. Please provide an overview of this proposal.
2. Please explain why DPH finds it critical that this projected be funded now. How has the state managed without the enhancements outlined in this proposal?

4. Women, Infant, and Children Program

Budget Issue. DPH requests approximately \$1.2 billion in federal trust fund and \$242 million in Women, Infant, and Children (WIC) Manufacturer Rebate Special Fund for 2015-16. As shown in the table below, the WIC estimate proposes total expenditures of \$1,188,528,224 in 2015-16, a \$28.5 million (2.5%) increase over the revised estimate for 2014-15, and a \$1.6 million (0.14%) decrease from the 2014 budget act

Table: WIC Expenditure Summary

	2014-15 Budget Act	2014-15 Estimate	2015-16 Proposed	BA to BY Change	% Change
Local Assistance	\$1,136,320,825	\$1,106,113,677	\$1,134,668,224	-\$1,652,601	-0.15%
State Operations	\$53,860,000	\$53,860,000	\$53,680,000	\$0	0%
Total Expenditures	\$1,190,180,825	\$1,159,973,677	\$1,188,528,224	-\$1,652,601	-0.14%

DPH estimates that about 1,389,906 WIC participants will access food vouchers in 2014-15 and 1,403,786 participants in 2015-16.

Background on WIC Funding. DPH states that California's share of the national federal grant appropriation is at about 17 percent. Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

- **Food.** Funds that reimburse WIC authorized grocers for foods purchased by WIC participants.
- **Nutrition Services and Administration.** Funds that reimburse local WIC agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition, education, breastfeeding support, and referrals to health and social services, as well as support costs.
- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with Infant Formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down federal WIC food funds.

Background on WIC Program. WIC is 100 percent federal fund supported. It provides supplemental food and nutrition to low-income women (185 percent of poverty or below) who are pregnant, breastfeeding, non-breastfeeding postpartum women, infants, and children under age five who are at nutritional risk. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

WIC participants are issued paper vouchers by local WIC agencies to purchase approved foods at authorized stores. Examples of foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amount and type of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support, and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged as being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

Maximum Reimbursement Rate Methodology. The maximum amount that vendors are reimbursed for WIC food is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances (referred to as MADR). Effective May 25, 2012, the USDA directed CA WIC to remove 1-2 and 3-4 case register WIC vendors from the MADR-determination process and instead set MADR for these vendors at a certain percentage higher than the average redemption value charged by vendors with five or more registers in the same geographic region. The USDA was concerned that California was paying 1-2 and 3-4 cash register stores up to 50 percent higher than prices paid to other vendors.

WIC Vendor Moratorium. WIC implemented a vendor moratorium in April 2011 so that it could address the backlog in new vendor applications. In April 2012, USDA directed California to maintain the moratorium until the peer group and reimbursement rate regulations (discussed above) are in effect. This moratorium has been lifted in phases over the past year... As of February 1, 2015, the moratorium was lifted fully for all types of new stores. Although new stores have come into the program, the overall number of WIC stores has declined, in part due to stores closing in response to the new reimbursement system put into place.

Electronic Benefit Transfer for WIC. In June 2015, DPH plans to formally release a Request for Proposal (RFP) for Electronic Benefit Transfer (EBT) services. DPH is partnering with Supplemental Nutrition Assistance Program/CalFresh on this procurement. WIC is moving to replace its current paper vouchers with EBT cards, per U.S. Department of Agriculture's mandate that all states move to EBT by October 1, 2020. When California moves to EBT for WIC, participants will continue to have regular appointments at the WIC sites to receive the same services that local agencies currently provide. Although SNAP and WIC are joining efforts for the RFP, the two programs will have separate EBT cards for their recipients.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as this estimate will be updated in the May Revision.

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

1. Please provide a brief summary of the WIC budget.
2. Please discuss steps DPH is taking to analyze participation in WIC and make improvements in program participation.

5. California Home Visiting Program

Budget Issue. DPH requests \$697,000 in federal funds in 2015-16 to extend 11.0 positions for three years and \$27,490,000 in federal funds in 2016-17 to extend an additional 16.0 positions for three years and provide \$24 million (federal funds) in local assistance annually for three years for the California Home Visiting Program (CHVP).

Background. CHVP was created as a result of the federal Affordable Care Act (ACA) of 2010. Section 2951 of the ACA established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program grant. In addition, California Health and Safety Code Section 123491 states that a voluntary home visiting program for expectant first-time mothers and their children be administered by CDPH. CHVP's mission is to provide leadership for integrated, collaborative, high-quality, maternal and early childhood interventions across multiple systems of health and human services to address the complex needs of diverse, high-risk pregnant and parenting women in California. Home visiting has been shown to lower rates of the following: childhood injuries including child maltreatment; infant mortality; emergency department visits; language delays in children; and subsequent pregnancies (lengthen inter-birth intervals). Home visiting has been shown to increase the following: prenatal care; breastfeeding; well-child visits; and school readiness.

The CHVP focus is to provide comprehensive, coordinated, in-home services to support positive parenting and to improve outcomes for families residing in identified at-risk communities. CHVP is an evidence-based, voluntary program offered to pregnant women and their children from birth to age 3. CHVP has sites in 22 local health jurisdictions (LHJs) that are located in 21 counties which provide services using one of two evidence-based, federally approved home visiting models: (1) Healthy Families America (HFA); and (2) Nurse Family Partnership (NFP). These two models were two of six approved models from which HRSA allowed states to choose. The grant funds provide funding to HFA and NFP in the state and LHJs for implementation and administration of home visiting programs at the local level. Programs are required to target participant outcomes which include the six federally-mandated benchmark areas: (1) improved maternal and newborn health; (2) prevention of child injuries, child abuse, neglect or maltreatment and reduction of emergency department visits; (3) improvements in school readiness and achievements; (4) reduction in domestic violence; (5) improvements in family economic self-sufficiency; and (6) improvements in the coordination and referrals for other community resources and supports. To date, the 22 CHVP sites have performed 30,296 home visits and 2,577 clients have been enrolled in the statewide program.

CPH was awarded MIECHV Program grants in 2010-11 and 2011-12 and received approval in 2010-11 and 2011-12 for 36.0 five year limited-term positions for the CHVP. To develop the appropriate home visiting models, develop fiscal reporting and compliance policies and procedures and program management, DPH requested and received approval to administratively establish 12.0 of the 36.0 positions on February 1, 2011. The remaining 24.0 positions were established on July 1, 2011. This proposal is requesting 27.0 three year limited-term positions instead of the original 36.0 due to a funding adjustment by HRSA.

The LHJs administer the home visiting program through their county departments of public health where they provide primary oversight of all home visiting activities. The \$24,000,000 in local assistance

funding to the LHJs provides the needed funding to employ four to five home visitors and one supervisor per site (22 sites). This funding is also used for the infrastructure needed to successfully run a CHVP program within the county.

On an annual basis, CHVP submits benchmark data into the federal reporting system. These data have been collected throughout the year by the LHJs who continuously enter the data into the statewide data system. CHVP monitors, analyzes, and reports to HRSA every October and has successfully done so over the past three federal reporting year cycles. CHVP also analyzes all quantitative and qualitative data for bi-annual federal progress reports that also include the budgets for CHVP and all 22 sites. Over the past three federal reporting-year cycles, CHVP has successfully met all federally-mandated reporting requirements.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. No issues have been raised.

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

1. Please provide an overview of this proposal.
2. Please provide an update on the federal appropriation of these funds.

6. Ebola Emergency Preparedness

Budget Issue. Through an April Finance Letter, DPH requests an increase of \$15.45 million in federal fund expenditure authority in 2015-16 to support accelerated state and local public health preparedness and operational readiness for responding to the Ebola virus. DPH will also receive \$250,000 in Ebola grant funds each year from 2016-17 to 2019-20.

Background. DPH's Emergency Preparedness Office 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 that support the department's emergency preparedness activities.

The Emergency Preparedness Office is funded primarily by federal Public Health Emergency Preparedness and Hospital Preparedness Program funds. These funds provide operational support to the department, which is responsible for the public health response to emergencies, including coordination between public health and medical care responsibilities. The surveillance of infectious diseases, detection and investigation of outbreaks, identification of etiologic agents and their modes of transmission, development of prevention and control strategies, and providing the public with accurate and timely information on the public health implications of emergencies are the responsibility of DPH and local health departments.

Since October 2014, California has implemented a robust program of preparedness and response for Ebola both at the state, local, and healthcare provider levels. The California Ebola program plan, protocols, and procedures have been coordinated with the operational and emergency response plans for the state, including activation of state and local emergency operations centers in keeping with established communicable disease outbreak response plans. DPH, in collaboration with the 61 local health departments, has implemented a traveler monitoring system to ensure active monitoring, investigation of, and locating any individual who is "lost" or not identified by the federal Centers for Disease Control and Prevention (CDC) but arrives in the jurisdiction, and a process to address noncompliant individuals.

The department, working closely with the California Emergency Medical Services Authority, local health departments, and healthcare systems, has identified eight Ebola treatment hospitals and is in the process of identifying regional Ebola assessment hospitals for the care of suspected/confirmed Ebola cases. The department established and maintains a 24/7 contact number for local health departments and clinicians to report traveler symptoms and consult with a public health clinician on suspected and confirmed cases, and maintains an Ebola hotline (telephone and email system) for questions from the general public. Local health departments have conducted drills focused on the safe and efficient transportation of suspected/confirmed Ebola cases to appropriate facilities. DPH and local health departments have worked with hospitals to ensure preparedness to evaluate, isolate, obtain, and ship laboratory specimens to Laboratory Response Network-certified laboratories able to test for Ebola, after consultation with the CDC.

There are currently four laboratories in California that are able to test for Ebola, including the DPH's laboratory in Richmond, the Los Angeles County Public Health Laboratory, the Sacramento Public

Health Laboratory and the Orange County Public Health Laboratory. California quickly responded to the possible public health threat of Ebola, collaborating with partners across the disciplines and agencies, preparing for the monitoring and management of travelers, and preparing for the care of any suspect or confirmed Ebola case. These activities will continue to be sustained throughout the project period and expanded to ensure protection of the public's health.

The threat of Ebola is a top national public health priority. To ensure that state and local health departments continue to actively monitor travelers and conduct surveillance of Ebola, and to ensure that the healthcare system can assess and treat suspect and confirmed Ebola patients, the federal government is providing \$145 million from the CDC for Public Health Emergency Preparedness and \$162 million in Part A Hospital Preparedness Program Ebola supplemental funding to existing awardees.

Public Health Emergency Preparedness supplemental Ebola funding supports state and local public health preparedness planning and operational readiness for responding to Ebola. The funding is intended to:

- Support accelerated public health preparedness planning for Ebola within state, local, territorial, and tribal public health systems;
- Improve and assure operational readiness for Ebola;
- Support state, local, territorial, and tribal Ebola public health response efforts; and
- Assure collaboration, coordination, and partnership with the jurisdiction's healthcare system to assist in the development of a tiered system for Ebola patient care.

The PHEP Ebola supplemental funding budget period and project period are 18 months: April 1, 2015 through September 30, 2016. The precise award date is unknown at this time. DPH will receive \$7.6 million to support activities in all California counties except Los Angeles, which will receive \$3.2 million directly from the CDC. Funding can be used by the state and local health departments to build preparedness capabilities in the following areas: Community Preparedness, Public Health Surveillance and Epidemiological Investigation, Public Health Laboratory Testing, Non-Pharmaceutical Interventions, Public Health Responder Safety and Health, Emergency Public Information and Warning/Information Sharing, and Medical Surge.

Hospital Preparedness Program funds support hospitals, clinics and other health care facilities and emergency medical services systems to respond to any suspected Ebola case. The United States Department of Health and Human Services is awarding a total of \$194.5 million in funding for Ebola healthcare system preparedness and response and the development of a regional Ebola treatment strategy across the 50 states and multiple territories. This funding is available over a five-year period with the expectation that most of the funds will be expended in the first year to build capacity. The application is due to the federal government on April 22, 2015 with an anticipated award date after May 18, 2015. The funding is divided into two parts: Part A funds are provided to support infrastructure costs, staff training, personal protective equipment, and annual exercises for California's identified Ebola treatment and assessment hospitals, outside of Los Angeles, to ensure readiness to respond to Ebola virus disease over the five-year project period. DPH will receive \$5.6 million in Part A funding and Los Angeles will receive \$2.2 million directly to address Ebola Treatment and Assessment Centers located in Los Angeles. Part B funds are provided on a competitive basis to states at high risk, such as California, to build a regional treatment center in each of the ten Health and Human Services regions creating a nationwide, regional treatment network for Ebola and other infectious diseases (\$2.25 million in year

one followed by \$250,000 each year for four additional years). California will receive a total of \$7.85 million in Part A and B funding in year one.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. No issues have been raised.

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

1. Please provide an overview of this proposal.

7. Proposition 99 - California Tobacco Health Protection Act of 1988

Budget Issue. The Governor’s budget projects an \$8.24 million increase in the Proposition 99 Health Education Account as a result of updated revenue projections and lower than originally projected prior year actual expenditures. DPH requests the following increases in expenditures in Proposition 99’s Health Education Account:

Line Item	Proposed Increase	Proposed Use of Funds
State Operations	\$471,000	The funds will be used to enhance administrative oversight and programmatic functions related to the statewide media campaign, community grants, and surveillance aimed at preventing and reducing tobacco use. Activities include processing grants and contracts, providing training and technical assistance to community-based organizations, implementing a statewide media campaign, and monitoring tobacco use.
Media Campaign	\$3,188,000	The funding will be used for tobacco education advertising to rural markets and increase ethnic media to reach populations that smoke at higher rates.
Competitive Grants	\$1,579,000	The funding will be made available to applicants applying for Request for Application 15-100 – Achieving Tobacco-Related Health Equity among California’s Diverse Populations (which will fund 25 to 35 five-year grants) for the period July 1, 2015 to June 30, 2020; provide training and technical assistance related to the Healthy Stores for a Healthy Community campaign; emphasize tobacco addiction in the behavioral health population; and promote a system within pharmacies and health plans to support the provision of cessation treatment.
Local Lead Agencies	\$2,773,000	This appropriation funds local health department tobacco control programs based on an allocation formula specified in legislation. As a result of this increase, the following 13 local lead agencies will receive additional funding: Alameda, Fresno, Los Angeles, Long Beach, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, Solano, and Sonoma.

Evaluation	\$526,000	These funds will continue to support the Behavioral Risk Factor Surveillance System (BRFSS)/California Adult Tobacco Survey (CATS), conduct a one-time surveillance of the illegal sales of electronic nicotine delivery devices/electronic cigarettes to youth, and field a public opinion poll related to emerging issues such as electronic cigarettes.
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Background. In November 1988, California voters approved the California Tobacco Health Protection Act of 1988, also known as Proposition 99. This initiative increased the state cigarette tax by 25 cents per pack and added an equivalent amount on other tobacco products. The new revenues were earmarked for programs to reduce smoking, to provide health care services to indigent persons, to support tobacco-related research, and to fund resource programs for the environment. The money is deposited by using the following formula: 20 percent is deposited in the Health Education Account (HEA); 35 percent in the Hospital Services Account; 10 percent in the Physician Services Account; 5 percent in the Research Account; 5 percent in the Public Resources Account; and 25 percent in the Unallocated Account (Revenue and Taxation Code 30124).

E-Cigarettes. DPH uses Proposition 99 cigarette tax revenues for efforts to prevent and reduce the use of tobacco, including e-cigarettes. Since 2010, Proposition 99 funds have been used by local lead agencies and competitive grantees to conduct presentations to community groups, youth, college students and others regarding e-cigarettes as a newly emerged tobacco-related product containing nicotine and concerns about its escalating use among youth and young adults. In 2011, DPH added e-cigarette questions to the California Tobacco Advertising Survey to monitor the extent to which tobacco retailers sold e-cigarettes. In 2013, questions about e-cigarette use were added to adult tobacco use surveys. Similar questions will be added to the 2015 California Student Tobacco Survey. Additionally, in 2013, DPH began conducting focus groups with adults to qualitatively assess knowledge, awareness, and how e-cigarettes are being used by smokers and non-smokers. In January 2015, CDPH released a health advisory related to e-cigarettes and released the State Health Officer’s Report on E-Cigarettes. Finally, in March 2015, DPH launched its statewide advertising campaign to inform the public about the dangers of e-cigarettes.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve these changes.

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

1. Please provide a brief review of the changes in expenditures for the Health Education Account
2. Please provide an overview of DPH’s efforts to inform the public about the dangers of e-cigarettes.
3. How did DPH work with stakeholders on its efforts to inform the public about the dangers of e-cigarettes?

4260 Department of Health Care Services

1. Family Health Programs

Budget Issue. The DHCS Family Health Estimate covers the non-Medi-Cal budgets of the following four programs: 1) California Children's Services (CCS); 2) Children's Health & Disability Program (CHDP); 3) Genetically Handicapped Person's Program (GHPP); and 4) Every Woman Counts (EWC).

Table: Family Health Estimate Summary

Program	Budget Act 2014-15	Projected 2014-15	Proposed 2015-16	CY to BY \$ Change
CCS	\$95,781,000	\$92,995,000	\$91,291,000	-\$1,704,000
CHDP	1,713,000	1,662,000	1,677,000	\$15,000
GHPP	128,739,000	130,915,000	136,337,000	\$5,422,000
EWC	58,583,000	54,311,000	42,356,000	-\$11,955,000
TOTAL	\$284,816,000	\$279,883,000	\$271,661,000	-\$8,222,000

California Children's Services (CCS)

Background. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to: chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, and cancer; traumatic injuries; and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools.

CCS is administered as a partnership between county health departments and the DHCS. Historically, approximately 70 percent of CCS-eligible children are Medi-Cal eligible; their care is paid for with state-federal matching Medicaid funds. The cost of care for the other 30 percent of children had been split equally between "CCS Only" and "CCS Healthy Families." The cost of care for CCS-only is funded equally between the state and counties. The cost of care for CCS Healthy Families children is funded 65 percent federal Title XXI, 17.5 percent State, and 17.5 percent county funds, even though these children have transitioned into Medi-Cal.

CCS Budget. Excluding Medi-Cal costs, the proposed 2015-16 CCS budget is \$91.3 million (\$17 million General Fund), as compared to the 2013-14 estimate of \$132 million (\$12.4 million General Fund).

Table: CCS Budget Summary (Non-Medi-Cal)

	2014-15	2015-16
Total	\$92,994,800	\$91,290,600
Federal Funds	\$65,635,300	\$4,578,000
General Fund	\$27,359,500	\$86,712,600

The non-Medi-Cal caseload is 16,062 for 2014-15 and 16,303 for 2015-16. The Medi-Cal caseload is 161,788 for 2014-15 and 164,268 for 2015-16.

CCS Carve Out and Redesign. For many years, the CCS program has operated as a managed care "carve-out," such that children who qualify for CCS services receive those services on a fee-for-service basis, through a network of specialty care providers, all of which is outside of any managed care plan. The most recent extension of the carve-out was approved through AB 301 (Pan), Chapter 460, Statutes of 2011, which extended the sunset on the carve-out until January 1, 2016.

In the fall of 2014, DHCS began a stakeholder process regarding the redesign of the CCS program and anticipates developing a proposal in the summer. The goals of the design process are:

1. Implement Patient and Family Centered Approach: Provide comprehensive treatment, and focus on the whole-child rather than only their CCS eligible conditions.
2. Improve Care Coordination through an Organized Delivery System: Provide enhanced care coordination among primary, specialty, inpatient, outpatient, mental health, and behavioral health services through an organized delivery system that improves the care experience of the patient and family.
3. Maintain Quality: Ensure providers and organized delivery systems meet quality standards and outcome measures specific to the CCS population.
4. Streamline Care Delivery: Improve the efficiency and effectiveness of the CCS health care delivery system.
5. Build on Lessons Learned: Consider lessons learned from current pilots and prior reform efforts, as well as delivery system changes for other Medi-Cal populations.
6. Cost-Effective: Ensure costs are no more than the projected cost that would otherwise occur for CCS children, including all state-funded delivery systems. Consider simplification of the funding structure and value-based payments, to support a coordinated service delivery approach.

Children's Health & Disability Program (CHDP)

Background. CHDP provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. CHDP oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

In July 2003, CHDP began using the "CHDP Gateway," an automated pre-enrollment process for non-Medi-Cal, uninsured children. The CHDP Gateway serves as the entry point for these children to enroll in ongoing health care coverage through Medi-Cal or formerly the Healthy Families program.

CHDP Budget. The proposed CHDP budget includes \$1.677 million (\$1.6 million General Fund and \$11,000 Childhood Lead Poisoning Prevention Fund), as compared to the current year estimate of \$1.662 million (\$1.65 million General Fund and \$11,000 Childhood Lead Poisoning Prevention Fund).

Genetically Handicapped Person's Program (GHPP)

Background. GHPP provides medical care for adults with specific genetically-handicapping conditions. Hemophilia was the first medical condition covered by the GHPP and legislation over the years has added other medical conditions including Cystic Fibrosis, Sickle Cell Disease, Phenylketonuria, Huntington’s disease, and Von Hippel-Lindau Disease.

The mission of GHPP is to promote high quality, coordinated medical care through case management services through:

- Centralized program administration;
- Case management services;
- Coordination of treatment services with managed care plans;
- Early identification and enrollment into the GHPP for persons with eligible conditions;
- Prevention and treatment services from highly-skilled Special Care Center teams; and,
- Ongoing care in the home community provided by qualified physicians and other health team members.

GHPP Budget. The proposed 2015-16 GHPP budget includes total funds of \$136.3 (\$118.3 million General Fund), compared to the 2014-15 estimate of \$130.9 million (\$67.2 million General Fund). The increase in General Fund is to account for the expected loss of federal Safety Net Care Pools funds as part of the state’s Section 1115 Medicaid Waiver Renewal proposal.

Table: GHPP Caseload

	2014-15	2015-16
GHPP State Only	946	967
GHPP Medi-Cal	866	905
Total	1,812	1,872

Every Woman Counts (EWC)

Background. The EWC provides breast and cervical cancer screenings to Californians who do not qualify for Medi-Cal or other comprehensive coverage. The EWC was transferred to DHCS from the Department of Public Health in 2012.

EWC Budget. The proposed 2015-16 budget includes \$423.4 million (\$4.6 million General Fund) for EWC, a \$11.9 million (22 percent) decrease from the 2014-15 estimate of \$54.3 million (\$16.6 million General Fund), which primarily reflects a decrease in caseload as a result of the federal Affordable Care Act and the transition of EWC caseload to Covered California or Medi-Cal.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending updates at May Revision.

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

1. Please provide an overview of the Family Health programs and budgets.
2. Please provide a brief update on the CCS redesign process and timeline and the department's thoughts on continuing to carve out this benefit.

2. Limited Benefit and Special Population Programs Eligibility Requirements

Budget Issue. The Administration proposes trailer bill language to:

- a. Require individuals applying for the Genetically Handicapped Persons Program (GHPP), to apply for insurance affordability programs through Covered California (Covered CA), in addition to the existing requirement that they apply for Medi-Cal, or in lieu of these requirements, provide evidence of other health care coverage. To the extent they are found eligible for an insurance affordability program and GHPP, they will be required to enroll in the insurance affordability program and receive only those specialized services in GHPP that would not otherwise be provided through Medi-Cal or Covered CA through their qualified health plan. This proposal does not prohibit eligible individuals from receiving GHPP services during the time they are awaiting an eligibility determination.
- b. Require enrolling providers who participate in Every Woman Counts (EWC), Family Planning Access Care and Treatment (FPACT), and IMProving Access, Counseling, and Treatment for Californians with Prostate Cancer (IMPACT), to provide to the enrolling individuals, information on how to apply for insurance affordability programs, in a manner determined by the Department of Health Care Services (DHCS). This proposal does not prohibit eligible individuals from receiving medically necessary services from these programs.

There are no savings associated with this proposal.

According to the Administration, the aim of this proposal is to ensure that individuals who are currently in limited benefit and special population programs that do not qualify as comprehensive coverage are being provided information about and, when appropriate, enrolling into comprehensive coverage, if eligible, in order to maintain eligibility for these specialized services. Additionally, DHCS cites that:

- The federal Affordable Care Act (ACA) requires consumers to obtain comprehensive coverage or pay a penalty. Certain populations, based on their income, will also be afforded financial subsidies which will result in no or low cost coverage.
- Prior to the advent of ACA, limited benefits programs were primarily established to provide limited coverage options to individuals unable to obtain coverage in publicly financed programs such as Medi-Cal or the commercial market.
- Compliance with the ACA requires health plans to cover a list of ten essential health benefits, including, but not limited to: maternity and newborn care, chronic disease management, rehabilitative services and devices, and laboratory services. Some of these essential benefits are duplicative of services provided by the limited benefits programs.
- Under ACA, insurers are no longer able to deny health care coverage due to pre-existing conditions and the expanded coverage options have resulted in declining caseloads for the limited benefit programs. Furthermore, limited benefits programs provide health services that do

not qualify as comprehensive coverage which is inconsistent with state policy goals and may result in enrollees being assessed the financial penalty.

- Many of the individuals enrolled in these limited benefit and special population programs are now eligible for coverage in Medi-Cal, Covered CA, or in the commercial market, and generally with more comprehensive benefits and lower or no cost to the individual.

Background. The FPACT program provides comprehensive family planning and reproductive health services at no cost to California residents at or below 200 percent of the FPL. FPACT currently has 2.8 million individuals enrolled in the program and serves 1.8 million income-eligible men, women, and adolescents annually through a network of 2,300 public and private providers.

The IMPACT program develops, expands, and ensures high quality prostate cancer treatment for, uninsured and underinsured California men who are age 18 and older and whose income is at or below 200 percent FPL. Eligible men are enrolled for twelve months of prostate cancer treatment service. The program collaborates statewide with local hospitals, clinics, and private practitioners to provide treatment services (in the nearest participating facility) including but not limited to surgery, radiation, hormone therapy, chemotherapy, and watchful waiting. Coverage also includes medical tests and services, hospital, outpatient, and pharmaceutical charges. IMPACT currently serves 413 men.

See previous agenda item for background information on GHPP and EWC.

Subcommittee Staff Comment and Recommendation—Modify TBL. It is recommended to modify this proposed trailer bill language by deleting the provisions related to GHPP. While the Administration’s goal to promote comprehensive coverage is understandable, the components of this proposal related to GHPP could disrupt care or increase the cost of care for some of the state’s most medically vulnerable persons. For example, persons on GHPP would likely have to pay higher prices for expensive drugs, such as clotting factor, if they are eligible and enroll in a Covered CA health plan. Additionally, although this proposal includes a “wrap” to provide specialized services in GHPP that would not be provided through a Covered CA health plan, the state has not yet implemented any Covered CA “wraps” and it is not clear when this could be accomplished.

Finally, in order to keep the cost of premiums affordable, Covered California plans have utilized selective contracting. There have been reports in the media and by stakeholders that enrollees could not find a Covered California plan that included their provider and sometimes it was not clear if the drug they needed would be on the formulary. Continuity of care for the individuals on GHPP is critical given that this is a fragile and chronically ill population.

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

1. Please provide an overview of this proposal.

3. Modification of Major Risk Medical Insurance Program

Budget Issue. DHCS proposes trailer bill language to modify the Major Risk Medical Insurance Program (MRMIP) and the Guaranteed Issue Pilot (GIP) Program, effective January 1, 2016. Specifically, this trailer bill language would:

- Permit subscribers, applicants, and their dependents, who are determined ineligible for coverage through the California Health Benefit Exchange (Exchange), ineligible for full scope no Share of Cost (SOC) Medi-Cal, and are unable to secure adequate private health coverage as defined in Welfare and Institutions Code Section 15884(b), to remain enrolled (subscribers) or to enroll (applicants and their dependents) in the modified program.
 - Individuals with End Stage Renal Disease (ESRD), who are under the age of 65 and have Medicare, would only be required to apply for the Medi-Cal Program to be determined for Medi-Cal eligibility. Those individuals that are determined ineligible for Medi-Cal would not be required to further apply, or show proof of ineligibility from the individual market to remain enrolled or enroll in the modified program.
- Clarify that an individual would not be eligible for MRMIP if:
 - The individual has not applied in a timely manner during any applicable Exchange open enrollment period or any special enrollment period following a qualifying life event; or
 - The application is rejected due to an individual's failure to provide sufficient information necessary for an eligibility determination to be made.
- Permit subscribers, who have applied for other health coverage during open enrollment for policy year 2016 and are still awaiting an eligibility determination, to continue to receive coverage through the modified program until the subscriber's eligibility and ineligibility for other health coverage is determined.
- Require DHCS to develop a notification process to inform all subscribers of the modifications to MRMIP and the coverage options available to them. This notification process would occur no later than 90 and 30 days prior to the start of open enrollment for policy year 2016.
- Allow DHCS to modify or replace the current MRMIP contribution structure.
- Allow DHCS to operate the modified program on such terms as DHCS deems reasonable and necessary if it is unable to secure sufficient health plan and vendor participation.
- Require DHCS to provide the Exchange, or its designee, with subscriber, applicant and dependent information it has collected for MRMIP use, in order to assist the Exchange with its eligibility determination. This information would be limited to the information that MRMIP and the modified program collect from subscribers and applicants for the purposes of determining eligibility for MRMIP and the modified program.
 - Currently, DHCS does not have legal authority to share the subscriber and applicant information it collects with the Exchange. This language would allow DHCS to share what information it currently collects or has collected from subscribers and applicants with the Exchange. Any additional information needed by the Exchange to determine eligibility would be the responsibility of the individual to provide, and the Exchange to collect.

- As in current practice, if an individual applies directly to, or is referred by the Exchange to the county for a Medi-Cal determination, it would be the responsibility of the individual to provide, and the county to collect, the necessary information for a Medi-Cal eligibility determination.
- Allow DHCS to use plan letters, plan or provider bulletins, or similar instructions in order to implement the modified program, until final regulations are adopted.
- Require DHCS to adopt emergency regulations no later than July 1, 2018. DHCS would be able to readopt the emergency regulations as long as they are the same, or substantially the same as the initial emergency regulations. The initial emergency regulations and one re-adoption would be exempt from review by the Office of Administrative Law (OAL); however, DHCS would be required to submit these to OAL for filing where they would remain in effect for 180 days.
- Extend the period of time to reconcile payments for the GIP Program from six to 18 months which is more consistent with historical timelines.

MRMIP Budget and Caseload. As noted in the table below, the budget includes \$27 million in funds for MRMIP in 2014-15; and \$26.5 million in funds for MRMIP in 2015-16.

Table: MRMIP Budget Summary

	2013-14	2014-15	2015-16
State Operations	\$746,000	\$1,304,000	\$1,457,000
Local Assistance	\$24,854,000	\$25,795,000	\$25,045,000
Total	\$25,602,000	\$27,099,000	\$26,502,000
Ending MRMIP Fund Reserve	\$51,355,000	\$45,077,000	\$23,073,000

As displayed in the chart below, MRMIP enrollment has dropped dramatically since implementation of the Affordable Care Act as ACA prohibits the denial of coverage to individuals due to a pre-existing condition and also prohibits charging individuals with a pre-existing condition a higher premium due to their condition. As a result, MRMIP has seen a dramatic decline in caseload since ACA open enrollment in the Exchange began.

Chart: MRMIP Enrollment Summary 2014-2015

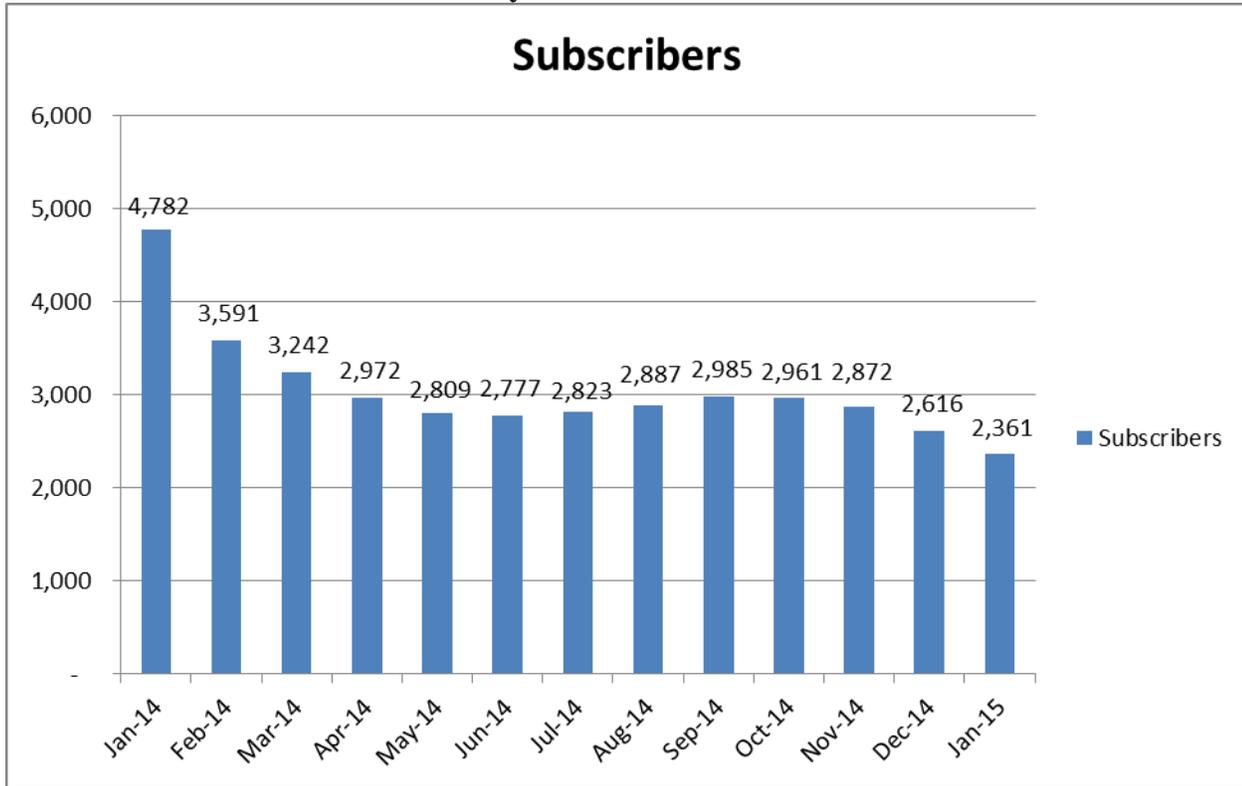


Chart: MRMIP Enrollment Summary 2011-2013

Major Risk Medical Insurance Program Enrollment by Month					
Jan-11	6,913	Jan-12	6,196	Jan-13	5,737
Feb-11	6,679	Feb-12	6,110	Feb-13	5,716
Mar-11	6,648	Mar-12	6,051	Mar-13	5,828
Apr-11	6,622	Apr-12	5,997	Apr-13	6,022
May-11	6,637	May-12	5,971	May-13	6,295
Jun-11	6,632	Jun-12	5,957	Jun-13	6,397
Jul-11	6,610	Jul-12	5,878	Jul-13	6,463
Aug-11	6,560	Aug-12	5,858	Aug-13	6,536
Sep-11	6,563	Sep-12	5,823	Sep-13	6,570
Oct-11	6,499	Oct-12	5,757	Oct-13	6,492
Nov-11	6,420	Nov-12	5,726	Nov-13	6,321
Dec-11	6,334	Dec-12	5,713	Dec-13	5,678
				Jan-14	4,782

MRMIP Background. AB 60 (Isenberg), Chapter 1168, Statutes of 1989, established MRMIP. Since 1991, MRMIP has provided health insurance to Californians who are unable to obtain coverage, or charged unaffordable premiums, in the individual health insurance market due to a pre-existing condition. Californians who qualify for MRMIP contribute to the cost of their health care coverage by

paying monthly premiums equal to 100 percent of the average market cost of premiums (based on the Silver level coverage through the Exchange), an annual deductible and copayments. These monthly premiums are subsidized through the Cigarette and Tobacco Products Surtax Fund (Proposition 99). MRMIP has an annual benefit cap of \$75,000, and a lifetime benefit cap of \$750,000. MRMIP is not an income-based eligibility program.

MRMIP was originally established as a state high-risk pool; however, the need for high-risk pools has been greatly reduced as a result of the passage of the federal Affordable Care Act (ACA).

DHCS assumed responsibility for MRMIP on July 1, 2014.

MRMIP Meets Minimal Essential Coverage. Effective January 1, 2014, the Affordable Care Act requires every individual to have minimum essential health coverage (known as “minimum essential coverage”) for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return. State high risk pool coverage programs established on or before November 26, 2014 qualify as minimal essential coverage.

Individuals with End Stage Renal Disease. When the federal government established the framework for Medicare supplemental coverage, control over the regulation of health insurance and health plans remained with the states. Medicare most commonly provides coverage for persons age 65 and older, and it is also available to persons under age 65 who have a disability or are disabled or diagnosed with ESRD.

The federal framework for Medicare supplemental coverage gives states flexibility as to whether to include persons under age 65 who have a disability or are or diagnosed with ESRD in the Medicare supplemental coverage market. Health and Safety Code Section 1358.11 and Insurance Code Section 10192.11 authorize the Medicare supplemental coverage market to include persons with disabilities but exclude persons under age 65 with ESRD, by specifically allowing insurers and plans to exclude them from coverage. As a result, MRMIP subscribers with ESRD use MRMIP as their Medicare supplemental coverage. About 50,000 Californians are believed to be diagnosed with ESRD and approximately 60 ESRD individuals are enrolled in MRMIP.

Individuals under the age of 65 with ESRD who have Medicare coverage do not qualify for coverage in the Exchange or in the individual market because of federal “anti-duplication” laws. Some of these individuals do not qualify for Medi-Cal because they do not meet eligibility requirements.

Guaranteed Issue Pilot (GIP) Program. In order to address the growing waiting list for MRMIP, the Legislature passed AB 1401 (Thomson) in 2002, which established the GIP. Under the GIP, subscribers were automatically disenrolled from MRMIP after 36 months. At that time, subscribers could select guaranteed continued coverage from insurers in the individual market. Plans were required to offer the same benefit packages as those available under MRMIP, but with a higher annual benefit cap (\$200,000 versus \$75,000), and a lifetime cap of \$750,000. The GIP program sunsetted in 2007.

MRMIP and GIP Reconciliations. DHCS is in the process of reconciling MRMIP and GIP actual plan expenditures and claims with what the state already paid these plans. There is currently a four-year

backlog in the reconciliation process. Consequently, it is unknown how much the state may owe plans or how much plans may owe the state.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue. The following issues should be considered in these discussions:

- **Proposal gives DHCS Broad Authority to Redesign MRMIP.** While the need for high-risk pools has been greatly reduced as a result of the ACA, this proposal gives DHCS very broad authority to redesign MRMIP without input from stakeholders or Legislative approval.
- **MRMIP as Safety-Net Option Would be Eliminated.** Under current law, MRMIP is a program where a person can purchase health coverage throughout the year if they missed the open enrollment period for commercial coverage or do not qualify for Medi-Cal. With this proposal, this safety net coverage option would be eliminated.
- **MRMIP and GIP Reconciliation Backlog Makes it Difficult to Understand Funding.** Based on the actual reduction in caseload for 2014-15 and the projected reduction in caseload for 2015-16, the MRMIP program is over budgeted. For example, given the actual caseload for 2014-15 and the estimated annual cost of \$5,500 per subscriber, the Governor's MRMIP local assistance budget is over budgeted by about \$13 million in 2014-15. However, as discussed above, there is a four-year backlog in processing MRMIP and GIP, which makes it difficult to quantify how much funding is available for the MRMIP program and for ongoing purposes.

Subcommittee staff has requested technical assistance from the Administration on methods to facilitate and expedite the reconciliation process. It is important to expedite this process, so that the state has an understanding of the true balance of the MRMIF and can consider options on how to best use these funds and modify the MRMIP.

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

1. Please provide an overview of the Administration's proposed trailer bill language.
2. Please explain the reconciliation process and the projected timeline to address the four-year backlog in reconciliations.

4. Medi-Cal: Coordinated Care Initiative

Budget Issue. The Governor’s budget includes a net General Fund savings of \$173.8 million in 2015-16 as a result of CCI, including the General Fund savings from the sales tax on managed care organizations. Without the tax revenue, CCI would have a General Fund cost of \$399 million in 2015-16. See table below for a fiscal summary.

Factors Affecting the Fiscal Solvency of CCI. SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013, requires the Department of Finance to annually determine if there are net General Fund savings for CCI. If CCI is not cost-effective, all components of CCI would cease operation. As part of the budget, the Administration identified the factors below that have occurred since the 2012 enactment of CCI that may jeopardize the fiscal solvency of this initiative. According to DOF’s current analysis, if these factors do not improve, there would be a net General Fund cost for CCI; and consequently, CCI would cease operating effective January 2017. The Administration indicates that it remains committed to implementing CCI to the extent that it can continue to generate program savings.

The following changes have occurred since enactment of 2012 budget act:

- More than 100,000 participants were exempted, including Medicare Special Needs Plans and certain categories of Medi-Cal beneficiaries based on age or health condition.
- Passive enrollment was delayed until 2014, and Alameda County will no longer participate in the demonstration due to concerns regarding one of the health plan’s readiness. Orange County will not begin passive enrollment until July 2015.
- Medicare and Medicaid savings were intended to be shared 50:50 with the federal government; however, the federal government reduced the amount of savings California was allowed to retain to approximately 25 to 30 percent.
- The federal government allowed a 3.975 percent tax on managed care organizations through June 30, 2016 which is attributable to the state’s participation in the demonstration. However, recent federal guidance indicates that this tax will not be allowed to continue in its current form.
- As of November 1, 2014 approximately 69 percent of eligible participants opted out of Cal MediConnect compared to initial projections of approximately 33 percent. Of the 69 percent that have opted-out, about 80 percent of these individuals are In-Home Supportive Services (IHSS) beneficiaries.
- Due to revised federal Fair Labor Standards Act (FLSA) regulations, IHSS providers are entitled to overtime compensation. Because CCI established a maintenance-of-effort (MOE) funding formula for IHSS, the state’s IHSS fiscal exposure has significantly increased. It should be noted that since the Governor’s budget was released, a federal district court ruled that the FLSA regulations be vacated; consequently, it is unclear how this change impacts CCI.

Table: Coordinated Care Initiative Cost Savings Analysis

Coordinated Care Initiative (CCI)		
	2014-15	2015-16
(In thousands)	General Fund	General Fund
Local Assistance Costs/Savings Total	\$453,828	\$201,958
Payments to Managed Care Plans	\$2,851,779	\$5,632,869
Transfer of IHSS Costs to DHCS	-\$723,243	-\$1,456,769
Savings from Reduced Fee for Service Utilization	-\$1,674,708	-\$3,974,142
Payment Deferrals Total	-\$345,729	-\$74,443
Defer Managed Care Payment	-\$382,473	-\$91,688
Delay 1 Checkwrite	\$36,744	\$17,245
Revenue Total	-\$375,061	-\$572,871
Increased MCO Tax from CCI (All Revenue)	-\$86,111	-\$194,418
Increased MCO Tax from non-CCI (Incremental increase from tax rate of 2.35 to 3.93 percent as part of 2013 agreement with CMS on managed care tax)	-\$288,950	-\$378,453
State Administrative Costs¹⁾	\$34,132	\$22,893
Department of Social Services – IHSS County MOE²⁾	\$175,064	\$248,593
Department of Social Services – IHSS County MOE, Costs Related to Fair Labor Standards Act	\$62,646	\$109,897
Net Impact to State	-\$57,766	-\$173,870

¹⁾Includes administrative costs for DHCS, Department of Social Services, Department of Managed Health Care, Department of Aging, and California Department of Human Resources.

²⁾The IHSS county Maintenance of Effort (MOE), which changes county responsibility from a share of cost to set expenditures tied to the 2011-12 base General Fund costs. All nonfederal costs exceeding the MOE are General Fund.

Background. The 2012 budget authorized the Coordinated Care Initiative¹ (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits. The CCI is being implemented in seven counties² (Los Angeles, Orange³, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).

1 Enacted in July 2012 through SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012, and amended by SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013.

2 Alameda County was initially part of CCI but given fiscal solvency issues with one of its plans, it will not participate in CCI.

3 It is projected that Orange County will begin CCI no sooner than July 2015.

CCI is composed of three major parts related to Medi-Cal:

- **Managed Long-Term Supports and Services (MLTSS) as a Medi-Cal Managed Care Benefit:** CCI includes the addition of MLTSS into Medi-Cal managed care. MLTSS includes nursing facility care (NF), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Community Based Adult Services (CBAS). This change impacts about 600,000 Medi-Cal-only enrollees and up to 456,000 persons eligible for both Medicare and Medi-Cal who are in Cal MediConnect.
- **Cal MediConnect Program:** A three-year demonstration project for persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system (health plan). No more than 456,000 beneficiaries would be eligible for the duals demonstration in the eight counties. This demonstration project is a joint project with the federal Centers for Medicare and Medicaid Services (CMS).
- **Mandatory Enrollment of Dual Eligibles and Others into Medi-Cal Managed Care.** Most Medi-Cal beneficiaries, including dual eligibles, partial dual eligibles, and previously excluded seniors and persons with disabilities (SPDs) who are Medi-Cal only, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits.

The purpose and goal of CCI is to promote the coordination of health, behavioral health, and social care for Medi-Cal consumers and to create fiscal incentives for health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than home and community-based care). See table below for enrollment summary information.

Table: Coordinated Care Initiative Enrollment Summary

County	Cal MediConnect as of March 1, 2015	Medi-Cal-Only Managed Care for MLTSS*
Los Angeles	54,541	350,000
Orange	-	51,000
Riverside	15,396	48,000
San Bernardino	15,202	50,000
San Diego	20,256	64,000
San Mateo	10,100	14,000
Santa Clara	8,744	31,000
Total	124,239	608,000

*As of January 1, 2015. Medi-Cal-only enrollees will receive only Medi-Cal benefits from the health plan, including MLTSS. These enrollees include full dual eligibles excluded from Cal MediConnect, partial dual eligibles, and senior and persons with disabilities.

CCI In-Home Supportive Services (IHSS) Changes. CCI established a county maintenance-of-effort funding formula for the IHSS program. Additionally, CCI established a Statewide Authority for purposes of collective bargaining with respect to the wages and benefits for IHSS providers in the CCI counties. The Statewide Authority for collective bargaining begins in a CCI county when enrollment

into CCI is completed in the county. San Mateo County transitioned to the Statewide Authority in February 2015, and will be followed by Los Angeles, Riverside, San Bernardino and San Diego counties in July 2015. Santa Clara County is anticipated to transition January 2016 and finally Orange County in August 2016.

CCI Universal Assessment. Lastly, another component of CCI was the development of a universal assessment tool (UAT) to be used to streamline the assessment process for connecting consumer to services, such as those defined as part of MLTSS. The Department of Social Services and the Department of Aging are the leads on this process. It is anticipated that the piloting of the UAT will occur in two CCI counties in 2016-17.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as the following issues are considered and further discussed:

- **Higher Than Expected Cal MediConnect Opt-Out Rate.** The Governor’s budget warns that if certain issues are not resolved, CCI and all of its parts, would cease to operate pursuant to current law. Of the key issues cited by the Administration as negatively affecting the CCI, the only issue for which the Administration has any ability to impact—without statutory changes or changes in the agreement with CMS—is the higher than expected opt-out rate for Cal MediConnect.

DHCS indicates that it is currently undertaking a study as to the demographics of those who have opted-out including trying to get a better understanding for the reasons these individuals opted-out of the demonstration. For example, DHCS is trying to assess why there are geographical differences in the opt-out rate. DHCS is aiming to have this demographic analysis posted on its website in the next couple weeks.

Cal MediConnect plans have committed significant financial and other resources to the success of this program. Ensuring a certain level of plan enrollment is critical not only to the success of the demonstration but potentially to the financial viability of the plans. It is essential that the Administration evaluate and address the reasons for the higher than expected opt-out rate. A related issue is the difficulty plans have reported in initially contacting enrollees due to inaccurate or missing contact information. The plans believe the inability to contact each new enrollee could be contributing to high opt out rates and is making it difficult to conduct risk assessments in a timely fashion.

- **Real-Time Data Needed to Evaluate if CCI is Meeting Goals of Improved Care Coordination and Health Outcomes.** While, unfortunately, there were implementation issues and disruptions as CCI rolled out, many of these issues are in the process of being resolved. If CCI is to continue, it will be important for the Legislature to have the data and metrics available to evaluate if CCI is meeting its goals of improved care coordination and improved health outcomes. Regardless of the trigger language that ceases operations of CCI if there is a net General Fund impact, the Legislature should consider CCI’s overall value to the state and Medi-Cal enrollees. For example, if health outcomes are dramatically improved because health plans

are aggressively using interdisciplinary care teams and providing care plan option services⁴ and there are modest increases in General Fund costs, it may be worthwhile to continue CCI.

Critical information necessary to make this evaluation include the type and volume of care plan option services provided by health plans and changes in utilization of services (e.g., change in use of long-term supports and services compared to nursing home care) and health care outcomes for both Cal MediConnect enrollees and the Medi-Cal-only enrollees.

While the Administration and the federal CMS plan to evaluate measures such as these as part of its overall evaluation of Cal MediConnect, this information is needed on a more immediate/real-time and public basis to understand if CCI is meeting its goals and how improvements can be made on a timely basis.

DHCS anticipates that health plans will likely begin submitting Medi-Cal encounter data to the federal system (Palmetto) in the next several months. DHCS still needs to test the data transfer process with Palmetto and the DHCS system. Once this is completed, DHCS would then have the capability to analyze the encounter data to determine, for example, the volume of care plan option services being provided

- **Evaluation Process for MLTSS Not Developed.** Most of the focus for CCI is on the component related to the duals demonstration project, Cal MediConnect. However, CCI's component related to the integration of MLTSS into Medi-Cal Managed Care impacts over 600,000 Medi-Cal enrollees. The state has yet to develop an evaluation plan or metrics to assess how and if managed coordination of long-term supports and services is improving the health outcomes for Medi-Cal only individuals.

DHCS indicates that is in discussions with an organization to do an evaluation specifically of MLTSS. The project period for this evaluation is proposed to be July 1, 2015 – June 30, 2018. This evaluation would look at LTSS utilization, patient characteristics and rate of institutionalization both pre and post CCI.

- **Planning for Transition of MSSP to Managed Care Benefit is Critical.** One key piece of MLTSS is the transition of MSSP as services provided under a federal home- and community-based waiver into managed care benefit in the CCI counties. This transition would occur 19 months after a county enrolls MSSP beneficiaries into a managed care plan pursuant to CCI or when federal approval is received, whichever is later. As part of this transition, DHCS, the Department of Aging, and the Department of Managed Health Care are required to submit a transition plan to the Legislature on how this transition would occur. The plan is required to incorporate the principles and standards of MSSP in the managed care benefit, and provisions to

⁴ Care Plan Options (CPO) services are optional services that a Cal MediConnect health plan may provide that are above and beyond MLTSS that could enhance a member's care, allowing them to stay in their homes safely and preventing institutionalization. These services could vary based on the needs of the consumer and the care plan developed for this person. These CPO services may include, supplemental personal care services (above authorized IHSS), nutritional supplements and home delivered meals, home maintenance and minor home adaptation, and medical equipment.

ensure seamless transitions and continuity of care. Managed care health plans are required, in partnership with local MSSP providers, to conduct a local stakeholder process to develop recommendations that the department is to consider when developing the transition plan. See below for a chart on with the MSSP transition timeline.

MSSP Transition Timeline	
County	MSSP Date of Transition
Los Angeles	05/01/16
Orange	04/01/17
Riverside	05/01/16
San Bernardino	05/01/16
San Diego	05/01/16
San Mateo	11/01/15
Santa Clara	05/01/16

DHCS is preparing an initial plan to transition MSSP that details the approach to ensuring active engagement of stakeholders and readiness review criteria assuring that health plans as well as MSSP sites are prepared to transition the MSSP participants within respective counties or regions. DHCS indicates that the San Mateo County transition plan will be available mid-May 2015 and will include the MSSP transition plan, summary of stakeholder comments and timeline depicting all major milestones achieved and anticipated. DHCS states that it meets weekly with the California Department of Aging to develop necessary assurances which must be established by health plans and MSSP sites, within a county or region, prior to transition.

Although the state is about one year away from this transition for all counties except San Mateo, as the state learned when CBAS became a Medi-Cal managed care benefit in 2012, ensuring a smooth transition requires significant efforts to establish program standards and consensus on processes between the plans and providers. It also requires substantial outreach and education efforts with regard to providers, enrollees and their families and caregivers.

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

1. Please provide an update on the Coordinated Care Initiative.
2. Please discuss the department’s preliminary analysis on the demographics of persons who opted-out of Cal MediConnect. What steps is DHCS taking to address the findings of this analysis?
3. Please describe how DHCS has increased its direct engagement with the Health Care Options call center and how this has improved CCI consumer interactions and the quality of the data.
4. Please describe how DHCS is planning for the transition of MSSP to managed care. Why does DHCS find that the transition of this benefit should occur given the future uncertainty of CCI?

5. Medi-Cal: Skilled Nursing Facility Quality Assurance Fee Extension

Budget Issue. DHCS requests trailer bill language (TBL) to:

- a. Extend the sunset date for the skilled nursing facility rate-setting methodology established under AB 1629 (Frommer), Chapter 875, Statutes of 2004, as well as the Quality Assurance Fee (QAF) and Quality/Accountability Supplemental Payment (QASP) programs, from July 31, 2015, to July 31, 2020.
- b. Specify that beginning 2015-16, the annual increase in the weighted average Medi-Cal reimbursement rate for skilled nursing facilities would be 3.62 percent. (The rate increase for 2013-14 and 2014-15 was 3 percent.)
- c. Set Quality Accountability Supplemental Payment Program (QASP) program payments at the same level as existed for 2014-15 (approximately \$90 million per year).
- d. Extends the DHCS Administrative Procedure Act (APA) exemption through July 31, 2020, and the California Department of Public Health (CDPH) Public Contract Code exemption through December 31, 2020.

Background. AB 1629 enacted the Medi-Cal Long Term Care Reimbursement Act of 2004, which establishes a reimbursement system that bases Medi-Cal reimbursements to skilled nursing facilities (SNFs) on the actual cost of care. Prior to AB 1629, SNFs were paid a flat rate per Medi-Cal resident. This flat rate system provided no incentive for quality care and reimbursed SNFs for less than it cost to care for their residents.

AB 1629 also allows the state to leverage new federal Medicaid dollars by imposing a quality assurance fee (QAF) on SNFs. This new federal funding is used to increase nursing-home reimbursement rates. (Federal Medicaid law allows states to impose such fees on certain health-care service providers and in turn repay the providers through increased reimbursements.) Because the costs of Medicaid reimbursements to health care providers are split between states and the federal government, this arrangement provides a method by which states can leverage additional federal funds for the support of their Medicaid programs and offset state costs. In 2015-16, it is projected that the SNF QAF will offset over \$500 million in General Fund expenditures.

AB 1629 contained a sunset date of July 1, 2008 and has been extended five times.

SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, established the Quality and Accountability Supplemental Payment (QASP) program. Under the QASP program, SNFs that meet minimum staffing standards can earn incentive payouts from a pool of supplemental funds. The payouts are awarded based on SNFs' performance on certain quality measures (including clinical indicators), as well as SNFs' improvement on these measures relative to the previous year. Under SB 853, a portion of each year's weighted average rate increase was to be set aside to fund the QASP payment pool. The set-aside amount was \$43 million in 2013-14, and \$90 million in the 2014-15 rate year. In 2013-14, about 477 out of 1,000 SNFs earned the QASP payouts.

Stakeholder Comments. The California Association of Health Facilities (CAHF), an association of SNFs and other health facilities, supports the Governor's proposal citing the overall benefits of the QAF and rate methodology contained in AB 1629. CAHF also states that the proposed rate increase will help "move skilled nursing facilities much closer to covering their costs of care by 2020." CAHF states that AB 1629 has benefited: 1) the state by creating an approximate \$500 million General Fund offset within Medi-Cal; 2) nursing homes by generating approximately \$6.5 billion in increased General Fund and federal fund revenue and by stabilizing the reimbursement system; and 3) patients by increasing quality of care. CAHF states that despite these benefits, the AB 1629 methodology currently reimburses providers at an amount that is less than 93 percent of the benchmarked costs of their services, equating to a shortfall of approximately \$14 per patient day.

Advocate groups for nursing home residents, including California Advocates for Nursing Home Reform, oppose this proposal. These groups argue that any reauthorization of AB 1629 should increase mandatory nurse staffing ratio requirements. These groups note that California has not increased minimum staffing requirements since 1999 and request that minimum nursing hours be increased to at least 4.1 nursing hours per resident day (it is currently 3.2), including at least 1.3 hours of care by licensed nurses, by 2019-20.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal. Numerous studies have shown a positive association between nurse staffing levels and the quality of care provided in nursing homes. Additionally, research suggests that the ratio of professional nurses—registered nurses and licensed vocational nurses—to other nursing personnel—such as certified nurse assistants—is an important predictor of the quality of care received. Having a greater number of professional nurses appears to have a positive effect on the lives of residents. However, increasing the nursing staff ratios would have an additional cost to the state. At this point, the fiscal impact of increasing nurse staff ratios is unknown.

It is important to consider this proposal in the context of the long-standing issues with the Licensing and Certification (L&C) program at the Department of Public Health and the state's inadequate oversight of long-term care health facilities. The budget also contains proposals by L&C to increase staffing and improve the state's oversight of SNFs. Improved oversight and monitoring of these facilities should lead to better quality and better care. Additionally, potential augmentations to the Long Term Care Ombudsman Program could also improve the quality of care provided in SNFs.

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

1. Please provide an overview of this proposal.
2. What is DHCS' assessment of AB 1629's impact on the quality of care in nursing homes?
3. Why does the Administration find that skilled nursing facilities should receive an annual 3.63 percent rate increase for the next five years?

6. Medi-Cal: Managed Care Office of the Ombudsman

Budget Issue. DHCS's Medi-Cal Managed Care Office of Ombudsman (OMB), requests nine two-year limited term full-time positions and expenditure authority of \$1,045,000 (\$522,000 General Fund and \$523,000 Federal Fund) to support the increased workloads as a result of the growth in the managed care program. As distinguished from other ombudsman offices, such as the Long-Term Care Ombudsman at the Department of Aging, this office primarily assists Medi-Cal only enrollees of Medi-Cal managed care plans.

Currently, the Medi-Cal Office of the OMB has nine permanent staff, seven who answer phone calls and two who perform clerical support. Additionally, DHCS has redirected 14 temporary staff to OMB to help with the call volume on a limited-term basis.

DHCS acknowledges that with the present staffing levels, staff is unable to answer between 250-350 calls on a daily basis. The inability to answer these calls results in unreported cases of possible inappropriate denials of medically necessary services, inability to effectuate rights to continuity of care or medical exemptions, and poses a potential threat to the health and safety of Medi-Cal beneficiaries. DHCS states that it is requesting limit-term positions because it finds that it is unclear whether the increase in call and case volume is related to initial enrollment into managed care or if it is indicative of ongoing workload.

Background. OMB serves as a resource for Medi-Cal managed care members and helps solve problems; from a neutral standpoint to ensure that members receive all medically-necessary covered services. In addition to assisting Medi-Cal beneficiaries, OMB provides guidance and assistance to county eligibility workers, the Legislature, stakeholders, other state departments, and various associations (foster children, pregnancy related, etc.). OMB currently receives approximately 25,000 calls a month, creating 13,000 new cases requiring detailed investigation.

The OMB works each call completely through resolution. According to DHCS, frequently a caller has already contacted their county, their provider, Health Care Options, the Fiscal Intermediary (Xerox) or others without any resolution. Consequently, OMB often handles complex calls that require coordination with multiple entities and OMB staff performs research, coordination, and may call multiple outside entities with the caller on-line to find a resolution. OMB call handling times range from two minutes to more than an hour.

In addition to handling and researching calls, the OMB processes disenrollment or enrollment for the current or past months of eligibility. This function assures continuity of care for members either with their health plan or in fee-for-service Medi-Cal. On a monthly basis, the OMB averages 1,900 emergency enrollments and disenrollments for managed care members.

Since January 2011, the Medi-Cal managed care program has doubled in enrollment from approximately 4 million enrollees to about 8 million in August 2014. Additionally, over the last few years, recorded call volume has increased between 5 to 15 percent each year with case volumes increasing between 25 to 50 percent each year. Call volumes increased 40 percent between December 2013 and June 2014 and

continue to increase sharply. The number of cases logged by OMB staff has increased by 100 percent since the beginning of the calendar year 2014.

New Telephone System. DHCS is in the final phases of implementing an updated telephone system for OMB, with the system expected to be implemented by June 30, 2015. This Voice over IP (VOIP) system is expected to increase the office's ability to respond to the concerns of beneficiaries significantly. For example, according to DHCS, the current system operates without redundancy leaving the call center at risk of becoming non-operational, while the new system will have built in redundancy and will be able to continuously service beneficiaries. Additionally, with the current system a caller must wait on the line before they can leave a voicemail for call back; on the new system the caller has an option to leave a call back number and not lose their place in the cue. There will also be an increased queue capacity from the current 30 callers to more than 500 callers. DHCS finds that this new phone system will increase the functionality, capacity, and responsiveness of the Ombudsman when compared to the system currently in place.

Additionally, according to DHCS, this new phone system provides the ability to collect data regarding wait times, call times, abandonment rates, and other full call center monitoring functions and provides supervisors the ability to adjust resources.

Subcommittee Staff Comment and Recommendation—Approve. It is clear that OMB needs additional staff to address the growing workload. The new phone system also appears to be a key tool in improving OMB and having the data to monitor the performance of this office.

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

1. Please provide an overview of this proposal.
2. Please describe how the new phone system will help DHCS manage the OMB and whether it is likely to meet the expected operational timeline of June 2015?
3. Although there is no prescribed performance standard for responding to calls, does OMB have any goals with regard to response times? How would this proposal improve response times?

7. Medi-Cal: Impact of President's Executive Order

Budget Issue. The Governor's budget does not include funding for the potential Medi-Cal costs related to the President's executive actions on immigration.

In November 2014, the President announced several executive actions intended to allow certain undocumented immigrants to pass a criminal background check and pay taxes in order to temporarily stay in the U.S. without fear of deportation. The Administration indicates that there is great uncertainty at this time regarding the effect of the President's actions and consequently the budget does not assume any higher costs for individuals that have a recognized immigration status under the President's executive order and, thus be eligible for Medi-Cal.

Background. The President's executive actions expand the Deferred Action for Childhood Arrivals (DACA) program and create the Deferred Action for Parents of Accountability (DAPA) program (also known as the Deferred Action for Parents of Americans and Lawful Permanent Residents program) as follows:

- ***Expands DACA Program.*** Previously, undocumented individuals who were younger than 31 years of age as of June 2012, had entered the United States prior to the age of 16, and had lived in the United States continuously since January 1, 2010, were eligible for DACA. The President's executive actions expand the population eligible for DACA to include people of any age who entered the United States before the age of 16 and meet the other DACA requirements. The President's executive actions also extend the period of DACA eligibility and work authorization from two years to three years.
- ***Creates DAPA Program.*** The President's executive actions also create the DAPA program, which allows undocumented immigrants who have lived in the United States continuously since January 1, 2010 and are parents of United States citizens or lawful permanent residents to request deferred action and work authorization for three years.

A lawsuit was filed in February by officials of 26 states who contend the President's executive actions violated the United States Constitution as an overreach of executive powers. The suit seeks an order blocking the immigration changes from taking effect. Initial arguments in the suit were heard by a United States district judge on January 15, 2015, where the states asked the judge to block the executive actions until they have been able to challenge the actions in court. The judge has halted implementation of the President's actions. Officials from 12 states, including California, and the District of Columbia recently filed an amicus or "friend of the court" brief supporting the President's executive actions.

Estimates for Number of DACA and DAPA Individuals that Could be Eligible for Medi-Cal. In March, the UC Berkeley Center for Labor Research and Education and UCLA Center for Health Policy Research released a report stating that between 360,000 and 500,000 Californians with DACA or DAPA could be eligible for Medi-Cal after several years of implementation. The report notes that analysis of take-up for this population in California has not been conducted and finds that there is great uncertainty to the take-up rate given that it is still unknown how the DACA and DAPA programs will be implemented.

LAO Analysis. The LAO finds that there will be a delay in the fiscal impact to the state if or when the executive actions are implemented because eligible individuals will need to apply for DACA or DAPA and that the United States Citizenship and Immigration Services estimates that it will take up to a year to process all applications from the time that the department begins accepting applications. After this, eligible individuals will then need to apply for Medi-Cal coverage. Additionally, given the lawsuit described above, the LAO finds that the state would at most experience partial-year and minimal costs in the budget year.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of how the President’s actions could impact the Medi-Cal caseload.

8. Medi-Cal: Continuation of 1115 Waiver Workload

Budget Issue. DHCS requests to convert 15 limited-term positions to full-time permanent positions and an annual \$1 million contract at a cost of \$2,311,000 (\$812,000 General Fund and \$1,499,000 federal funds) in 2015-16. The \$3,000,000 in expenditure authority is over a three-year period (\$1 million annually, \$250,000 General Fund and \$750,000 federal funds) for the External Quality Review Organization (EQRO) contract. According to DHCS, these 15 positions will continue to support the activities and programs that provide ongoing support of critical functions of “California’s Bridge to Reform” 1115 Waiver. The positions are being requested as permanent positions because the department anticipates a subsequent waiver starting in 2015-16. Each waiver is five years in length and the department anticipates a continued need for waiver funding; consequently, DHCS finds that this workload will continue in the foreseeable future.

Background. The 1115 “Bridge to Reform” Demonstration Waiver Renewal became effective on November 1, 2010. To support the new workload associated with this 1115 waiver, 15 temporary positions were established in 2010-11 and in 2011-12 to operationalize the transition of the seniors and persons with disabilities (SPD) population to Medi-Cal managed care. According to DHCS, the conversion of these positions to permanent full-time permanent is necessary to continue the transition of new populations to Medi-Cal managed care, along with the ongoing monitoring, oversight and reporting for a number of different population groups. DHCS indicates that recruitment of qualified candidates for these classifications, with the duties required, is considerably more challenging when only offered on a limited-term basis. The nature of the workload associated with these positions is complex and requires an extensive working knowledge of the programs. The retention of knowledgeable and experienced staff is essential to the program.

California’s Request for Renewal of Section 1115 Waiver Demonstration. On Friday, March 27, 2015, DHCS submitted a request to renew the state’s section 1115 Medicaid Waiver for a new five-year term. The new waiver, “Medi-Cal 2020,” seeks approximately \$17 billion in federal investment to further the achievements California has made in health care reform through a set of payment and delivery system transformation strategies. The application and concept paper (attached) is available on the [DHCS website](#). DHCS is seeking approval of the Waiver from the Centers for Medicare and Medicaid Services (CMS) by November 1, 2015. Over the next few months, DHCS and CMS will collaborate on the terms and conditions of the new Waiver. DHCS has engaged in an extensive stakeholder process over the past four months, using primarily foundation funding. Concurrently, DHCS states it will continue to engage stakeholders, along with Administration and Legislative partners in the refinement of the waiver concepts.

AB 72 (Bonta and Atkins) and SB 36 (Hernandez and De León) pending in this session are intended to contain the necessary statutory changes to implement the 2020 waiver once the Special Terms and Conditions (STCs) are negotiated with CMS.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this item.

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

1. Please provide an overview of this proposal.
2. Please provide a brief overview of the 1115 Waiver Renewal proposal submitted to CMS in March. What is the timeline and process for this renewal proposal?

9. Medi-Cal: Palliative Care

Budget Issue. DHCS requests \$125,000 (\$63,000 General Fund and \$62,000 federal funds) in 2015-16 and \$116,000 (\$58,000 General Fund and \$58,000 federal funds) in 2016-17 and one two-year limited-term position. The requested position (Health Program Specialist I) will implement provisions of SB 1004 (Hernandez), Chapter 574, Statutes of 2014.

SB 1004 requires DHCS to establish minimum standards for eligibility for and delivery of palliative care services concurrent with curative services, and to provide technical assistance to managed care plans to ensure and monitor the appropriate delivery of palliative care services.

Background. Palliative care is specialized, interdisciplinary care and support that focuses on physical, psychological, emotional, and spiritual needs of people with serious and progressive illness and their families. According to the federal Centers for Medicare and Medicaid Services (CMS), palliative care means patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

In California statute, palliative care is defined to mean medical treatment, interdisciplinary care, or consultation provided to a patient or family members, or both, that has as its primary purpose the prevention of, or relief from, suffering and the enhancement of the quality of life, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life (Health and Safety Code, Section 442(e)).

SB 1004 requires DHCS to establish standards for palliative care services delivered concurrent with curative services to Medi-Cal beneficiaries served by Medi-Cal managed care health plans. The goal of palliative care is to improve patient choice and satisfaction and reduce unwanted higher cost services such as hospital stays and readmissions, and emergency room visits.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. No issues have been raised. DHCS has already convened stakeholder meetings to discuss palliative care models and options for implementing SB 1004.

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

1. Please provide an overview of this proposal.

10. Medi-Cal: CA-MMIS

Oversight Issue. DHCS is currently in a multi-year process to replace the California Medicaid Management Information System (CA-MMIS) which processes Medi-Cal fee-for-service health care claims.

The total cost to replace CA-MMIS is \$479.7 million (\$95.9 million General Fund and \$383.8 million federal funds). Additionally, it is anticipated that the Administration will be submitting a Budget Section Letter in the near-term for an augmentation of \$21.1 million because of project delays.

On February 19, 2015, the California State Auditor sent a letter to the Governor and Legislature citing its concerns with CA-MMIS. These concerns include:

- Although Xerox implemented the first major release, implementing Release 2 will be significantly more challenging. Release 2 is anticipated to provide functionality for processing claims and for plan management as well as financial management for the Child Health and Disability Prevention program. The state auditor finds that since Release 2 will provide functionality to users beyond DHCS and Xerox; and addresses significantly more functional requirements than Release 1, there is great risk that Release 2 will not be completed on June 2015 as planned.
- In April 2014, this project switched from a “waterfall” approach to an “agile” approach to more quickly and frequently deliver and test enhancements and changes. The state auditor notes that while this presents opportunities for the project, there are risks in that neither DHCS nor Xerox has extensive experience in the agile software development methodology.
- Xerox has experienced problems implementing Medicaid Management Information Systems in other states. The state auditor finds that this suggests that DHCS has a high-risk of experiencing more delays and problems before the new system is fully implemented.

DHCS acknowledges the concerns recently raised by the state auditor. DHCS intends to address these concerns by hiring a recognized industry leader in agile software development to conduct periodic assessments of the project’s software development methodology. Additionally, DHCS notes that it has a contract amendment in process that would include 120 discrete pay points (deliverables that trigger payments to Xerox) that are tied to that functionality. The intent of this amendment would be to ensure that Xerox is only paid for business functionality that is successfully delivered into production.

Background. CA-MMIS processes and pays approximately \$19.8 billion a year in Medi-Cal fee-for-service health care claims to providers for medical care services provided to Medi-Cal beneficiaries, as well as the claims for other DHCS health care programs. The fiscal intermediary (FI), currently Xerox, operates and maintains the system as a contractor of DHCS.

DHCS is responsible for the overall administration, management, oversight, and monitoring of the FI contract with Xerox and all services provided under the contract. Other FI services include: the operation of a telephone service center and provider relations functions (publications, outreach, and

training), system operations, updates and enhancements, processing eligibility inquiry transactions, treatment authorization requests, and service authority requests. The FI is also responsible for planning, developing, designing, testing, and implementing a new replacement system to replace the current thirty year-old legacy system that will put into effect current technology and support a service-oriented architecture, consistent with the new federally mandated Medicaid Information Technology Architecture (MITA).

SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, requires the California State Auditor (state auditor) to monitor the transfer of operational responsibility for the California Medicaid Management Information System (CA-MMIS) to Affiliated Computer Services, a Xerox company (from the prior contractor, Hewlett-Packard), and the subsequent design, development, and implementation of a replacement system. The legislature has received anecdotal complaints from providers that under the current system there is a very high rate of claims that are inappropriately denied

Subcommittee Staff Comment and Recommendation—Informational Item. Given the significance of this system and the vendor’s track record in other states, as noted by the state auditor, it is important that DHCS continue to provide state control agencies and the Legislature with regular updates on the status of this project and be transparent in identifying issues as they arise.

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

1. Please provide an overview of steps DHCS is taking to address the state auditor’s concerns.
2. What is the status of the contract amendment?

11. Medi-Cal: Electronic Health Records Incentive Program - Staffing

Budget Issue. DHCS requests the extension of two limited-term positions for two years (July 1, 2015 through June 30, 2017) and the conversion of six limited-term positions to permanent positions for the Medi-Cal Electronic Health Records (EHRs) Incentive Technical Assistance Program. The positions will continue efforts to advance the adoption and meaningful use of EHRs and the establishment of a provider technical assistance program. These positions have never been filled because DHCS was unable to secure external funding to support these positions.

Additionally, DHCS requests funding for a consulting contract with subject matter experts on federal/state administrative oversight and reporting relative to the technical assistance program with a cost of \$200,000 per year (\$20,000 MRMIF, \$180,000 Federal Fund) for 2015-16 through 2017-18. Total annual costs for the positions and contract funding are \$1,162,000 (\$117,000 Major Risk Medical Insurance Fund (MRMIF) and \$1,045,000 Federal Fund).

These requests are made to support the funding (\$3.75 million MRMIF) authorized by SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014, to support the Medi-Cal Electronic Health Records Incentive Program and to receive \$37,500,000 million in federal funds for a statewide provider technical assistance program for eligible providers.

DHCS also requests the following budget bill language to allow SB 870's funding to be available for encumbrance or expenditure until June 30, 2018:

4260-490 – Reappropriation, Department of Health Care Services. Notwithstanding any other provision of law, as of June 30, 2015, the amounts specified in the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure until June 30, 2018:

0313 ---- Major Risk Medical Insurance Fund,

(1) Up to \$3,750,000 in Section 15, Chapter 40, Statutes of 2014, for purposes of electronic health records technical assistance in accordance with the State Medicaid Health Information Technology Plan as specified in Section 14046.1 of the Welfare and Institutions Code.

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 the outlay of federal money estimated to be roughly \$4.5 billion for California and \$45 billion nationally for Medicare and Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade and use electronic health records in accordance with the act's requirements. The goal of HITECH is to improve the quality, safety, and efficiency of health care through "meaningful use" of EHRs. HITECH will result in a significant increase in provider adoption and use of EHR systems, resulting in HITECH's desired health care improvements, and an overall improvement in public health. The use of EHR technology in this manner includes the use of electronic prescribing (ePrescribing), submission of clinical quality measures, reporting to immunization and disease registries, and exchanging health information among Medi-Cal providers, hospitals and DHCS to improve the quality of patient care.

The Medi-Cal EHR Incentive Program is a multi-year program that began on October 3, 2011 for eligible hospitals, November 15, 2011 for groups/clinics, and January 3, 2012 for eligible providers. The incentive program will operate through December 31, 2021. Since the implementation of the Medi-Cal EHR Incentive Program, DHCS has authorized more than 20,000 incentive payments to over 15,000 providers and 260 hospitals. This has resulted in more than \$1 billion in incentive payments made to date. DHCS expects to distribute between \$100 and \$200 million per year for the remainder of the program. DHCS has estimated approximately \$2 billion will be distributed to providers over the course of the ten year program.

DHCS's Office of Health Information Technology (OHIT) received federal approval for 90/10 reimbursement for the implementation of a \$37.5 million direct technical assistance program for advancement of EHR adoption and provider participation in the Medi-Cal Incentive program that is similar to the sunseting REC program. As part of the 2014 budget, \$3.75 million from MRMIF was provided to DHCS to draw down the \$37.5 million in federal funds. This funding will allow OHIT to procure vendors for the statewide provider technical assistance effort as well as fund state staff and consulting services necessary to implement the program. The program will primarily target providers and specialists not previously supported by the RECs. As discussed above, due to existing workload, current OHIT staff cannot perform the additional work necessary to implement the additional technical assistance program that has been approved by CMS.

According to DHCS, the approval of this proposal will provide the state with resources needed to continue and further advance the Medi-Cal EHR Incentive Program through technical assistance to providers as described in the Project Book above. Advancement of the program constitutes workload above and beyond what OHIT can support without these positions. Without sufficient resources to coordinate and conduct these activities, the department may be unable to continue meeting the requirements for state participation in the program, which is expected to result in a total distribution of \$2 billion in federal incentive funds to California providers, and ensure continue enhanced federal funding for administration of the program.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal to continue efforts to advance the adoption and meaningful use of EHRs in the Medi-Cal program.

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

1. Please provide an overview of this proposal.
2. What is the status of the awarding of the \$41.25 million (\$37.5 million in federal funds) for the direct technical assistance program?

12. Medi-Cal: Behavioral Health Treatment

Oversight Issue. SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014 requires DHCS to add behavioral health treatment (BHT) services, such as applied behavioral analysis (ABA), as a covered benefit in Medi-Cal to the extent required by federal law. Subsequent to the enactment of the 2014 budget, the federal government issued guidance indicating that BHT should be a covered Medicaid benefit for eligible children and adolescents with autism spectrum disorder (ASD). In response to the guidance, DHCS submitted [State Plan Amendment \(SPA\) 14-026](#) to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2014 to seek the necessary approval to include BHT as a covered Medi-Cal service for individuals under 21 years of age with ASD.

DHCS's interim guidance requires Medi-Cal managed care plans to provide medically necessary BHT services for eligible children and adolescents with ASD effective September 15, 2014. All children receiving BHT services on September 14, 2014 through a regional center will continue to receive those services through the regional center until such time that DHCS and the Department of Developmental Services (DDS) develop a transition plan.

The Medi-Cal budget includes \$89 million General Fund in 2014-15 and \$151 million General Fund in 2015-16 for the provision of BHT services to eligible children with ASD. As part of the budget, DHCS assumed that the average monthly cost of BHT is \$3,000-\$3,750 and that an estimated 4,000-5,000 children in 2014-15 and 8,000-10,000 children in 2015-16 would receive these services.

The Governor's proposed 2015-16 budget for DDS also assumes a \$2 million decrease (\$1 million General Fund) over the current year budget to reflect a reduction in expenditures for an estimated 292 new consumers who would receive BHT services through the DHCS as a Medi-Cal benefit instead of at the regional centers.

Since September 2014, DHCS has convened monthly public stakeholder meetings regarding the implementation of this benefit.

Comprehensive Diagnostic Evaluation. Generally, Medi-Cal children age three or older would be eligible for BHT when a comprehensive diagnostic evaluation (CDE) indicates that evidence-based BHT services are medically necessary and recognized as therapeutically appropriate. The CDE has multiple components and includes evaluations in cognition, speech and language, and other motor skills.

Concerns have been raised regarding waitlists for CDEs. DHCS indicates that it is not aware of any wait lists for CDEs for Medi-Cal beneficiaries. DHCS conducts monitoring of network adequacy through secret shopping; analysis of grievances and appeals, ombudsman calls, and monthly utilization data; stakeholder input; and regular check-ins with Medi-Cal managed care health plans. DHCS is also in the process of convening a CDE workgroup which will provide input into how to best utilize the CDE process.

Transition Plan. DHCS and DDS are in the processing of developing a transition plan that will describe how children receiving BHT services at regional centers will transition to receiving these benefits through Medi-Cal. In 2013-14, there were about 7,700 children and adolescents enrolled in Medi-Cal

who receive BHT services through DDS. DHCS and DDS are in the process of determining how many of these children have Medi-Cal as their primary coverage and would be transitioned to Medi-Cal. Of the 7,700 it is estimated that approximately 1,922 are “institutionally deemed” for Medi-Cal, meaning that only the income and resources of the child (ages 3 to 18) are considered when determining eligibility (instead of the entire family’s income and resources). Institutional deeming is part of the federal home and community-based waiver program. If a child/family chose to no longer be deemed eligible for Medi-Cal, they could continue receiving BHT through a regional center.

DHCS notes that it plans to phase this transition based factors such as the number of children in each county receiving these services and the number of regional centers in the county. DHCS indicates that once the state has a draft transition plan, it will seek comments from stakeholders.

DHCS indicates that the regional centers and Medi-Cal managed care plans each have identified liaisons to assist in the transition and coordination of BHT services. The liaisons already are, and will continue, communicating regularly to identify and remedy potential issues that may arise. Additionally, regional centers regularly review implementation of the individual program plan (IPP) with families to determine if satisfactory progress is being made and/or if any changes to the IPP are needed. DHCS notes that these IPP reviews provide an opportunity to verify that the child is receiving BHT services through Medi-Cal.

LAO Assessment. LAO finds that based on the rate of the ongoing phase-in of BHT services and its review of the preliminary data used to estimate the cost of BHT services in the Governor’s budget, the estimated costs to provide BHT services (excluding costs in the DDS budget) in 2014–15 and 2015–16 are likely to be lower at the time of the May Revision.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the implementation of this benefit. The following issues should be considered:

- **Budget to Implement BHT is Overstated** – Subcommittee staff concurs with the LAO assessment that the Medi-Cal budget overstates the level of funding (for the current year in particular) for the implementation of this benefit. As of March 6, 2015, 814 children in Medi-Cal were receiving BHT. As noted above, in the current year the Medi-Cal budget assumes that 4,000 to 5,000 children are receiving BHT, which is thousands more than the number of children actually receiving BHT in Medi-Cal.
- **BHT Rate Not Yet Finalized.** DHCS is still in the process of determining the rate to be paid to Medi-Cal managed care plans to provide this benefit. DHCS expects to have this rate available no sooner than May. This rate level is important because it must be sufficient to ensure enough providers participate.
- **A Thoughtful Transition Plan Will Be Critical.** The policies outlined in the transition plan will be critical to ensure that there are no disruptions in treatment for these children. Subcommittee staff finds that DHCS intends to proceed cautiously and thoughtfully and plans to engage stakeholders prior to the finalization of the transition plan. However, it will be important for DHCS and DDS to (1) engage stakeholders and consumer groups, early

and often, on how the state plans to communicate these changes to consumers, (2) share data to assist in the planning for this transition, (3) make efforts to retain the current providers for continuity, and (4) minimize any impact to consumers and families.

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

1. Please provide an overview of the implementation of BHT as a Medi-Cal benefit.
2. Please provide an update on the development of the transition plan with the Department of Developmental Services. How is DHCS planning to ensure that consumers receiving these services through regional centers do not experience any interruption in services or see a reduction in the quality and quantity of services?
3. How is DHCS engaging with stakeholders in the development of the transition plan?
4. If an ASD diagnosis is not established through the comprehensive diagnostic evaluation, do federal Early and Periodic Screening, Diagnostic, and Treatment requirements provide that a Medi-Cal child could receive BHT, if BHT is determined to be medically necessary?
5. Is DHCS aware of any wait lists or long waits to get a comprehensive diagnostic evaluation? How is DHCS monitoring this?

13. 1991 Realignment Technical Trailer Bill Language

Budget Issue. The Administration proposes trailer bill language to eliminate the need to redirect sales and use tax and vehicle license fee revenues between the Health and Social Services Subaccounts and make necessary technical and clarifying changes related to AB 85 (Committee on Budget), Chapter 24, Statutes of 2013.

Background. AB 85 modified 1991 Realignment Local Revenue Fund (LRF) distributions to capture and redirect county savings resulting from the implementation of federal health care reform effective January 1, 2014. AB 85 established the Family Support Subaccount within the LRF beginning in 2013-14.

The Family Support Subaccount receives sales tax revenues redirected from the Health Subaccount, which then redistributes the funds to counties for the CalWORKs program. While this redirection mechanism frees up General Fund resources to pay for Medi-Cal costs, according to the Administration, the process to achieve this is significantly burdensome for the State Controller's Office and the Department of Finance.

The Administration indicates that this proposal to streamline the distribution of realignment funds will significantly reduce workload and improve administrative efficiencies for the State Controller's Office and the Department of Finance. This proposal does not result in any material change to 1991 State and Local Realignment.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt this proposed placeholder trailer bill language. No concerns have been raised with this technical trailer bill language.

Questions. The Subcommittee has requested the Department of Finance to respond to the following:

1. Please provide a brief overview of this proposal.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

**OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, April 23 (Room 4203)
Agenda Part A – Health Related Issues**

4265 Department of Public Health

1. Oral Health Program

- Informational item

2. Office of Health Equity

- Informational item

3. Richmond Laboratory – Capital Outlay

- Motion to approve as budgeted.
- Vote - 2-0, Senator Stone absent

4. Women, Infant, and Children Program

- Held open

5. California Home Visiting Program

- Motion to approve as budgeted.
- Vote - 2-0, Senator Stone absent

6. Ebola Emergency Preparedness

- Motion to approve as budgeted.
- Vote - 2-0, Senator Stone absent

7. Proposition 99 - California Tobacco Health Protection Act of 1988

- Motion to approve as budgeted.
- Vote - 2-0, Senator Stone absent

4260 Department of Health Care Services

1. Family Health Programs

- Held open

2. Limited Benefit and Special Population Programs Eligibility Requirements

- Motion to approve staff recommendation.
- Vote - 2-0, Senator Stone absent

Subcommittee Staff Comment and Recommendation—Modify TBL. It is recommended to modify this proposed trailer bill language by deleting the provisions related to GHPP. While the Administration’s goal to promote comprehensive coverage is understandable, the components of this proposal related to GHPP could disrupt care or increase the cost of care for some of the state’s most medically vulnerable persons. For example, persons on GHPP would likely have to pay higher prices for expensive drugs, such as clotting factor, if they are eligible and enroll in a Covered CA health plan. Additionally, although this proposal includes a “wrap” to provide specialized services in GHPP that would not be provided through a Covered CA health plan, the state has not yet implemented any Covered CA “wraps” and it is not clear when this could be accomplished.

Finally, in order to keep the cost of premiums affordable, Covered California plans have utilized selective contracting. There have been reports in the media and by stakeholders that enrollees could not find a Covered California plan that included their provider and sometimes it was not clear if the drug they needed would be on the formulary. Continuity of care for the individuals on GHPP is critical given that this is a fragile and chronically ill population.

3. Modification of Major Risk Medical Insurance Program

- Held open

4. Medi-Cal: Coordinated Care Initiative

- Held open

5. Medi-Cal: Skilled Nursing Facility Quality Assurance Fee Extension

- Held open

6. Medi-Cal: Managed Care Office of the Ombudsman

- Motion to approve as budgeted.
- Vote - 2-0, Senator Stone absent

7. Medi-Cal: Impact of President’s Executive Order

- Held open

8. Medi-Cal: Continuation of 1115 Waiver Workload

- Motion to approve as budgeted.
- Vote - 2-0, Senator Stone absent

9. Medi-Cal: Palliative Care

- Motion to approve as budgeted.
- Vote - 2-0, Senator Stone absent

10. Medi-Cal: CA-MMIS

- Informational item

11. Medi-Cal: Electronic Health Records Incentive Program - Staffing

- Motion to approve as budgeted.
- Vote - 2-0, Senator Stone absent

12. Medi-Cal: Behavioral Health Treatment

- Held open

13. 1991 Realignment Technical Trailer Bill Language

- Motion to adopt placeholder trailer bill language as proposed.
- Vote - 2-0, Senator Stone absent

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Holly J. Mitchell

**Senator Jeff Stone, Pharm. D.
Senator William W. Monning**



**April 23, 2015
9:30 a.m. or Upon Adjournment of Session
Room 4203**

PART B

Consultant: Samantha Lui

<u>Item</u>	<u>Department</u>	<u>Page</u>
5180	Department of Social Services	
1.	BCP #9: Coordinated Care Initiative – Extension of Limited Term Positions	2
4170	Department of Aging	
1.	Overview	4
2.	Oversight: Expanding Capacity to Service Persons with Dementia in Managed Care Plans Grant	7
3.	Oversight: Model Approaches to Statewide Legal Assistance Systems Phase II Grant	8
4.	April Letter - BCP #1: Medicare Improvements for Patients and Providers Act 2014 Grant	9
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6.	April Letter – BCP #4: Supplemental Nutrition Assistance Program-Education Program Extension	14
7.	Advocate Proposals	17

PLEASE NOTE: Only items contained in the agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the Agenda, unless otherwise directed by the Chair. 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**1. BCP #9: Coordinated Care Initiative Limited -Term Positions Extension**

Budget Issue. The Administration requests a two-year extension of nine existing limited-term positions. The positions will certify managed care agencies; implement and manage contract provisions between a managed care health plan and agencies; develop provider training curriculum; and revise existing social worker training modules to comply with new managed care requirements.

Background. The 2012 budget authorized the Coordinated Care Initiative¹ (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits. The CCI is being implemented in seven counties² (Los Angeles, Orange³, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). The purpose and goal of CCI are to promote the coordination of health, behavioral health, and social care for Medi-Cal consumers and to create fiscal incentives for health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than home and community-based care). See table below for enrollment summary information.

CCI established a county maintenance-of-effort funding formula for the In-Home Supportive Services (IHSS) program. Additionally, CCI established a Statewide Authority for purposes of collective bargaining with respect to the wages and benefits for IHSS providers in the CCI counties. The Statewide Authority for collective bargaining begins in a CCI county when enrollment into CCI is completed in the county. San Mateo transitioned to the Statewide Authority in February 2015, and will be followed by Los Angeles, Riverside, San Bernardino and San Diego in July 2015. Santa Clara is anticipated to transition January 2016 and finally Orange in August 2016.

Justification. According to the department, “failure to provide the requested resources to ensure oversight of CCI financial funds could result in millions of dollars lost and delayed payments to IHSS providers.” Examples of job activities for the request positions include:

- Create all county letters, all county information notices, and county fiscal letters to communicate policy and regulations;
- Maintain knowledge of statutory and regulatory rules;
- Develop a referral process for appeals, related to the additional plan benefits;
- Establish fee structure for the monitoring of qualified agencies to assure compliance; and,
- Develop IHSS training curricula.

Staff Comment and Recommendation. **Approve.** The Governor’s budget warns that if certain issues are not resolved, all parts of CCI would cease to operate. Approving the existing limited-term positions for an additional two years appears (a) consistent with the pace of CCI implementation, and (b) prudent,

¹ Enacted in July 2012 through SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012, and amended by SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013.

² Alameda County was initially part of CCI but given fiscal solvency issues with one of its plans, it will not participate in CCI.

³ It is projected that Orange County will begin CCI no sooner than July 2015.

given the Administration's monitoring of CCI. For more staff comment related to CCI, please see pages 34-36 on Part A of the agenda.

Questions

1. To DSS: Please summarize the proposal and need for the extension of existing positions.
2. To DSS/DOF: If CCI ceases to operate, will these positions be eliminated?

4170 Department of Aging

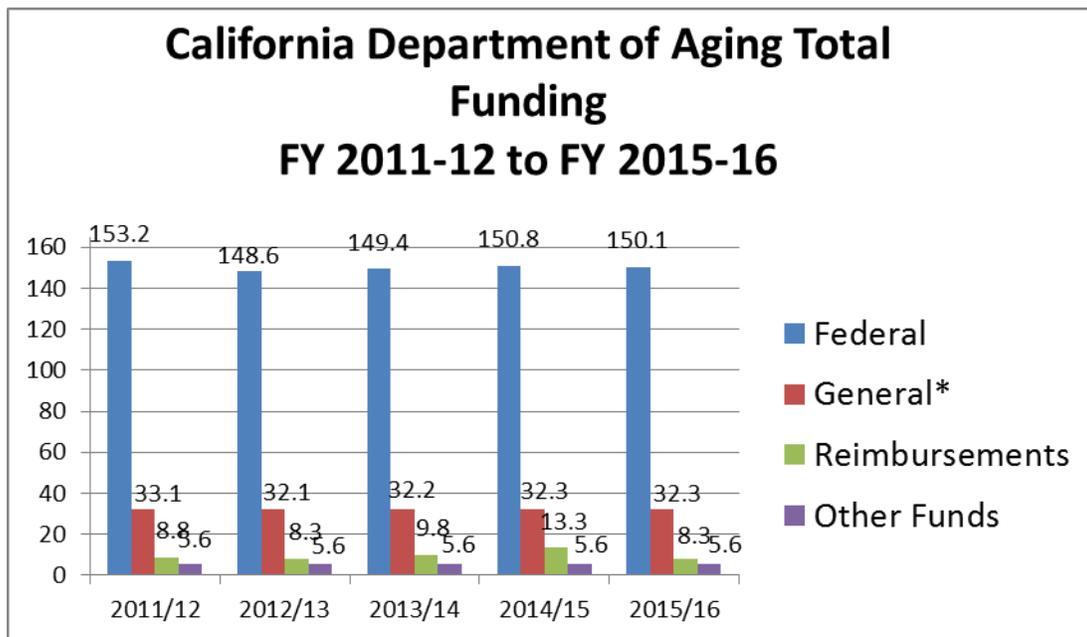
1. Overview

With a proposed 2014-15 budget of \$194.45 million (\$30.5 million General Fund) and 115 positions, the California Department of Aging (CDA) administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State. The department is the federally designated State Unit on Aging, and administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program.

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

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

Funding. The table below shows CDA’s funding history for the last five years, starting in fiscal year (FY) 2010-11 to the budget year.



Between July 2007 and June 2012, the CDA budget was reduced by approximately \$30.1 million in GF. 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, representing a loss of approximately \$2.6 million.
- Sequestration - Federal Fiscal Year (FFY) 2013 and ongoing. CDA lost approximately \$9.8 million in federal funding in FFY 2013 for its senior programs due to the federal sequestration. The Nutrition sequestration reduction was partially offset in FY 2013-14 and FY 2014-15 with \$2.7 million received from the Assembly Speaker's Office. In 2014, Nutrition federal funding was restored to the 2012 funding levels. Sequestration cuts have continued for Supportive Services, Preventive Health, Family Caregiver, Ombudsman, and Elder Abuse Prevention in the FFYs 2014 and 2015.
- Ombudsman Funding Changes. All General Fund local assistance funding for the Ombudsman program was eliminated during FY 2008-09. Between FY 2009-10 and FY 2011-12, several one-time appropriations and funding solutions were utilized to partially backfill lost General Fund and federal Citation Penalties Account monies. In 2012-13 and 2013-14, the implementation of federal sequestration reduced federal Ombudsman funding by about \$0.2 million. Local Assistance funding for Ombudsman, currently amounts \$6.3 million includes federal and state funds from the Skilled Nursing Facility Quality Assurance Fund and the state Citation Penalties Account funds. According to the department, this is \$2.3 million lower than the 2008-09 funding level.
- General Fund. Between FY 2007-08 and FY 2011-12, the department's budget was reduced by approximately \$30.1 million General Fund. This includes reduced state local assistance funding for Community Based Services, Supportive Services, Ombudsman and Elder Abuse Prevention, Senior Community Employment, and a reduction in MSSP funding. Please see the chart on the following page.

General Fund Reduction History

Program	Fiscal Year				Total Reduction	General Fund 2015/16
	2008/09	2009/10	2010/11	2011/12		
Nutrition	-569,000				-569,000	8,306,000
Community Based Services Program (CBSP)	-1,189,000	-10,374,000	-3,458,000		-15,021,000	0
Senior Legal Hotline	-250,000				-250,000	0
Supportive Services	-1,707,000				-1,707,000	0
Ombudsman and Elder Abuse Prevention	-3,846,000				-3,846,000	0
Senior Community Employment	-3,290,000				-3,290,000	0
State Operations	-206,000	-106,000	-104,000		-416,000	956,000
Multipurpose Senior Services Program (MSSP)*	-2,526,000			-2,500,000	-5,026,000	20,232,000*
State Operations					0	2,844,000
Grand Totals	-13,583,000	-10,480,000	-3,562,000	-2,500,000	-30,125,000	12,106,000

* The \$20,232,000 is displayed in CDAs budget. However, upon enactment of the budget the funds are transferred to DHCS for the funding of the MSSP program

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

- Administration on Aging, Chronic Disease Self-Management Education Grant**
 In 2012, CDA was awarded a \$1.5 million, three year (September 1, 2012 to August 31, 2015) Chronic Disease Self-Management Education (CDSME) Grant from the Administration on Aging. CDA is collaborating with CDPH and Partners in Care Foundation (the grant technical assistance center), to make of the Chronic Disease Self-Management Program available to older and younger adults with chronic health conditions. Funded counties include Los Angeles, Orange, Napa, San Diego, and Solano. This six-week evidence based workshop empowers participants to make important behavioral changes to improve their health and well-being. Although this grant does not end for six months, California has met and exceeded its performance goals with 7,600 workshop completers to date and is the highest performing state among the 21 grantees.

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

Questions

1. To CDA: Please provide an overview of the department’s programs and services.

2. Oversight: Expanding Capacity to Service Persons with Dementia in Managed Care Plans Grant

Budget Issue. Last year, CDA received \$820,000 in budget authority (\$153,000 in FY 2013-14; \$276,000 for FY 2014-15; \$311,000 for FY 2015-16; and \$80,000 for FY 2016-17) for a three-year (October 1, 2013, to September 30, 2016) grant from the federal Administration on Community Living.⁴ The grant funding focuses on building a dementia-capable integrated system of care for patients with Alzheimer's disease, or related disorders, enrolled in California's Cal Medi-Connect. Specifically, the grant educates care managers to provide person-centered services; and, provides care coordination to individuals and family caregivers, including referrals to services and community support.

Background. In April 2013, the Administration on Aging released a competitive funding opportunity for State Units, and CDA was awarded \$820,000 for its proposal to work with local Alzheimer's Association Chapters to target patients, family caregivers, and care managers associated with health plans in the pilot counties involved. CDA partners with Department of Health Care Services, Alzheimer's Association Chapters, and participating managed care plans to provide training and technical assistance to Cal Medi-Connect care managers focused on increasing their ability to successfully identify and serve plan members with dementia and refer these individuals and family caregivers to community based services. Local Alzheimer's Association Chapters cover the match requirement.

According to the department, the Northern and Southern California Alzheimer's Association chapters have trained 143 Cal MediConnect care managers from HealthNet, Anthem, Care 1st, Health Plan of San Mateo, and Santa Clara Family Health Plan. A more intensive level of training is being developed for the dementia care specialists within each of these health plans that will occur this summer. Reference materials, a dementia specialist toolkit, monthly case consultation, and a referral process to the Alzheimer's Association and other community based organizations has also been developed.

Staff Comment & Recommendation. No action needed. The item is included for oversight purposes.

Question

1. To CDA: Please provide an update on the grant. Has the department received positive feedback from care managers regarding the training and tools?

⁴ The Administration on Community Living bring together the efforts of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability to serve as the Federal agency responsible for increasing access to community supports

3. Oversight: Model Approaches to Statewide Legal Assistance Systems - Phase II Grant

Budget Issue. Last year, CDA received \$536,000 in federal local assistance expenditure authority (\$179,000 for FY 2013-14 through Section 28 process; \$179,000 for FY 2014-15; and, \$179,000 for FY 2015-16) over three state fiscal years (August 1, 2013, to July 31, 2016) for the Model Approaches Phase II grant.

Background. In 2009, CDA, in partnership with the LSNC and Legal Aid Association of California, applied for and were awarded a four-year federal Model Approaches to Statewide Legal Assistance Systems Phase I grant. With the Phase I grant, CDA and its partners developed a model of delivering coordinated, cost-effective legal services, responsive to the needs of seniors, particularly those who are low-income or have limited English proficiency.

In May 2013, the Administration of Community Living released a competitive three-year funding opportunity to implement a Phase II grant. CDA was awarded the Phase II grant, which seeks to deliver and increase the availability of high quality, low cost legal assistance to vulnerable California seniors; provide training and make accessible online self- help legal educational materials; and improve cohesiveness of the statewide network of partners. CDA currently partners with Legal Services of Northern California (LSNC) and the Legal Aid Association of California to implement the grant.

According to the department, during the reporting period, the funding has supported the following:

- Provision of direct legal services, such as estate planning, to more than 150 seniors in three rural communities;
- More than 10 free trainings and webinars to legal advocates on elder abuse prevention and OAA priority legal issues;
- Expansion of the LawHelpCA.org and AyudaLegalCA.org, which are free online self-help resource accessible to seniors and legal advocates, available in English and Spanish;
- A survey on the capacity of OAA legal programs to serve older Californians facing elder abuse, neglect, and financial exploitation. This survey will be a useful tool to develop recommendations on addressing priority legal issues, including those specifically related to elder abuse, neglect, and financial exploitation.
- Updating the California Statewide Guidelines for Legal Services, a tool that defines the elements of a high-quality, high-impact, cost-efficient legal services delivery system to effectively target limited resources to those elders in greatest need.

Staff Comment and Recommendation. Without additional federal or state funds, it may be unlikely that services provided by this grant can or will be sustained. Information is included for oversight and discussion; no action at this time.

Question

1. To CDA: Please provide an update on how the grant funding is supporting activities that assist seniors.

4. April Letter - BCP #1: Medicare Improvements for Patients and Providers Act 2014 Grant

Budget Issue. The budget request includes two components.

First, the Department of Aging (CDA) Health Insurance Counseling and Advocacy Program (HICAP) requests \$2.9 million in federal budget authority over four state fiscal years, as follows:

- \$975,000 (\$878,000 in local assistance and the remainder in state operations) for the budget year;
- \$1 million (\$900,000 in local assistance and \$100,000 in state operations) for 2016-17; and,
- \$300,000 (\$270,000 in local assistance and \$30,000 in state operations) for 2017-18.

Current year authority (\$641,000) is being requesting through the Section 28 letter process. Once CDA receives the second- and third-year grant awards, local assistance funding will be allocated to the Area Agencies on Aging (AAA). The table below details the federal budget authority request, by fiscal year.

	2014-15*	2015-16	2016-17	2017-18	Total
State Operations	63,000	97,000	100,000	30,000	290,000
Local Assistance	578,000	878,000	900,000	270,000	2,626,000
Total	641,000	975,000	1,000,000	300,000	2,916,000

CDA will distribute Medicare Improvements for Patients and Providers Act (MIPPA) grant funds to the 33 AAAs, which will subcontract a portion of, or all of, their funds to HICAP and Aging and Disability Resource Centers (ADRCs). These contracts will use funds to provide outreach and assistance to the individuals, including those who live in rural areas, as well as beneficiaries who may be eligible for low-income subsidy program (LIS), Medicare Savings Program, and Medicare Prescription Drug Coverage. No state match is required for this grant. No new positions are being requested.

Second, the department also requests provisional budget bill language to allow carryover of unspent prior year local assistance funds into the following state fiscal year for the grant duration.⁵ According to the department, since there will be variation in the challenges faced by various entities in accessing hard-to-reach individuals, and there are inherent differences between the state and federal fiscal years, the ability to carryover funds will ensure that CDA can maximize the use of all available grant funding.

Background. In 2008, Congress enacted MIPPA, which includes provisions to strengthen Medicare access for low-income beneficiaries, reduce racial/ethnic disparities, and increase accountability measures for Medicare Advantage programs. Since 2008, MIPPA grants have helped millions of low-income people on Medicare in paying for their prescriptions and health care.

CDA has received three MIPPA grants (2009 - \$1.3 million for a two-year project; 2010 - \$2.2 million for a two-year project; and 2013- \$901,746 for a one-year project) to help Medicare beneficiaries learn about and apply for LIS, MSP, and Part D; and to help beneficiaries learn about Medicare’s health and wellness benefits. During MIPPA 2013, hundreds of project-related outreach and enrollment activities took place in senior centers, food banks, Social Security offices, pharmacies, Independent Living Centers,

⁵ As of April 22, 2015, the department estimates around \$578,000 in local assistance funds would be eligible for carryover.

churches, low-income housing complexes, farmers markets, and grocery stores. Approximately two million consumers were reached during the one-year project, generating around 5,311 LIS/MSP applications, and exceeding by 840 applications the federally established goal of 4,471 applications.

In June 2014, the U.S. Department of Health and Human Services, Administration for Community Living (ACL) released a new MIPPA formula funding opportunity open to state entities that administer the state SHIPs for a new three-year MIPPA project. Funding is being awarded one year at a time, with \$20 million available nationwide for the project’s first year. CDA was awarded \$915,145 for the first year (September 30, 2014, through September 29, 2015) to help Medicare beneficiaries learn about and apply for LIS, MSP, and Part D. The funds will also help to support outreach aimed at preventing disease and promoting wellness. CDA anticipates receiving a similar amount for each of the remaining two federal fiscal years, for a total of \$2.9 million over the project period. The grant period extends from September 30, 2014, to September 29, 2017.

Justification. MIPPA has helped California support enhanced outreach and enrollment assistance related to LIS, MSP, Medicare Part D, and Medicare disease prevention and wellness benefits. This current request will allow CDA to continue these efforts through the participating AAAs and their subcontractors. With this grant, AAAs will focus particularly on reaching low-income beneficiaries and those who live in rural areas. These funds will also help to support outreach aimed at preventing disease and promoting wellness. CDA proposes the following allocation timetable for the MIPPA 2014 grant.

MIPPA	(Section 28) FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	Total
AAA	244,566	372,214	382,000	114,600	1,113,380
ADRC	253,488	385,138	395,000	118,500	1,152,126
SHIP	142,546	217,193	223,000	66,900	649,639
Total	640,600	974,545	1,000,000	300,000	2,915,145

Staff Comment and Recommendation. Approve. Staff recommends approving the request for federal expenditure authority as well as adopting placeholder provisional budget bill language to allow carryover of prior year local assistance funds. No concerns have been raised.

Questions

1. To CDA: Please provide an overview of the proposal.

5. April Letter – BCP #3; Aging and Disability Resource Connection Program Extension

Budget Issue. The department requests an extension of the Aging and Disability Resource Connection (ADRC) program in CDA for the next five years, including an extension for 2.5 five-year limited-term positions and reimbursement authority. CDA reimbursement authority will be required to collect federal funds from Department of Health Care Services (DHCS) and State Independent Living Council (SILC) through reimbursement through interagency agreements. The SILC portion of the funding is only for budget year and will be used for ADRC activities that target veterans. This request will not result in a General Fund increase. The table below outlines the budget authority request by fiscal year:

Funding Request	BY 2015-16	2016-17& Ongoing
CDA (Non-Add Authority)	143,000	143,000
Reimbursement Fund	330,000	337,000
Total	473,000	480,000

Given that CDA, DHCS, SILC, and the ADRC program have correlated missions and goals, the ADRC program will be funded jointly by CDA, DHCS, and SILC during FY 2015-16, and by CDA and DHCS from FY 2016-17 through FY 2019-20. DHCS will use its MFP demonstration (\$248,000) federal grant funds to provide partial funding for ADRC Program activities via an interagency agreement with CDA. CDA also will enter into an interagency agreement with SILC, in order for CDA to use SILC’s ACL funding (\$82,000) to continue to enhance the ADRC program infrastructure as it relates to serving veterans. Likewise, CDA will use existing ACL federal administrative funds (\$143,000) for the remainder of the program. Below is a table of workload delineated by funding source:

Funding Source	2015-16	2016-17 & Ongoing
CDA (Non-Add Authority)	143,000	143,000
DHCS	248,000	337,000
SILC	82,000	-
Total	473,000	480,000

Specifically, by funding source:

- From 2015-16 through 2019-20, CDA’s federal administration funds will support department staff to maintain, update, and deliver no fewer than six ADRC Options Counseling training for ADRC partners and others, as well as supporting up to six new ADRCs annually.
- From 2015-16 through 2019-20, DHCS Money-Follow-the-Person (MFP) federal grant⁶ funds will support staff to coordinate with assisted living representatives to implement strategies to

⁶ In January 2007, the California Department of Health Care Services (DHCS) was awarded a federal grant, a Money Follows the Person Rebalancing Demonstration, known as “California Community Transitions” (CCT). CCT demonstration services are available through September 30, 2016. DHCS works with lead organizations to identify eligible Medi-Cal beneficiaries, who have continuously resided in state-licensed health care facilities for a period of 90 consecutive days or longer. Facility stays for short-term rehabilitation services reimbursed by Medicare are not counted toward the 90-day required period. Lead

increase availability of assisted living units to MFP participants in need to housing; develop a procedure manual and training materials; and, collaborate with DHCS to work with skilled nursing facility providers to increase successful nursing-facility to community transitions for MFP participants.

- For the budget year, ADRC staff will collaborate with regional Veterans Affairs (VA) medical centers, so that the Veteran-Directed Home and Community Based Services Program becomes a core of ADRC functions. The Veteran-Directed HCBS program provides veterans the opportunity to self-direct their long-term supports and services and continue to live independently at home. Eligible veterans manage their own flexible budgets, decide for themselves what mix of goods and services best meet their needs, and to hire and supervise their own workers.

Background about ADRCs. Historically, older adults and individuals with disabilities received long-term supports and services (LTSS) in institutions, such as nursing homes, more often than in the community. Over the past 25 years, a number of key events have promoted shifting the balance toward community living. In 1990, Congress passed the Americans with Disabilities Act (ADA), which prohibited discrimination based on disability. In addition, the 1999 U.S. Supreme Court's Olmstead decision affirmed that the ADA applied to individuals with all disabilities, and it underscored a person's right to receive community-based LTSS in the most integrated setting possible. As a result, in 2003, the Administration on Aging, now called the Administration for Community Living (ACL) joined with the Centers for Medicare and Medicaid Services (CMS) to promote and fund the ADRCs in California. The ADRC model is a voluntary local initiative, built on the existing networks and funding of Area Agencies on Aging (AAAs) and Independent Living Centers (ILCs) to provide information and assistance and services to support community living. The object is also to improve access to existing services rather than create yet another parallel system of services.

ADRCs are intended to be a highly visible resource in the community where people can turn for information on the full range of LTSS options and a single (or coordinated) entry point for public LTSS and benefits. These centers are a resource for both public and private pay individuals and they serve older adults, younger adults with disabilities, and family caregivers, as well as persons preparing for future LTSS needs. Many of the individuals who contact the regional ADRCs are looking for Home and Community-Based Services resources; but, many are also trying to understand the different types of out-of-home care options, including residential (assisted living) and skilled nursing care.

Currently, six ADRC partnerships serve six counties (i.e., Alameda, Nevada, Orange, Riverside, San Diego, and San Francisco). A seventh, formerly designated partnership serving Butte, Colusa, Glenn, Plumas, and Tehama counties, is pending re-designation. There are also additional partnerships in the developing stages in Contra Costa, Marin, Monterey, San Benito, Santa Cruz, Ventura, and Yolo counties.

Staff Comment and Recommendation. Approve. Staff recommends approving the proposal to ensure that the department can continue its collaboration with various departments and partners to simplify access to long-term supportive services. In addition, the ADRC program can enhance the capacity of

organizations employ or contract with transition coordinators who work directly with willing and eligible individuals, support networks, and providers to facilitate and monitor their transition from facilities to community settings.

Money-Follows-the-Person organizations to conduct effective nursing facility transitions, and to work closely with Veterans Affairs Medical Centers and programs.

Questions

1. To CDA: Please briefly summarize the proposal, including how the department will continue to collaborate with DHCS Long-Term Care Division Staff and with SILC.
2. To CDA: Since the interagency agreement for funding with SILC is only for the budget year, how will the department ensure that ADRCs, in the future years, will continue to strengthen their partnership with veteran organizations?

6. April Letter – BCP #4: Supplemental Nutrition Assistance Program – Education Program Extension

Budget Issue. The Spring Finance Letter includes two parts:

First, the department requests expenditure authority for \$3.75 million in federal reimbursement funds, over four state fiscal years, to continue the Supplemental Nutrition Assistance Program-Education Program (SNAP-Ed) grant. CDA will receive these funds through an interagency agreement with the Department of Social Services (DSS).

CDA will administer grant activities and distribute funding to 19⁷ local Area Agencies on Aging (AAAs) that will provide SNAP-Ed interventions to low-income older adults either directly or through subcontracts with local providers.

Second, the department requests the extension of two limited-term positions (one Aging Program Analyst II and one Associate Governmental Program Analyst), in addition to funding authority (non-add position) for the Public Health Nutrition Consultant, who will provide oversight of the SNAP-Ed program for the duration of the grant period for four state fiscal years (three federal fiscal years - October 1, 2015 through September 30, 2018). The total cost will be \$1,087,000 in State Operations and \$2,663,000 in Local Assistance across four state fiscal years.

Reimbursement Authority Request by Fiscal Year

	2015-16*	2016-17	2017-18	2018-19	Total
State Operations	302,000	361,000	367,000	89,000	1,087,000
Local Assistance	648,000	889,000	883,000	211,000	2,663,000
Total	950,000	1,250,000	1,250,000	300,000	3,750,000

Background. The SNAP-Ed Program provides nutrition education and obesity prevention activities for low-income adults aged 60 and older, who are eligible for, or receiving, benefits from the Supplemental Nutrition Assistance Program (SNAP), known as CalFresh in California. The SNAP-Ed grant is 100 percent federally funded from the United States Department of Agriculture’s, Food and Nutrition Service (USDA, FNS), with no required state contribution or match. CDA currently is the only State Unit on Aging in the country providing SNAP-Ed evidence-based nutrition education and obesity prevention programs targeted to older adults. CDA became an official SNAP-Ed State Implementing Agency (SIA) on December 18, 2013, via its interagency agreement with CDSS.

⁷ The 19 participants include: California State University, Chico Research Foundation for PSA 2; CSU, Chico Research Foundation; Area 4 Agency on Aging; City and County of San Francisco, Department of Aging and Adult Services; Contra Costa County Employment and Human Services Department Area Agency on Aging; Alameda County; Ventura County AAA; Los Angeles County, Community and Senior Services; Riverside County; San Diego County; Imperial County, AAA; City of Los Angeles; AAA PSA 26; Sonoma County, AAA; AAA – Serving Napa and Solano counties; Stanislaus County, Department of Aging and Veteran Services; Merced County, AAA; Monterey County; and Kern County.

There are five SNAP-Ed SIA's that provide SNAP-Ed services to California's eligible population: CDSS, California Department of Public Health, Nutrition Education and Obesity Prevention Branch (NEOPB), University of California CalFresh Nutrition Education (UC CalFresh), CDA, and Catholic Charities of California (CCC). Starting on July 1, 2014, AAAs (either directly or through subcontractors) began providing SNAP-Ed services to older adults at eligible congregate nutrition sites and through other venues, such as low-income senior housing sites, farmers' markets, community centers, Title IIIIC home-delivered meal programs and other sites where SNAP-Ed eligible older adults congregate. The Department of Social Services allocated \$2.5 million to CDA in state fiscal year 2013-14 and 2014-15 to provide SNAP-Ed services through participating AAAs.

SNAP-Ed interventions are based on USDA, Food and Nutrition Service-approved evidence-based nutrition education and obesity prevention programs. These interventions are designed to increase the older adult participants' knowledge and foster behavioral changes so that older adult participants will make healthier food choices within their limited budgets and increase their physical activity. SNAP-Ed programs also provide indirect education, including distribution of materials such as cookbooks, recipes and nutrition fact sheets.

Local assistance funding is distributed to the participating local AAAs through subvention contracts. Each AAA receives \$20,000 as a base allocation. The remainder of the allocation is based on the number of Medi-Cal eligible individuals in the service area, a count of the unduplicated Older Americans Act Nutrition Program participants and a factor for geographic isolation (based on the geographic distribution of older individuals in the state) to develop an equitable method of distributing funds to the AAAs. The Medi-Cal eligible factor provides an estimate of the number of low-income individuals in the service area and aligns to SNAP-Ed's primary target populations. The unduplicated OAA Nutrition Program client count provides information on the total client reach of the service provider. The geographic isolation factor is included to provide sufficient funding in order to deliver services in hard to reach rural locations.

Justification. When compared to other age cohorts, older adults are at greater risk of having multiple chronic diseases. SNAP-Ed interventions will address two of the four modifiable health risk behaviors: physical activity and nutrition. Nutrition and physical activity interventions with older adults may reduce or delay the onset of many chronic diseases, decrease risk of falls, and reduce age-related loss of skeletal muscle mass. If CDA did not receive approval to continue SNAP-Ed services, thousands of low-income older adults would be unable to receive and benefit from SNAP-Ed interventions.

According to the department, "Delivering SNAP-Ed through the OAA Title IIIIC Nutrition Program and at other eligible sites is an efficient use of resources as the services provided to older adults in venues that already serve the exact target audience. The Nutrition Program offers the environmental supports necessary to facilitate the adoption of nutrition and physical activity choices conducive to the proper health and well-being of low-income and rural living older adults."

Some of the projected outcomes include:

Projected Outcomes

Workload Measure	2015-16 BY	2016-17 BY+1	2017-18 BY+2	2018-19 BY+3
Number of SNAP-Ed direct education activities (e.g.: classroom instruction/lessons, planned one-on-one nutrition education, grocery store or farmers' market tours, and cooking demonstrations)	5,480	7,560	7,480	1,800
Number of SNAP-Ed indirect education activities (e.g.: mass communications, public events and materials distribution that are not part of direct education efforts).	8,220	11,340	11,220	2,700

Staff Comment and Recommendation. Approve. Staff recommends approving the expenditure of federal reimbursement funds to continue supporting the SNAP-Ed program, as well as the extension of two limited-term positions across four state fiscal years.

Question

1. To CDA: Please briefly summarize the proposal.

7. Advocate Proposals

The subcommittee received the following requests for investment.

7A. California Association on Area Agencies on Aging

Budget request. The California Association of Area Agencies on Aging (C4A) is requesting consideration of a cumulative proposal of \$37 million General Fund for various programs:

- \$14 million for access to and coordination of services;
- \$6 million for senior nutrition to provide additional meals and nutrition support through the Brown Bag program (\$1 million) and Home-Delivered Meals (\$5 million);
- \$7.5 million for caregiving and family support for three programs that support caregivers: \$5 million for Alzheimer's Day Care, \$900,000 for Respite Purchase of Services, and \$1.6 million for Senior Companion.; and,
- \$9.5 million for protection against elder abuse This amount includes \$5 million for Adult Protective Services (APS) and \$4.5 million for the California Long-Term Care Ombudsman Program..

7B. Long-Term Care Ombudsman

Budget request. Long-Term Care Ombudsman requests:

- \$2.8 million for quarterly monitoring visits to all long-term care facilities in California through the addition of 45 positions.
- \$351,000 to supervise and train volunteers; and,
- \$1.1 million to investigate around 6,000 more complaints per year, through the addition of 18 positions.

Background. Total allocated local assistance funding for the program in 2015 stands at \$6.7 million compared to \$11.2 million in 2007-08.

Staff Comment and Recommendation. Staff recommends holding the above items open for further consideration.

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Holly J. Mitchell

Senator Jeff Stone, Pharm. D.
Senator William W. Monning



April 23, 2015
9:30 a.m. or Upon Adjournment of Session
Room 4203

PART B

Consultant: Samantha Lui
Outcomes in red

Item Department

5180 Department of Social Services

1. BCP #9: Coordinated Care Initiative – Extension of Limited Term Positions
Approve as budgeted (2-0; Sen. Stone absent)

4170 Department of Aging

1. Overview : Informational item.
2. Oversight: Expanding Capacity to Service Persons with Dementia in Managed Care Plans Grant: Informational item.
3. Oversight: Model Approaches to Statewide Legal Assistance Systems Phase II Grant
Informational item.
4. April Letter - BCP #1: Medicare Improvements for Patients and Providers Act 2014 Grant
Adopt staff recommendation to approve as budgeted. Adopt placeholder provisional budget bill language. (2-0; Sen. Stone absent)
5. April Letter – BCP #3: Aging and Disability Resource Connection Program Extension
Approve (2-0; Sen. Stone absent)
6. April Letter – BCP #4: Supplemental Nutrition Assistance Program Education Program Extension
Approve expenditure authority and extension of two limited-term positions. (2-0; Sen. Stone absent)
7. Advocate Proposals
Hold open.

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Holly J. Mitchell

**Senator Jeff Stone, Pharm.D.
Senator William W. Monning**



**April 30, 2015
9:30 a.m. or Upon Adjournment of Session
Room 4203, State Capitol**

Staff: Samantha Lui

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PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order noted in the Agenda unless otherwise directed by the Chair. 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. Thank you.

5175 Department of Child Support Services

1. Overview

The Department of Child Support Services (DCSS) is the single state agency designated to administer the federal Title IV-D mandated Child Support Program (CSP). California’s Child Support Program seeks to enhance the well-being of children and families’ self-sufficiency by providing professional services to locate parents, establish paternity, and establish and enforce orders for financial and medical support. DCSS estimates that there are over 1.3 million child support cases in California.

Administration and funding. The Child Support Program is locally administered and funded through federal and state funds, 66 percent and 34 percent, respectively. The program earns federal incentive funds based on the state's performance in the five federal performance measures (to be discussed below). Eligibility for federal Temporary Assistance to Needy Families (TANF) Block Grant funding is also contingent upon continuously providing federally-required child support services.

Service delivery. Local and regional child support agencies deliver services, which are available to all California residents. Families may be referred to CSP through public assistance programs. Non-aided families may apply for services at an office or online, and support is passed directly to the custodial party. After the initial application or referral, the family proceeds to case intake.

Collections. Basic collections represent the ongoing efforts of Local Child Support Agencies (LCSAs) to collect child support payments from parents paying support. Basic collections are collected from the following sources: wage assignments; federal and state tax refund intercepts; unemployment insurance benefit intercepts; lien intercepts; bank levies; and, direct payments from parents paying support. Collections made on behalf of non-assistance families are forwarded directly to custodial parties; while collections for families receiving assistance are retained and serve as recoupment of past welfare costs.

Total Collections Received, by source (FY 2013-14)	
Wage Withholding	\$1.6 billion
IRS federal income tax refund	\$168 million
FTB state income tax refund	\$33 million
Unemployment Insurance Benefits	\$62 million
Collections from other IV-D states	\$93 million
Non-custodial parents regular payments	\$310 million
Other sources* (Liens, workers’ compensation, disability insurance benefits offset, California insurance intercepts, and full collections program without wage levies)	\$94.8 million

Total child support distributed collections have grown from \$2.3 billion (FY 2003-04) to a projected \$2.316 billion for the budget year (\$1.95 billion non-assistance payments; \$367 million assistance payments). According to the Administration, wage withholding continues to be the most effective way to collection child support, constituting 67 percent (\$1.5 billion) of the total collections received. For more information about total collections received by source, please see the department’s chart, above.

Disregard payments to families. In addition to the California Work Opportunity and Responsibility to Kids (CalWORKs) grant, the custodial party receiving support also receives the first \$50 of the current month’s child support payment collected from the non-custodial parent. Forwarding the disregard portion of the collection to the family, instead of retaining it as revenue, results in reduced collection revenues for state and federal governments.

Automation System. Federal law requires each state to create a single statewide child support automation system that meets federal certification standards. There are two components of the California Child Support Automation System—Child Support Enforcement (CSE) and State Disbursement Unit (SDU).

- **Child Support Enforcement.** The CSE system contains tools to manage the accounts of child support recipients and to locate and intercept assets from non-custodial parents who are delinquent in their child support payments. In addition, it funds the local electronic data processing maintenance and operation costs.
- **State Disbursement Unit.** The SDU provides services to collect child support payments from non-custodial parents and to disburse these payments to custodial parties. The SDU complements the CSE system by providing services to collect and distribute child support obligation payments for both the IV-D and non- IV-D populations¹, and to prepare collection payment transactions for processing by the CSE system.

The California Child Support Automation System (CCSAS) has been implemented since 2008, and it received its federal certification as the statewide automation system shortly thereafter. The program's cost was approximately \$1.5 billion dollars, and implementation took around eight years. DCSS must maintain the automation system, and is responsible for ensuring that LCSAs can access the system. Ongoing annual costs for the CCSAS are approximately \$118.79 million (\$103.8 million CSE; \$14.97 million SDU).

2013 Federal Performance Measures. Federal incentive payments are based on the state's annual data reliability compliance and its performance in five measures, which were established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and the Child Support Performance and Incentive Act of 1998. The five performance measures are:

1. **Statewide Paternity Establishment Percentage (PEP)** measures the number of children born out-of-wedlock for whom paternity was acknowledged or established in the fiscal year compared to the total number of children in the state born out-of-wedlock during the preceding fiscal year. California measured 98.6 percent for Federal Fiscal Year (FFY) 2013, a decreased of three percentage points from FFY 2012 to FFY 2013. 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 89 percent for FFY 2013, an increase of 1.1 percentage points from FFY 2012 to FFY 2013. 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 63.3 percent for FFY 2013, an increase of 1.9 percentage points from FFY 2012 to FFY 2013. The federal minimum performance level is 40 percent.

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

4. **Cases with Collections on Arrears** measures the number of cases with child support arrearage collections as compared with the number of cases owing arrearages during the federal fiscal year. California measured 65.1 percent for FFY 201, an increase of 1.6 percentage points from FFY 2012 to FFY 2013. The federal minimum performance level is 40 percent.
5. **Cost Effectiveness for California** compares the total amount of distributed collections to the total amount of expenditures for the fiscal year, expressed as distributed collections per dollar of expenditures. California measured \$2.54 for FFY 2013, an increase of seven cents from FFY 2012 to FFY 2013. The federal minimum performance level is \$2.00.

DCSS estimates that California will be entitled to \$40.6 million in federal incentive funds for fiscal year (FY) 2014-15 and the budget year.

On December 11, 2014, the department issued Child Support Services letter 14-12, which outlines how the department will shift from evaluating statewide and local performance improvement efforts exclusively by the five federal performance measures to a more “customer-oriented, family-centered approach.” Performance management plans will be reviewed within the context of practice improvement indicators, as provided by the department; and, regional administrators will monitor LCSA implementation.

Update on Local Child Support Agency Revenue Stabilization. Since July 1, 2009, the state provides \$18.7 million (\$6.4 million General Fund) for 51 LCSAs to stabilize caseworker staffing, and to avoid a loss in child support collections. To receive an allocation of revenue stabilization funds, DCSS requires that revenue stabilization funds are distributed to counties based on their performance on two key federal performance measures—1) collections on current support and 2) cases with collections on arrears. According to 2013-14 data, DCSS found that revenue stabilization funds maintained statewide child support collections. Specifically, the stabilization funds have assisted in retaining:

- 231 child support caseworkers
- \$131.4 million in total distributed collections.
- \$17.7 million in net total assistance collections.
- \$8.4 million GF share of assistance collections.
- \$113.7 million in total non-assistance collections.

Uniform Interstate Family Support Act (UIFSA). The UIFSA governs the establishment, enforcement, and modification of interstate child and spousal support orders by providing jurisdictional standards and rules for determining which state’s order is controlling and whether a tribunal of this state may exercise continuing, exclusive jurisdiction over a support proceeding. The UIFSA was first developed by the National Conference of Commissioners on Uniform State Laws in 1992, was amended in 1996, 2001, and 2008. All states were required to enact UIFSA in 1998 as a condition to receive federal funds for family support enforcement. As a result, UIFSA is currently state law in all 50 states and jurisdictions.

The UIFSA 2008: 1) allows states to redirect support payments to a new state when all parties have left the state that originally issued a support order; 2) requires courts to permit out-of-state parties to appear telephonically in proceedings to establish, modify, or enforce a support order; and, 3) allows for the

provision of child support services to residents of other countries pursuant to the 2007 Hague Convention on the International Recovery of Child Support and Other Forms of Maintenance.

On September 29, 2014, the President signed the Preventing Sex Trafficking and Strengthening Families Act (Public Law (P.L.) 113-183), which, among its provisions requires the adoption of the UIFSA 2008 by the end of each state's 2015 legislative session, as a condition of federal child support program funding. The key changes from the 1996 version to the 2008 version include:

- Allowing California to redirect support payments to a new state when all parties have left the state that originally issued a support order;
- Requiring courts to permit out-of-state parties to appear telephonically in proceedings to establish, modify, or enforce a support order; and
- An expansion for provision of child support services to residents of other countries pursuant to the Hague Convention on the International Recovery of Child Support and Other Forms of Maintenance (Convention).

Currently, a policy bill is moving through the legislative process to address this federal provision of law. The department indicates that failure to enact the provisions of this measure may risk approximately \$680 million in annual federal child support funding.

Child Support Automation System – Information Technology Contract Staff. Last year, the budget authorized the department, starting in the budget year and until FY 2016-17, to shift \$11.95 million (\$4.06 million General Fund) from local assistance funding to state operations, and authorized the DCSS to establish 100 new full-time permanent positions to replace 100 information technology contract staff over a three year period. The resources would continue the maintenance and operations of the federally-mandated California Child Support Automation System (CCSAS) Child Support Enforcement (CSE) system. The Administration notes that this transition will result in a reduction of \$699,196 (\$237,727 GF) over three years. DCSS included the following timeline for the replacement of contractor staff with permanent state civil staff within multiple sections of the Technology Services Division.

Transition Schedule: Child Support Enforcement System, Maintenance, & Operations Resources

Fiscal Year	Contract Positions	Contract Costs	Civil Service Positions	Civil Service Costs	Annual Savings
2014-15	35	\$4,374,068	35	\$4,129,888	\$244,180
2015-16	38	\$4,910,975	38	\$4,562,277	\$348,698
2016-17	27	\$3,365,790	27	\$3,259,472	\$106,318
Total	100	\$12,650,833	100	\$11,851,637	\$699,196

To date, DCSS notes that they have filled 34 of the 35 positions approved for the current year. The department also expects to meet the projected annual savings for the current year.

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

Question

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

2. TBL 606: Continued Suspension of Performance and Health Insurance Incentive Payments

Budget Issue. The budget proposes suspending the health insurance incentive and the top ten improved performance incentive for two years. A continued suspension of these incentive payments results in \$4 million General Fund (GF) savings annually -- \$3 million GF for health insurance incentives and \$1 million GF for the performance incentive. No matching federal funds are available for these incentive payments.

Background on health insurance incentives. Existing state law requires the Department of Child Support Services to provide a health insurance incentive (\$50 per case) to the local child support agency (LCSA) for obtaining third-party health coverage, or insurance, for beneficiaries, if the budget provides GF support for the incentive. Since 2003, these health insurance incentive payments to LCSAs have been suspended. Currently, LCSAs must seek health coverage for children in their caseload. Given the recent changes regarding the responsibility of individuals to obtain health coverage introduced by the Affordable Care Act, DCSS is evaluating where this program fits into the overall health coverage framework and whether it should be retained or modified.

Background on improved performance incentives. Federal law sets minimum performance standards for the child support program. Existing state law requires the department to provide to ten counties, which demonstrate the best performance on federal and state performance standards, an additional five percent of the state's share of those counties collections used to reduce or repay aid. The counties must use the increased recoupment for child support-related activities that may not be eligible for federal child support funding under Part D of Title IV of the Social Security Act, including, but not limited to, providing services to parents to help them better support their children financially, medically, and emotionally. Since 2002, these top ten performance incentive payments to LCSAs have been suspended. DCSS is currently evaluating how to restructure the program to better target incentives towards specific reforms or innovations that could improve collections and the reliability of payment of child support owed by non-custodial parties.

Justification. According to the department, as part of the department's strategic plan for state fiscal years 2015-19, improving program performance, including establishing orders for monetary and medical support, is a priority. The department has been closely monitoring local performance over the years and the budget proposal is anticipated to result in GF savings.

Staff Comment & Recommendation. **Approve; adopt placeholder trailer bill language.** Staff notes that the department, in collaboration with LCSA directors, is evaluating current practice indicators and metrics. The department notes that it is considering how the Affordable Care Act has increased health coverage, which affects the provision of health insurance incentive payment. By the fall, the department anticipates sharing with staff how the department may redesign the incentive payments, so incentives are structured to encourage behavior that would not otherwise occur, and to reward innovation.

Questions

1. DCSS/DOF: Please summarize the trailer bill provisions and need for the trailer bill.
2. DCSS: Given that these incentive programs have been suspended for 13 years, has the department seen any difference in performance absent the incentives (e.g., Have some LCSAs been successful in identifying health coverage and improved performance without a payment incentive)?
3. DCSS: While these programs have been suspended, how has the department been monitoring local performance to ensure that a) children are being connected with health coverage, and that b) LCSAs are being recognized for improved performance?

5180 Department of Social Services, Community Care Licensing (CCL)**1. Overview**

Background. The Community Care Licensing (CCL) Division in the Department of Social Services (DSS) oversees the licensure or certification of approximately 66,000 licensed community care facilities, and has responsibility for protecting the health and safety of individuals served by those facilities. Around 460 licensing analysts monitored and license facilities. CCL does not license skilled nursing facilities, which instead, are licensed by the Department of Health Care Services; or, facilities that provide alcohol and other drug treatment. The table below shows some of the facilities licensed by CCL.

Facility Type	Description
Child Care Licensing Family Child Care Home	24 hr. non-medical care in licensee's home.
Children's Residential Facilities Crisis Nursery	Short-term, 24-hr., non-medical care for eligible children under 6 years of age.
Group Homes	24-hr., non-medical care to children in structured environment; facilities are of any capacity.
Small Family Homes & Foster Family Home	24-hr. care in the licensee's home for 6 or fewer children, who have disabilities.
Transitional Housing Placement	Provides care for 16+ yrs. old in independent living.
Adult & Elderly Facilities Adult Day Programs	Community based facility/program for person 18+ years old.
Adult Residential Facilities (ARF)	24-hr. non-medical care for adults, 18-59 years old.
Adult Residential Facility for Persons with Special Healthcare Needs	24-hr. services in homelike setting, for up to 5 adults, who have developmental disabilities, being transitioned from a developmental center.
Residential Care Facilities for the Chronically Ill	Facilities with maximum capacity of 25.
Residential Care Facilities for the Elderly (RCFE)	Care, supervision, and assistance with activities of daily living to eligible persons, usually 60+ yrs. old. Facilities range from 6 beds or less, to over 100 beds.
Continuing Care Retirement Communities (CCRC)	Long-term continuing care contract; provides housing, residential services, and nursing care.
Social Rehabilitation Facilities	24-hr. non-medical care in group setting to adults recovering from mental illness.
Special Agencies Certified Family Homes (CFH)	CFHs are certified by foster family agencies.

Background Check. 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 within the Community Care Licensing Division. If an individual has criminal history, DOJ sends the record to the Bureau, where staff reviews the transcript and determines if the convictions for crimes may be exempt. For individuals associated with a facility that cares for children, an additional background check is required through the Child Abuse Central Index. According to DSS, there are approximately 175,000 fingerprint submissions annually, with approximately 1,300 (0.6 percent) individuals denied criminal record exemptions.

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. According to DSS, around 1.4 million Californians rely on CCL enforcement activities to ensure that the care they receive is consistent with standards set in law.

DSS must conduct pre- and post-licensing inspections for new facilities, including when a previously licensed facility changes hands. In addition, the department must conduct unannounced visits to licensed facilities under a statutorily required timeframe. Prior to 2003, these routine inspection visits were required annually for all facilities except family child care homes, which received at least triennial inspections. In 2003, a human services budget trailer bill AB 1752 (Budget Committee), Chapter 225, Statutes of 2003, reduced the budget for CCL by \$5.6 million, and reduced the frequency of these inspections. As a result, CCL must visit a small number of specified facilities and conduct random, comprehensive visits to at least 10 percent of the remaining facilities annually.

Ultimately, the department must visit all facilities at least once every five years, which is less frequent than required in most states. In addition, there is a “trigger” by which annually required inspections increase if citations increase by 10 percent from one year to the next. For FY 2012-13, the annual required inspection requirement was met 80 percent of the time, while the annual random inspection requirement was met 94 percent of the time.

Below is a chart that summarizes the type of inspection conducted in licensed facilities, how many inspections utilized the Key Indicator Tool (KIT), and how many comprehensive inspections were triggered after the KIT.

**CCL Inspections in All Facilities
By Type of Inspection and Protocol
Fiscal Year 2012-13**

<u>Type of Inspection</u>	<u>Total of Inspections</u>	<u>How many inspections utilized the Key Indicator Tool (KIT)?</u>	<u>How many inspections that utilized the KIT triggered a comprehensive inspection?</u>
Annual Required Inspection	6,054	5,515 (91.1%)	419 (7.6%)
Random Inspection	17,233	16,682 (96.8%)	1,217 (7.3%)
Required Five-Yr. Visit	3,984	3,673 (92.2%)	375 (10.2%)

*As of SFY 2012-13 Quarter 3, CDSS is able to document percentage of inspection visits utilizing comprehensive versus KIT. Additionally, CDSS is now able to document the percentage of KIT visits that triggered a comprehensive visit.

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

CCL contracted, until December 31, 2014, with the California State University, Sacramento, Institute of Social Research (CSUS, ISR) to provide an analysis and recommendations regarding the development and refinement of the KIT. CSUS, ISR is currently reviewing and analyzing four years of licensing data, both pre and post KIT implementation. However, due to the unforeseen data clean-up and the narrative basis of the data, the project’s approach is currently being re-examined.

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 must respond to complaints within 10 days, and may conduct related onsite investigations. During FY 2012-13, DSS received 13,127 complaints and initiated 12,996 (99 percent) of these investigations within ten days of receipt. The department indicates that as of February 10, 2014, there are 5,291 complaints pending, of which 3,151 (59.5 percent) have been ongoing more than 90 days.³ The table, created by the LAO, denotes the division’s open and overdue complaints, as of January 2015.

Community Care Licensing (CCL) Division’s Open and Overdue Complaints
January 2015

Facility Type	Total Open Complaints	Complaints Open Over 90 Days ^a
Child care	550	65
Children’s residential care	1,615	820
Adult and senior care	2,505	1,565
Totals	4,670	2,450

^aCCL allots a 90–day period for investigating and addressing substantiated complaints. Complaints that remain open beyond 90 days are referred to as “overdue” complaints.

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 used to partially offset the cost of CCL enforcement and oversight activities. 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 deposited into the Technical Assistance Fund, and are required to be used by the department for technical assistance, training, and education of licensees.

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

³ DSS notes that due to the complexity of complaints and other entity involvement, such as law enforcement, complaints may require more than 90 days of investigation.

In FY 2013-14,, CCL collected 94 percent of its annual fees. During state FY 2012-13, CCL invoiced \$1,370,400 in civil penalties; the amount of civil payments received for FY 2012-13 was \$572,000.⁴

Recent Events. Several high-profile cases in child and adult residential facilities recently surfaced, pertaining to the following:

- **2011 Bureau of State Audits report.**⁵ In October 2011, the California State Auditor issued a report, which found that more than 1,000 addresses for licensed facilities and out-of-home child placements matched with addresses for registered sex offenders in the DOJ's Sex and Arson Registry. DSS immediately began legal actions against eight licensees and issued 36 exclusion orders, barring individuals from licensed facilities; counties also removed children and ordered sex offenders out of homes. While county child welfare service agencies performed the required background checks, the audit report found that they did not consistently notify DSS of deficiencies or forward required information to DOJ.
- **Castro Valley Assisted Living Facility.** In October 2013, DSS closed Valley Springs Manor, a Residential Care Facility for the Elderly (RCFE) located in Castro Valley, but news articles reported that more than a dozen elderly residents were left in the facility more than two days after the state ordered the facility to be closed.

Budget actions. Last year, the budget included \$7.5 million (\$5.8 million GF) 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 at least once every five years, as statutorily required; increase staff training; establish clear fiscal, program, and corporate accountability; develop resources for populations with medical and mental health needs; and updated facility fees. The budget recognized that although CCL currently has no staff with medical expertise, DSS licenses facilities that do allow for incidental medical care. Of the 71.5 positions, all positions, except the one nurse practitioner position, which was intended to develop a process and regulations regarding medical conditions and treatments, have been filled. In addition, recent events surrounding Castro Valley exposed the division's limited ability to effectively levy and collect fines, shut down poor performing actors, and recoup related expenses. In response, the budget also established a temporary manager and receivership process. The 2014 budget also included statutory language noting the Legislature's intent to increase the frequency of CCL-regulated facility inspections to annually for some or all facilities.

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

Questions

1. DSS: Please provide a brief overview of CCL's program and budget, including an update on implementation of last year's budget actions and the department's contract for the KIT analysis. When can the Legislature expect to see a report on whether the KIT has been successful and accurate in identifying compliance?

⁴ The department notes that civil payments may not coincide with the invoiced amount because payments in FY 2012-13 may have been for civil penalties assessed in the previous fiscal years. Also, penalty assessments may be appealed, reduced, or dismissed.

⁵ Full text of the 2011 report can be found at <http://www.bsa.ca.gov/pdfs/reports/2011-101.1.pdf>.

2. BCP #3 & TBL 601: CCL Next Phase: Quality Enhancement

Budget Issue. The Administration requests 136 permanent positions (eight position authority) to strengthen enforcement; 13 two-year limited-term positions to improve the timeliness of complaint investigations; nine positions to expand technical assistance and establish a Southern California training unit; and \$2.8 million for infrastructure costs (hardware/software, network, and telecommunication costs) for the budget year through 2019-20 and \$588,701 in ongoing costs. The Administration also requests a corresponding \$859,000 for FY 2016-17 through 2019-20 for the Office of Administrative Hearing (OAH) and other hearing-related costs, and \$397,000 in ongoing costs. The proposal is comprised of two objectives: 1) strengthen enforcement, and 2) improve performance, quality, and outcomes.

Strengthen enforcement. This phase of the quality enhancement and program improvement addresses one of the most significant impacts resulting from the sustained decrease in inspection frequency, which over-relies on complaints as the primary means to monitor facilities. The department proposes to increase the frequency of inspections from the current level of at least once every five years, to once every three years for child care facilities; once every two years for children’s residential facilities; and annual inspections for adult and senior care facilities. The table (below), created by the LAO, compares current law to the Governor’s proposed inspection requirements, by facility type and over time.

Inspection Frequency: Current Law and Governor’s Proposal, by Facility Type

Facility Type	Current Law	Governor’s Proposal		
		Stage 1: January 2017	Stage 2: January 2018	Stage 3: January 2019
Inspections must occur at least once every . . .				
Child care facilities	5 years	3 years	3 years (unchanged from stage 1)	3 years (unchanged from stage 1)
Children’s residential care facilities	5 years	3 years	2 years	2 years (unchanged from stage 2)
Adult and senior care facilities	5 years	3 years	2 years	1 year

The CCL division would continue to conduct random inspections on at least 30 percent of all facilities annually, as is current practice. The department also assumes the need for three additional regional offices, strategically located throughout the state, for licensing staff.

Performance, quality, and outcomes. Specifically, of the nine positions to expand technical assistance and establish a Southern California training unit, the budget assumes two positions for the Child Care Advocate Program; three positions for the Technical Support Program (TSP) for residential care facilities; and four positions to establish a training unit in Sothern California. Currently, there is only one unit located in Sacramento that trains all new licensing program analysts.

Trailer bill. The budget provides for an accompanying trailer bill that proposes language to implement the provisions discussed above.

Background. For background on the CCL, please see pages 10-14 of the agenda.

LAO Comment and Recommendation. In the *2015-16: Analysis of the Human Services Budget*, the LAO finds that the Governor's proposal is responsive to the Legislature's interest in decreasing the time interval between required inspections. Increasing the inspection frequency for all facility types to at least once every three years (the first stage of the Governor's proposal) is a reasonable first step. However, future-year changes to further increase inspection frequencies should be based on the need for targeted inspections of the most problematic facilities as identified by data analysis rather than solely on broad facility type, as proposed by the Governor.

- **Inspection frequency.** Inspections that are more frequent could help overcome some of the recent health and safety incidents discovered at facilities under the regulatory purview of CCL, including incidents of neglect and abuse. Although a three-year inspection interval appears to be a reasonable minimum standard for inspection frequency moving forward, the optimal inspection interval is difficult to identify and likely varies among facilities. The LAO recommends that the choice of increased inspection frequencies (above the once every three years level) be based on data that target resources to individual facilities with the greatest likelihood of improving compliance. Also, the LAO recommends only approving stage one of the Governor's proposal, while directing DSS to develop a data-driven model to determine the appropriate frequency of inspections for the future stages of the Governor's plan.
- **Workload study.** Also, the LAO raises concerns about the Governor's request for staffing resources, which is based on a 2001 outdated workload study. In some cases workload has increased, such as through the addition of new statutory responsibilities. On the other hand, the introduction of the Key Indicator Tool has reduced workload for licensing analysts. The net effect of these changes on licensing analysts' workload is uncertain. Therefore, the 2001 study may no longer accurately reflect a licensing analyst's workload. To the extent possible, the approved level of staffing should reflect the findings from an updated workload study currently in progress.
- **Impact of Child Care and Development Block Grant (CCDBG).** The recent reauthorization of the federal CCDBG requires annual inspections of child care facilities, as a requirement of continued federal funding. The Administration is awaiting additional federal guidance, although the earliest deliverable date is March 2016, for a three-year state plan. For additional information and discussion about the CCDBG, please see Senate Subcommittees No. 1 on Education and No. 3 on Health and Human Services agenda for their April 16, 2015 hearing.

In addition, the LAO recommends that the Legislature consider the following:

- Approve the following positions:
 - 13 two-year, limited-term positions and associated expenditure authority to address the backlog in overdue complaints;
 - 1.5 nurse consultant positions to provide medical expertise to licensing analysts;
 - Five positions to expand CCAP and reestablish TSP;
 - Four positions and associated expenditure authority to establish a new Southern California training unit and to extend ongoing training offerings to current managers and licensing analysts.

Staff Comment and Recommendation. Hold open both proposals. The Administration proposes significant investment into the department's licensing improvement efforts, which appears to be responsive to the Legislature's interests, but most importantly, protects the nearly 1.4 million Californians in the 66,000 facilities statewide. The department builds on the momentum and leadership from last year's budget actions and various policy vehicles to increase training of staff, centralize complaints, enhance health and safety of clients, improve customer service, and modernize the licensing process. However, the Governor's proposal sets inspection frequencies based on three very broad categories of facility type, and based on the degree to which "informal" oversight is available. For example, child care facilities receive the highest level of informal oversight through the flow of parents in and out of facilities on a daily basis. By comparison, the Administration indicates adults and seniors are the most vulnerable as they receive the least amount of informal oversight and therefore require the most frequent inspections.

Staff recommends holding open both the budget proposal and associated trailer bill for further discussion.

Questions

1. DSS: Please briefly summarize the proposal and trailer bill language.
2. DSS: What steps will the department take to ensure that a three-year ramp-up is feasible and remains on track?
3. DSS: How did the department determine the appropriate inspection frequency for each type facility?
4. DSS: How is the department considering and working with the Department of Education in compliance with the CCDBG for child care facility inspections?

3. TBL 600: Continue Suspension of Fingerprint Licensing Fee Exemption

Budget Issue. The Administration proposes suspending, for two additional years, existing law that prohibits the Department of Social Services (DSS) and the Department of Justice (DOJ) from charging a fee to process a criminal history check of individuals who are licensed to operate child and adult facilities, to provide care in a facility, or who reside at that facility. Specifically, this proposal allows DSS to charge fees for this criminal history check.

Background. Individuals who are licensed to operate child and adult facilities, to provide care to clients in those facilities, or who reside at a facility must undergo a comprehensive background check. DSS requires a fingerprint-based background check from the DOJ and from the Federal Bureau of Investigation (FBI) for individuals wishing to provide care. DOJ bills the department \$35 per person (\$17 for the FBI and \$18 for the Live Scan service). For individuals associated with children's facilities that serve six or fewer children, the background check also includes a check of the Child Abuse Central Index (CACI), which incurs an additional \$15 fee.

Justification. According to the Administration, since 2003-04, budget trailer bill language has been enacted annually to suspend existing statute that prohibits the DSS from charging the fingerprint licensing fee to process a criminal history check of specified individuals. To the extent the prohibition to charge a fee is not suspended, and fee collection for this service ended, the state must fund this activity with GF.

Staff Comment & Recommendation. Approve and adopt placeholder trailer bill language. Staff recommends approving the proposal, as no concerns have been raised.

Questions

1. DSS: Please briefly summarize the trailer bill language.

4. BCP #7: AB 1217 - Home Care Services Consumer Protection Act

Budget Issue. The Administration proposes a General Fund loan of \$5.5 million to the Home Care Fund, utilizing \$4.3 million for staff resources⁶ (25.5 permanent, 11.5 limited-term for a total of 37 positions in 2015-16). The Administration states that the General Fund will be repaid with fee revenue in future years, and the new program will be entirely fee-supported. These resources will enable to timely implementation of AB 1217 (Lowenthal), Chapter 790, Statutes of 2013, which requires DSS to regulate home care organizations and provide for background checks of affiliated, and independent, home care aides who wish to be listed on a registry. Implementation will begin on January 1, 2016.

Background. AB 1217 enacted the Home Care Services Consumer Protection Act, effective January 1, 2016. The Act requires DSS to:

- Develop licensing requirements to regulate organizations that hire aides;
- Obligate licensee and aide applicants of the HCOs to submit to state and federal criminal background checks; and,
- Maintain a public Web-based registry, which will list aides who have passed a criminal background check and which home care organization(s) an aide is affiliated, if applicable.

Aides, who are employed by a HCO as of January 1, 2016, will have until July 1, 2016, to complete their background check. The department estimates that around 70,000 background checks need to be conducted. AB 1217 also provides that DSS has no responsibility for the oversight of home care aides (HCAs). Independent home care aides, who are not employed by a licensed home care organization, are not subject to regulatory oversight, but may voluntarily apply to be listed on the registry.

Finally, AB 1217 established the Home Care Fund, into which fees of the home care organizations and aides will be deposited to repay the GF loan. AB 1217 required that the Act to be fully supported by fees paid by the HCO and home care aides.

2014 Budget Act. Last year, the budget included General Fund for vendor contract funding (\$251,000) and ten positions to establish, and maintain, the operational and administrative components of the Home Care Services Consumer Protection Act.

Staff Comment & Recommendation. **Approve.** Staff recommends approving the proposal, as no concerns have been raised.

Questions.

1. DSS: Please briefly summarize the proposal.
2. DSS: How has the Administration involved stakeholders in the development of this proposal?

⁶ 24 permanent and 9.5 two-year limited term positions in the Community Care Licensing Division; three permanent positions, effective January 1, 2016, in the legal division; and an extension of two one-year limited-term positions in the information systems division

5. BCP #52: Residential Care Facilities for the Elderly – Related Legislation

Budget Issue. The budget requests \$2.3 million General Fund to fund 8.8 permanent and 5.3 limited-term positions, for a total of 14.1 in 2015-16, at a cost of to implement recently enacted legislation.

Background. Last year, the Governor signed 19 bills to reform licensing programs, as administrated by the Community Care Licensing Division to improve the quality of care and improve department oversight. These bills focused on improving Residential Care Facilities for the Elderly (RCFE) care, empowering residents, and providing the department will tolls to ensure compliance with regulatory standards. Specifically, these new laws increase civil penalties for licensed facilities throughout the state and, for RCFEs, prohibits problem licensees from admitting new residents, strengthens residents' personal rights, and expands training to increase compliance.

The budget proposes staffing to implement the following legislation:

Improve training requirements for RCFE staff:

- AB 1570 (Chesbro), Chapter 698, Statutes of 2014, which increased training to 80 hours of coursework (60 hours of which must be in-person) for applicants and direct care staff at RCFEs;
- SB 911 (Block), Chapter 705, Statutes of 2014, which increased training for RCFE administrators and create new civil penalties for discriminating or retaliating against a resident or employee for calling 911;

Promote alternative to license revocation:

- AB 2236 (Maienschein and Stone), Chapter 813, Statutes of 2014, which increased civil penalties for licensed facilities;
- SB 1153 (Leno), Chapter 706, Statutes of 2014, which placed a prohibition on new clients for some RCFEs; and,

Expand personal rights of residents in RCFEs:

- AB 2171 (Wieckowski), Chapter 702, Statutes of 2014, which expanded personal rights of residents in RCFEs.

Staff Comment and Recommendation. **Approve.** Staff recommends approving the request for positions to implement the enacted legislation.

Question

1. To DSS: Please briefly describe how the positions will implement the related legislation.

6. BCP #12: Staffing to Detect Registered Sex Offenders in Out-of-Home-Care

Budget Issue. The Administration requests \$443,000 total funds (\$364,000 General Fund) to make permanent four two-year limited-term positions that are set to expire on June 30, 2015.

Background. In a 2011 report, *California Can and Must Provide Better Protection and Support for Abused and Neglected Children*, the Bureau of State Audits found over 1,000 addresses in the Department of Justice's Sex Offender Registry (DOJ SOR) match addresses of department of county licensed facilities or homes of children in the child welfare system. The report recommended the department and counties regularly compare addresses reported to the DOJ against addresses of current and prospective caregivers in the Licensing Information System (LIS) and the Child Welfare Services Case Management System (CWS/CMS).

Currently, the Department of Social Services (DSS) conducts address matches with DOJ's California Sex Offender and Arson Registry, the LIS, and CWS/CMS. The Budget Act of 2013-14 established positions to investigate complaints and a position in the information systems division.

Justification. According to the department, "At this time, limited-term and existing staff have been redirected to identify and remove RSOs on a temporary basis. The redirection of this staff significantly delays critical responsibilities, including investigation; legal support; criminal arrest inquiries; and agency referrals."

Staff Comment and Recommendation. Approve. Making permanent these positions would help the department achieve compliance with applicable laws related to tracking sex offenders residing in facilities; conduct monthly analysis and review of DOJ SOR address data, as normalized and compared by the RSO match process; and provide policy direction, education, and technical assistance to county welfare and probation departments to correctly investigate address matches.

Staff recommends approving the proposal, as no concerns have been raised.

Question

1. DSS: Please briefly summarize the proposal.
2. DSS: Since the creation of these positions, in 2013-14, how many addresses in the DOJ registry matched addresses of DSS or county licensed facilities in the homes of children in the child welfare system?

7. BCP #54: Positions to Implement Assembly Bill 388

Budget Issue. The Administration requests \$726,000 General Fund to establish two permanent and 4.5 limited-term positions to implement AB 388 (Chesbro), Chapter 760, Statutes of 2014. The department notes that it will return with a subsequent request for permanent licensing program analyst positions.

Background. AB 388 requires DSS to include in its annual listing of licensed community care facilities the number, types and outcomes of licensing complaints made by facility staff or children in group homes and other youth residential facilities. It requires facilities to report to DSS any incidents concerning a child involving contact with law enforcement and DSS to inspect those facilities reporting an excessive number of calls to law enforcement. It also requires DSS to cross-report internally and to the Department of Health Care Services (DHCS) depending upon which entity licensed the facility.

Staff Comment and Recommendation. Approve. As the number of facility inspections is expected to increase, the department expresses its need for additional staff to review protocols, collect data from facilities, and make data available to county child welfare agencies, juvenile courts, and the public. In addition, given the recent congregate care reforms and recommendations put out by the department, the trajectory of existing group home licensure and inspection frequency may need to be further evaluated. Staff recommends approving the positions to implement AB 388.

Question

1. To DSS: Please briefly summarize the proposal and need for the positions.
2. To DSS: How are these positions being coordinated with the Continuum of Care Reform process? Does the department anticipate an equal number of facility inspections annually, as group homes are recommended to be re-classified into short-term residential treatment centers (STRTCs)?

5180 Department of Social Services – CalFresh**1. Overview and Governor’s Budget**

Budget Issue. The Governor’s budget includes \$2.0 billion (\$0.7 billion GF) for CalFresh administration in 2015-16, a \$67.4 million (\$13.7 million GF) decrease from the 2014-15 appropriation. This decrease is largely attributable to revised caseload projections. The base CalFresh caseload is projected to increase 6.9 percent in the current year, and an additional 6.4 percent in 2015-16. The CalFresh caseload is projected to reach an average of 1.9 million households in 2014-15 and 2.0 million households in 2015-16.

Background. CalFresh is California’s name for the national Supplemental Nutrition Assistance Program (SNAP). As the largest food assistance program in the nation, SNAP aims to prevent hunger and to improve nutrition and health by helping low-income households buy the food they need for a nutritionally adequate diet. CalFresh food benefits are funded nearly exclusively by the federal government.

Californians are expected to receive a \$8.0 billion (all federal funds) in CalFresh benefits in 2014-15, rising to \$8.5 billion in 2015-16. According to the U.S. Department of Agriculture’s Economic Research Service, every \$5 in new SNAP/CalFresh benefits generates as much as \$9 of economic activity (gross domestic product), which represents a multiplier effect of 1.79.

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.⁷ In an average month in 2012-13, approximately \$630 million in CalFresh food assistance was disbursed to around 4.2 million Californians. The average monthly benefit per household is around \$308 (\$143 per person). Since 1997, California has also funded the California Food Assistance Program (CFAP), a corresponding program for legal permanent non-citizens, who are ineligible for federal nutrition assistance due to their immigration status. The proposed CFAP budget includes \$65.6 million GF for food benefits, with an expected average monthly caseload of around 19,000 households (with about 47,000 recipients).

A Snapshot

- In 2014, approximately 1.9 million households (4.2 million people) received CalFresh benefits.
- More than half of recipients are children.
- Average monthly benefit per household is \$308.
- In 2012, nearly 4 million Californians were food insecure.

Eligibility and benefits. CalFresh households, except those with an aged or disabled member or where all members receive cash assistance, must meet gross and net income tests. Most CalFresh recipients must have gross incomes at or below 130 percent of the federal poverty level (which translates to approximately \$2,008 per month for a family of three) and net incomes of no more than 100 percent of the federal poverty level (\$1,545 per month for a family of three), after specified adjustments. The average monthly benefit per household is around \$339 (\$151 per person).

⁷ Non-allowable items under CalFresh include: alcoholic beverages, tobacco products, medicines, vitamins, or any non-food items, like pet food, soap, household supplies, or cosmetics.

Efforts to improve participation. The participation rate for the working poor population was 65 percent nationally. California's overall participation rate was the lowest in the nation at an estimated 55 percent.⁸ California's participation rate⁹ for the working poor population was also the lowest in the nation at an estimated 49 percent.¹⁰ Reasons offered for California's poor performance with respect to CalFresh participation include, among others, a lack of knowledge regarding eligibility among individuals who are eligible, frustration with application processes, concerns about stigma associated with receiving assistance, and misconceptions in immigrant communities about the impacts of accessing benefits.

Several recently enacted program changes seek to improve CalFresh program participation. Some of those program changes include:

1. **Elimination of fingerprint imaging requirement.** AB 6 (Fuentes), Chapter 501, Statutes of 2011, eliminated the fingerprinting requirement, which was intended to prevent duplicate receipt of aid. However, fingerprint imaging created the perception of stigma and other measures were already in place to prevent duplicative receipt.
2. **Semiannual reporting.** Evidence suggested that a number of CalFresh households may leave the caseload after failing to correctly submit regular reports, only to reapply a few months later. AB 6 also amended the reporting requirement from three quarterly reports in a certification period to one report in a certification period.
3. **Face-to-face interview waiver.** All counties offer telephone interview in lieu of a face-to-face interview for intake and recertification appointments for CalFresh-only clients.

DSS indicates that California continues to make significant program changes to increase access to the CalFresh program. Several of these changes were included in recently enacted legislation or administrative decisions to streamline application and other administrative policies. In addition to other recent forums for county/state dialogue about CalFresh efficiency and increased participation, and partly in response to a request from this subcommittee last year, the Director of DSS has also asked each county to undertake a goal-setting process with respect to increased participation.

2014 Federal Farm Bill. Every five years, Congress passes legislation, known as the "Farm Bill," which contains provisions governing federal policy for agriculture, nutrition, conservation, and forestry. On February 7, 2014, President Obama was signed the Agricultural Act (Act) of 2014,¹¹ enacting sweeping changes to federal nutrition programs, including \$8.6 billion cuts from the Supplemental Nutrition Assistance Program. Specifically, the federal Farm Bill will:

⁸ DSS has noted that the federal government does not count the state's "cash-out" policy for SSI/SSP recipients (whereby those individuals receive a small food assistance benefit through SSP and are not eligible for additional CalFresh benefits) in its participation rate. The Department estimates that the state's participation rate could be a few percentage points higher if many those individuals who would otherwise be eligible for CalFresh were counted as participating. The state would still have the lowest participation rate in the nation.

⁹ While this is the participation rate methodology recognized by the federal government, there has been continuous debate about the accuracy of this methodology for California due to the underrepresentation of the immigrant population in the census data.

¹⁰ While California's caseload has doubled in recent years, this does not necessarily alter the state's participation rate in a significant way because the number of eligible households and individuals has also risen steeply.

¹¹ H.R. 2642 (Stabenow), P.L. 113-79

- Clarify certain SNAP eligibility rules, in that lottery winners and specified college students are not eligible for SNAP.
- Strengthen SNAP program integrity and combat benefits trafficking.
- Test strategies to connect more SNAP participants to employment, including a pilot project to spark state innovation.
- Improve access to healthy food options by requiring stores to stock more perishable foods and testing new ways for clients to make purchases with their SNAP benefit card.

Several provisions impacted California; specifically:

- LIHEAP payments made to households, in order to get the automatic Standard Utility Allowance, must be greater than \$20 annually.
- No funds appropriated by the Farm Bill may be used for recruitment activities, designed to persuade an individual to apply for SNAP.
- Excessive requests for replacement EBT cards may be declined, unless the household provides an explanation for the loss.
- The promotion of “physical activity” is now permitted as use of the federal Nutrition Education funding.

Staff Comment and Recommendation. Information included for discussion; no action needed. Research finds that food-insecure adults face higher risks of chronic diseases, like diabetes and hypertension, as well as depression and poor mental health. For children, food insecurity is also linked to poor academic outcomes.

Questions

1. DSS: How can the state partner with local agencies to ensure that eligible low-income Californians receive federally-funded CalFresh food benefits?
2. DSS: What opportunities have been leveraged to reach more Californians during ACA implementation?

2. BCP #11: CalFresh Technical Assistance & Program

Budget Issue. The Administration requests \$747,000 in federal expenditure authority for six positions to support SNAP-Ed implementation by conducting ongoing fiscal and programmatic program reviews, improved contract oversight, and to increase the level of technical assistance to state implementing agencies and local implementing agencies.

Background. SNAP-Ed, known as CalFresh Nutrition Education in the state, is a 100 percent federally-funded program, which offers nutrition education to millions of CalFresh eligible, low-income individuals. California receives more SNAP-Ed funding than any other state in the country – a total of \$136 million. As a result of this funding increase, the department must ensure appropriate program management and oversight, as required by the U.S. Department of Agriculture, Food, and Nutrition Services (US-FNS)'s management evaluation of the department. Federal emphasis on nutrition education and obesity prevention has increased significance, such as an increase in program tracking requirements and increase in data being reported to the federal government.

In addition, the number of contractors and grantees has increased to five implementing agencies, including the department with 19 county welfare departments and 105 local implementing agencies. Examples of state agencies and partner non-profit organizations include the Department of Public Health, Nutrition Education Obesity Prevention Branch, the U.C. Davis CalFresh Nutrition Education Program, Department of Aging, and the Catholic Charities of California.

The federal government has approved the additional funding for these six positions.

Staff Comment and Recommendation. **Approve.** As the requests positions have no state GF implication, staff recommends approving the positions.

Question

1. DSS: Please summarize the proposal.

3. Drought Food Assistance Program

Budget Issue. In January 2014, Governor Brown declared an emergency drought. SB 103 (Budget and Fiscal Review), Chapter 2, Statutes of 2014, enacted the \$687 million drought relief package. SB 103 includes provisions that provide up to \$25 million General Fund to the Department of Social Services (DSS) for drought food assistance. AB 91 (Budget), Chapter 1, Statutes of 2015 provides \$17 million and re-appropriates an existing \$7 million General Fund to expand food assistance to persons affected by the drought to include the counties of Imperial, San Luis Obispo, Santa Barbara, Ventura, and Coachella Valley in Riverside County.

Background. The CalFresh program is intended to help families prevent hunger, with emergency food programs as a safety net resource. To be eligible for food programs, a recipient must have income below 150 percent of federal poverty level, be a local resident, and use the food received in their personal home. The Drought Food Assistance Program (DFAP) is the temporary program developed in response to the Governor's Drought Emergency Declaration, and seeks to provide food assistance to drought-affected communities with high levels of unemployment.

Distribution timeline. DFAP food is provided by the California Emergency Foodlink, the non-profit CDSS contractor which normally purchases and distributes USDA food statewide. Counties that will receive DFAP are those with unemployment rates that were above the state-wide average in 2013, and which have a higher share of agricultural workers than California as a whole. For 2013, the average unemployment rate for California was 8.9 percent, and the share of workers employed in agriculture was 2.64 percent. Receiving counties include Amador, Butte, Colusa, Fresno, Glenn, Kern, Kings, Lake, Lassen, Madera, Merced, Modoc, Monterey, San Benito, San Joaquin, Santa Cruz, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Tulare, Yolo, and Yuba.¹² AB 91 also added four counties and the Coachella Valley to those eligible to receive DFAP.

According to the department, as of January 2015, DFAP has provided over 400,000 boxes to food banks that have distributed boxes to nearly 190,000 households.

Eligibility and content. Household DFAP eligibility is based on a self-certification process, whereby recipients identify themselves as the head of a household in an affected community where the household's unemployment or underemployment is directly related to the drought. DFAP food boxes are prepackaged, weigh approximately 25 pounds, and designed to provide food for a household of four people for about five days. Contents include, among others, spaghetti, pinto beans, apple sauce, green beans, corn, and tomato sauce.

Outreach. The department envisions that participating food banks will inform affected households of the location and availability of DFAP food distributions. Food banks are expected to collaborate with other local community organizations that may be engaged with these families. Eligible households with longer-term needs also will be offered information and assistance in applying for CalFresh.

¹² According to DSS, this list is subject to change, as more information about drought impacts becomes available, including the results of a University of California, Davis, study that is currently underway.

Staff Comment & Recommendation. The item is informational and is included for discussion. No action is required.

Questions

1. DSS: Please briefly provide an overview of the drought emergency food assistance, the food banks' role in food distribution, and who is eligible for DFAP.
2. DSS: Please provide an update on the newly eligible counties and areas who may qualify to receive DFAP boxes.

4. Proposals for Investment

The subcommittee received the following requests for investment.

4A. State Emergency Food Assistance Program

Panelist: SEFAP - Andrew Cheyne, Policy Director, CA Association of Food Banks

Budget Issue. The California Association of Food Banks (CAFB) requests a \$5 million General Fund appropriation for the State Emergency Food Assistance Program (SEFAP). Currently, there is no on-going General Fund dedicated for this use. In the 2013-14 fiscal year, the state Assembly donated \$1 million for one-time use. The \$5 million SEFAP request would be distributed to all counties based on the established formula for the distribution of Emergency Food Assistance Program, currently funded with federal dollars.

Background. The SEFAP funds provide additional flexibility to food banks, as they can purchase the items that they need to complement the types of foods that are currently available to them.

4B. Nutrition Incentive Program/Market Match

Panelist: Justin Rausa, Policy Director, Roots of Change

Budget Issue. A large coalition of organizations has written with the "Market Match" proposal, led by Roots of Change, Latino Coalition for a Healthy California, Ecology Center, and the Public Health Institute. This proposal would provide annually \$5 million General Fund to establish a statewide nutrition incentive program for purchasing California-grown fruits, nuts and vegetables (i.e. specialty crops), benefiting low-income families and California's economy.

Background. California's Market Match, beginning in 2009, doubles the purchasing power of nutrition assistance benefits (e.g. CalFresh) when spent on specialty crops at participating farmers' markets.

Staff Comment and Recommendation. Hold open. Staff recommends keeping the above proposals for investment open for further discussion and review.

5180 Department of Social Services – Other**1. TBL 604: Employment Development Data Sharing**

Budget Issue. The Administration proposes trailer bill language that authorizes the Employment Development Department (EDD) to share data with federal, state, or local government departments or agencies, or their contracted agencies, to support social services administration.

The department notes that there are no additional costs associated with this issue. Instead, the Department of Social Services bears the cost for its existing data sharing agreement, which is accounted for in existing administration costs. The current inter-agency data sharing agreement is a three-year contract (July 1, 2014, through June 30, 2017) for approximately \$89,000.

In addition the language posted on the Department of Finance’s website, the department offers the following revision in paragraph (7) of Section 1095 of the UICS:

(7) To enable federal, state, or local government departments or agencies, or their contracted agencies, subject to federal law **including the confidentiality, disclosure, and other requirements set forth in Part 603 of Title 20 of the Code of Federal Regulations**, to evaluate, research or forecast the effectiveness of public social services **programs provided administered** pursuant to Division 9 (commencing with Section 10000) of the Welfare and Institutions Code, or Part A of Title IV of the Social Security Act (42 U.S.C. Sec. 601 et seq.), when the evaluation, research, or forecast is directly connected with, and limited to, the administration of **the** public social services **programs**.

The above change clarifies the following:

- Emphasizes that CDSS will be subject to the confidentiality and disclosure requirements
- Notes that the purpose is to evaluate the effectiveness of public social services "programs administered," which addresses concerns that the data might be used for purposes other than the statutorily-authorized research projects.

Background. Existing law authorizes the use of EDD data for verification and eligibility purposes. However, it does not address data sharing for evaluation, research, budget development, and forecasting purposes. EDD does have the discretion to share with other government entities, but would prefer the establishment of explicit statutory authority. The three-year agreement between DSS and EDD to acquire confidential wage and Unemployment Insurance claim information files for current and/or previous public assistance and program recipients of CalWORKs, CalFresh, Medi-Cal, foster care, Supplemental Security Income, and In-Home Supportive Services Program. This agreement has been in place, and renewed, since 1996. Under this contract, DSS submits lists of Social Security numbers (SSNs) to match with EDD databases. This output data from EDD provides employer-reported quarterly earnings for nearly 95 percent of California employment. This data allows DSS to create analyses for internal research, budget development, performance monitoring, and program evaluation.

According to the department, most recently, San Francisco and Los Angeles counties have requested EDD data to conduct specific projects within their counties; however, EDD denied the requests, citing the inability for the DSS to re-disclose data to counties.

Staff Comment and recommendation. Hold open. The department and Employment Development Department have been working collaboratively on the language. In a letter received on March 2015, the federal Department of Labor expressed their support for the language conformity, “so long as all requirements for agreements, payment of costs, and safeguards and security requirements are adhered to [sic].” Any action taken in this subcommittee will also need a conforming action in Senate subcommittee No. 5 on Corrections, Public Safety, Judiciary and Labor, which includes EDD in its jurisdiction.

Question

1. To DSS: Please provide a summary of the trailer bill language and need for its provisions.

5180 Department of Social Services – State Hearings Division (SHD)
0530 Health and Human Services Agency, Office of Systems Integration

1. Overview

State hearings, which are adjudicated by Administrative Law Judges (ALJs) employed through DSS, are used to provide due process to recipients of, and applicants for, many of California’s health and human services’ programs, including Medi-Cal, CalWORKs, CalFresh, and In-Home Supportive Services, when a recipient disagrees with a decision made by their local county welfare department. The *King v. McMahon* and *Ball v. Swoap* court decisions mandate that DSS provides recipients with timely due process for the adjudication of appeals hearings. Additionally, these court orders impose financial penalties on DSS for failing to adjudicate decisions within specified timeframes. The penalties are paid to the prevailing claimant. Federal mandates require that all requests for hearings be adjudicated within 90 days, or 60 days for CalFresh, of a recipient’s request.

Penalty structure. Under the court orders, the minimum daily penalty amount is \$5.00 per day, or a minimum of \$50, whichever is greater. However, if 95 percent of all decisions are not issued within the required deadlines in a given month, the daily penalty rate for that programmatic category increases by \$2.50 over the penalty rate being paid to claimants the previous month. In contrast, if 95 percent of all decisions related to that particular program are issued on time in a given month, the corresponding daily penalty rate decreases by \$2.50 from the penalty rate being paid the previous month. The maximum daily rate under the court orders is \$100 per day.

According to the department, since August 1, 2013, the State Hearings Division is currently achieving a 95 percent overall monthly timeliness each month, creating a steady decline in the daily rate in each program area. As of April 2015, the penalty rate per day of a late decision was \$72.50 for Medi-Cal, \$20 for CalWORKs, \$5.00 for CalFresh, and \$82.50 for IHSS. Penalties levied on the state for untimely SHD adjudication in 2012-13 totaled \$5.2 million. In contrast, in January 2014, the penalty rate per day of a late decision was \$82.50 for Medi-Cal, \$55 for CalWORKs, \$12.50 for CalFresh. The penalty rate per day for a late decision for IHSS remains the same at \$82.50.

According to DSS, recent processing times, average penalties, and total penalties paid by program are listed below:

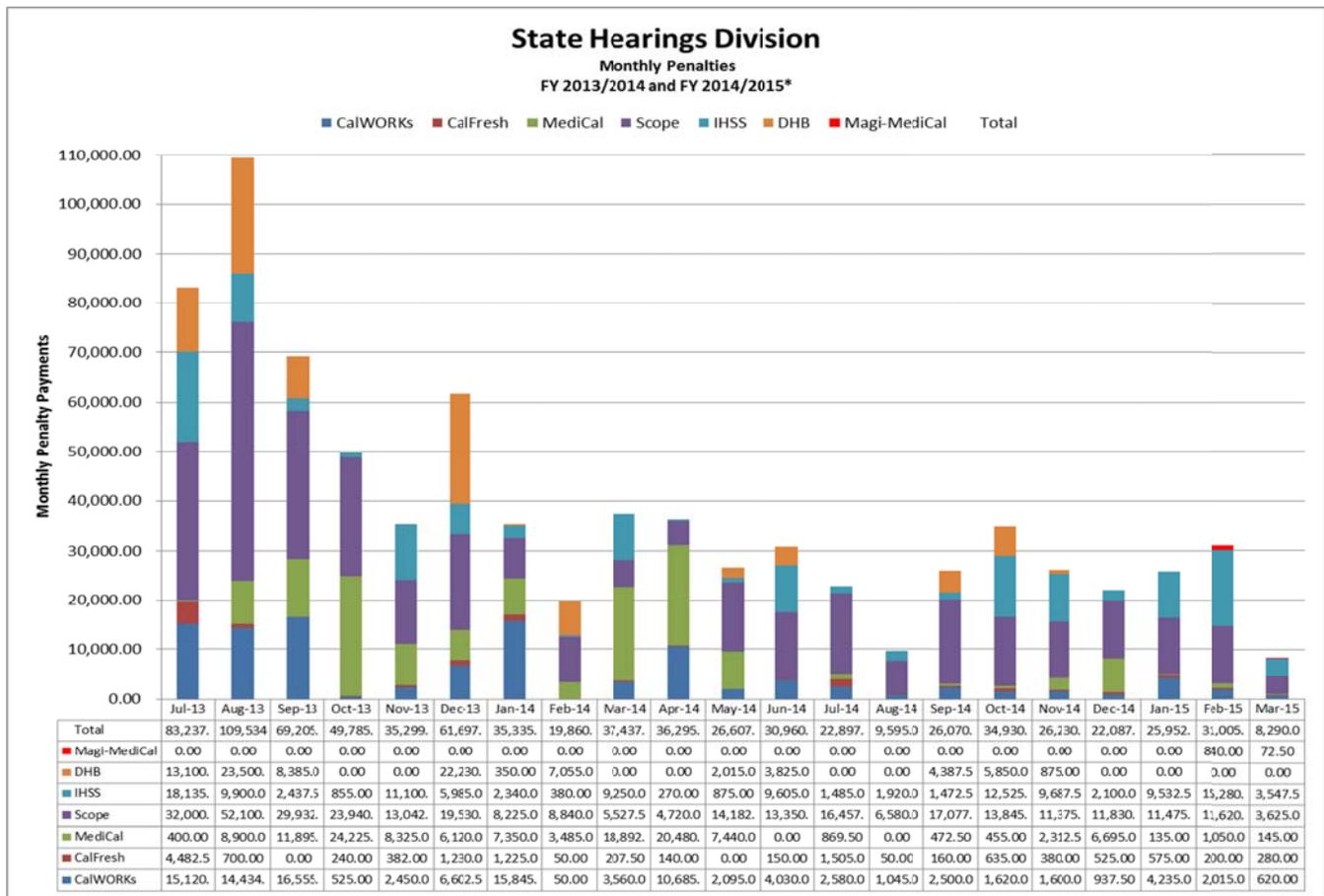
Program	Timeliness Requirement	Average Processing Time of Late Cases	Average Days Late	Average Penalty
	(In Days)	(In Days)		
CalFresh	60	81.09	21.09	\$125.94
CalWORKs	90	104.28	14.28	\$209.04
IHSS	90	101.57	11.57	\$857.18
Medi-Cal	90	112.01	22.01	\$1,478.60

State Hearing Penalties by Program for the Last 5 Fiscal Years

Total Penalties Paid by Program					
FY	CalWORKs	CalFresh	Medi-Cal	IHSS	Total
FY 08/09	\$30,063	\$6,670	\$212,948	\$1,430	\$251,110
FY 09/10	\$179,585	\$43,422	\$369,305	\$158,790	\$751,102
FY 10/11	\$169,630	\$67,988	\$215,508	\$231,320	\$684,445
FY 11/12	\$176,133	\$59,170	\$482,280	\$389,158	\$1,106,740
FY 12/13	\$250,955	\$54,948	\$3,396,300	\$597,618	\$4,299,820
FY 13/14	\$91,952	\$8,807	\$423,363	\$71,133	\$595,255
FY 14/15 YTD	\$16,532	\$4,030	\$124,202	\$54,003	\$198,767

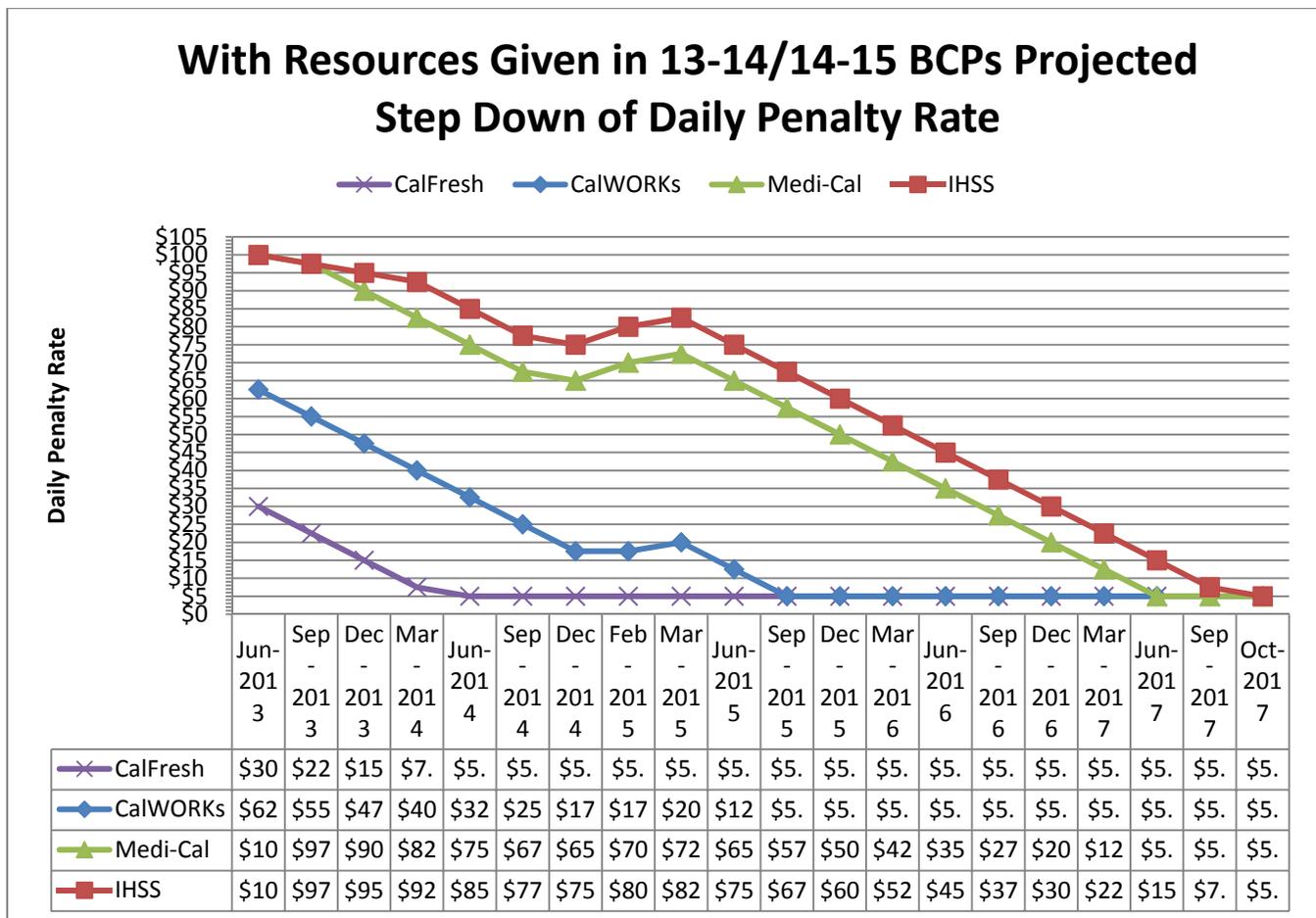
The department notes several contributing factors to the increase in penalties from fiscal years 2008-09 through 2012-13, such as a 26 percent increase in overall workload and inadequate resources from a hiring freeze, furloughs, and retirements. The Medi-Cal spike was associated with CBAS cases and was one-time workload.

In FY 2013-14, \$595,255 was paid for penalty payments. Below is a chart that captures the monthly penalties, from FY 2013-14 to the current year, according to program.



Last year, the Governor’s budget proposed, and the Legislature approved, 41 permanent positions (24 ALJs and 17 support staff) to handle an increased state hearings caseload. DSS indicates that these late decisions are a result of caseload growth and that the amount of penalties has increased since 2006, totaling \$1.1 million for 2011-12, and projected to be as high as \$1.8 million yearly over the next three years.

The chart, as provided by the department, projects a declining penalty rate, as associated for the CalFresh, CalWORKs, Medi-Cal, and IHSS programs, with the additional resources given in the last two budgets.



Recent Caseload Growth. The department indicates that the state hearings caseload has increased significantly in the past five years, specifically, from approximately 80,000 requests for hearing and 14,000 decisions issued in 2007-08, to 85,500 hearing requests and 15,000 decisions in 2013-14. The department projects to receive around 96,000 hearing requests, due to increased Medi-Cal eligibility and scopes cases, as well as Modified Adjusted Gross Income (MAGI) coming online, and 19,300 decisions for 2014-15. The Great Recession and corresponding state fiscal crisis led to billions of dollars in reductions to California’s health and human services programs, along with corresponding contractions in eligibility for and/or services provided by those programs.

Hearing requests filed and decisions written. The two attachments display more specific information about the total number of hearing requests filed and the number of decisions rendered.

Staff Comment. The item is informational, and no action is required.

Questions

1. DSS-SHD: Please briefly provide an overview of the function of the state hearings division and the structure of the timeliness requirements and penalties for not meeting them.

5180 Department of Social Services – State Hearings Divisions

0530 Health and Human Services Agency, Office of Systems Integration

2. State Hearings Appeals Case Management System (ACMS) Project

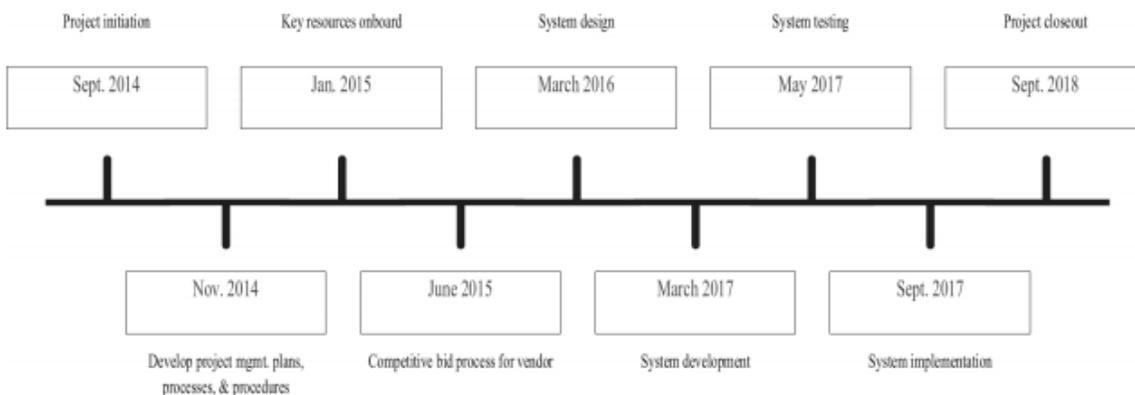
Budget Issue. The Administration requests a net increase in \$176,000 for the Office of Systems Integration (OSI) spending authority, including the extension of one limited-term position (\$131,000). In addition, the budget includes a shift of \$45,000 in vendor costs from current year to budget year. This is a shift in cost due to the revised procurement schedule and does not reflect an increase in project costs.

These changes reflect a nine-month shift in procurement schedule, because the Feasibility Study Report (FSR) did not account for two federal and one state review periods of funding documents, procurement documents, and the unsigned vendor contract. The original project schedule also did not allow for a new procurement procedure of the Statewide Technology Procurement Division.

Background on the Appeals Case Management System (ACMS). The ACMS mainframe application is housed at the Office of Technology Services and 21 ad-hoc applications hosted at DSS headquarters in Sacramento. The ACMS tracks, schedules, and manages appeal requests from California’s 58 counties. Collectively, these systems are known as the State Hearings System (SHS). DSS indicates that the current SHS does not meet existing business requirements and will not be able to handle the anticipated increase of volume, associated with ACA implementation. SHS runs Natural and COBOL programming languages, which the state can no longer support. Due to these factors, DSS notes that there has been a 417 percent increase in state General Fund civil penalties over the prior five-year period for untimely state hearing decisions.

In August 2011, the Office of Management and Budget (OMB) authorized an exception to federal cost allocation funding rules to encourage states to leverage ACA resources to develop informational linkages between their health and social services system. The enhanced federal financial participation for implementation of health care reform is available through December 2015, for development, implementation, and maintenance and operations activities for functionalities implemented by that date.

The ACMS project timeline is below:



The Governor’s budget includes \$3.9 million total funds (\$1.7 million GF) for ACMS.

Staff Comment and Recommendation. Approve. Despite the extended procurement schedule, the department expects to meet the original implementation date of October 2017. Staff recommends approving the funding authority to extend the one limited-term position.

Question

1. OSI: Please briefly summarize the proposal, including how the department will ensure that it will meet the target implementation date of October 2017.

5180 Department of Social Services – Automation
0530 Health and Human Services Agency, Office of Systems Information

1. Child Welfare Services - New System Project (CWS-NS)

Budget issue. The Governor’s budget includes \$16.6 million total funds (\$7.2 million GF) for the CWS-NS Project.

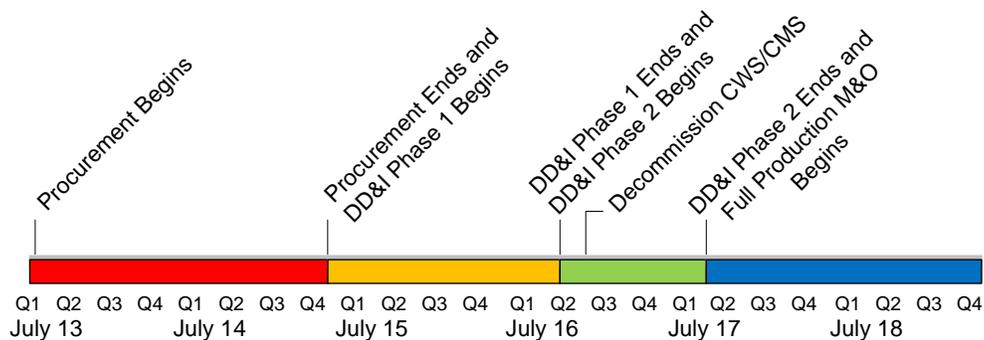
Background. Child Welfare Services/Case Management System (CWS/CMS) was fully implemented and transitioned to its operational phase in 1998. DSS has overall responsibility for the system, including providing project and program direction to OSI. OSI provides information technology expertise and is responsible for implementation and day-to-day operations of the system. The current contract for CWS/CMS runs through November 2016, with potential extensions of up to three years.

According to the Office of Systems Integration (OSI), the anticipated total one-time costs up through the design and development of the system, which is expected to finish in 2017, are \$351.1 million (\$154.9 million GF). Compared to continuing to operate the current system and making necessary changes to it, however, the Administration estimated that the state will realize savings by completing the CWS-NS system because of its reduced maintenance and operations costs.

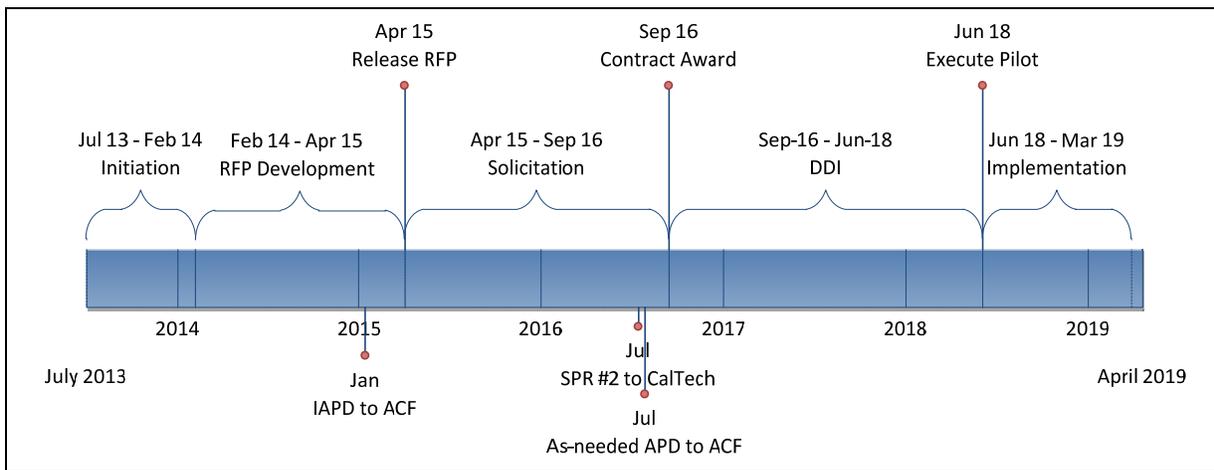
As of April 1, 2014, there was a projected 19-month delay for CWS-NS. Specifically, the planning and procurement process added 14 months: nine months because the department was unable to fill necessary state positions due to the two-year, limited-term nature of the positions; and an additional five months to complete the request for proposal, among other items. Also, the design, development, and implementation (DDI) phase added five months for additional testing.

The previous timeline for the project was:

Table 1 – CWS-NS Project Timeline



The new timeline for the CWS New System Project is below:



Currently, the department notes the following milestones:

<i>Milestone</i>	<i>Date</i>	<i>Status</i>
Implementation Advance Planning Document (IAPD) Submission to Administration for Children and Families (ACF)	April 2015	On Schedule
RFP Released to Bidders	September 2015	On Schedule
Contract Award	February 2017	On Schedule

Possible risks that may impact the project include the unanticipated extension of an RFP schedule or if using the Statewide Automated Welfare System Consortia to meet Title IV-E eligibility determination and financial management functionality will comply with pending federal Statewide Automated Child Welfare Information System regulations. The department also recognizes the delay in the development of the project management plan will cause inconsistent execution of the project process. In addition, the department notes its concern to recruit and retain qualified candidates for limited-term positions will impact the schedule, quality, and costs of the project.

Staff Comment & Recommendation. Informational only, included for oversight and discussion. While the department raises concerns about the potential risk posed to IT projects by limited-term positions (as they are more prone to recruitment and retention challenges than permanent positions), staff notes that it is common for IT staff to be limited-term while a project is being developed and implemented because this workload is not ongoing. Permanent positions are generally provided to projects once it is in the maintenance and operation phase, as there is ongoing workload associated with maintaining an IT system.

Questions.

1. OSI: Please summarize the current CWS-NS timeline and project costs.
2. OSI: How are the department and OSI working to ensure the system is on-course and that there are appropriate and competitive bids?

2. Oversight: Automation and LEADER Replacement System

Budget issue. The budget includes approximately \$380 million (\$119.8 million GF) for automation projects, like SAWS, Statewide Fingerprint Imaging System, the Electronic Benefit Transfer Project, and the State Hearing Division Appeals Case Management System. Specifically, the department estimates around \$97 million (\$23 million GF) for the Los Angeles Eligibility, Automated Determination, Evaluation, and Reporting Replacement System (LEADER Replacement System, or LRS Project).

Background. In March 2015, the LRS Project completed the development (coding/programming) phase. The LRS Pilot Go-live date is being rescheduled from the end of August to the end of September, to provide ample time to complete testing. As a result, the User Acceptance Testing (UAT) start date will be adjusted by one month as well, but the overall implementation schedule is on track. The project remains on schedule to fully deploy the LRS solution for LA County's DPSS and DCFS by November 2016 with no change to project costs.

During a February legislative briefing, the department recommended that there are two time periods when significant policy changes should be avoided are:

- September 2015 through December 2015 (the period during and shortly after Pilot).
- March 2016 through November 2016 (the period during and shortly after Countywide Implementation, which remains the same).

Although certain changes, such as Cost of Living Adjustments (COLAs), and certain numerical rate changes may be coded during these periods, new programs and policies, as well as more complex policy changes, cannot be automated within these periods. Any significant policy changes made within these periods will require a manual work-around until automation is possible, with potential negative consequences for clients, county caseworkers, and the smooth countywide roll-out of LRS. Therefore, close collaboration between the state and county on the scope and timing of future program and policy changes will be essential.

Staff Comment and Recommendation. Item included for oversight and discussion purposes. No action needed. OSI and CDSS provide quarterly updates to legislative staff. Staff recommends the continuation of these meetings, and recognizes the department and OSI's current monitoring of the LRS project progress.

Question

1. To DSS/OSI: Please provide an overview on the progress of LRS.

3. Electronic Benefit Transfer (EBT) 3 Project – Transition to New EBT Services

Budget issue. The Administration requests an increase of \$1.6 million to the Office of Systems Integration (OSI) expenditure authority, beginning January 1, 2016, for the following one-time costs associated with the transition to a new Electronic Benefit Transfer (EBT) Service Provider:

- New EBT service provider transition costs, and
- EBT 3 Transition Team, which includes:

EBT 3 Consultant Transition Team	
Consultant Position	Cost
Transition Manager (1 full-time consultant)	\$150,998
Technical Manager (1 full-time consultant)	\$150,998
Master Project Scheduler (1 part-time consultant)	\$90,399
County Manager (1 full-time consultant)	\$122,198
County Liaison (3 full-time consultants)	\$366,593
Project Management Support (1 full-time consultant)	\$112,595
Integration Services Support (1 part-time consultant)	\$90,399
TOTAL	\$1,084,180

The estimated costs are based on actual transition costs associated with the previous food and cash transition, and projected costs for the EBT 3 transition effort. Specifically, the \$1,084,180 cost for the EBT 3 Consultant Transition Team is based on projections utilizing current standard hourly rates (e.g., estimated hourly service rate, annual hourly cap, travel, and per capita) for the various consultant classifications.

Background on EBT. The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 required the replacement of the paper-based food benefit distribution process with EBT technology. In August 1997, California enacted AB 1542 (Ducheny), Chapter 279, Statutes of 1997, to codify this requirement, and provided each county with the option to issue certain cash assistance benefits via EBT.

The California EBT Project is responsible for automating the issuance, delivery, redemption, settlement, and reconciliation of California's food and cash assistance program benefits. The benefiting programs under the California EBT Project include the CalFresh, as well as the following assistance programs: California Work Opportunity and Responsibility to Kids (CalWORKs) Program, the Refugee Cash Assistance Program, the State Utility Assistance Subsidy (SUAS) (formerly known as the Low-Income Home Energy Assistance Program), the Cash Assistance Program for Immigrants, and General Assistance/General Relief.

The California EBT system distributes food benefits to recipients through the use of magnetic-stripe cards at point-of-sale terminals and automated teller machines (ATMs), and other electronic fund transfer devices. According to the department, the EBT system issues over \$11 billion annually in food and cash aid benefits to over two million EBT cardholders that comprise California's most vulnerable population.

According to CDSS, in 2013, there were 35.5 million EBT transactions, with about one-fifth of them charged fees or surcharges. Of that, 17 million transactions were used for direct purchases, 2.5 million were for cash back only from a purchase of service location and nearly 5.5 million transactions were purchases with cashback. These transactions incurred relatively minimal fees. However, 71 percent of the 10.4 million transactions that were cash withdrawals (7.4 million transactions) incurred fees.

Background on the EBT Project. The Department of Social Services, as the EBT Program Sponsor, contracts with the OSI to manage the California EBT Project and to procure and manage the California EBT Services Contract. The current EBT services contract with service provider, Xerox State & Local Solutions, Inc., expired in March 2015. The contract has three one-year extensions available, which, when executed by the state, would extend the contract to March 2018. Given the length of time for the previous reprocurement effort, OSI is in procurement phase for new EBT services.

California is also looking for ways to realize economies of scale, leverage existing systems or service offerings where feasible, and to comply with the State's strategic direction towards horizontal integration. The California Department of Public Health (CDPH) is federally required to transition the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) participants from the current paper-based food instruments to EBT issuance by October 1, 2020. The automation of WIC is known as eWIC EBT. To meet this federal deadline and leverage OSI's EBT expertise and the California EBT system, the CDPH will contract with the OSI for EBT transaction processing and cardholder services.

The previous migration from the initial EBT Service Provider (J. P. Morgan Electronic Financial Services, Inc.) to the current EBT Service Provider (Xerox) was successfully completed in 18 months. The department anticipates a similar 18-month transition schedule for the upcoming EBT 3 transition, with cutover to a new California EBT system no later than September or October 2017.

After the successful bidder is identified and the Intent to Award is announced, the OSI will request federal and state approval for the transition to new maintenance and operations (M&O) services and any necessary funding. No costs for the EBT 3 implementation will be incurred until the OSI receives both federal and state approval.

Staff Comment and Recommendation. Hold open. Staff recommends holding the item open for further consideration. Specifically, some issues to discuss include:

- **Fees and Charges.** The California Reinvestment Coalition's March 2014 report found that \$19 million per year in public benefits is going to pay for bank fees and an additional \$6.7 million is spent annually on fees to pay bills and make purchases using prepaid cards, money orders, independent check cashers and in-person pay locations. In total, "\$25.7 million of the state's aid meant to support the wellbeing of families is instead going to fees charged to conduct the most

basic financial transactions.”¹³ The report found that some ATM owners charge a fee of up to \$4 every time someone uses an EBT cards in their machines. The OSI notes that it is working to increase in-network ATMs to preserve benefits and reduce to incidences of surcharges. Further, the OSI is working to leverage new technologies to use mobile phones for free cash access, such as Code for America mobile applications like “EBT Near Me,” which identifies stores and surcharge-free ATMs; or “Balance,” which lets anyone check their EBT balance with a text message.

- System stability. On October 12, 2013, Xerox, the state's EBT system vendor, reported that all EBT systems in 17 states with Xerox contracts were down, including California. The shutdown was prompted by a routine testing of a backup system. Despite these glitches, the department is working to ensure that those who use EBT do not see any service disruptions during the migration and in daily use. For example, the department works with over 35,000 retailers in California and rolls-up reconciliation information from all 58 counties on a daily and monthly basis. During the migration process, it estimates that the system will go dark for 20-36 hours. To prevent any challenges for EBT users, the department will take preventative maintenance steps, and will require that the security measures are a strong component for the Request for Proposal (RFP) solicitation. The department also notes that it will benefit from the lessons learned from previous challenges associated with the prior migration, where in five separate occurrences, less than one half of one percent of EBT cardholders' accounts were incorrectly debited for transactions denied at a retailer or ATM.

Questions

1. To OSI: Please summarize the proposal.
2. Although department anticipates a migration time of 18 months, what are some possible challenges that could arise (and that the Legislature should monitor) to make sure everything is on track?
3. What is the department doing to ensure that those who use EBT don't see any service disruptions?
4. How is the department working to ensure that clients are aware of EBT that do not incur fees?

¹³ “THE \$19 MILLION ATM FEE: How Better Banking Services Would Protect Our Public Investment in Families,” California Reinvestment Coalition, March 2014.

4. BCP #9: Horizontal Integration

Budget issue. The Administration requests to make permanent two limited-term positions and provide funding for the Assistant Director of Horizontal Integration. The requested positions will e plan for and implement horizontal integration efforts involving multiple automated systems, such as Statewide Automated Welfare System (SAWS), Child Welfare Services – New System (CWS-NS), Medi-Cal Eligibility Determination System (MEDS), Leader Replacement System (LRS), and the Appeals Caseload Management System (ACMS). The staff will establish standards for data exchange, attempting to ensure that new systems are able to communicate and share recipients’ information and implement improvements to streamline recipient paperwork and social worker workload. Total staffing costs are \$371,000 total funds (\$162,000 GF).

Background. Over the last year and a half, the horizontal integration staff has focused on ensuring that integration is accounted for in interactions and developments regarding Affordable Care Act (ACA) efforts, as well as other integration opportunities within the Health and Human Services Agency. The unit identifies integration opportunities, researches global examples to implement integration, and provides a cultural change in vision to drive staff to move beyond silos. Specifically, the unit sees possible integration efforts with the Department of Health Care Services, Department of Public Health, Employment Development Department, Department of Education, and the courts system.

Justification. According to the department, possible outcomes include an increased number of eligible people connected to programs, reduction in the duration and level of services received, and increased satisfaction with the process to obtain, and to retain, those services. Examples of explicit outcomes include using existing data sources to pre-populate forms and reduce the need for clients to re-provide the data; automate the verification of information; and conduct data matching inquiries to ensure program integrity.

Staff Comment and Recommendation. Approve. Staff recommends approving the positions as no concerns have been raised.

Question

1. To DSS: Please briefly describe the proposal and need for an extension of positions.
2. To DSS: What are examples of projects that have been better integrated as a result of these positions?

SUBCOMMITTEE #3: Health & Human Services

April 30, 2015
9:30 a.m. or Upon Adjournment of Session
Room 4203, State Capitol

Outcomes in Red

Item Department

5175 Department of Child Support Services

1. Overview
Informational.
2. TBL 606: Continued Suspension of Performance and Health Insurance Incentive Payments
Approve, adopt placeholder TBL (3-0)

5180 Department of Social Services – Community Care Licensing

1. Overview
Informational.
2. BCP #3: CCL Next Phase: Quality Enhancement and Program Improvement
TBL 601: CCL Next Phase: Quality Enhancement
Held open BCP #3 and TBL 601.
3. TBL 600: Continue Suspension of Fingerprint Licensing Fee Exemption
Approve; adopt placeholder TBL (3-0)
4. BCP # 7: AB 1217: Home Care Services Consumer Protection Act – Phase II
Approve (2-1, Stone voting “no”)
5. BCP #52: Residential Care Facilities for the Elderly - Related Legislation
Approve (3-0)
6. BCP #12: Registered Sex Offenders –Convert Limited-Term Positions to Permanent
Approve (3-0)
7. BCP #54: Positions to Implement Assembly Bill 388
Approve (3-0)

5180 Department of Social Services – CalFresh

1. Overview
Informational.
2. BCP #11: CalFresh Technical Assistance & Program
Approve (3-0)
3. Drought Food Assistance Program
Informational.
4. Proposals for Investment
Held open.

5180 Department of Social Services – Other

1. TBL 604: Employment Development Data Sharing
Held open.

5180 Department of Social Services – State Hearings Division

0530 Health and Human Services Agency, Office of Systems Integration

1. Overview of State Hearings Division
Informational.
2. BCP #2: State Hearings Appeals Case Management Procurement Support Extension
Approve (3-0)

5180 Department of Social Services – Automation

1. Oversight: Child Welfare Systems – New System
Informational.
2. Oversight: LEADER Replacement System/SAWS
Informational.
3. Electronic Benefit Transfer (EBT) 3 Project –Transition to New EBT Services
Held open.
4. BCP #9: Horizontal Integration
Approve (3-0).

Chair, Senator Holly J. Mitchell
Senator Jeff Stone, Pharm. D.
Senator William W. Monning



May 7, 2015
9:30 a.m. or upon adjournment of Floor Session
John L. Burton Hearing Room 4203

PART A

Staff: Peggy Collins

4300 Department of Developmental Services (DDS)

Community Services

Issue 1 Federal Overtime Changes – Budget Request 3

Developmental Centers

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Issue 2 Future of Developmental Centers - Oversight 7
Issue 3 New Initiatives Funded in 2014 Budget Act - Oversight 12
Issue 4 Closure of Lanterman Developmental Center – Budget Request 13
Issue 5 Employee Compensation and Other Baseline Adjustments –
Budget Request 17
Issue 6 Staffing Adjustment for Acute Crisis Units – Budget Request 18
Issue 7 Expansion of the Secure Treatment Program at Porterville
Developmental Center – Budget Request 18
Issue 8 Sonoma Developmental Center GF Backfill for Lost Federal Funds -
Budget Request 20
Issue 9 Program Improvement Plans – Budget Request 21
Issue 10 Staffing Adjustments (Population) – Budget Request 22
Issue 11 Sonoma Creek Pump Station – Budget Request 22
Issue 12 Fire Alarm System Upgrade at Porterville Developmental Center –
Capital Outlay Project - Budget Request 23
Issue 13 Deferred Maintenance Projects – Budget Request 24

0530 Health and Human Services Agency (HHSA)

Issue 1 Office of Law Enforcement Support – Spring Finance Letter 25

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the agenda unless otherwise directed by the Chair.

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. Thank you.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

COMMUNITY SERVICES

ISSUE 1: FEDERAL OVERTIME CHANGES – BUDGET REQUEST

John Doyle, Chief Deputy Director, DDS
Tom Heinz, Executive Director, Eastbay Innovations
Shawn Martin, Legislative Analyst's Office

Background: In September 2013, the United States Department of Labor made regulatory changes to federal Fair Labor Standards Act (FLSA) by revising the definition of “companionship services” and requiring overtime compensation for service providers previously exempt. Among the services purchased by regional centers, supported living programs, in-home respite programs, and personal assistance services would have been impacted by this change. The 2014 Budget Act provided a 5.82 percent rate increase, at a cost of \$9.5 million (\$5.2 million GF), to in-home respite services, supported living services and personal assistants, and trailer bill language, to reflect the cost of complying with Federal Labor Standards Act change.

On December 31, 2014, a federal district court delayed implementation of the revised definition of “companionship services” and on January 14, 2015, the court vacated the revised definition. The U.S. Department of Labor appeal of this ruling will be heard on May 7, 2015. Pending an outcome of that appeal, DDS rescinded the rate increase and has recouped the funds appropriated for this purpose that were previously allocated to the regional centers.

The FLSA issue had a corresponding impact on in-home supportive services (IHSS) workers. However, unlike the solution adopted for DDS-funded services, the IHSS solution included both funding for overtime costs and a limitation on the amount of overtime that could be worked by an IHSS provider. Implementation of the IHSS changes associated with the FLSA issue has also been delayed.

Should the U.S. Department of Labor decision be upheld in appeal, the state changes to the IHSS and DDS-funded services will be implemented. The state could also choose to move forward with the changes approved last year, without reference to direction provided by the FLSA regulations. However, concerns have been raised since the passage of the 2014 budget that for regional center consumers who rely on both IHSS and a regional center-funded service, most notably supported living services (SLS), that utilize the same worker, implementation may be particularly complex. Specifically, there is ongoing concern that the overtime rule may apply accumulatively for workers who are employed as both an IHSS provider and SLS provider (otherwise referred to as the “dual employer” issue). Additionally, because state law requires regional centers to utilize generic services prior to purchasing DDS-funded services, the cap on allowable hours for IHSS recipients, along with the cap on allowable overtime for IHSS providers, will likely push significant overtime costs onto the DDS-funded SLS system, where there is no statutory cap on recipient hours or cap on allowable overtime for SLS providers.

Governor’s Budget: The Governor’s budget proposes to increase current year funding related to the implementation of the FLSA overtime regulations by \$3.7 million (\$1.9 million GF). In the budget year, the Governor proposes \$24.4 million (\$13.1 million GF) to reflect the full year implementation of this policy. However, as noted early, implementation has been delayed pending the outcome of a federal court hearing.

Legislative Analyst’s Office (LAO) Recommendation: The LAO makes two recommendations regarding the DDS budget related to the FLSA issue:

- If the Legislature is concerned about the possibility DDS could spend some or all of the 2014-15 funding appropriated for FLSA-related costs on other purposes, the Legislature would want to enact legislation specifically reverting these funds so that they would be available for any legislative priority.
- The Legislature should wait until the May Revision before making a decision related to the 2015-16 FLSA-related appropriations DDS, at which time, we may know the outcome of the Department of Labor appeal.

Question for Mr. Heinz:

- *Please describe your concerns about the implementation of the overtime rule for supported living service providers and consumers.*

Question for LAO:

- *Please describe your recommendation.*

Questions for DDS:

- *Please discuss your perspective on the “dual employer” issue that has been raised by supported living providers.*
- *Please confirm that the funding provided through the 2014 Budget Act related to the FLSA issue has been recouped from regional centers and will not be utilized for any other purpose without express Legislative approval.*
- *Has the Administration considered whether it would be simpler, safer, and more successful to consumers’ outcomes, to allow supported living services to provide the entire complement of required attendant services, rather than requiring regional center consumers to first use IHSS services?*

Staff Comments and Recommendation: Hold open pending the May Revision.

PUBLIC TESTIMONY

DEVELOPMENTAL CENTERS

ISSUE 1: BACKGROUND AND GOVERNOR'S BUDGET OVERVIEW- INFORMATIONAL

Background: DDS operates three state institutions, known as developmental centers (DCs), and one smaller state-leased and operated community facility, that care for adults and children with developmental disabilities.

California has served persons with developmental disabilities in state-owned and operated institutions since 1888. At its peak, the developmental center system included eight facilities and housed over 13,400 individuals in seven facilities. As the state developed a network of community-based services and supports, placements in state developmental centers declined. Since 1995, the state has closed four developmental centers: Stockton Development Center in 1995; Camarillo State Hospital, which served both persons with developmental disabilities and persons with mental illness, in 1997; Agnews Developmental Center in 2009, and Lanterman Developmental Center in 2014. A second state-leased and operated community facility, Sierra Vista, was closed in 2009.

Of the three remaining developmental centers, the oldest is Sonoma Developmental Center (1891) and the youngest is Fairview Developmental Center (1959). Canyon Springs Community Facility, a state-leased and operated community facility, was opened in 2000. The following chart shows the population at each facility, based on the April 29, 2015 census report.

Facility	Location	Year Opened	Population as of 4/29/15
Fairview Developmental Center	Costa Mesa	1959	279
Porterville Developmental Center	Porterville	1953	366 ¹
Sonoma Developmental Center	Eldridge	1891	405
Canyon Springs Community Facility	Cathedral City	2000	47

The decline in developmental center use is consistent with the development of a community-based network of services and supports that promote successful integrated living in California communities and reflects national trends that support reduced reliance on institutions and greater

¹ 166 residents in the Secure Treatment Program (STP); 200 residents outside the STP.

support for community-based integrated services, directed in part by changes in state and federal law, and multiple court cases, including the United States Supreme Court's 1999 decision in *Olmstead v. L.C., et al.*²

Numerous changes to the regional center planning and service development process have further reduced use of developmental centers. Person-centered planning has resulted in more appropriate and successful community-based services and supports for individuals who utilize regional center services. Additionally, regional centers use an annual community planning and placement (CPP) allocation, \$67.8 million (total funds) proposed in the budget year, to develop community-based services and supports for individuals moving out of a developmental center, and to deflect new placements into developmental centers. The Governor's budget projects an average in-center population of 1,010 in the budget year, a reduction of 106 over the average in-center population in the enacted current year budget. The budget estimates the total developmental center population on June 30, 2016 will be 951.

Statutory changes, adopted as part of the 2012-13 state budget, AB 89 (Committee on Budget), Chapter 25, Statutes of 2012, restricted new developmental center admissions, except under specified conditions, including commitments under the state's Incompetent to Stand Trial statute. Additionally, individuals who are in crisis can be placed temporarily at the Fairview Developmental Center or Sonoma Developmental Center.

The declining DC population, its aging infrastructure, and fixed costs has led to increasingly high per resident costs associated with maintaining this model of residential care. Based on the Governor's budget figures, the average per capita cost of services provided to a resident in a developmental center in the current year is \$504,391 annually (total funds). In the budget year, that cost rises to \$510,099 annually. By comparison, the average per capita cost of a person receiving community-based services in the current year is \$19,900 annually (total funds; excluding the Early Start Program). In the budget year, the cost rises to \$20,403 annually.

Current Year Budget Adjustment: The Governor's budget proposes to update the current year budget for the DCs to \$562.9 million (\$309.6 million GF), a net increase of \$34.7 million (\$33.6 million GF) in the current year, to serve 1,116 residents, an increase of four residents over the enacted budget. The budget proposes to increase the current year staff level by 220 positions. The Administration indicates that these adjustments will be updated in the May Revision. The Administration intends to pursue funding for the current year unanticipated costs through a supplemental appropriations bill.

Budget Year Proposal: The January budget proposes an appropriation of \$515.2 million (\$279.8 million GF) to serve an estimated average in-center population of 1,010 residents in 2015-16. Compared with last year's enacted budget, this reflects an anticipated decline of 102 residents; and an overall net decrease of \$12.9 million in total funding, but an increase of \$3.8 million GF. The budget proposes to decrease positions by 410.9 over the adjusted current year.

² See page 7 of the agenda.

Question for DDS:

Please present a brief overview of the Governor’s budget for developmental centers.

Staff Comments and Recommendation: This is an informational issue. No action is required.

ISSUE 2: FUTURE OF DEVELOPMENTAL CENTERS – OVERSIGHT ISSUE

PANEL:

Michael Wilkening, Undersecretary, Health and Human Services Agency

Santi Rogers, Director, DDS

Shawn Martin, Legislative Analyst

Kathleen Miller, President, Parent Hospital Association for Sonoma Developmental Center

Terry DeBell, President, CASHPCR

Dion Aroner, former Assembly Member; Partner, AJE Partners

Catherine Blakemore, Executive Director, Disability Rights California

Jacque Foss, CEO, S.T.E.P. Agency

Secretary Dooley’s Plan for the Future of Developmental Centers in California. On January 13, 2014, the Secretary of the California Health and Human Services Agency released her “*Plan for the Future of Developmental Centers in California*” (plan). The plan was developed pursuant to trailer bill language that required the Secretary to submit to the Legislature a master plan for the future of DCs. The plan was developed in consultation with a task force comprised of a broad cross-section of system stakeholders, including individuals with developmental disabilities, family members, regional center directors, consumer rights advocates, labor representatives, legislative representatives, and DDS staff.

The secretary’s plan discusses numerous changes in federal and state law and various court rulings that have served to move California and other states away from institutional care in favor of community-based services and supports.

These include:

- *Association for Retarded Citizens v. Department of Developmental Services (1985)*, 38 Cal.3d 384 (ARC), in which the court interpreted the Lanterman Act as creating an “entitlement” to services that enables each person with intellectual and developmental disabilities to live a more independent and productive life in the community.
- *Americans with Disabilities Act*, 42 U.S.C. sec. 12100, et seq. (ADA). In 1990, the ADA was enacted to prohibit discrimination on the basis of disability in the provision of government programs and services.

- *Coffelt v. Department of Developmental Services (1990) (Coffelt)*. The Coffelt class action lawsuit alleged unnecessary placements of persons in DCs who could live in the community. The case was settled in 1994 resulting in more than 2,000 DC residents moving into the community over five years, and other system reforms.
- *Olmstead v. L.C. (1999), 527 U.S. 581 (Olmstead)*. In *Olmstead*, the United States Supreme Court held that discrimination under the ADA includes unnecessary institutionalization of people with disabilities who can live in the community.
- *Capitol People First v. Department of Developmental Services (2001) (CPF)*. The CPF class action lawsuit alleged unnecessary segregation of Californians with developmental disabilities in large congregate public and private institutions. The lawsuit was settled in 2009, resulting in a greater focus on development of community resources, DC residents and families being provided information on community living options, and regional center resources to work with the DC residents and families.
- *AB 1472 (Committee on Budget), Chapter 25, Statutes of 2012*. With ongoing budget constraints and many challenges facing the DCs, significant new policy limiting DC admissions and the use of institutional care in the community was enacted in the trailer bill to the 2012-13 budget. Among other provisions, a moratorium was placed on DC admissions, with only limited exceptions for individuals involved with the criminal justice system or in acute crisis; comprehensive assessments were required for all DC residents to determine if community services are available to meet their needs; a new model of care was authorized that would allow for secured perimeters with delayed egress in a community home; and resources were prioritized to reduce state and local institutionalization.

As the secretary states in her plan, “Today, state and federal laws and court decisions clearly favor community integration over institutional care, defined nationally as congregate facilities with a capacity of 16 residents or more. Throughout the United States the population of persons with developmental disabilities receiving services in large settings of 16 or more has dramatically decreased. In 1977, this population represented 83.7 percent of the total number served. In 2007, 30 years later, it represented 14.3 percent. Thirteen states and the District of Columbia have no large state-operated institutions, while many other states have active plans for closure of some, if not all, of their large facilities. In California, the Lanterman Act entitlement to services ensures that an individual will receive appropriate services with any transition out of a large state-operated facility.”

While the plan did not provide a time-specific roadmap for transitioning away from the developmental center model in California, it did put forth six consensus recommendations to develop the community resources necessary to serve individuals with enduring and complex medical needs and/or challenging behaviors and support needs, like those currently living in a developmental center. These recommendations are:

1. *More community style homes/facilities should be developed to serve individuals with enduring and complex medical needs using existing models of care.*

2. *For individuals with challenging behaviors and support needs, the State should operate at least two acute crisis facilities (like the program at Fairview DC), and small transitional facilities. The State should develop a new “Senate Bill (SB) 962 like” model that would provide a higher level of behavioral services. Funding should be made available so that regional centers can expand mobile crisis response teams, crisis hotlines, day programs, short-term crisis homes, new-model behavioral homes, and supported living services for those transitioning to their own homes.*
3. *For individuals who have been involved in the criminal justice system, the State should continue to operate the Porterville DC-STP and the transitional program at Canyon Springs Community Facility. Alternatives to the Porterville DC-STP should also be explored.*
4. *The development of a workable health resource center model should be explored, to address the complex health needs of DC residents who transition to community homes.*
5. *The State should enter into public/private partnerships to provide integrated community services on existing State lands, where appropriate. Also, consideration should be given to repurposing existing buildings on DC property for developing service models identified in Recommendations 1 through 4.*
6. *Another task force should be convened to address how to make the community system stronger.*

Certification Challenges. In January 2013, four out of 10 intermediate care facility (ICF) units at Sonoma Developmental Center (SDC) were withdrawn from federal certification by DDS, in response to notice that the federal government was moving to decertify the larger group of ICF units at the facility. These actions came on the heels of widely reported revelations of multiple instances of abuse, neglect, and other lapses in caregiving at the institution.

In March 2013, DDS entered into a Program Improvement Plan (PIP) agreement with the state Department of Public Health (DPH), which was accepted by the federal Centers for Medicare and Medicaid Services. As a condition of the PIP, DDS contracted with an outside consultant to conduct a root cause analysis of the problems at SDC, and develop an action plan to ensure SDC is in compliance with federal and state licensing and certification requirements.

On October 31, 2013, the DPH accepted the SDC action plan which included the opening of a new ICF unit, 118.5 new staff positions, three new wheelchair transport vehicles, and extensive staff training. The Administration assumed these corrective actions would result in the restoration of certification and federal funding by July 1, 2014. However, this did not occur. Rather, a survey of the seven certified ICF units at SDC occurred May of 2014, and these units were found to be out-of-compliance in four out of eight conditions, resulting in their decertification. However, CMS has extended the date on which federal funding for these units will be withdrawn several times, while they have been engaged in active conversation with the

Administration. As of April 1, 2015, the date for federal funding withdrawal is now May 7, 2015.

Following the SDC loss of federal certification, DPH conducted surveys at Fairview (FDC), Porterville (PDC), and Lanterman (LDC) developmental centers and found ICF units at each facility to be out of compliance with federal requirements. Like SDC, areas of non-compliance include treatment plans, protection of residents, client health and safety, and client rights. In January 2014, DDS and DPH reached an agreement to avoid decertification at these three facilities. The agreement requires the development of a root-cause analysis and action plan for PDC and FDC, similar to what was required at SDC. For LDC, the agreement required DDS to contract with an independent monitor to provide oversight, among other requirements.

FDC was resurveyed in February of 2015 and PDC was resurveyed last month. Although the outcome of these resurveys is not yet known, early indications are that PDC may be found to still be out of compliance in four of the eight conditions of participation.

The loss, or risk of loss, of federal certification has cost the state General Fund in two ways: General Fund augmentations to backfill for the lost federal dollars; and, General Fund augmentations to implement the program improvement plans intended to result in recertification and restoration of federal funding. The chart below outlines these General Fund costs.

	FY 2012-13		FY 2013-14		FY 2014-15		FY 2015-16	
	GF Backfill	PIP	GF Backfill	PIP	GF Backfill	PIP	GF Backfill	PIP
Fairview	\$0	\$0	\$0	\$1,104	\$0	\$4,008	\$32,400	\$3,459
Lanterman	\$0	\$0	\$0	\$54	\$0	\$140	\$0	\$0
Porterville	\$0	\$0	\$0	\$979	\$0	\$4,776	\$27,600	\$3,027
Sonoma	\$7,400	\$0	\$15,707	\$3,528	\$8,800	\$5,122	\$44,400	\$0
Total	\$7,400	\$0	\$15,707	\$5,665	\$8,800	\$14,046	\$104,400	\$6,486

1/ Dollars in thousands.

2/ Figures represent General Fund amounts only.

3/ Figures from Budget with exception of 2015-16 General Fund ICF FFP at Risk

4/ Estimate for BY 2015-16 ICF FFP at Risk based on expenditures from FY 2014-15, population as of March 31, 2015, and allocation statistics from FY 2013-14.

5/ Associated PIP funding received in one fiscal year will be treated as base budget funding in future years.

6/Through February 2015, additional GF backfill will be identified in the May Revision.

United States Department of Justice (USDOJ) Actions Pending: According to the Governor’s budget, the following two issues are pending and may have future fiscal impacts:

- DDS received notification from the USDOJ in March 2014 of a civil investigative demand to determine whether a violation had occurred at SDC relative to the Medicare and Medicaid Program. DDS is reviewing this request and has contracted with outside counsel to determine the appropriate response.

- Over a period of more than eight years, the USDOJ has conducted investigations of Sonoma and Lanterman developmental centers and has issued findings pursuant to the Civil Rights for Institutionalized Persons Act (CRIPA). According to DDS, the USDOJ may pursue resolution of these findings in the future, potentially resulting in GF costs.

LAO Recommendation: The LAO’s analysis of the Governor’s January budget requests that the Administration be required to report at budget hearings on their long-term plan for Fairview and Sonoma developmental centers. Specifically, the LAO writes:

“In its plan for the long-term future of DCs, the Task Force on the Future of DCs convened by the administration recognized the need to maintain state-operated facilities for individuals in acute crisis or involved in the criminal justice system. We agree with the task force on the need to maintain state-operated facilities for individuals involved in the criminal justice system and find that Porterville DC should continue to operate for this purpose. However, we find significant fiscal and policy justification for closing Fairview and Sonoma DCs and seeking to transition all residents in these facilities to community settings. On a fiscal basis, we find that providing services and supports to former DC residents in community settings is cost-effective. On policy grounds, the provision of services and supports in integrated community settings is consistent with federal and state policy. We therefore come to the conclusion that DDS should close both Fairview and Sonoma DCs within ten years. We would defer to the department’s judgment as to which DC should be closed first. We recognize that DDS may not be in a position to submit a closure plan for Fairview or Sonoma DC to the Legislature by April 1, 2015, as required under existing state law in order to begin closure activities in 2015–16. We therefore recommend that the Legislature require DDS to report at budget hearings on its long-term plan for Fairview and Sonoma DCs. Upon considering the department’s testimony at budget hearings, the Legislature may seek to enact legislation providing a closure timeline for Fairview and Sonoma DCs.

Questions for HHSA:

- *Please describe the status of discussions with CMS, relative to the certification of developmental centers and federal funding participation.*

Questions for DDS:

- *Please describe the activities and associated costs relative to implementation of PIPs, and other efforts to regain or maintain certification at developmental centers.*
- *Please discuss the nature of the investigations being conducted by the USDOJ.*

Question for LAO:

- *Please present your recommendation.*

Questions for Community Panelists:

- *Please provide your perspective on this issue.*

Staff Comments and Recommendation: This discussion is presented as an oversight issue. No action is required.

ISSUE 3: NEW INITIATIVES FUNDED IN THE 2014 BUDGET ACT – OVERSIGHT ISSUE

Related to the recommendations made in the Health and Human Services Agency’s “*Plan for the Future of Developmental Centers in California*,” the Administration proposed, and the Legislature approved, the following new initiatives:

- Approved \$3.2 million (\$2 million GF), and trailer bill language, to establish two acute crisis centers at Fairview and Sonoma developmental centers. Each acute crisis center will serve up to five individuals. **This issue is discussed later in this agenda.**
- Approved trailer bill language to expand the community state staff program, previously limited to persons moving from Agnews and Lanterman developmental centers, to support individuals transitioning from a developmental center to the community and to prevent the unnecessary institutionalization and hospitalization of persons with developmental disabilities. **This issue is discussed later in this agenda.**
- Approved \$5.4 million (GF) and trailer bill language for a pilot program to develop up to six enhanced behavioral support homes each year. These homes will be certified by DDS and licensed by the Department of Social Services (DSS).
- Approved \$3.9 million (GF) and trailer bill language to develop two community crisis homes for individuals at risk of admission to a developmental center or other restrictive setting. The homes, one in northern California and one in southern California, will be certified by DDS and licensed by DSS.
- Approved \$1.5 million (GF) to develop two transitional homes, and \$900,000 (GF), to develop an adult residential facility for persons with special health care needs (ARFPSHN) that includes behavioral supports, to serve persons moving from a developmental center. These models currently exist and do not require additional statutory authority.
- Approved \$1.2 million (\$1.1 million GF) to increase regional center staffing to support resource development, quality assurance, support for specialized behavioral and medical care homes, and enhanced case management.
- Approved the re-appropriation of \$13 million (GF), a portion of which is unspent community placement plan funds, to be used to implement selected recommendations made in the Health and Human Services Agency’s “*Plan for the Future of Developmental Centers in California*”.

Affordable Housing Model at Fairview Developmental Center: As discussed earlier, one of the six recommendations made in the Secretary’s *Future of Developmental Centers* report is that the state *should enter into public/private partnerships to provide integrated community services on existing State lands, where appropriate*. Such a project was established in 1985 with the opening of Harbor Village on the grounds of the Fairview Developmental Center (FDC). This housing development was a partnership of the state, City of Costa Mesa, the local regional center and a private developer. Its 564 apartments house persons with and without developmental disabilities.

In 2008, the Department of General Services (DGS) issued a request for proposals (RFP) for a second housing development on the FDC grounds, called Shannon’s Mountain. The project moved forward, albeit at a slow pace, but in 2013 the project halted due to new concerns raised by DGS. Efforts to resolve these new issues were unsuccessful and the project has languished since 2013. Earlier this year, legislative staff met with representatives of DDS, DGS, the Health and Human Services Agency and the Government Operations Agency. At that time, staff was advised that productive discussions were occurring and that the Administration was hopeful the project would move forward.

Questions for DDS:

- *Please provide a brief update on the status of the above initiatives, excluding those that will be discussed later in the agenda.*
- *Please provide an update on the Shannon’s Mountain project at Fairview Developmental Center.*

Staff Comment and Recommendation: This issue is provided for oversight purposes. No action is required.

ISSUE 4: CLOSURE OF LANTERMAN DEVELOPMENTAL CENTER – OVERSIGHT ISSUE

Background: In December, 2014, the last resident of Lanterman Developmental Center moved to the community. This marked the end of a closure process that was approved by the Legislature as a part of the Budget Act of 2010. The LDC closure plan borrowed heavily from the process employed to close Agnews Developmental Center (ADC), including the use of Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHN); improved health care through managed care plans for persons transitioning from LDC to the community; implementation of a temporary outpatient clinic at LDC to ensure continuity of medical care and services as individuals transfer to new health care providers; and the use of LDC staff to provide services in the community to former LDC residents.

The following chart describes the type of community placements that have occurred for 358 LDC movers:

LDC Placement Information	Dec. 23 2014***
Total Placements	358**
CCF (L4i, 113's, RCFE's)	255
CCF – ARFPSHN	65
ICF – DD N	9
ICF – DD H	7
SLS	7
Family Home/Other	3
Congregate Living Health Facility	2
Family Teaching Homes (FTH)	3

** Includes 7 individuals in long-term subacute for over a year, now considered transitioned.

***Date last resident moved from LDC

The following chart shows the final status of employee separation from LDC.

Transfer	552
Retirement	342
Resignation	95
Limited-Term Expired	38
Layoff	241
Other ³	40

First utilized in the closure of Agnews Developmental Center (ADC), a component of the LDC closure process was the Community State Staff (CSS) Program. As initially approved in SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, this program authorized LDC employees to work in the community with former LDC residents, through a contract with a regional center or direct service provider, while remaining state employees for up to two years following the closure of LDC. AB 89 (Committee on Budget), Chapter 25, Statutes of 2013, removed the two-year limitation. SB 856 (Committee on Budget and Fiscal Review), Chapter 30, Statutes of 2014, expanded the program statewide, for use in supporting persons transitioning from a developmental center to the community or to prevent the unnecessary institutionalization and hospitalization of persons with developmental disabilities.

A total of 123 ADC employees were hired into a community program through the community state staff program, while only 17 LDC employees have utilized this program. No other contracts for employees from the other developmental centers have been established for a community program since the CSS program was expanded last year, pending finalization of discussion with the associated bargaining units.

³ Dismissal, death, etc.

LDC Outpatient Clinic: SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, authorized the operation of an outpatient clinic at LDC to provide health and dental services to individuals who move from LDC, in order to ensure the continuity of medical care as these individuals transfer to new health care providers in the community. This clinic will operate until DDS is no longer responsible for the property. The following chart⁴ shows the total services received at the LDC Outpatient Clinic.

SERVICE TYPE	2011*	2012	2013	2014	2015 (thru Feb.)	Total	Services Provided in 2014 & 2015 6+ Months After Placement
Attending Physician	0	2	0	0	1	3	
Dental	3	30	50	87	27	197	3
Dermatology	0	6	21	5	0	32	
Lab Work	0	0	2	1	0	3	
Neurology	0	4	2	8	5	19	
Occupational Therapy	1	2	2	18	32	55	
Ophthalmology	0	2	2	7	0	11	
Other	0	0	6	51	16	73	3
Orthopedic	0	1	5	0	0	6	
Physical Therapy	0	0	1	0	0	1	
PM&R	0	1	4	47	8	60	
Podiatry	0	9	18	37	10	74	
Psychiatry	0	9	6	10	3	28	2
Psychology	0	0	0	0	0	0	
Rehab. Engineering	0	12	21	19	8	60	3
X-Ray	0	0	1	5	0	6	
Total Outpatient Services Received	4	78	141	295	110	628	11

*Outpatient Clinic Opened 11/2011

LDC Property: The Governor’s budget assumes that DDS will be in possession of the LDC property until June 30, 2015. The Governor’s budget assumes the LDC property will transfer to the California State University System on July 1, 2015, at which time DDS would no longer have

⁴ DDS, March 11, 2014

responsibility for maintaining the property in warm shutdown and would no longer be statutorily required to operate the outpatient clinic.

Among other recommendations, Secretary Dooley's report on *The Future of Developmental Centers*, recommends that the state enter into public/private partnerships to provide integrated community services on existing state lands, where appropriate; and, consider repurposing existing buildings on DC property for developing various service models. This recommendation reflects the position of many advocates that lands, previously dedicated to the benefit of persons with developmental disabilities, should continue to benefit this population through post-closure utilizations or through dedication of sale proceeds. Despite this recommendation, the budget proposes no benefit to the broader developmental disabilities community relative to the disposition of the LDC land.

Governor's Budget Requests: The Governor's budget makes the following request related to the closure of LDC.

1. 13.0 positions for the post-closure period in the budget year, and beyond, for transitioning of consumers into the community. Specifically, the budget requests:
 - (a) Retain six positions to extend the Regional Resource Development Projects (RRDP) to ensure LDC movers have successfully transitioned to the community. The positions would include one community program specialist IV; two community program specialists II; two community program specialists I; and, one office technician.
 - (b) Retain two positions, now housed at FDC, for the administration of the CSS program. The positions would include a program director and one personnel specialist I, at a cost of \$283,000 (\$219,000 GF).
 - (c) Extend the program reauthorization of five positions at headquarters, including a CEA Level A, research program specialist, research program analyst II, associate information systems analyst, and an associate personnel analyst, at a cost of \$591,000 (\$459,000 GF).
2. \$17.3 million (\$9.1 million GF) to pursue settlement of open workers' compensation claims of LDC employees. For one year after the closure of the facility, the state has the possibility of claiming matching funds for these expenditures.

Questions for DDS:

- *What options were considered, relative to the disposition of the LDC land that would have benefited the broader developmental disabilities community?*
- *Describe the activities and function of the various staff under your proposal as it relates to the ongoing work associated with the CSS program for former Agnews and Lanterman developmental center staff, and as the statewide CSS program is implemented.*
- *Why has the utilization of the community state staff program differed in the closure of Agnews Developmental Center versus the closure of LDC?*
- *Discuss the timeline for implementing the community state staff program statewide. What efforts are being made to improve participation?*
- *Discuss how the proposal related to the settlement of workers' compensation claims differs from past practices?*

Staff Comments and Recommendations: Approve \$17.3 million (\$9.1 million GF) to pursue settlement of open workers' compensation claims of LDC employees. Hold other items open pending May Revision.

ISSUE 5: EMPLOYEE COMPENSATION AND OTHER BASELINE ADJUSTMENTS – BUDGET REQUEST

Background: Control Section 3.60 sets forth the state's retirement contributions for its employees for the 2015-16 fiscal year. Collective bargaining agreements between the state and state employee bargaining units establish compensation rates for employees and are reflected in memoranda-of-understanding (MOUs) approved by the Legislature.

Budget Request: The Governor's budget requests \$6.8 million (\$4.1 million GF), in the current year; and, \$6.8 million (\$4.1 million GF) in the budget year, to reflect updated employer retirement contribution rates. The budget requests \$6.5 million (\$3.9 million GF) in the current year; and, \$6.4 million (\$3.8 million GF) in the budget year for salary increases for DDS employees approved through the collective bargaining process. The budget also requests a decrease of \$.04 million in Lottery Education Funds and a \$0.3 million increase for rental payments on lease-revenue bonds.

Questions for DDS:

- *Please briefly describe your request.*

Staff Comments and Recommendations: No issues have been raised about this request. Staff recommends approval.

ISSUE 6: STAFFING ADJUSTMENTS FOR ACUTE CRISIS UNITS – BUDGET REQUEST

Background: As discussed above, the 2014 budget included \$3.2 million (\$2 million GF), and trailer bill language, to establish two acute crisis centers at Fairview and Sonoma developmental centers. Each acute crisis center will house up to five individuals at a time. The budget assumed federal funding participation for these units.

Budget Request: The Governor’s budget requests \$0.2 million (\$0.1 million GF) and 3.5 positions (net increases) associated with level of care (LOC) staffing adjustments for these units, and \$0.3 million (\$0.2 million GF) and 4.5 positions associated with non-level of care (NLOC) staffing adjustments, in the current year.

Questions for DDS:

- *Please describe the status and staffing of each crisis unit, and the process for admittance to a crisis unit. How does this compare to the community crisis homes approved in last year’s budget?*
- *Is the SDC crisis unit currently certified and receiving federal funding?*
- *If the Administration is unsuccessful in recertifying ICF units at SDC, will the crisis unit also lose its certification?*

Staff Comments and Recommendations: Should federal funding participation be lost at Sonoma or Fairview developmental centers, these units may become solely reliant on general fund. Hold open pending the May Revision.

ISSUE 7: EXPANSION OF SECURE TREATMENT PROGRAM (STP) AT PORTERVILLE DEVELOPMENTAL CENTER – BUDGET REQUEST

Background: Porterville Developmental Center (PDC) currently serves 169 residents⁵ in the Secure Treatment Program. The program is statutorily limited to 230 beds, consisting of 170 beds in the secure area and 60 beds available as transition beds in the general treatment area. These individuals have been judicially committed as incompetent to stand trial (IST). Although some of these individuals may be Medi-Cal eligible, DDS does not receive federal matching funds for the STP population due to lack of federal certification because of the “correctional-type” of setting in which services are provided. As a result, the STP is 100 percent GF supported.

As of January 7, 2015, there are an estimated 52 individuals who have been issued court orders to receive competency training and are currently in jail or prison, pending space becoming available in the STP. According to DDS, superior courts have begun issuing “orders to show

⁵ Based on the April 29, 2015 census.

cause” to DDS, requiring legal counsel to appear in court. All individuals admitted to the STP, or awaiting admittance, have been charged with a violent and/or sexual offense and all have been determined to be incompetent to stand trial (IST). Admittance in the STP is for the purpose of restoration of competency or a clinical determination that competency cannot be restored.

The following chart shows how the number served in this program has varied over the last 10 years.

YEAR¹	NUMBER SERVED
6/30/2004	292
6/30/2005	295
6/30/2006	295
6/30/2007	287
6/30/2008	285
6/30/2009	277
6/30/2010	261
6/30/2011	264
6/30/2012	193
6/30/2013	168
6/30/2014	168

¹Year-end census

Other options to STP: While the need for providing IST services in a secure environment is increasing, it is not clear that a large institutional setting is the best option. In the state mental health system, greater efforts are being made to provide treatment in a community setting. However, for the developmental disability system, statutory barriers exist to such options. For example, the recently approved delayed-egress community home model could serve this population if a secured perimeter were added. However, state statute requires that delayed-egress homes utilizing secured perimeters be eligible for federal funding participation and CMS will not provide funding for secured perimeter homes as they consider it to be an institutional-type facility. Additionally, state law was amended in recent years to allow IST services be

provided to persons with mental illness in county jails, but a similar allowance for persons with developmental disabilities in county jails was not made.

Budget Request: The Governor’s budget requests \$9.0 million GF and 92.3 positions in the current year; and, \$18.0 million GF and 184.5 positions in the budget year, related to the proposed expansion of the STP by 32 beds.

Questions for DDS:

- *Outside of requiring DDS legal counsel to appear in court, has the court indicated it may take any other action relative to delays in placements?*
- *Briefly describe the activities undertaken to restore competency and how this program was designed. What is the average stay of residents in the STP? What percentage of residents have competency restored and are able to stand trial for their offense? What happens to residents when it is determined that competency cannot be restored?*
- *Discuss population trends for the STP.*
- *How has the department addressed the needs of this population in a setting other than a developmental center?*
- *What efforts have been undertaken to engage the Judicial Council, regional centers and other stakeholders to identify better treatment environments and early intervention strategies?*
- *Describe the challenges in utilizing delay egress, and/or secure perimeter community facilities for this population.*

Staff Comments and Recommendation: Hold open pending the May Revision.

ISSUE 8: SONOMA DEVELOPMENTAL CENTER (SDC) GENERAL FUND (GF) BACKFILL FOR LOST FEDERAL FUNDING – BUDGET REQUEST

Background: As discussed above, four of eleven ICF units at SDC have been decertified since January of 2013, foregoing federal matching funds and relying solely on the GF for their operations. Since that time, the Administration has requested, and the Legislature has approved, GF augmentations to fund enhanced services, enriched staffing, and other improvements intended to bring these, and other ICF units, into compliance in order to regain, or maintain, certification and restore federal funding participation. Nonetheless, certification has not been restored for these four units; and, the remaining ICF units at SDC, as well as the ICF units at Fairview and Porterville (non STP) developmental centers, have since failed certification surveys, pending appeal.

Budget Request: The Governor’s budget requests \$8.8 million GF to offset lost federal funding for the four decertified units at SDC for the first eight months of the current year (the 2014-15 budget assumed these units would be recertified as of July 1, 2014).

Questions for DDS:

- *What is the GF impact, to date, of lost federal funding at Sonoma? What will be the annualized cost if federal funding is lost for all ICF units at SDC, and separately for the new crisis unit at SDC? What is the annualized cost if federal funding is lost at Fairview DC and in the general treatment program at Porterville DC?*

Staff Comments and Recommendations: The Governor’s budget assumes recertification would occur at the end of February 2015, and that all ICF units would be certified for the entirety of the 2015-16 fiscal year. However, as noted before, currently all the ICF units at the state DC’s are at risk of losing certification and the Administration is engaged in discussions with CMS related to this issue. Hold open pending the May Revision.

ISSUE 9: PROGRAM IMPROVEMENT PLANS – BUDGET REQUEST

Background: As previously discussed, significant GF resources have been invested in the Administration’s efforts to make the improvements necessary to regain, or maintain, certification of the ICF units at SDC and the other developmental centers. The scope and nature of these improvements are determined through a program improvement plan (PIP) that DDS has entered into with the state Department of Public Health (see chart on page 10 for PIP-related costs). Prior to implementation of the PIP, DDS was required to contract with independent consultants to develop a root-cause analysis and the PIP. These consultants have also provided on-going consultation and monitoring as the PIPs are implemented, and assist DDS in preparing for recertification surveys.

The chart below shows these contract costs.

	FY 2012-13	FY 2013-14	FY 2014-15
DelMarva	\$219,141	\$2,082,202	\$894,212
H&W	\$216,521	\$450,000	\$450,000

1/ Whole dollars, General Fund only.

2/ The above DelMarva amounts are a subset of the PIP totals provided on Page 10, General Fund Costs, and not in addition.

3/ The above H&W, also known as Hayes & Wiesel Independent Solutions, amounts were not included in the PIP totals provided on Page 10. The contract was funded within the Base Budget.

Budget Request: The Governor’s budget requests an \$11.9 million (\$7.5 million GF) and an increase of 119.7 positions, to cover eight months of costs to implement two PIPs at the Fairview and Porterville developmental centers that were entered into with the state Department of Public Health on January 15, 2015. In the budget year, the Administration requests \$12.2 million (\$6.5 million GF) and 179.5 positions for the full year costs of these PIPs.

Questions for DDS:

- *What are the costs, to date, for these enhancements? What are the annualized costs?*
- *Why have these efforts been unsuccessful in regaining certification?*
- *DDS contracted with the Delmarva Foundation, an independent consultative review expert, to develop a root cause document; and to develop and monitor the implementation of a program improvement plan at each developmental center. Given that these efforts have not been successful, why does DDS continue to use this contractor?*

Staff Comments and Recommendations: As the nature and outcome of the discussions between the Administration and CMS is currently unknown, hold open pending the May Revision.

ISSUE 10: STAFFING ADJUSTMENTS RELATED TO POPULATION – BUDGET REQUEST

Background: In the January and May budget documents, the Administration updates the population estimates for the developmental center, which drives staffing needs at these facilities.

Budget Request: The Governor’s budget requests a decrease of \$12 million (\$6.6 million GF) and a reduction of 149.4 positions due to an anticipated population decline of 134 residents.

Questions for DDS:

- *Please briefly describe these adjustments.*

Staff Comments and Recommendation: As this estimate will likely be updated in the May Revision, hold open at this time.

ISSUE 11: SONOMA CREEK PUMP STATION – BUDGET REQUEST

Background: SDC’s only source of water comes from two local lakes that are fed primarily by seasonal diversion from three nearby creeks. Water is pumped to, or fed by gravity ditches from, the creeks to the lakes. SDC’s on-site water treatment facility can be fed from either lake. The water is treated prior to distribution and potable use for SDC facilities and fire protection purposes. Water diversions from the creeks are monitored by water meters installed at their

intake structures and reported annually to the State Water Resources Control Board (SWRCB). SDC diverts water pursuant to two SWRCB-issued water diversion licenses issued in the 1930s.

The existing Sonoma Creek Pump Station intake structure has been damaged by large storm floods over an extended period and this damage, combined with the recent chronic low flows associated with the drought, has not allowed SCD to fully utilize the pump station equipment at maximum capacity. Existing law requires water diverters make full and beneficial use of allocated water and water volumes not utilized for a period of five years or more could be subject to forfeiture. As the water rights attached to the existing licenses can be transferred to a new owner, the loss of these water rights could substantially impact the value of this state land.

Budget Request: The Governor’s budget requests \$1.6 million GF (\$900,600 for preliminary plans; \$695,500 for working drawings) for Phase 1 of a project to replace the Sonoma Creek Pump Station Intake System located at SDC.

Questions for DDS:

- *If SDC were to close in the next few years, would funding this project still be prudent?*

Staff Comments and Recommendations: The Department of General Services estimates that \$2 million GF will be needed for the construction portion (Phase 2) of this project. Staff recommends this issue be held open pending May Revision.

ISSUE 12: FIRE ALARM SYSTEM UPGRADE AT PORTERVILLE DEVELOPMENTAL CENTER - CAPITAL OUTLAY PROJECT – BUDGET REQUEST
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Background: According to DDS, the existing fire alarm system is comprised of subsystems of varying ages, all of which are outdated and well beyond useful life. The system is not integrated and there are gaps in coverage and functionality, and the older systems do not meet current fire codes. According to DDS, the existing systems fail at an unacceptable rate, and the majority of alarm triggers are the result of false alarms caused by system malfunctions.

Budget Request: \$0.8 million GF, through the Capital Outlay process, to prepare preliminary plans (\$309,000) and working drawings (\$493,000) for a high priority fire, life, and safety project at the Porterville DC (Phases 1 & 2).

Questions for DDS:

- *If the non-secure portion of PDC were to be closed in the next few years, would this project be prudent?*

Staff Comments and Recommendation: According to the Department of General Services, Phase 3 of the project, construction, would cost an estimated \$7.2 million GF and will be requested for the 2016-17 fiscal year. The total project cost, over two years, is estimated at \$8.0 million GF. Staff recommends this issue be held open pending May Revision.

ISSUE 13: DEFERRED MAINTENANCE PROJECTS – BUDGET REQUEST

Background: According to the Governor’s Five-Year Infrastructure Plan, DDS estimates the currently identified deferred maintenance projects at the developmental centers would cost approximately \$386.7 million GF to complete. This does not include ongoing repair projects, or other projects that DDS absorbs within its discretionary developmental center funds, such as the work already completed to prepare for the expansion of the STP at Porterville Developmental Center.

Budget Request: Control Section 6.10 of the Governor’s budget proposes that the Department of Finance (DOF) may allocate \$125 million GF to various state departments to address a portion of deferred maintenance needs, including \$7.0 million GF to DDS. DOF must provide their approved list of projects to be funded through the authority granted in this Control Section to the Joint Legislative Budget Committee (JLBC) 30 days prior to the allocation of these funds. Additionally, any change to the list must be approved by DOF, subject to a 30 day review by the JLBC. Note that proposed Control Section 6.10 is being considered in Senate Budget Subcommittee No. 4 on State Administration and General Government.

On April 29, 2015, the Legislature was supplied with an initial list of projects proposed for funding pursuant to Control Section 6.10. For DDS, the following projects at Porterville DC were included:

- Repair of groundwater wells for an estimated \$225,000.
- Replacement or retrofit of existing boilers for an estimated \$5,410,000.
- Security camera upgrade in the STP for an estimated \$400,000.
- Re-key the entire facility to a master/submaster key schedule for an estimated \$750,000.

Questions for DDS:

- *Briefly describe the importance of each project.*
- *If Porterville DC were to close in the next few years, would all of these projects still be prudent?*

Staff Comments and Recommendation: The replacement or retrofitting of the existing boilers at Porterville DC was proposed last year and rejected by the Legislature. Following the release of the May Revision, the subcommittee may wish make recommendations to Senate Budget Subcommittee No. 4 on the projects proposed by DDS for funding through Control Section 6.10.

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 1: OFFICE OF LAW ENFORCEMENT SUPPORT – SPRING FINANCE LETTER

Governor’s Proposal: The Administration requests \$1,965,000 GF, \$600,000 one-time reimbursement authority, and 15.0 permanent positions to establish a Professional Standards Section and a Vertical Advocate Unit within the Office of Law Enforcement Support (OLES), and reimbursable services contracts for subject matter expertise.

Law Enforcement Activities within DDS: The Department of Developmental Services (DDS) conducts law enforcement activities at state developmental centers through their Office of Protective Services (OPS). OPS is housed within the Development Centers Division of DDS and includes 13 staff positions consisting of a chief, supervising special investigators, investigators and non-sworn support staff. Additionally, individual OPS commanders are assigned to each developmental center and manage law enforcement operations at the facilities. Although these facility commanders work closely with the facility executive director, they take direction and report to the OPS chief at headquarters.

History of Health and Safety Problems: Like other large state institutions, developmental centers have a long history of problems related to alleged abuse, neglect and mistreatment of its residents. According to a report by the CHHSA, discussed in more detail below, the “...past failures of OPS have resulted in intense media attention, increased legislative scrutiny, and a loss of federal funding.” The CHHSA cites two critical state agency reports, published more than a decade apart, to illustrate the ongoing problems with safety and security at developmental centers – the 2002 report of the California Attorney General’s Office entitled, “Policing in the Department of Developmental Services, A Review of the Organization and Operations 2000-2001” and the 2013 report of the California State Auditor entitled, “Developmental Centers: Poor-Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and Untimely Licensing Reviews Put Residents at Risk.”

Center for Investigative Reporting (CIR): On April 7, 2015, the Center for Investigative Reporting (CIR) published a report asserting that “abuse, neglect and lack of supervision at California’s state-run homes for the developmentally disabled have directly caused the deaths of 13 people since 2002, newly released records from the state Department of Public Health show.” According to this report, “The developmental centers ... bear some responsibility for the deaths of another six residents because they allowed living situations so dangerous that there was a great probability that deaths would occur.” The CIR report is based on a review of citations issued by the state Department of Public Health against DDS.

Administration’s 2014 Budget Proposal: During last year’s budget process, the Administration proposed to establish an Office of Investigations and Law Enforcement within the Health and Human Services Agency (CHHSA). Specifically, the Administration requested \$1,175,000 GF to establish nine permanent positions for the proposed office. Under the proposal, the office

would oversee and support law enforcement and investigative services for DDS and the Department of State Hospitals (DSH), including implementation of new internal affairs activities, oversight and quality control of investigations, and standardization of law enforcement policies and procedures. Additionally, the Administration requested \$600,000 in increased reimbursement authority to contract with the California Highway Patrol (CHP) to provide subject-matter expertise and technical and operational assistance to the office through an interagency agreement.

Ultimately, the 2014 budget included \$787,000 GF and six permanent positions, and \$600,000 in one-time reimbursement authority for the contract with the CHP, for the establishment of the Office of Law Enforcement Support within CHHSA to provide uniform training, policies, and protocols for the peace officers employed by the state hospitals and developmental centers. In addition, the 2014 budget included \$600,000 in one-time reimbursements for a contract with the CHP. Approved trailer bill language requires CHHSA to work with system stakeholders to improve the quality and stability of law enforcement practices and the development of uniform procedures; and requires the agency to report to the Legislature on the new procedures by July 1, 2015.

CHHSA Report: The aforementioned report was submitted to the Legislature on March 6, 2015. The report makes a number of recommendations to improve law enforcement functions within DDS and DSH in the following areas:

- Standardized policy development.
- Standardized testing, hiring, background investigations, and intra-departmental transfer practices.
- Standardized training plan; development and monitoring.
- Use-of-Force reporting; development and monitoring.
- Early intervention system; development and monitoring.
- Employee discipline and professional standards accountability.
- Criminal and administrative investigation monitoring, review, and auditing.

New Administration Proposal: On April 1, 2015, the Administration submitted a new proposal to expand the Office of Law Enforcement Support (OLES) within the Health and Human Services Agency. Specifically, the Administration requests an increase of \$1.96 million General Fund, \$600,000 one-time reimbursement authority, and 15 permanent positions to establish a professional standards section and a vertical advocate unit within OLES, and reimbursable services contracts for subject-matter expertise.

Specifically, the Agency requests nine permanent investigative unit positions, four attorney positions, and two support positions. According to the finance letter, these positions will enable CHHSA to “directly conduct independent investigations of serious incidents which occur at the state hospitals and developmental centers, such as suicides, deaths, sexual assaults, etc. In addition, as part of each investigation, the OLES team will thoroughly review DSH and DDS internal administrative investigations, identify and correct errors and gaps in policy and procedures, and assign independent legal staff to engage in the entire investigation and/or employee disciplinary processes through appeal. OLES also intends to contract for a lieutenant

and sergeant from the CHP and one senior assistant inspector general from the Office of the Inspector General (OIG) with extensive experience in internal affairs and criminal investigations.

Shared Jurisdiction with Senate Budget Subcommittee No. 5: This issue relates to both the Department of Developmental Services and the Department of State Hospitals (DSH). Senate Budget Subcommittee No. 5 on Corrections, Public Safety, and the Judiciary oversees the DSH budget and heard this issue on March 19, 2015. The subcommittee took no action but directed the Legislative Analyst's Office to work with budget staff to develop the necessary language for expanding the authority of the Office of the Inspector General to include state hospitals and psychiatric programs.

LAO: As of the time of this writing, the LAO has not made a recommendation on this proposal. However, they have indicated that a recommendation is forthcoming.

Questions for HHSA:

- *Please describe your proposal, the function of the current office and the function of the proposed professional standards section and the vertical advocate unit.*
- *What stakeholders did HHSA work with in the development of the recommendations made in your March 6th report?*
- *How might this proposal change as developmental centers downsize or close?*

Questions for LAO:

- *Please present your recommendation.*

Staff Comments and Recommendation: Hold open pending the May Revision. Direct subcommittee staff, LAO and the Administration to work together on a proposal to be present to both subcommittees at the May Revision hearings.

Peggy Collins 651-1891 or 651-4103
Senate Budget and Fiscal Review Committee

OUTCOMES: Senate Subcommittee #3 on Health and Human Services
Thursday, May 7, 2015
Agenda Part A: Developmental Services
Health and Human Services Agency

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

COMMUNITY SERVICES

ISSUE 1: FEDERAL OVERTIME CHANGES – BUDGET REQUEST

- **Hold open pending the May Revision.**

DEVELOPMENTAL CENTERS

**ISSUE 1: BACKGROUND AND GOVERNOR’S BUDGET OVERVIEW-
INFORMATIONAL**

- **Informational.**

ISSUE 2: FUTURE OF DEVELOPMENTAL CENTERS – OVERSIGHT ISSUE

- **Informational.**

**ISSUE 3: NEW INITITIVES FUNDED IN THE 2014 BUDGET ACT – OVERSIGHT
ISSUE**

- **Informational.**

ISSUE 4: CLOSURE OF LANTERMAN DEVELOPMENTAL CENTER – OVERSIGHT ISSUE

- **Approve \$17.3 million (\$9.1 million GF) to pursue settlement of open workers' compensation claims of LDC employees: VOTE: 3-0**
- **Hold other items open pending May Revision.**

ISSUE 5: EMPLOYEE COMPENSATION AND OTHER BASELINE ADJUSTMENTS – BUDGET REQUEST

- **Approve: VOTE: 3-0**

ISSUE 6: STAFFING ADJUSTMENTS FOR ACUTE CRISIS UNITS – BUDGET REQUEST

- **Hold open pending the May Revision.**

ISSUE 7: EXPANSION OF SECURE TREATMENT PROGRAM (STP) AT PORTERVILLE DEVELOPMENTAL CENTER – BUDGET REQUEST

- **Hold open pending the May Revision.**

ISSUE 8: SONOMA DEVELOPMENTAL CENTER (SDC) GENERAL FUND (GF) BACKFILL FOR LOST FEDERAL FUNDING – BUDGET REQUEST

- **Hold open pending the May Revision.**

ISSUE 9: PROGRAM IMPROVEMENT PLANS – BUDGET REQUEST

- **Hold open pending the May Revision.**

ISSUE 10: STAFFING ADJUSTMENTS RELATED TO POPULATION – BUDGET REQUEST

- **Hold open pending May Revision.**

ISSUE 11: SONOMA CREEK PUMP STATION – BUDGET REQUEST

- **Hold open pending May Revision.**

ISSUE 12: FIRE ALARM SYSTEM UPGRADE AT PORTERVILLE DEVELOPMENTAL CENTER - CAPITAL OUTLAY PROJECT – BUDGET REQUEST

- **Hold open pending May Revision.**

ISSUE 13: DEFERRED MAINTENANCE PROJECTS – BUDGET REQUEST

- **Hold open pending May Revision.**

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

ISSUE 1: OFFICE OF LAW ENFORCEMENT SUPPORT – SPRING FINANCE LETTER

- **Hold open pending the May Revision. Direct subcommittee staff, LAO and the Administration to work with stakeholders on a proposal to be present to both subcommittees at the May Revision hearings.**

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Holly J. Mitchell
Senator Jeff Stone, Pharm. D.
Senator William W. Monning



May 7, 2015
9:30 a.m., or Upon Adjournment of Session
Room 4203, State Capitol

Part B

Staff: Samantha Lui

ISSUES RECOMMENDED FOR VOTE-ONLY

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APPENDIX A

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order noted in the Agenda unless otherwise directed by the Chair. 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. Thank you.

ISSUES RECOMMENDED FOR VOTE ONLY**4185 California Senior Legislature****1. TBL 606: Successor Fund Designation**

The Administration proposes trailer bill language to establish the California Senior Legislature Fund as the successor fund of the California Fund for Senior Citizens. Because the Fund for Senior Citizens did not meet the minimum contribution amount of \$250,000, it fell off the tax check-off for the 2014 tax return. As of March 3, 2015, there is \$343,000 in the Surplus Money Investment Fund. Senior Legislature members felt that there may have been confusion as to which senior fund to donate, creating the decline in donations. The Administration proposes establishing and renaming the successor fund with a title that is identifiable with the organization's name, and authorizing the ability to roll-in the current amount in the Surplus Money Investment Fund.

Recommendation. Approve. The subcommittee heard and discussed this item during its March 26, 2015 hearing. No concerns have been raised.

5160 Department of Rehabilitation**1. BCP #1: Statewide Funding of Social Security Beneficiary Work Incentives Planners**

The department requests \$3.11 million in federal fund authority for 31 ongoing full-time permanent positions (Work Incentives Planners, or WIPs). The WIPs will provide financial literacy and benefits planning services to eligible consumers who receive Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits. 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 budget assumes that the 31 WIPs will generate the level of SSA reimbursements to fund these positions.

During the March 12, 2015, hearing, the subcommittee asked how the department plans to accommodate the positions if projected federal Social Security Administration (SSA) reimbursements do not come to fruition. The department noted its commitment to fund independent living centers and interprets ILC funding and personnel funding as separate and distinct, even though these positions and ILCs both receive funding from SSA reimbursements. Instead, the department committed to living within its budget at the department level.

Recommendation. Approve; adopt placeholder provisional budget bill language. Staff recommends adopting provisional budget bill language that authorizes the department to fund up to 31 positions, contingent on the available federal funding for the positions. The subcommittee also may wish to have the Department of Rehabilitation, at next year's legislative hearing, report on the status of hiring the 31 Work Incentive Planner positions, as well as the success of drawing down federal Social Security reimbursements. This subcommittee, as well as the Assembly Subcommittee No. 1 on Health and Human Services, may wish to ask the department to conduct a workgroup comprised of stakeholders, recipients, and legislative staff before October 2015, in order to evaluate how additional funding drawn down by the WIPs can be utilized to increase funding to the community.

5180 Department of Social Services – Child Welfare Services**1. TBL 602: Approved Relative Caregiver Funding Options Program Clean-Up**

The Administration proposes trailer bill language to “administratively streamline the application process for grant payments, maximize federal funding, and ensure that families do not experience a break in services or payment.” Specifically, the language includes the following provisions:

1. Foster children and non-minor dependents (NMDs), who are eligible to receive an approved relative caregiver (ARC) payment will be placed into a separate assistance unit.
2. The CalWORKs portion of the payment will be the exempt maximum aid payment for an assistance unit of one.
3. If the approved relative caregiver is needy, his or her assistance unit size will include the number of ARC children, or NMDs, only for purposes of determining program income and eligibility of the CalWORKs assistance unit. For purposes of calculating the grant amount for the needy caregiver, the ARC child and NMD is excluded.
4. Foster care resource limits will be used to determine eligibility of an ARC child and NMD.
5. Overpayments will be collected pursuant to existing foster care program requirements.
6. County of court jurisdiction has payment responsibility for ARC children and NMDs.
7. An approved relative caregiver is exempt from Statewide Fingerprint Imaging Systems, reporting, immunization, and other CalWORKs requirements.
8. The General Fund (GF) appropriation must be increased annually by an amount greater than the CNI to ensure that the caregiver payments get a full California Necessities Index (CNI) adjustment.
9. The GF portion of the ARC payment may be countable towards maintenance-of-effort (MOE), only if the GF is not counted as MOE for another purpose.

Recommendation. Approve and adopt placeholder trailer bill language. The subcommittee heard and discussed this item during its April 9, 2015 hearing.

2. BCP #50: AB 1978 Child Welfare Social Worker Empowerment and Foster Child Protection Act

The Administration requests one staff services manager and associated operating expenses and equipment to implement a confidential process whereby child welfare social workers can inform the Department of Social Services (DSS) of local policies, procedures, or practices that endanger a child’s welfare. Within the department, social worker disclosures are received, evaluated against established criteria, investigated, and reported.

Recommendation. Approve. The subcommittee heard and discussed this item during its April 9, 2015 hearing.

3. April Letter – BCP #83: Implementing Child Victims of Human Trafficking

The Administration requests two permanent associate governmental program analysts to support the implementation of the Commercially Sexually Exploited Children (CSEC) program and the federal Preventing Sex Trafficking and Strengthening Families Act (PL 113-183). These two positions will engage nonprofits, service providers, social service agencies, law enforcement, and health and mental health agencies in the development of state policies and program guidelines for services to children and youth at risk of, or victimized by, commercial sexual exploitation. The requested positions will also support county programs to provide prevention activities, intervention activities, and services to children who are victims, or at risk of becoming victims, of commercial sexual exploitation.

Recommendation. Approve. The subcommittee heard and discussed this item during its April 9, 2015 hearing.

5180 Department of Social Services**1. TBL 604: Employment Development Department Data Sharing**

The Administration proposes trailer bill language that authorizes the Employment Development Department (EDD) to share data with federal, state, or local government departments or agencies, or their contracted agencies, to support social services administration.

Recommendation. Approve; adopt placeholder trailer bill language. The subcommittee heard and discussed this item during its April 30, 2015 hearing.

0530 Health and Human Services Agency, Office of Systems Integration**5180 Department of Social Services****1. Electronic Benefit Transfer (EBT) 3 Project – Transition to New EBT Services**

The Administration requests an increase of \$1.6 million to the Office of Systems Integration (OSI) expenditure authority, beginning January 1, 2016, for the following one-time costs associated with the transition to a new Electronic Benefit Transfer (EBT) Service Provider: (1) new EBT service provider transition costs; and (2) EBT 3 transition team.

Recommendation. Approve. The subcommittee heard and discussed this item, along with the department's strategies to improve EBT utilization to reduce surcharges for clients, during its April 30, 2015 hearing.

ISSUES FOR DISCUSSION

Public testimony will be taken at the end for all items listed in this section.

Multiple Departments

1. Proposals for Investment

Various stakeholders have submitted proposals for funding restoration, augmentation, or program expansion. The table below includes issues that have not been previously discussed. The subcommittee has invited a panel, including the Legislative Analyst’s Office and proponents of the proposals, to provide a background and context.

5160 Department of Rehabilitation		
Program	Description	Amount Requested
Traumatic Brain Injury	Disability Rights California, California Foundation for Independent Living Centers (CFILC), and Traumatic Brain Injury Services of California request augmenting the TBI Fund through the Driver Training Penalty Assessment Fund to maintain the program over the next 4 years.	\$1 million annually and trailer bill
Restore cuts to Assistive Technology Services	CFILC requests to restore the 30% cut to Assistive Technology Services that was made in 2004.	\$903,000
Independent Living Center funding	CFILC requests to provide base funding to all 28 ILCs in the amount of \$235,000.	\$705,000 annually
Better Jobs Incentive Payment	A pilot project in the Greater East Bay DOR District to provide an incentive payment for Department of Rehabilitation supported employment vendors to find consumers jobs that earn higher wages.	\$1,500 for each supported employer vendor each time a consumer in employment is placed.

5180 Department of Social Services		
Program	Description	Amount Requested
One California: Coordinating Citizenship and Immigration Assistance	Assist qualified non-profits to provide education, outreach, and application assistance to lawful permanent residents eligible for lawful permanent residents eligible for citizenship and undocumented immigrants eligible for administrative relief.	\$20 million GF ongoing
Child Welfare Services – Specialized Care Increment	Authorize foster families to access existing specialized care increment rates available in the counties and allocating \$15 million GF to offset the costs of expanding the pool of families eligible for these payments.	\$15 million GF ongoing
American Red Cross	Seeking a multi-year appropriation, as distributed to the Department of Social Services and allocated to the American Red Cross for disaster services in California.	\$7.5 million (\$2.5 million annually until FY 2017-18)

Staff Comment and Recommendation. Hold open. Staff recommends holding open the above proposals for further discussion and review.

Appendix A

Appendix A lists other human services-related proposals that have been discussed previously, including:

March 26, 2015

Supplemental Security Income/State Supplemental Payment		
Program	Description	Amount Requested
SSI/SSP	Request restoration on the SSP grant cuts and the cost-of-living adjustment (COLA).	Varies

CalWORKs		
Program	Description	Amount Requested
Maximum Family Grant (MFG)	Repeal MFG	approx. \$210 million GF
Housing Support Program	Augment the CalWORKs Housing Support Program	\$30 million GF ongoing
California Partnership to End Domestic Violence	Enact trailer bill to require counties to waive any program requirement for individual who is a past or present victim of abuse, among other provisions.	Unknown
Additional proposals	<ul style="list-style-type: none"> • Increase CalWORKs grants; • Restore the CalWORKs cost-of-living adjustment; • Restore the value of the Earned Income Disregard and index it to inflation; • Require Department of Social Services to develop options for reducing sanctions in consultation with stakeholders, with a report to the Legislature in 2016; • Suspend all transfers to the TANF 24-month-clock; and, • Require the Department of Social Services to develop alternatives to the TANF 24 month clock to result in fewer sanctions. 	Varies

April 9, 2015

Child Welfare Services		
Program	Description	Amount Requested
Bringing Families Home	Establish a county matching grant program for child-welfare involved families that may be experiencing homelessness.	\$10 million GF
Foster Parent Recruitment, Retention, and Support	(1) Target recruitment and support efforts to better match foster families and foster children; (2) direct services and supports to foster and kin caregivers; (3) and intensive family finding, engagement and support.	\$30.2 million GF
Foster Family Agencies (FFA) Social Workers	Fund the Foster Family Agency (FFA) social worker rate to increase the social work component of the FFA rate by \$200/month.	\$18.9 million GF
Transitional Housing Program-Plus (THP+) for Nonminor Dependents Aging Out of Care and to Homeless Youth	Expand THP+ for non-minor dependents aging out of care and for homeless youth. by modifying eligibility criteria to allow homeless youth, ages 18 to 24, to participate in the program.	\$30 million GF

March 26, 2015 and April 23, 2015

Aging		
Program	Description	Amount Requested
Access to and coordination of services	Same.	\$14 million GF
Nutrition	Provide additional meals and nutrition support through the Brown Bag program (\$1 million) and Home-Delivered Meals (\$5 million)	\$6 million GF
Support caregivers	Enhance caregiving and family support for three programs that support caregivers: \$5 million for Alzheimer's Day Care, \$900,000 for Respite Purchase of Services, and \$1.6 million for Senior Companion	\$7.5 million GF
Protection against elder abuse	Same.	\$9.5 million GF
Long-Term Care Ombudsman	(1) \$2.8 million for quarterly monitoring visits to all long-term care facilities in California through the addition of 45 positions; (2) \$351,000 to supervise and train volunteers; and, (3) \$1.1 million to investigate around 6,000 more complaints per year, through the addition of 18 positions.	\$4.25 million GF
Adult Protective Services training	California Commission on Aging, California Justice Coalition, and California Welfare Directors Association request funding to create a statewide Adult Protective Services (APS) training program for new APS staff, for supervisor training, and for new policy training.	\$5 million GF

April 30, 2015

Nutrition and Food Related		
Program	Description	Amount Requested
State Emergency Food Assistance Program	Distribute state emergency food assistance to all counties, based on existing methodology.	\$5 million GF
Nutrition Incentives/Market Match	Establish Nutrition Incentive Matching Grant Program, building off of California Market Match, which doubles purchasing power of CalFresh benefits when spent on specified crops at farmer's markets.	\$5 million GF ongoing

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Holly J. Mitchell
Senator Jeff Stone, Pharm. D.
Senator William W. Monning



May 7, 2015
9:30 a.m., or Upon Adjournment of Session
Room 4203, State Capitol

Part B

OUTCOMES IN RED

Item Department

4185 California Senior Legislature

1. TBL 606: Successor Fund Designation
Approve (3-0)

5160 Department of Rehabilitation

1. BCP #1: Statewide Funding of Social Security Beneficiary Work Incentives Planners
Approve; adopt provisional budget bill language, noting staff recommendation (3-0)

5180 Department of Social Services – Child Welfare Services

1. TBL 602: Approved Relative Caregiver Funding Options Program Clean-Up
Approve; adopt placeholder trailer bill language (3-0)
2. BCP #50: AB 1978 Child Welfare Social Worker Empowerment and Foster Child Protection Act
Approve (2-1, Sen. Stone voting no)
3. April Letter: Implementing Child Victims of Human Trafficking
Approve (3-0)

5180 Department of Social Services – Other

1. TBL 604: Employment Development Department Data Sharing
Approve ; adopt placeholder trailer bill language (3-0)

0530 Health and Human Services Agency, Office of Systems Integration

5180 Department of Social Services

1. Electronic Benefit Transfer (EBT) 3 Project – Transition to New EBT Services
Approve (3-0)

ISSUES FOR DISCUSSION

Item Department

Multiple Departments

1. Proposals for Investment
Held open.

Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.



May 7, 2015

9:30 a.m. or Upon Adjournment of Session

Room 4203, State Capitol

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Part C
(Michelle Baass)

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PLEASE NOTE:

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Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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VOTE ONLY

4265 Department of Public Health (DPH)

1. California Gambling Education and Treatment Services (CalGETS)

Budget Issue. DPH's Office of Problem Gambling (OPG) requests two permanent positions and \$5 million (Indian Gaming Special Distribution Fund) in 2015-16 to make permanent the regional pilot California Gambling Education and Treatment Services (CalGETS) program. Of this request, \$4 million will be allocated to local governments, public universities, and/or community organizations for treatment programs serving problem and pathological gamblers and their families. This proposal includes trailer bill language to delete outdated verbiage related to the program.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Trailer Bill Language.

2. Biomonitoring Resources and April Finance Letter

Budget Issue. In the January budget, DPH requested six, two-year limited-term positions and \$900,000 annually for fiscal years 2015-16 and 2016-17 to support the California Environmental Contaminant Biomonitoring Program (CECBP) including investigating the feasibility of detecting and measuring emerging chemical threats to California. Funding for this request is split between the Toxic Substances Control Account (\$775,000) and the Birth Defects Monitoring Fund (\$125,000).

An April finance letter requested a technical correction to this proposal. It is requested that funding from the Toxic Substances Control Account be decreased by \$150,000 and that the funding from the Birth Defects Monitoring Fund be increased by \$175,000. The letter also notes that the requested amount in the budget bill is incorrectly overstated by \$350,000 for DPH.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

3. Food Safety Inspection

Budget Issue. DPH requests six permanent positions and \$804,000 (Food Safety Fund) in the Food and Drug Branch (FDB) to carry out statutorily mandated responsibilities to inspect food processors and distributors. DPH will utilize registration fee revenues collected specifically for this purpose to fund the activities.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

4. Food Safety Stipulated Judgment Appropriation and Trailer Bill Language

Budget Issue. DPH requests four five-year limited-term positions and \$716,000 (Food Safety Fund) to implement the food safety transportation enforcement activities as a result of the Sysco Corporation stipulated judgment. DPH also requests budget trailer bill language (TBL) to amend Health and Safety Code Section 110050 to authorize the deposit into the Food Safety Fund of awards to the department pursuant to court orders or settlements for food safety-related activities.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Trailer Bill Language.

5. USFDA Tobacco Retail Inspection Contract

Budget Issue. DPH requests nine limited-term positions and \$1,078,000 additional reimbursement authority coinciding with the remainder of DPH’s contract with the federal Food and Drug Administration (FDA) for its Stop Tobacco Access to Kids Enforcement (STAKE) Unit to inspect 20 percent of tobacco retailers annually in California.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

6. Inspection of Public Beaches Resources (SB 1395, 2014)

Budget Issue. DPH requests one three-year limited-term position and \$384,000 (General Fund) in 2015-16 and \$182,000 (General Fund) in 2016-17 and ongoing to implement the mandated provisions of SB 1395 (Block), Chapter 928, Statutes of 2014. This bill authorizes the department to develop regulations for alternative beach water quality test that would shorten the amount of time required to produce results.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

7. Medical Waste Resources (AB 333, 2014)

Budget Issue. DPH requests \$333,000 (Medical Waste Management Fund) in 2015-16 and 2016-17, and three two-year limited-term positions to implement the mandated activities specified in AB 333 (Wieckowski), Chapter 564, Statutes of 2014. This bill provides updates to the Medical Waste Management Act, and ensures public health protection for the proper transportation, temporary storage, and disposal of medical waste.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

8. Notification of Increases in Federal Grants – Budget Bill Language

Oversight Issue. Existing budget bill language requires the Administration to report federal fund grant increases over \$400,000 to the Legislature on a timely basis. Given that DPH receives numerous federal grants, the practice of reporting these federal grant increases to the Legislature has occurred on an annual basis (instead of on a more timely basis). If the Legislature does not become aware of the a federal grant increase (for an existing grant or a new grant) on a timely basis, its review of the request for change in expenditure authority may not have any significance because the department may have already received the funds and implemented program changes.

Subcommittee Staff Comment and Recommendation—Modify Budget Bill Language. It is recommended to modify budget bill language to require the Administration to report increases in federal grants (over \$400,000) on a quarterly basis. The report to the Legislature would include the project title, budget act appropriation amount, quarter, adjustment, date department received notice of grant award, and comments. The modified budget bill language for items 4265-001-0890 and 4265-111-0890 is:

1. Of the funds appropriated in this item, \$61,108,000 shall be available for administration, research, and training projects. Notwithstanding Section 28.00, the State Department of Public Health shall report, **no later than 30 days after the end of each quarter**, under that section any new project over \$400,000 or any increase in excess of \$400,000 for an identified project.

4120 Emergency Medical Services Authority (EMSA)

1. Document Imaging Workload and Efficiencies

Budget Proposal. EMSA requests one permanent Office Technician, three Seasonal Clerks and \$366,000 (Emergency Medical Services Personnel (EMSP) Fund) in 2015-16 to address increased workload associated with the document imaging of paramedic licensure and enforcement files.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

2. Disaster Preparedness and Emergency Response Resources for California

Budget Issue. EMSA requests \$500,000 General Fund and two permanent Senior Emergency Services Coordinators. The additional funding and new positions would be utilized to reestablish the southern California component of the California Medical Assistance Team, stabilize existing disaster medical preparedness programs, and coordinate joint activities with the Department of Public Health's (DPH) Emergency Preparedness Office including catastrophic event planning, and emergency operations center planning and development.

This issue was discussed at the March 5th Subcommittee hearing. EMSA submitted the supplemental report, as required by the 2014 budget, to the Legislature in April.

Subcommittee Staff Recommendation—Approve.

0530 California Health and Human Services Agency

1. Office of the Patient Advocate

Budget Issue. The Office of Patient Advocate (OPA) requests \$206,000 in 2015-16 and \$182,000 ongoing to convert one limited-term position, expiring June 30, 2015, to a permanent position, a data warehouse, and other services to implement the Complaint Data Reporting Project. The source of funding for this proposal is the Managed Care Fund (90 percent) and the Insurance Fund (10 percent).

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

4140 Office of Statewide Health Planning and Development

1. Elective Percutaneous Coronary Intervention Program Outcomes Reporting

Budget Issue. OSHPD requests two permanent positions, one Research Scientist III and one Research Program Specialist I, and increased expenditure authority of \$372,000 in 2015-16 and \$319,000 ongoing from the California Health Data and Planning Fund for the implementation of SB 906 (Correa), Chapter 368, Statutes 2014. This bill establishes the Elective Percutaneous Coronary Intervention (PCI) Program and requires OSHPD to produce annual risk-adjusted public performance reports on participating hospital's PCI-related mortality, stroke, and emergency coronary artery bypass graft outcomes.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to approve these positions as limited-term for two years. Subcommittee staff finds that once the data procedures and processes to create the report are established, ongoing workload for two staff positions may not be justified.

2. Authority for Inter-Item Transfer of Funds – Budget Bill Language

Budget Issue. An April finance letter requests budget bill language to allow for the transfer of funds between 4140-101-0143 to 4140-001-0143. Item 4140-101-0143 is for the support of locally-administered activities and includes grants from the California Endowment. Beginning in 2013-14, the California Endowment committed over \$52 million over four years to OSHPD's healthcare workforce development programs. The grant agreement includes the provision to evaluate program priorities each year consistent with the goals of OSHPD and the California Endowment to train and increase the healthcare workforce. According to annual program priorities, some funds may be transferred to support programs funded at the state level such as the Rotations in Community Health Program (CalSEARCH) and the California Post-Baccalaureate Program (CalPostBac).

In 2015-16, \$850,000 in grant funding would be transferred as follows:

- CalPostBac: \$300,000
- CalSEARCH: \$400,000
- California Department of Public Health Fellowship Program: \$150,000

CalSEARCH provides grants to clinics and community health centers to support externships, internships and clinical rotations for community health workers/promotores, frontline workers, as well as primary care providers.

CalPostBac provides grants to post-baccalaureate educational entities whose efforts will support under-represented minority undergraduates re-apply to medical schools.

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Budget Bill Language.

4150 Department of Managed Health Care (DMHC)

1. Federal Mental Health Parity Rules

Budget Issue. DMHC requests 11.0 positions (5.5 permanent and 5.5 two-year limited-term) to address workload associated with conducting medical surveys of the 45 health plans affected by the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). In addition, two additional positions are requested starting in 2016-17, providing 7.5 permanent positions ongoing.

This issue was discussed at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

2. Additional Enrollment in Individual Market

Budget Issue. DMHC requests seven permanent positions and \$1,134,000 for 2015-16 and \$1,070,000 for 2016-17 and ongoing to address the increased workload resulting from the revised projected increase in enrollment in the individual market pursuant to SB 2 X1 (Hernandez), Chapter 2, Statutes of 2013-14 of the First Extraordinary Session. This request includes \$208,000 for 2015-16 and ongoing for expert witness and deposition costs for enforcement trials.

This issue was discussed at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

3. Large Group Claims Data Exposure (SB 1182, 2014)

Budget Issue. DMHC requests one permanent position (a senior legal analyst), effective January 1, 2016, and \$85,000 for 2015-16 and \$148,000 for 2016-17 and ongoing to address the increased workload resulting from the implementation of SB 1182 (Leno), Chapter 577, Statutes of 2014, regarding large group claims data exposure. This request also includes \$23,000 for 2015-16 and \$45,000 for 2016-17 and ongoing for clinical consulting services to provide methodology and statistical sampling of the claims data provided.

This issue was discussed at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

4. Dental Plans Medical Loss Ratio (AB 1962, 2014)

Budget Issue. DMHC requests 1.5 permanent positions and \$189,000 for 2015-16 and \$173,000 for 2016-17 and ongoing to address the increased workload resulting from the implementation of AB 1962 (Skinner), Chapter 567, Statutes of 2014, regarding dental plan medical loss ratios (MLR).

This issue was discussed at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

ITEMS FOR DISCUSSION

4150 Department of Managed Health Care

1. Annual Health Care Service Plans Timeliness Standards (SB 964, Hernandez)

Budget Issue. DMHC, through an April finance letter, requests 25 permanent positions and \$3,802,000 (Managed Care Fund) for 2015-16 and \$3,594,000 (Managed Care Fund) for 2016-17 and ongoing to address the increased workload resulting from the implementation of SB 964 (Hernandez), Chapter 573, Statutes of 2014. The requested positions are:

Program/Classification	2015-16 & ongoing
Office of Plan Licensing	
Attorney IV	1.5
Attorney III	3.0
Attorney I	3.0
Health Program Specialist I	4.5
Associate Health Program Advisor	4.0
Research Program Specialist II	2.0
Research Program Specialist I	2.0
AGPA	2.0
Health Program Manager I	1.0
Help Center	
Attorney I	1.0
AGPA	1.0
TOTAL	25.0

This request includes \$230,000 for 2015-16 and ongoing for statistical consulting services to assist the Office of Plan Licensing in conducting accurate network reviews. The consultant will be responsible for interpreting data, developing standards, and determining network trends.

Office of Plan Licensing. DMHC regulates health care service plans in California under the provision of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended. The DMHC Office of Plan Licensing (OPL) is tasked with reviewing new license applications, material modifications (those filings requesting approval of a major change such as a merger, acquisition, new product, etc.) and amendments to any previously approved documents of licensed health plans in California. Workload within the OPL review process includes an assessment of provider networks (including doctors, specialists, and hospitals) for new license applicants, service area expansions, block transfer filings, Covered California annual certification, and every time a health plans network changes 10 percent or more. OPL is also tasked with reviewing plans’ annual reports regarding compliance with timely access requirements (required to be submitted to the DMHC for review by California Code of Regulations Title 28, Section 1300.67.2.2).

According to DMHC, SB 964 legislation adds the following new requirements:

- Review health plan compliance with timely access standards and make recommendations for changes on an annual basis.
- Review all full service and mental health plan networks for adequacy and availability of providers – separately for Medi-Cal, individual market, and all other markets.
- Review grievances submitted to health plans regarding network adequacy and timely access.
- Post approvals for waivers from, or alternate standards for, timely access requirements on website on and after January 1, 2015.
- Post findings from timely access compliance review on website beginning December 1, 2015.

In addition, the new legislation gives DMHC authority to require health plans to use a standardized methodology for reporting compliance with timely access regulatory requirements. According to DMHC, OPL currently lacks adequate staffing to perform the reviews of the networks as required by SB 964. Existing staff is at capacity and cannot absorb this workload which requires knowledge about provider contracting, networks, enrollee communications and the health care delivery system.

Throughout California's 58 counties, each health plan's multiple provider networks must be reviewed individually for network adequacy. Developing new standardized methodologies will be a time-intensive and highly sophisticated process requiring a level of expertise not currently found in OPL.

There are a total of 45 health plans in California, all operating in one or more counties, which are subject to annual network reviews under SB 964. In order to perform a complete network review of a health plan, OPL must evaluate the health plans on an individual basis in all 58 counties. Reviewing the health plans at the county level is necessary due to differences in geographic location, demographics, and availability of provider options. For example, in San Luis Obispo County there are seven participating health plans that provide coverage (Aetna, Anthem Blue Cross, Blue Shield, Cigna HealthCare, GEMCare Health Plan, CenCal Health, and United Healthcare). In Los Angeles County, there are 12 participating health plans that provide coverage (Aetna, Anthem Blue Cross, Anthem Blue Cross Partnership Plan, Blue Shield, Care1st Health Plan, CIGNA, Health Net, Kaiser, LA Care, Molina, Seaside Health Plan, and United Healthcare).

Each of these participating health plans includes up to five different types of provider networks that DMHC must review, with each type requiring a separate review process. The five provider type categories are:

- Primary care providers
- Specialty care physicians
- Hospitals
- Mental health providers
- Ancillary providers, which include: acupuncture, pediatric dental and vision, home health, skilled nursing facilities, pharmacy, durable medical equipment, and hospice care

Together, these five provider type categories are considered a Plan Network Offering. There are four unique types of Plan Network Offerings: (1) Health Maintenance Organization (HMO), (2) Preferred Provider Organization (PPO), (3) Exclusive Provider Organization (EPO), and (4) Medi-Cal.

For every Plan Network Offering, the primary care, specialty care, and hospital care networks all warrant separate reviews because each one has different requirements for adequacy. For example, primary care providers must be accessible within 15 miles or 30 minutes, whereas the required access for specialty care physicians is a “reasonable” standard. Accordingly, each of these provider networks must be looked at separately by each Plan Network Offering. However, each health plan has only one mental health network and one ancillary network within each of the counties in which they operate, regardless of how many Plan Network Offerings they offer. As such, only one review of each is required.

In addition to network reviews, SB 964 also imposes new requirements concerning the review of annual timely access reports submitted by full service and mental health plans. One of the new requirements is that each of the 45 health plans subject to annual timely access reporting requirements must now report timely access compliance separately for (1) Medi-Cal, (2) individual market, and (3) all other markets. This yields 135 ($45 \times 3 = 135$) separate timely access reports, all of which the OPL is now required to review on an annual basis.

Help Center. To ensure health plan compliance with the law, DMHC Help Center’s Division of Plan Surveys conducts routine medical surveys of health plans every three years, and non-routine surveys more often, if necessary. The scope of the surveys are developed to focus on evaluating a health plan for compliance regarding: access and availability, quality management, the health plan’s record for handling enrollee grievances and appeals, utilization management, and overall performance in meeting enrollees’ health care needs.

SB 964 requires the DMHC to perform an annual comprehensive assessment of the enrollee grievances regarding network adequacy and timely access that health plans are now required to annually submit to the DMHC under this legislation. In addition, SB 964 requires DMHC to post its finding on its public website. The Division of Plan Surveys will incorporate their findings into the scope of their existing triennial routine medical surveys. Their findings may also serve as the basis for conducting non-routine surveys and making other inquiries regarding barriers consumers may be facing in accessing care.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal as the more systematic and organized review of health plan networks, as required by SB 964, will result in increased workload for DMHC. Prior to SB 964, DMHC reviewed approximately 500 health plan networks for timely access and adequacy on a piecemeal-basis. With SB 964, DMHC anticipates conducting about 5,000 health plan network reviews on an annual and systematic-basis.

Questions. The Subcommittee has requested DMHC respond to the following questions.

1. Please provide an overview of this request.
2. Please provide a status update on DMHC’s implementation of SB 964.
3. How is DMHC working with stakeholders to implement SB 964?

2. Health Premium Rate Review Federal Grant and Budget Bill Language

Budget Issue. DMHC, through an April finance letter, requests an increase in expenditure authority of \$589,000 federal funds to administer the Health Insurance Rate Review (Cycle IV) federal grant. As outlined in the Cycle IV grant requirements, and in support of the Affordable Care Act (ACA) and conforming state legislation, SB 1163 (Leno), Chapter 661, Statutes 2010, the federal funds will be used for actuarial consulting services and to enhance the information technology (IT) infrastructure of the DMHC premium rate review program. This grant was awarded to DMHC on September 19, 2014. The Administration notes that although DMHC provided timely notice of the increase in federal grant funds, the review by the Department of Technology (because of the IT component) resulted in this proposal coming forward as an April finance letter, instead of in the fall as a Section 28.00 budget letter.

As part of this request, DMHC requests the addition of the following provisional budget bill language to item 4150-001-0890:

Notwithstanding any other provision of law, of the funds appropriated in this item, up to \$395,000 is available for the Premium Rate Review Cycle IV Website Enhancement Implementation costs, for expenditure or encumbrance until June 30, 2016. Funding provided pursuant to this provision shall be made available only upon approval of the Department of Finance and approval of a Feasibility Study Report (FSR) or an FSR Reporting Exempt Request by the Department of Technology.

Background. The Cycle IV federal grant will enhance the DMHC premium rate review program through the implementation of best practices used by other state rate review agencies. The major goals of the grant are to: incorporate best practices that will enhance DMHC's rate review process; continue to build upon and improve DMHC's existing rate review program; improve the IT infrastructure that supports DMHC rate review functions, including more robust data analyses; and develop statistical reports using information from rate filings and financial reports submitted to the DMHC by health plans.

DMHC will utilize \$395,000 of the Cycle IV federal grant funds to contract with an IT consultant to assist in the design, development, and implementation of new analytical capabilities to assess the validity of rate increases and improve the IT infrastructure that supports the DMHC rate review functions. The consultant will be responsible for:

- Collaborating with DMHC rate review and IT staff to plan the development of new analytical capabilities to assess the validity of rate increases.
- Conducting a baseline assessment of the existing DMHC rate review website.
- Providing recommendations for enhancements to the content of the website; including how information is gathered and stored, page layouts, and visual design based on stakeholder comments.
- Developing and implementing webpages and features for consumer ease of access.

DMHC will utilize the remaining \$194,000 of the Cycle IV federal grant funds for actuarial consulting services to provide rate reviews. The department currently has a similar contract through September 2015 funded by the Cycle II federal grant. The actuarial consultant will be responsible for:

- Providing guidance and consultation to DMHC rate review staff on complex rate review matters such as base rates, risk adjustment factors, benefit valuation, capitation, risk-sharing mechanisms, underwriting issues, and target loss ratios.
- Performing trend analyses for health plan products.
- Providing recommendations for improvements to materials and forms related to the process for rate review and financial reporting.
- Providing guidance on legislative or regulatory changes on premium rates and the health care industry.
- Analyzing health plan premium rates to identify unreasonable, unjustified and/or excessive rate increases.

The successful completion of the IT and actuarial consulting contracts will support DMHC in improving its collection of premium rate data, analysis and reporting capabilities, and consumer access to understandable information and data. It will also help DMHC to ensure that consumers are confident that health insurance premium rates are truly reflective of the underlying factors.

The Cycle IV federal grant funds must be expended and all grant activities completed by September 18, 2016. In order to meet this deadline, it is important that the DMHC is able to execute the IT and actuarial contracts upon approval of this request. The DMHC is currently drafting the Scope of Work and Request for Proposal for the actuarial consultant services.

Subcommittee Staff Comment and Recommendation—Approve and Modify Budget Bill Language. It is recommended to approve the funding request and to modify the proposed budget bill language to allow DMHC to proceed with procuring a vendor if the Department of Technology does not reject the Feasibility Study Report (FSR) by July 1, 2015. DMHC has until September 2016 to expend and complete all grant activities; consequently, it is recommended to provide the Department of Technology with a timeframe to take action on the FSR to ensure that DMHC is able to complete these activities.

Modified budget bill language:

Notwithstanding any other provision of law, of the funds appropriated in this item, up to \$395,000 is available for the Premium Rate Review Cycle IV Website Enhancement Implementation costs, for expenditure or encumbrance until June 30, 2016. Funding provided pursuant to this provision shall be made available only upon approval of the Department of Finance and approval of a Feasibility Study Report (FSR) or an FSR Reporting Exempt Request by the Department of Technology. **If the Department of Technology does not approve the FSR by July 1, 2015, the Department of Managed Health Care may proceed with the Premium Rate Review Cycle IV Website Enhancement Implementation, assuming all other conditions contained in this Item have been met.**

Questions. The Subcommittee has requested DMHC respond to the following questions.

1. Please provide an overview of this request.

Multiple Departments

1. Health-Related Proposals for General Fund Investment

Various stakeholders have submitted proposals to the Subcommittee for General Fund investments. The table below includes issues that have not been previously discussed in this Subcommittee. General Fund proposals that have been previously discussed in a subcommittee hearing can be found in Appendix A.

Table: Health-Related Proposals for General Fund Investment

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
Department of Health Care Services		
Medi-Cal		
1. Restore Optional Benefits	The 2009 budget eliminated several Medicaid optional benefits from the Medi-Cal program. These benefits were eliminated for budgetary, not policy, reasons in response to the fiscal crisis. There is considerable support for restoring these benefits to the Medi-Cal program. See table below for more information on these costs.	
	Acupuncture	\$1.8 million
	Audiology	\$2 million
	Chiropractic	\$257,000
	Incontinence Cream and Washes	\$5 million
	Optician / Optical Lab	\$4.9 million
	Podiatry	\$1.1 million
	Speech Therapy	\$131,000
	Adult Dental (full restoration)	\$93.1 million
2. Pediatric Day Health Care Centers Rate Increase	Pediatric day health center providers request a five percent increase in the Medi-Cal reimbursement rate. These providers are not subject to the AB 97 payment reductions, but note that they have not seen rate increases in over 10 years and cannot adequately cover their costs.	unknown

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
3. Investment in Children's Health	Various children's advocates propose increased investments in children's health care. This includes increased funding to establish targeted remedies for identified problems in children's access to care, invest in data monitoring and tracking of children's Medi-Cal access to care, and addressing identified access shortcomings, and enroll uninsured children eligible for Medi-Cal, particularly children of color.	unknown
4. Estate Recovery	Senator Hernandez and multiple advocates request to limit estate recovery in the Medi-Cal program by requiring collection for only those health care services required to be collected under federal law, to make it easier for individuals to pass on their assets by using a narrower definition of "estate" in federal Medicaid law, and to allow a hardship exemption from estate recovery for a home of modest value. SB 33 (Hernandez) would implement these changes.	\$27.4 million
5. Community Clinic Reimbursement for Drugs and Supplies	Planned Parenthood requests to revise the Medi-Cal and Family PACT reimbursement formula for drugs and supplies dispensed by specified clinics, by requiring the clinic dispensing fee to be the difference between the actual acquisition cost of a drug or supply and the Medi-Cal reimbursement rate, and remove the maximum dispensing fee caps in existing law. Planned Parenthood makes this request because it finds that the current billing system the clinics must use is overly complex, and leads to numerous billing errors which require staff time at both the clinic and the state to resolve. These errors can take months to resolve and chronically deny the clinics Medi-Cal fees to which they are entitled. SB 447 (Allen) would implement this change.	\$6 million (could be higher depending on what drugs and supplies are covered)

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
6. Increase the Medi-Cal Aged and Disabled Program Level to 138% FPL	Advocates request to increase the amount of income that is disregarded in calculating eligibility for purposes of the Medi-Cal aged and disabled (A&D) program. The Western Center on Law and Poverty notes that the A&D program is a critical part of the Medi-Cal program and it provide free, comprehensive coverage to persons over the age of 65 and those with disabilities while simultaneously allowing them to have a monthly income. The A&D program was enacted in 2000, with an income eligibility standard of 199% FPL plus income disregards, making the eligibility criteria equivalent to 133% of the FPL. However, the disregards lose real value every year, with the resulting income standard today at only 123% of the FPL. When a senior has even a small increase in their income that puts them over 123% FPL, they are forced into the Medi-Cal Medically Needy program with a high share of cost. AB 763 (Burke and Bonilla) would implement this change.	\$30 million (per Assembly Appropriation's analysis)
7. Increase Personal Needs Allowance (PNA) for Individuals In Skilled Nursing Facilities	Assembly Members Gipson and Brown request an increase of the PNA from \$35 to \$80. For persons residing in a nursing home, Medicaid allows the resident to retain only a small amount of income each month, called a PNA. Federal law establishes a minimum PNA of \$30 a month for an individual (\$60 for couples). States may set higher levels. The PNA has not been increased since 1984.	\$13.4 million
8. AIDS Medi-Cal Waiver Rate Increase	AIDS Project Los Angeles proposes a rate increase for the AIDS Medi-Cal Waiver program. It notes that provider reimbursement rates for this program are lower than Medi-Cal rates for the same services. It argues that agencies have been forced to either reduce services or withdraw from the program due to inadequate funding.	\$4.8 million
9. Program of All-inclusive Care for the Elderly (PACE) Geographic Rate Differential	CalPACE requests funding to address the geographic rate differential between PACE facilities in southern California and northern California.	\$4.4 million (per CalPACE estimate)

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
10. Expand Medi-Cal to Cover Remaining Uninsured Regardless of Immigration Status	Advocates request to fund SB 4 (Lara) in the budget. SB 4 extends eligibility for full-scope Medi-Cal benefits to individuals who are otherwise eligible for those benefits but for their immigration status; and requires the Secretary of California Health and Human Services Agency to apply to the federal Department of Health and Human Services for a Section 1332 innovation waiver in order to allow persons otherwise not able to obtain coverage through Covered California because of their immigration status to obtain coverage without premium or cost-sharing subsidies by waiving the requirement that Covered California offer only qualified health plans. SB 4 also establishes the California Health Exchange Program for All Californians as a state exchange for individuals ineligible for Covered California because of their immigration status in the event federal approval of the Section 1332 waiver is not granted.	likely hundreds of millions
Other		
11. Robert F. Kennedy Health Plan	The United Farm Workers request funding to sustain its Robert F. Kennedy Farm Workers Medical Plan. The 2014 budget included \$3.2 million special fund to support this health plan.	\$2.5 million
12. Caregiver Resource Centers (CRCs)	Advocates request funding for the CRCs. CRCs are community-based centers that offer services to families designed to assist unpaid family caregivers of adults with chronic, disabling health conditions. Funding for CRCs was reduced by 74 percent in 2009.	\$7.6 million
Department of Public Health		
13. Children’s Dental Disease Prevention Program (DDPP)	Advocates propose to restore funding for DDPP. From 1980 to 2009, the DDPP provided school-based oral health prevention services to approximately 300,000 low-income school children in 32 counties in California. Participating sites provided fluoride supplementation, dental sealants, plaque control, and oral health education.	\$3.2 million
14. Teen Pregnancy Prevention	Advocates propose to restore funding for teen pregnancy prevention efforts.	\$10 million

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
15. Sexually Transmitted Disease (STD) Prevention and Services	Multiple groups propose an increase in funding to local health jurisdictions to address STD screening, testing, and diagnosis and to support outreach and education. Currently, \$1.6 million is allocated to local health jurisdictions for STD prevention purposes.	\$10 million
16. Drug Overdose Grant Program	The Drug Policy Alliance (DPA) requests to establish a grant program for local agencies and community-based organizations in order to reduce the rate of fatal drug overdose caused by prescription analgesics and other drugs. DPA estimates this investment would save 800 lives.	\$2 million
17. Pre-Exposure Prophylaxis (PrEP) Access & Affordability Program	Advocates propose funding for a PrEP Access and Affordability pilot program that would include: outreach and education, patient navigation, clinical and non-clinical provider training, and cost-sharing assistance for uninsured and underinsured individuals. If used correctly, PrEP is over 90 percent effective in preventing new infections. However, according to advocates, knowledge and use of this preventive drug therapy is quite limited due to several barriers, including the high cost of the drug.	\$3 million
18. AIDS Drug Assistance Program (ADAP)/Office of AIDS Health Insurance Premium Payment (OA-HIPP) Stability Funding	Advocates propose \$2 million to increase staff (enrollment workers) and \$1 million to implement program improvements. Advocates explain that as the healthcare world has changed substantially, primarily as a result of Affordable Care Act implementation, enrollment in these programs has increased substantially. Moreover, in 2016, OA-HIPP will begin to cover medical out-of-pocket costs, and therefore advocates estimate a doubling of enrollment in the program. In addition to helping individuals enroll in these programs, enrollment workers also often serve as the only point of contact for a client in resolving access problems with the programs.	\$3 million (potential to use special/federal funds)

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
19. HIV/AIDS Initiatives in Mid-Size and Small Counties	Advocates propose funding to support "high-impact" HIV services in small and mid-size counties. During the recent recession, at least \$82 million was cut from the Office of AIDS for HIV prevention and testing, which advocates state affected small and mid-size counties the most, resulting in a substantial reduction in services in these counties. Although large counties represent a majority of HIV cases, some small counties have experienced recent surges in HIV rates that are going unaddressed, according to supporters of this proposal.	\$3 million
20. State Syringe Exchange Program	Advocates request funding for syringe exchange and disposal programs by creating a state clearinghouse in order to purchase sharps disposal containers, sterile syringes, and other materials vital to the operation of these programs. The proposal is based on the notion that the state, as a single large buyer, could obtain these materials at lower cost than is available to each individual program, thereby reducing costs and providing much-needed support to the programs at the same time. Syringe exchange programs are the longest standing evidence-based intervention to prevent HIV and hepatitis C among injection drug users. Syringe programs have proven to dramatically reduce infection rates among active injection drug users. Advocates argue that, due to the long-standing ban on federal funding, coupled with the elimination of state funding, the effectiveness of this proven intervention has been diminished in California.	\$3 million
21. Hepatitis C (HCV) Rapid Testing Kits	Advocates request funding to purchase rapid hepatitis C antibody test kits—with the requested amount it is estimated that approximately 33,333 kits could be provided to community-based programs that serve low-income communities, especially the remaining uninsured. Advocates state that testing is a key component to preventing the spread of this, or any, disease.	\$600,000

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
22. HCV Linkage & Retention in Care Demonstration Projects	Advocates request funding to support at least three 3-year demonstration projects to include innovative outreach, screening, and linkage to and retention in care efforts for people with HCV. The proposal estimates that these projects would serve approximately 55,555 people and would be modeled after successful programs on HIV patient navigation and linkages/retention in care. Supporters of this proposal state that projects such as these would serve to reduce new HCV infections, improve health outcomes, reduce disparities in vulnerable populations, and reduce transmission of the virus to others.	\$5 million
23. Parkinson Registry	Advocates and individuals with Parkinson's propose funding for three years to fund the California Parkinson's Disease Registry to support competitive grants/contracts to research institutes, universities and nonprofit organizations to implement and maintain a comprehensive Parkinson's disease registry. Advocates report that the economic burden of the disease is at least \$14.4 billion a year, nationwide. Supporters state that investment in medical research that leads to better treatments for Parkinson's disease could save millions of dollars each year and that if new therapies could be found that could produce even a modest ten percent delay in the progression of Parkinson's disease, hundreds of millions of dollars could be saved every year.	\$3.7 million
24. Alzheimer Questions on Survey	The California Council of the Alzheimer Association requests funds to support the addition of the federal Centers for Disease Control and Prevention's Caregiver Module in the annual Behavioral Risk Factor Surveillance System survey. AB 1526 (Committee on Aging and Long-Term Care) would implement this.	\$70,000

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
25. Adolescent Family Life Program (AFLP)	AFLP addresses the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to pregnant and parenting teens and their children. AFLP emphasizes promotion of positive youth development, focusing on and building upon adolescents’ strengths and resources to work towards improving the health of the pregnant or parenting teen, improving graduation rates, reducing repeat births, and creating networks of support for these parents. Funding for AFLP was reduced substantially in 2009, with a loss of \$10.7 million General Fund.	\$7.8 million
26. Autism Surveillance and Reporting	Advocates request funding to establish an autism surveillance and public health information program that will link Department of Developmental Services' records, vital statistics records, and other existing data in order to: track the numbers of children with autism in the state and monitor time, demographic, and geographic trends in occurrence; explore possible environmental causes of autism, including gene-environment, generational and epigenomic factors, and other risk factors, contributing to prevention; and provide government officials, public health leaders, scientists, medical professionals and community members with data, including an annual report to the public as well as a California autism data website, and other epidemiologic information for planning, prevention, intervention, and advocacy.	\$500,000
Office of Statewide Health Planning and Development		
27. Song-Brown Residency Program Funding	Advocates for physicians propose that the budget include an ongoing increased appropriation of \$8 million from the California Health Data Planning Fund (CHDPF) for the Song Brown Program in order to provide ongoing support for existing residency slots as well as to create opportunities to expand and create additional slots in the future.	\$8 million from CHDPF

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
Local Government Request		
28. City of Carson - Stroke Center	The City of Carson requests \$500,000 to support its Joseph B. Jr. and Mary Anne O'Neal Stroke Center.	\$50,000

Table: Summary of Costs to Restore Optional Medi-Cal Benefits

	Total Funds	General Fund	Federal Funds**
<u>Optional Benefits Restoration:</u>			
Acupuncture	\$3,724,000	\$1,780,000	\$1,944,000
Audiology	\$4,303,000	\$2,056,000	\$2,246,000
Chiropractic	\$538,000	\$257,000	\$281,000
Incontinence Cream & Washes	\$11,503,000	\$5,013,000	\$6,491,000
Optician / Optical Lab	\$10,132,000	\$4,921,000	\$5,210,000
Podiatry	\$2,376,000	\$1,135,000	\$1,240,000
Speech Therapy	\$273,000	\$131,000	\$143,000
Dental*	\$260,140,000	\$93,122,000	\$167,018,000
Grand Total	\$292,989,000	\$108,415,000	\$184,573,000

* Dental: Additional costs to restore all adult dental benefits. Costs for partial dental restoration are already budgeted in the Governor's budget.

** The Department receives 100% federal financial participation for services provided to Affordable Care Act optional Medi-Cal expansion population.

Subcommittee Staff Comment. At the May Revision, the Legislature will have a better understanding of the state's fiscal situation and can better evaluate proposals for investment.

Subcommittee staff has requested LAO to provide a brief overview of these proposals.

Appendix A

Health-Related Proposals for Restoration and Augmentation that Have Previously Been Discussed in Subcommittee

These proposals are included for reference and are not agenda items for this Subcommittee hearing.

Program	Description	General Fund Amount Requested
Medi-Cal Rates	<p>Consumer advocates, providers, provider associations, and other stakeholders are concerned that the existing Medi-Cal rates, payment reductions, and rate freezes directly impact an enrollee’s ability to access Medi-Cal services. These stakeholders find that the existing payments do not cover the costs to provide services to Medi-Cal enrollees and are not sufficient enough to sustain their operations. Multiple stakeholders have requested an increase in Medi-Cal rates.</p> <p>Discussed at the March 19th Subcommittee hearing.</p>	<p>\$275 million annually for prospective, includes:</p> <ul style="list-style-type: none"> • \$11 million for CBAS • \$30 million for dental • \$11.1 million for ICF-DD <p>\$163-\$325* million one-time for retrospective</p> <p>\$24.5 million for ICF-DD rate freeze</p>
Medi-Cal Primary Care Rate Bump	<p>The Affordable Care Act required Medi-Cal to increase primary care physician services rates to 100 percent of the Medicare rate for services provided from January 1, 2013 through December 31, 2014. The state received 100 percent federal funding for the incremental increase in Medi-Cal rates. Federal funding for this incremental rate increase expired December 31, 2014. It has been proposed to continue to fund this rate increase with state funds.</p> <p>Discussed at the March 19th Subcommittee hearing.</p>	<p>More than \$1.6 billion</p>
Medi-Cal Dental Anesthesia Rate	<p>Multiple advocates request that state provide rate parity between general anesthesia and dental anesthesia providers. (The cost of equalizing facility fees and anesthesia to medical rate.)</p> <p>Discussed at the March 19th Subcommittee hearing.</p>	<p>\$4.3 million</p>

*General Fund amounts are based on the ability of the state to get federal fund participation for the elimination of this payment reduction.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

**OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, May 7 (Room 4203)
Agenda Part C – Health Related Issues**

ISSUES RECOMMENDED FOR VOTE ONLY

4265 Department of Public Health (DPH)

1. California Gambling Education and Treatment Services (CalGETS)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Trailer Bill Language.

2. Biomonitoring Resources and April Finance Letter

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Recommendation—Approve.

3. Food Safety Inspection

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

4. Food Safety Stipulated Judgment Appropriation and Trailer Bill Language

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Trailer Bill Language.

5. USFDA Tobacco Retail Inspection Contract

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

6. Inspection of Public Beaches Resources (SB 1395, 2014)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

7. Medical Waste Resources (AB 333, 2014)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

8. Notification of Increases in Federal Grants – Budget Bill Language

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Comment and Recommendation—Modify Budget Bill Language. It is recommended to modify budget bill language to require the Administration to report increases in federal grants (over \$400,000) on a quarterly basis. The report to the Legislature would include the project title, budget act appropriation amount, quarter, adjustment, date department received notice of grant award, and comments. The modified budget bill language for items 4265-001-0890 and 4265-111-0890 is:

1. Of the funds appropriated in this item, \$61,108,000 shall be available for administration, research, and training projects. Notwithstanding Section 28.00, the State Department of Public Health shall report, **no later than 30 days after the end of each quarter**, under that section any new project over \$400,000 or any increase in excess of \$400,000 for an identified project.

4120 Emergency Medical Services Authority (EMSA)**1. Document Imaging Workload and Efficiencies**

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

2. Disaster Preparedness and Emergency Response Resources for California

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Recommendation—Approve.

0530 California Health and Human Services Agency**1. Office of the Patient Advocate**

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Recommendation—Approve.

4140 Office of Statewide Health Planning and Development**1. Elective Percutaneous Coronary Intervention Program Outcomes Reporting**

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to approve these positions as limited-term for two years. Subcommittee staff finds that once the data procedures and processes to create the report are established, ongoing workload for two staff positions may not be justified.

2. Authority for Inter-Item Transfer of Funds – Budget Bill Language

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Budget Bill Language.

4150 Department of Managed Health Care (DMHC)**1. Federal Mental Health Parity Rules**

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Recommendation—Approve.

2. Additional Enrollment in Individual Market

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

3. Large Group Claims Data Exposure (SB 1182, 2014)

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Recommendation—Approve.

4. Dental Plans Medical Loss Ratio (AB 1962, 2014)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

ITEMS FOR DISCUSSION**4150 Department of Managed Health Care****1. Annual Health Care Service Plans Timeliness Standards (SB 964, Hernandez)**

- Vote to approve staff recommendation: 2-0 (Senator Stone absent.)

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal as the more systematic and organized review of health plan networks, as required by SB 964, will result in increased workload for DMHC. Prior to SB 964, DMHC reviewed approximately 500 health plan networks for timely access and adequacy on a piecemeal-basis. With SB 964, DMHC anticipates conducting about 5,000 health plan network reviews on an annual and systematic-basis.

2. Health Premium Rate Review Federal Grant and Budget Bill Language

- Vote to approve staff recommendation: 2-0 (Senator Stone absent.)

Subcommittee Staff Comment and Recommendation—Approve and Modify Budget Bill Language. It is recommended to approve the funding request and to modify the proposed budget bill language to allow DMHC to proceed with procuring a vendor if the Department of Technology does not reject the Feasibility Study Report (FSR) by July 1, 2015. DMHC has until September 2016 to expend and complete all grant activities; consequently, it is recommended to provide the Department of Technology with a timeframe to take action on the FSR to ensure that DMHC is able to complete these activities.

Modified budget bill language:

Notwithstanding any other provision of law, of the funds appropriated in this item, up to \$395,000 is available for the Premium Rate Review Cycle IV Website Enhancement Implementation costs, for expenditure or encumbrance until June 30, 2016. Funding provided pursuant to this provision shall be made available only upon approval of the Department of Finance and approval of a Feasibility Study Report (FSR) or an FSR Reporting Exempt Request by the Department of Technology. **If the Department of Technology does not approve the FSR by July 1, 2015, the Department of Managed Health Care may proceed with the Premium Rate Review Cycle IV Website Enhancement Implementation, assuming all other conditions contained in this Item have been met.**

Multiple Departments**1. Health-Related Proposals for General Fund Investment**

- Held open

Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.



May 18, 2015

10:30 a.m.

Room 112, State Capitol

Agenda
(Michelle Baass)

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PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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. Thank you.

VOTE ONLY

0530 Office of Systems Integration

1. CalHEERS Adjustment

Budget Issue. The May Revision proposes a decrease of \$14 million for the Office of Systems Integration (OSI) to reflect a transfer of project management for the Unemployment Insurance Modernization project from OSI to the Employment Development Department. This decrease is partially offset by an increase of \$2.4 million to reflect increased costs associated with the California Healthcare Eligibility, Enrollment, and Retention System and the implementation of the 24-month road map. This proposal also includes the following conforming changes to budget bill language:

Item 0530-001-9745, Provision 3:

Of the funds appropriated in this item, ~~\$160,242,000~~ \$162,654,000 is for the support of activities related to the California Healthcare Eligibility, Enrollment, and Retention System project also known as CalHEERS. Expenditure of these funds is contingent upon review and approval of a plan submitted to the Director of Finance.

Subcommittee Staff Recommendation—Approve.

0977 California Health Facilities Financing Authority (CHFFA)

1. Investment in Mental Health Wellness Act of 2013

Budget Issue. As discussed at the April 9, 2015 Subcommittee No. 3 hearing, the CHFFA board is considering extending eligibility for its Mental Health Wellness Grants to peer respite programs to prompt small county interest in providing support to people at risk for, or experiencing, a mental health crisis. These peer respite programs provide a temporary stay at a residence staffed by professionally trained peers. Research indicates that peer respite programs are more affordable to operate and may fit the needs of many rural and suburban counties. Of the \$149.8 million in Mental Health Wellness Grant funds appropriated to CHFFA, approximately \$50 million in funds remain (if all third round grant applications are approved).

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt the placeholder trailer bill language below to allow CHFFA to use up to \$3 million in unencumbered Mental Health Wellness Grant funds for peer respite programs.

Current law requires that these remaining unencumbered funds be used for crisis residential and crisis stabilization services. This language would provide CHFFA with the flexibility to allow this grant funding to be used to support peer respite programs if CHFFA finds that peer respite programs meet the intent of the Investment in Mental Health Wellness Act’s goal to improve access to and capacity for mental health crisis services in California.

Proposed Placeholder Trailer Bill Language:

For the 2015-16 fiscal year, the California Health Facilities and Financing Authority (CHFFA) may authorize up to \$3 million in unencumbered funds as appropriated in Item 0977-101-0001 for Mental Health Wellness Grants, Chapter 20 (AB 110), Statutes of 2013, to develop peer respite sites.

Any grant awards authorized by CHFFA for peer respite sites shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase bed capacity for peer respite support services. This may include, but not be limited to, the purchase of property, purchase of equipment, and the remodeling or construction of housing for the purpose of operating a peer respite site.

Any recipient of a grant to develop peer respite sites shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

CHFFA may adopt emergency regulations relating to grants for peer respite sites, including emergency regulations that define eligible costs, and determine minimum and maximum grant amounts. The adoption of these regulations shall be in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) and shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

4260 Department of Health Care Services

1. May 2015 Medi-Cal Estimate (DOF Issue 501 and 502)

Budget Issue. The May Revision requests that the technical adjustments noted below be made to the following budget bill items to reflect a variety of caseload and cost changes not highlighted in the other Medi-Cal proposals:

- Item 4260-101-0001 be decreased by \$184,978,000 and reimbursements be decreased by \$189,645,000
- Item 4260-101-0890 be decreased by \$8,264,259,000
- Item 4260-101-3168 be increased by \$7,834,000
- Item 4260-101-3213 be increased by \$1.3 million
- Item 4260-102-0001 be increased by \$84,000
- Item 4260-102-0890 be increased by \$84,000
- Item 4260-106-0890 be decreased by \$5,728,000
- Item 4260-113-0001 be decreased by \$336,814,000
- Item 4260-113-0890 be increased by \$495,132,000
- Item 4260-117-0001 be decreased by \$350,000
- Item 4260-117-0890 be increased by \$70,000

Subcommittee Staff Recommendation— Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken. This is a technical adjustment.

2. Eliminate Cost-of-Living Adjustment for County Eligibility Administration

Budget Issue. DHCS proposes trailer bill language to suspend the county administration cost-of-living adjustment (COLA) on a permanent basis.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Modify Trailer Bill Language. It is recommended to modify the proposed placeholder trailer bill language by suspending the county COLA for the budget year only and not on a permanent basis. The May Revision proposes increased funding for county eligibility administration (see item later in agenda).

3. Child Health and Disability Prevention (CHDP) Program Dental Referral

Budget Issue. DHCS proposes trailer bill language requiring CHDP programs and providers to refer all Medi-Cal-eligible children participating in CHDP who are one year of age and older to a dentist participating in the Medi-Cal program, rather than at age three.

The May Revision assumes annual costs of \$1.6 million (\$761,850 General Fund) for additional dental services for children referred to a dentist at one year of age or later.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language.

4. Health Care Reform – Workload Extension

Budget Issue. DHCS requests the extension of six limited-term positions and expenditure authority to support the continued implementation of and ongoing work required under the federal Affordable Care Act (ACA), including but not limited to the implementation of enhanced provider screening under the program integrity requirements and the support of the anticipated enhancements to the existing Medi-Cal Eligibility System (MEDS) and its sub-applications in order to meet the business needs of the health insurance-exchange, and county consortia including Electronic Health Information Transfer integration requirements.

The total limited-term expenditure authority request for 2015-16 is \$716,000 (\$129,000 General Fund and \$587,000 federal funds) and for 2016-17 is \$547,000 (\$78,000 General Fund and \$469,000 federal funds).

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

5. Medi-Cal Annual Open Enrollment Period

Budget Issue. DHCS proposes trailer bill language (TBL) to establish an Annual Health Plan Open Enrollment process for specified Medi-Cal managed care health plan (MCP) beneficiaries who are enrolled in counties that have more than one Medi-Cal managed care health plan (MCP) option. DHCS estimates that this proposal would result in a net General Fund savings of \$1 million (and a total fund savings of \$2 million). This savings comes from the reduction in the number of initial health assessments (IHAs) and reduced mailing costs to implement Annual Health Plan Open Enrollment.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Reject. The Legislature has denied similar proposals in the last few years because it found that it is important to ensure that Medi-Cal enrollees have the ability to change health plans at any time to ensure that his or her health needs are met. Although this proposal includes the ability for someone to switch plans if they have “good cause,” having to demonstrate this and go through this process could be a barrier to ensuring timely treatment.

6. CalHEERS Electronic MAGI Determination Trailer Bill Language

Budget Issues. DHCS proposes trailer bill language to remove the sunset provision to allow for continued electronic verification of Medi-Cal eligibility information.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language.

7. Health Care Reform Financial Reporting Resources

Budget Issue. DHCS requests expenditure authority of \$1,959,000 (\$980,000 General Fund and \$979,000 federal funds) for 2015-16 and \$1,797,000 (\$899,000 General Fund and \$898,000 federal funds) on-going for 18 three-year limited term positions. The resources will address the increases in federal Centers for Medicare and Medicaid Services (CMS) mandated reporting requirements.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

8. Hospital Quality Assurance Fee Resources

Budget Issue. DHCS requests extending 9.5 limited-term positions and expenditure authority, set to expire on December 31, 2015, to December 31, 2018. DHCS also requests \$350,000 in additional limited-term expenditure authority for two contracts to calculate and actuarially certify increased capitation rates as well as for high level counsel and assistance for federal submissions associated with the Hospital Quality Assurance Fee (HQAF) program.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

9. Martin Luther King Jr. Hospital Resources

Budget Issue. DHCS requests two full-time permanent positions and \$745,000 (\$373,000 Federal Fund and \$372,000 Reimbursement) including annual contract funding of \$500,000. This request is needed to meet the department’s workload requirements related to Welfare and Institutions Code (WIC) Section 14165.50 to facilitate the financial viability of a new private nonprofit hospital that will serve the population of South Los Angeles. This population was formerly served by the Los Angeles County Martin Luther King, Jr. – Harbor Hospital.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

10. MEDS and Securing Medi-Cal Eligibility Information Resources

Budget Issue. DHCS requests the conversion of ten limited-term positions to permanent and a two-year extension of one limited-term position. The expenditure authority requested for the 11 positions is \$1,497,000 (\$714,000 General Fund and \$783,000 federal funds). The resources are necessary to perform 1) the ongoing workload of managing, protecting, and securing confidential Medi-Cal eligibility information, 2) ensuring compliance with requirements of the federal Social Security Administration (SSA), and 3) monitoring access to the Medi-Cal Eligibility Data System (MEDS). The 11.0 limited-term positions are scheduled to expire on June 30, 2015.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

11. Intergovernmental Transfer Program Resources

Budget Issue. DHCS requests two new permanent positions, the conversion of three limited-term positions to permanent, and \$467,000 expenditure authority (\$120,000 federal funds and \$347,000 reimbursements). The requested staffing resources would address the additional and ongoing workloads from Medi-Cal managed care expansion and mandated statutory requirements to implement SB 208 (Steinberg) Chapter 714, Statutes of 2010. The three limited-term positions are set to expire on October 31, 2015. Starting in 2016-17, and on-going, the requested expenditure authority would be \$540,000 (\$164,000 federal funds and \$376,000 reimbursements).

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

12. Drug Medi-Cal Provider Enrollment

Budget Issue. DHCS' Provider Enrollment Division requests to extend 11 limited term positions that expire June 30, 2015 for one more year for work associated with certifying and recertifying Drug Medi-Cal (DMC) providers. According to DHCS, these requested positions are essential to address provider fraud, waste, and abuse in the DMC program by certifying only providers meeting standards of participation in Medi-Cal, and decertifying fraudulent providers by conducting a thorough screening including collecting disclosure statements, performing monitoring checks, and making referrals to the DHCS Audits and Investigations Division for onsite reviews.

This issue was heard at the April 9th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

13. Drug Medi-Cal Provider Monitoring

Budget Issue. DHCS requests 10 positions in its Substance Use Disorder Prevention, Treatment, and Recovery Services Division for workload associated with monitoring Drug Medi-Cal (DMC) providers.

According to DHCS, these positions would be used to increase program integrity within the program and mitigate the risk of fraud, waste, and abuse. For example, these positions would review the on-site operations of every DMC provider at least once every five years (approximately 133 sites annually) and be responsible for follow-up with DMC providers on all corrective action plans to ensure any deficiencies DHCS identifies are rectified by the DMC providers.

This issue was heard at the April 9th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

14. Substance Abuse – Recovery and Treatment Services (AB 2374, 2014)

Budget Issue. DHCS requests to establish two permanent, full-time positions at a cost of \$246,000 (General Fund) due to the enactment of AB 2374 (Mansoor), Chapter 815, Statutes of 2014.

This issue was heard at the April 9th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

15. Performance Outcomes System for EPSDT Medi-Cal Specialty Mental Health Services

Budget Issue. DHCS requests three full-time permanent positions at a cost of \$377,000 (\$189,000 General Fund and \$188,000 Federal Trust Fund) to support the program management, coordination with

counties and other partners, data collection and interpretation and research needs of the Performance Outcomes System project as required by SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012 and AB 82 (Committee on Budget), Chapter 34, Statutes of 2013.

This issue was heard at the April 9th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

16. Family Health Programs Adjustments (DOF Issue 505, 505-MR, 506-MR)

Budget Issue. The May Revision requests adjustments to the California Children’s Services (CCS), Child Health and Disability Prevention Program (CHDP), the Genetically Handicapped Person’s Program (GHPP), and the Every Woman Counts (EWC) program. See tables below for details.

Table: Family Health Estimate May Revision Summary

Program	Budget Act 2014-15	Projected 2014-15	January Budget Proposed 2015-16	May Revision Proposed 2015-16
CCS	\$95,781,000	\$92,995,000	\$91,291,000	\$87,182,000
CHDP	1,713,000	1,662,000	1,677,000	1,359,000
GHPP	128,739,000	130,915,000	136,337,000	121,519,000
EWC	58,583,000	54,311,000	42,356,000	53,312,000
TOTAL	\$284,816,000	\$279,883,000	\$271,661,000	\$264,055,000

Additionally, the May Revision indicates that the Administration finds that the CCS, CHDP, GHPP, and EWC program caseloads will experience a decline due to the implementation of the federal Affordable Care Act, which allowed individuals to qualify for Medi-Cal or subsidized coverage through the Exchange. Consequently, the caseloads for these programs in 2015-16 are estimated to be at the same level as 2014-15.

Subcommittee Staff Recommendation—Approve.

17. Modify Major Risk Medical Insurance Program

Budget Issue. DHCS proposes trailer bill language to modify the Major Risk Medical Insurance Program (MRMIP) and the Guaranteed Issue Pilot (GIP) Program, effective January 1, 2016.

This issue was heard at the April 23rd Subcommittee hearing.

Subcommittee Staff Comment and Recommendation--Reject proposed trailer bill language. As previously discussed, the proposal gives DHCS broad authority to redesign MRMIP without any input from stakeholders and it eliminates a safety-net option whereby individuals could purchase health coverage throughout the year if they missed the open enrollment period for commercial coverage or do not qualify for Medi-Cal. For these reasons, it is recommended to reject this proposal.

4265 Department of Public Health

1. Genetic Disease Screening Program Update & AB 1559 (2014) (DOF ISSUE 010-MR)

Budget Issue. The May Revision proposes a decrease of \$776,000 compared to the January budget, for total funding of \$118.6 million (Genetic Disease Testing Fund) for the Genetic Disease Screening Program (GDSP).

Included in the GDSP budget estimate is the following proposal:

- **Expanding California’s Newborn Screening Program** – DPH requests one permanent position and \$1.975 million from the Genetic Disease Testing Fund in 2015-16 of which \$1.825 is one-time funding and \$150,000 is requested to be appropriated annually thereafter to implement with AB 1559 (Pan), Chapter 565, Statute of 2014, which expands the statewide Newborn Screening Program to include screening for adrenoleukodystrophy (ALD) as soon as ALD is added to the federal Recommended Uniform Screening Panel (RUSP).

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve Genetic Disease Screening Program Estimate and Budget Change Proposal.

2. Office of AIDS: ADAP Client Eligibility Verification Resources

Budget Issue. DPH requests \$536,000 in expenditure authority from the AIDS Drug Assistance Program Rebate Fund and five positions to manage the increase in client eligibility verification workload within the AIDS Drug Assistance Program (ADAP). These positions are needed to ensure program integrity and to comply with federal Health Resources and Services Administration client eligibility verification requirements.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

3. ADAP Modernization

Issue. The Subcommittee is in receipt of proposals to expand eligibility for the AIDS Drug Assistance Program (ADAP) medication program and the ADAP insurance assistance programs--the OA-Health Insurance Premium Payment (HIPP) program. These proposals, which may result in program savings in out years because of the current drug rebate return, and include:

- a. Update Family Size - Financial eligibility for OA-HIPP and ADAP are the same. Currently the programs serve individuals with incomes up to \$50,000 annually based on federal adjusted gross income (FAGI) with no regard for family size. The result is that a single individual is treated the same as a person with dependents. Historically, ADAP served primarily single men with no dependents. Changes in the epidemic, changes in marriage and

family rights for the LBGT community as well as new insurance coverage opportunities through the Affordable Care Act (ACA) make it important to consider the programs' eligibility standards regarding family size.

- b. Increase Income Limit - Another issue for consideration is increasing the income limit of \$50,000 for these programs, which is estimated to be 447 percent federal poverty level (FPL) to 500 percent FPL or \$58,350 for a single individual and \$98,950 for a three-person household. Currently five other high income states operate programs with this income eligibility, including Maine, Maryland, Massachusetts, New Jersey and the District of Columbia.

This issue was discussed at the March 5th Subcommittee hearing.

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt placeholder trailer bill language to modernize ADAP as specified above.

4. May Revision Estimate Updates (DOF ISSUE 400-MR, 009-MR, 010-MR, 400-MR)

Budget Issue. The May Revision proposes the following estimate updates:

- **Women, Infants, and Children (WIC)** – A decrease of \$8.5 million in federal funds and \$4.8 million in WIC Manufacturer Rebate Special Funds for 2015-16, for a total of \$1.2 billion for the WIC program.
- **Proposition 99** - A decrease of \$3.6 million in the Health Education Account and decrease of \$675,000 in the Research Account in local assistance; and a \$2.3 million decrease in the Health Education Account in state operations.

Subcommittee Staff Recommendation—Approve.

ITEMS FOR DISCUSSION

4260 Department of Health Care Services

1. 2011 Realignment Behavioral Health Growth Account Allocation

Oversight Issue. At the April 9th Subcommittee hearing, the Administration indicated that it plans to follow the same allocation formula for the \$60.1 million in 2013-14 Behavioral Health Growth Account funds as was used last year. That is, first priority of the Behavioral Health Growth Account funding would be given to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Drug Medi-Cal. Specifically, this allocation provided additional funding to counties in which the approved claims for EPSDT and Drug Medi-Cal services in the fiscal year were greater than the funding they received from the base account. The remaining balance of this growth account was then distributed using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount.

However, it has recently come to the Subcommittee's attention that the DHCS is considering changing this allocation to distribute this growth funding using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount. With this change, counties who spent more than their allocation to provide entitlement services would not necessarily be made whole.

Background. SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012, created the permanent structure for 2011 Realignment. SB 1020 codified the Behavioral Health Subaccount which funds Medi-Cal Specialty Mental Health Services (for children and adults), Drug Medi-Cal, residential perinatal drug services and treatment, drug court operations, and other non-Drug Medi-Cal programs. Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs and counties have a responsibility to provide for these entitlement programs.

Government Code Section 30026.5(k) specifies that Medi-Cal Specialty Mental Health Services shall be funded from the Behavioral Health Subaccount, the Behavioral Health Growth Special Account, the Mental Health Subaccount (1991 Realignment), the Mental Health Account (1991 Realignment), and to the extent permissible under the Mental Health Services Act, the Mental Health Services Fund. Government Code Section 30026.5(g) requires counties to exhaust both 2011 and 1991 Realignment funds before county General Fund is used for entitlements. A county board of supervisors also has the ability to establish a reserve using five percent of the yearly allocation to the Behavioral Health Subaccount that can be used in the same manner as their yearly Behavioral Health allocation, pursuant Government Code Section 30025(f).

Consistent with practices established in 1991 Realignment, up to 10 percent of the amount deposited in the fund from the immediately preceding fiscal year can be shifted between subaccounts in the Support Services Account with notice to the Board of Supervisors, pursuant to Government Code Section 30025(f). This shift can be done on a one-time basis and does not change base funding. In addition, there is not a restriction for the shifting of funds within a subaccount, but any elimination of a program, or reduction of 10 percent in one year or 25 percent over three years, must be duly noticed in an open session as an action item by the Board of Supervisors, pursuant to Government Code Section 30026.5(f).

Government Code Section 30026.5(e) also requires 2011 Realignment funds to be used in a manner to maintain eligibility for federal matching funds.

DHCS issued Mental Health Services Division Information Notice 13-01 on January 30, 2013, to inform counties that 2011 Realignment did not abrogate or diminish the responsibility that, “they must provide, or arrange for the provision of, Medi-Cal specialty mental health services, including specialty mental health services under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit.” As noted above, Government Code Section 30026.5(k) specifies fund sources for Medi-Cal Specialty Mental Health Services. The Administration continues to work with the California State Association of Counties and the California Behavioral Health Directors Association to ensure all counties are aware of these entitlement programs and clients cannot be denied services.

On May 19, 2014, DHCS issued Mental Health and Substance Use Disorder Services Information Notice 14-017 indicating that first priority of the Behavioral Health Growth Account funding would be given to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health EPSDT and Drug Medi-Cal. Specifically, this allocation provided additional funding to eight counties in which the approved claims for EPSDT and Drug Medi-Cal services in 2012-13 were greater than the funding they received in 2012-13 from the Behavioral Health Subaccount. The remaining balance of this growth account would then be distributed using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount.

Subcommittee Staff Comment and Recommendation—Hold Open. DHCS’s potential change in methodology to distribute these growth funds undermines the state’s direction that counties must provide for the provision of Medi-Cal specialty mental health services, including specialty mental health services under EPSDT, and Drug Medi-Cal, as these are entitlement programs. Additionally, it provides no assurance to counties that if they follow-through with the requirements to provide these services that they would be compensated for the increase in utilization. Although DHCS notes that this is “county” money, Government Code Section 30029.07 requires these funds to be allocated based on a schedule created in consultation with the appropriate state agencies and counties. DHCS should assume a leadership position in the allocation of these funds in a manner that would promote statewide objectives to improve and increase utilization of these services and not allocate these funds without any regard to county performance.

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

1. Please provide an overview of this issue.
2. When does DHCS plan to formulate the methodology to distribute the \$60 million in 2013-14 growth funds?
3. How has DHCS worked with non-county stakeholders in the development of this methodology?
4. What is DHCS’s view on how this growth account funding could be used to incentivize counties to increase utilization of specialty mental health and Drug Medi-Cal services?

2. Drug Medi-Cal Waiver Implementation (DOF ISSUE 001-MR)

Budget Issues. The May Revision requests the authority to establish 13 permanent full-time positions, additional training funds, and limited-term contract funding for an External Quality Review Organization (EQRO) to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS). Details on the proposed funding for this request are displayed in the chart below.

Table: Summary of Proposed Request

Proposed	FY2015-16	FY2016-17	FY2017-18	FY2018-19	FY2019-20	Total
Personal Services:						
13.0 Perm Positions	\$ 1,290,000	\$ 1,290,000	\$ 1,290,000	\$ 1,290,000	\$ 1,290,000	\$ 6,450,000
Operating Expenses and Equipment (OE&E):						
Staff OE&E	\$ 366,000	\$ 249,000	\$ 249,000	\$ 249,000	\$ 249,000	\$ 1,362,000
EQRO Contract	\$ 500,000	\$ 2,300,250	\$ 2,300,250	\$ 2,300,250	\$ 2,300,250	\$ 9,701,000
Technical Assistant Training (Contract)	\$ 1,000,000	\$ 1,000,000	\$ 500,000	\$ 500,000	\$ 500,000	\$ 3,500,000
Total per FY	\$ 3,156,000	\$ 4,839,250	\$ 4,339,250	\$ 4,339,250	\$ 4,339,250	\$21,013,000

In addition, the May Revision proposes the following budget bill language:

Add the following provision to Item 4260-001-0001:

X. Of the appropriation in Schedule (1), \$1,578,000 may not be expended until the Centers for Medicare and Medicaid Services approval is received for the Drug Medi-Cal Organized Delivery System 1115 Demonstration Waiver.

Add the following provision to Item 4260-001-0890:

X. Of the appropriation in Schedule (1), \$1,578,000 may not be expended until the Centers for Medicare and Medicaid Services approval is received for the Drug Medi-Cal Organized Delivery System 1115 Demonstration Waiver.

Proposed Drug Medi-Cal Waiver. As previously discussed by the Subcommittee, DHCS is pursuing a DMC Organized Delivery System Waiver as an amendment to the current Section 1115 Bridge to Reform Demonstration Waiver. DHCS proposes this waiver amendment to demonstrate how an organized system of care for substance use disorder care would increase successful outcomes for DMC beneficiaries. The state’s proposal is currently under federal CMS review. According to DHCS, CMS

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to only approve six of the 13 requested positions as the workload justification for these positions appears exaggerated. For example, DHCS proposes that it would take 25 days (200 hours) to prepare for each quarterly Waiver Advisory Group meetings. DHCS has also used the assumption that all 53 counties that have expressed interest will apply and fails to account for its own phased-in approach. Additionally, many of the proposed workload activities are one-time in nature, such as the review and approval of county

implementation plans, which would only occur once. It is recommended to approve the proposed budget bill language.

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

1. Please provide an overview of this request.
2. When does DHCS plan to release the updated terms and conditions of this proposed waiver?
3. When does DHCS anticipate federal action on the proposed waiver?

3. Drug Medi-Cal Residential Treatment Services

Budget Issue. The May Revision includes \$47 million (\$14.8 million General Fund) for the provision of residential treatment services in Drug Medi-Cal. This estimate assumes the approval of the Drug Medi-Cal Waiver by June 30, 2015 and that 22 counties will begin providing residential treatment services in the budget year, with 11 counties starting in September.

Background. As part of the Drug Medi-Cal waiver proposal, DHCS has indicated that it has received informal approval from CMS that under this waiver proposal, the Institutions for Mental Disease (IMD) payment exclusion would not apply for counties that opt-into this demonstration. Consequently, federal funds would be available to provide residential treatment services to all eligible adults and inpatient voluntary detox in chemical dependency treatment facilities and freestanding psychiatric facilities.

Additionally, DHCS has indicated that residential treatment providers would not have their Medi-Cal provider enrollment applications processed until the federal Centers for Medicare and Medicaid Services (CMS) has approved the Drug Medi-Cal Waiver.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. Given past Subcommittee discussions about how long it takes for the Provider Enrollment Division to process provider applications, it is unclear how providers in 11 counties would be able to begin providing residential treatment services. Additionally, even if CMS approves the waiver before the end of June, counties must first complete their implementation plans and DHCS must approve these plans. Consequently, it is highly unlikely that these services would commence in September and at the level projected in the budget year.

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

1. Please provide an overview of this request.
2. Please explain why DHCS is confident that residential treatment services will be provided in 11 counties starting in September.

4. Medi-Cal: Caseload Update

Budget Issue. The May Revision projects total Medi-Cal expenditures in 2015-16 to be \$91.3 billion (\$18.2 billion General Fund) which is an increase of \$9.6 billion (\$650.3 million General Fund) as compared to the Governor’s January budget. It is projected that 12.1 million individuals will be enrolled in Medi-Cal in 2014-15 and 12.4 million in 2015-16. See tables below for funding details.

Table: January to May Revision Comparison

	January	May Revision	Difference
	2015-16	2015-16	
Benefits	\$91,331,800,000	\$87,040,600,000	-\$4,291,200,000
County Administration	\$3,617,300,000	\$3,789,600,000	\$172,300,000
Fiscal Intermediaries	\$463,300,000	\$475,300,000	\$12,000,000
Total	\$95,412,400,000	\$91,305,400,000	-\$4,107,000,000
General Fund	\$18,610,500,000	\$18,171,800,000	-\$438,700,000
Federal Funds	\$61,637,100,000	\$59,111,800,000	-\$2,525,400,000
Other Funds	\$15,164,700,000	\$14,021,800,000	-\$1,142,900,000

Key adjustments to the Governor’s January budget included in the May Revision are:

- **Children’s Health Insurance Program (CHIP) Enhanced Federal Matching Rate.** The May Revision reflects a \$381.1 million General Fund offset due to the enhanced federal matching rate for the Children’s Health Insurance Program (CHIP) from 65 percent to 88 percent starting October 1, 2015 (through September 2017). The full year estimate of this offset is \$650 million. According to DHCS, the \$381.1 million reflects that this enhanced rate is in effect for only part of 2015-16 and considers lags based on date of service and date of payment.
- **Managed Care Rate Adjustment.** An increase of \$125 million General Fund related to increases in managed care rates.

LAO Findings on Caseload. The LAO raises concerns regarding the Medi-Cal caseload estimate, but does not recommend any adjustments at this time. The LAO’s concerns include that DHCS does not account for how the improving economy would impact caseload (fewer people become or remain eligible for Medi-Cal).

LAO Findings on CHIP Funding. The LAO finds that the Administration’s full year estimate of CHIP savings (\$650 million) is reasonable. It notes that the budget year estimate (\$381 million) is more difficult to assess as the method the Administration used to determine the lags between date of service and date of payment is not transparent. Additionally, the LAO points out that the Administration did not use the enhanced CHIP matching rate for administrative costs associated with CHIP. DHCS indicates it

is awaiting federal guidance regarding this question. If the state is able to claim the enhanced CHIP rate for administrative expenses, the General Fund savings would likely be in the low millions to tens of millions dollars higher.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the May Revision caseload estimate, with any changes to conform as appropriate to other actions taken by the Subcommittee.

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

1. Please provide an overview of the May Revision adjustments to the Medi-Cal caseload and budget.
2. Please explain how DHCS considered payment lags in regard to the CHIP budget year savings.

5. Medi-Cal: County Administration Augmentation (DOF ISSUE 515-MR)

Budget Issue. The May Revision proposes to increase Medi-Cal county administration funding by \$150 million (\$48.8 million General Fund) due to ongoing implementation issues related to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) information technology system built to implement the federal Affordable Care Act (ACA). This augmentation would fund county administration at the current year level for ACA-related workload at \$390 million (\$195 million General Fund).

Background. Beginning with the 2013-14 budget and each year since, counties have received supplemental funding related for eligibility determination workload related to the ACA. SB 28 (Hernandez) Chapter 442, Statutes of 2013, directs DHCS in consultation with the counties and County Welfare Directors Association (CWDA) to design and implement a new budgeting methodology for county administrative costs that reflects the impact of the ACA on county administrative work and present that methodology to the Legislature no later than March 2015. The new county budget methodology is intended to be an improved process that will include specific reviews of annual time studies, claimed expenditures, and other data metrics. This new methodology has not yet been developed given the issues with CalHEERS and the process workarounds necessary to determine eligibility. DHCS indicates it has begun collecting data to develop this methodology.

Subcommittee Staff Comment and Recommendation—Hold Open. Counties have raised concerns that the proposed level of funding will not enable counties to perform the eligibility-related workload necessary to ensure program integrity and delivery quality customer service. Additionally, counties are requesting the development of the new methodology, pursuant to SB 28, to be used in for the 2016-17 budget. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide a review of this proposal. What is the basis for the \$150 million augmentation?
2. How did DHCS work with counties on developing this estimate?
3. What is DHCS's proposed timeline to implement a new budgeting methodology?

6. Medi-Cal: Impact of President’s Executive Order (DOF ISSUE 521-MR)

Budget Issue. The May Revision includes \$33.1 million (\$27.8 million General Fund) to reflect the costs of providing Medi-Cal to newly qualified individuals as a result of the President’s Executive Order on immigration. However, this number has been revised by the Administration and the estimated cost for this proposal is \$41.5 million (\$33.2 million General Fund) in 2015-16 and \$206 million (\$165.2 million General Fund) on an ongoing basis. These numbers were revised to include dental and managed care carve-outs in the per member per month rate (revised from \$242.09 to \$274.54).

The Administration assumes that beginning October 1, 2015, individuals that qualify under the President’s order will begin enrolling in Medi-Cal and that it would take 12 months to reach full enrollment. The following assumptions are then used:

Total Eligible for Anticipated DACA/DAPA in California less total Eligible for DACA/DAPA in DHCS existing undocumented population.	1,221,283
Based on past experience with DACA, estimate that 55% of those immediately eligible will apply for DACA.	55.00%
Total Applicants for Anticipated DACA/DAPA.	671,706
Based on past experience with DACA, estimate that approximately 80% of those who apply will be approved.	80.80%
Total Approved Applicants for Anticipated DACA/DAPA (parents/guardians and expanded children).	542,792
Estimated approved DACA/DAPA population with incomes less than 138% FPL.5	43.80%
Universe of those under 138% FPL, who are eligible for Medi-Cal.	237,635
A 10 percent take-up rate for this population is assumed.	23,763
Estimated FY 2015-16 Average Monthly Undocumented Population ⁶	701,433
Percentage of undocumented Californian's eligible for DAPA/DACA. 10	50%
Total Eligible for DACA/DAPA.	350,717
Based on past experience with DACA, estimate that 55% of those immediately eligible will apply for DACA.	55.00%
Total Applicants for Anticipated DACA/DAPA.	192,894
Based on past experience with DACA, estimate that approximately 80% of those who apply will be approved.	80.80%
Estimated Undocumented population currently on Medi-Cal that would be approved for DACA/DAPA.	155,874
A 50 percent take-up rate for this population is assumed.	77,937
TOTAL	101,700

Background. The President’s executive actions expand the Deferred Action for Childhood Arrivals (DACA) program and create the Deferred Action for Parents of Accountability (DAPA) program (also known as the Deferred Action for Parents of Americans and Lawful Permanent Residents program) as follows:

- **Expands DACA Program.** Previously, undocumented individuals who were younger than 31 years of age as of June 2012, had entered the United States prior to the age of 16, and had lived in the United States continuously since January 1, 2010, were eligible for DACA. The President’s executive actions expand the population eligible for DACA to include people of any age who entered the United States before the age of 16 and meet the other DACA requirements. The President’s executive actions also extend the period of DACA eligibility and work authorization from two years to three years.
- **Creates DAPA Program.** The President’s executive actions also create the DAPA program, which allows undocumented immigrants who have lived in the United States continuously since January 1, 2010 and are parents of United States citizens or lawful permanent residents to request deferred action and work authorization for three years.

A lawsuit was filed in February by officials of 26 states who contend the President’s executive actions violated the United States Constitution as an overreach of executive powers. The suit seeks an order blocking the immigration changes from taking effect. Initial arguments in the suit were heard by a United States district judge on January 15, 2015, where the states asked the judge to block the executive actions until they have been able to challenge the actions in court. The judge has halted implementation of the President’s actions. Officials from 12 states, including California, and the District of Columbia recently filed an amicus or “friend of the court” brief supporting the President’s executive actions.

LAO Findings. The LAO notes that there are significant uncertainties with regard to the executive actions in that it is unclear when and if the President’s actions may be implemented, many eligible for this program may not enroll, and individuals would have to proactively enroll into Medi-Cal. Additionally, the LAO finds that the Administration’s estimated expenditures for this proposal are likely overstated because the enrollment phase-in is likely to take longer than estimated by the Administration.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide a review of this proposal and the assumptions used to develop this estimate.

7. Coordinated Care Initiative: Multipurpose Senior Services Program Transition Timeline

Budget Issue. Current statute authorizing the Coordinated Care Initiative (CCI) states that the Multipurpose Senior Services Program (MSSP) will transition from a federal waiver to a managed care benefit after 19 months of MSSP beneficiary enrollment into managed care. This proposal will extend the transition deadline to December 31, 2017, but would allow an earlier transition in a county or region when the MSSP sites and managed care plans mutually agree they are ready to transition and want to transition early; in addition both the MSSP sites and managed care plans would have to demonstrate that they have met readiness criteria that is developed by DHCS, California Department of Aging (CDA), MSSP providers, managed care plans and stakeholders.

Background. MSSP beneficiary managed care enrollment was staggered with CCI counties; however, a majority of the CCI counties plan to integrate MSSP as a managed care benefit beginning May 1, 2017. During MSSP integration, there have been operational issues that slowed the transition of the MSSP benefit into managed care. After the MSSP transition, MSSP will no longer operate as a federal 1915(c) waiver in CCI counties for eligible Medi-Cal beneficiaries enrolled in Medi-Cal managed care but will be a managed care benefit authorized and managed by Medi-Cal managed care plans. Other Medi-Cal beneficiaries ineligible to enroll in Medi-Cal managed care, and non-CCI counties, may receive MSSP through Fee-For-Service under the 1915(c) waiver.

Concerns have been raised that the transition timeline is too short due to insufficient time to resolve outstanding operational issues between the managed care plans and the MSSP providers. According to DHCS, it is their intent to transition MSSP only upon managed care plans' and MSSP providers' mutual agreement that both entities demonstrate readiness to fully integrate the MSSP benefit. The proposed language also requires DHCS to notify the appropriate fiscal and policy committees of the Legislature 30 days in advance of the MSSP services transition to a managed care plan benefit in CCI counties.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic

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

1. Please provide a review of this proposal.

8. Medi-Cal: Behavioral Health Treatment (DOF ISSUE 524-MR)

Budget Issue. The May Revision proposes expenditures of \$27.1 million (\$13.6 million General Fund) in 2014-15 and \$201.6 million (\$100.8 million General Fund) in 2015-16 for the provision of behavioral health therapy (BHT) series to eligible Medi-Cal children with autism spectrum disorder (ASD). The projected number of Medi-Cal children receiving BHT in 2014-15 is 1,500 and 7,000 in 2015-16. This does not include children who may transition from receiving BHT through the regional centers. The department anticipates finalizing the rate for BHT services in Medi-Cal managed care in June.

Additionally, DHCS requests the following language to transfer funds from the Department of Developmental Services to DHCS as children transition from receiving BHT through regional centers to receiving these services through Medi-Cal:

Add the following provision to Item 4260-101-0001 (similar language is proposed for item 4300-101-0001):

X. The Department of Finance may authorize the transfer of expenditure authority from Item 4300-101-0001 Schedule (2) 4140019 Purchase of Services to this item to support the transition of current Medi-Cal eligible regional center clients receiving Behavioral Health Treatment services upon completion of the statewide transition plan.

The Director of Finance shall provide notification to the Joint Legislative Budget Committee of any transfer of expenditure authority approved under this provision not less than 30 days prior to the effective date of the approval. The 30-day notification shall include a description of the transfer, including the number of children affected and assumptions used in calculating the amount of expenditure authority to be transferred.

Transition Plan. DHCS and DDS are in the processing of developing a transition plan that will describe how children receiving BHT services at regional centers will transition to receiving these benefits through Medi-Cal. DHCS plans to release a draft version of this transition plan on May 22nd at its next BHT Stakeholder Workgroup meeting.

Number of Children by County Currently Receiving BHT in Medi-Cal. At its April 23rd Subcommittee hearing, the Subcommittee requested information on the number of children receiving BHT through Medi-Cal since implementation of this as managed care benefit on September 15, 2014. Below is a chart from DHCS reflecting this information as of May 5, 2015.

Table: Number of Children Receiving BHT in Medi-Cal, as of May 5, 2015

County	# of Beneficiaries Receiving BHT Services
Alameda	73
Alpine	0
Amador	0
Butte	0
Calaveras	<11

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County	# of Beneficiaries Receiving BHT Services
Colusa	0
Contra Costa	15
Del Norte	0
El Dorado	<11
Fresno	16
Glenn	0
Humboldt	0
Imperial	0
Inyo	0
Kern	<11
Kings	0
Lake	0
Lassen	0
Los Angeles	89
Madera	<11
Marin	<11
Mariposa	0
Mendocino	0
Merced	16
Modoc	0
Mono	0
Monterey	22
Napa	0
Nevada	0
Orange	330
Placer	15
Plumas	0
Riverside	75
Sacramento	87
San Benito	0
San Bernardino	62
San Diego	12
San Francisco	<11
San Joaquin	31
San Luis Obispo	<11
San Mateo	<11
Santa Barbara	15
Santa Clara	48

County	# of Beneficiaries Receiving BHT Services
Santa Cruz	<11
Shasta	<11
Sierra	0
Siskiyou	<11
Solano	37
Sonoma	<11
Stanislaus	<11
Sutter	<11
Tehama	0
Trinity	0
Tulare	<11
Tuolumne	0
Ventura	<11
Yolo	<11
Yuba	<11

Subcommittee Staff Comment and Recommendation—Approve Budget Bill Language (BBL). It is recommended to approve the revised cost estimates related to providing BHT in Medi-Cal. Additionally, it is recommended to modify the proposed BBL to require the departments to provide more information about the transfer amount. The modified BBL is noted below:

Add the following provision to Item 4260-101-0001:

X. The Department of Finance may authorize the transfer of expenditure authority from Item 4300-101-0001 Schedule (2) 4140019 Purchase of Services to this item to support the transition of current Medi-Cal eligible regional center clients receiving Behavioral Health Treatment services upon completion of the statewide transition plan.

The Director of Finance shall provide notification to the Joint Legislative Budget Committee of any transfer of expenditure authority approved under this provision not less than 30 days prior to the effective date of the approval. The 30-day notification shall include a description of the transfer, including the number of children **per regional center** affected, the **cost difference per regional center client compared to the cost per Medi-Cal enrollee**, and assumptions used in calculating the amount of expenditure authority to be transferred.

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X. The Department of Finance may authorize the transfer of expenditure authority from Schedule (2) 4140019-Purchase of Services to Item 4260-101-0001 to support the transition of current Medi-Cal eligible regional center clients receiving Behavioral Health Treatment services upon completion of the statewide transition plan.

The Director of Finance shall provide notification to the Joint Legislative Budget Committee of any transfer of expenditure authority approved under this provision not less than 30 days prior to the effective date of the approval. The 30-day notification shall include a description of the transfer, including the number of children **per regional center** affected, the **cost difference per regional center client compared to the cost per Medi-Cal enrollee**, and assumptions used in calculating the amount of expenditure authority to be transferred.

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

1. Please provide a review of this proposal and the assumptions used to develop this estimate.
2. Please provide an update on the transition planning.

9. Medi-Cal: Enrollment Application Assistance Payments

Budget Issue. The May Revision proposes trailer bill language to:

- Reallocate any remaining funds for Medi-Cal application assistance payments, for eligible applications submitted through June 30, 2015, to county outreach and enrollment grants.
- Extend the date by which county outreach and enrollment grant funds can be spent from June 30, 2016 to June 30, 2018.

Section 70 of AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, authorized in-person enrollment application assistance payments of \$58 per approved Medi-Cal application. This provision sunsets on June 30, 2015. Once all in-person enrollment assistance payments have been made for the approved Medi-Cal applications received through June 30, 2015, this proposal would reallocate any remaining funds to the county outreach and enrollment grants authorized under Section 71 of SB 101 (Committee on Budget and Fiscal Review), Chapter 361, Statutes of 2013. This proposal would also extend the date by which these county grant funds could be allocated to June 30, 2018.

Of the \$23.5 million dedicated to county outreach and enrollment grants, as of April 2015, approximately \$3.8 million has been distributed to counties. Under current law, these funds must be fully expended by June 30, 2016.

Background. Section 70 of AB 82 authorized DHCS to accept contributions by private foundations, specifically The California Endowment (TCE), in the amount of \$14 million. These funds were matched with federal funds and provided a total of \$28 million for in-person enrollment application assistance. Section 71 of SB 101 authorized DHCS to accept private contributions by private foundations, specifically TCE, in the amount of \$12.5 million. These funds were also matched with federal funds and provided a total of \$25 million for county outreach and enrollment grants.

Covered California (CC) currently administers payments to Certified Enrollment Entities (CEEs) for in-person enrollment assistance for individuals who apply for insurance affordability programs, are found eligible, and enroll in either Medi-Cal or a CC Qualified Health Plan. In addition, CC pays Certified Insurance agents (agents) for applications that result in a Medi-Cal eligibility determination. Agents receive compensation from health plans for Qualified Health Plan enrollment. CC currently holds contracts with more than 900 CEEs and nearly 15,000 agents. CC has an Interagency Agreement with DHCS, which provides funding for the \$58 payments made to agents and CEEs and also provides reimbursement for a portion of CC's cost to administer the application assistance program.

Beginning July 1, 2015, CC is implementing a new payment model for Qualified Health Plan enrollment assistance work under the Navigator Grant Program. The Navigator Program is required pursuant to federal Exchange regulations, but does not provide compensation for applications with Medi-Cal eligible individuals. CC will no longer be providing application assistance payments to CEEs and agents for applications with Medi-Cal eligible individuals received after June 30, 2015. CC confirmed that it will make the payments to assisters for valid Medi-Cal applications received through June 30, 2015.

Of the \$28 million dedicated to agents and CEEs for Medi-Cal applications, as of April 2015, \$18.2 million has been identified for applications submitted October 2013 through December 2014. Based on current enrollment trends, DHCS estimates CC will pay out an additional \$7.3 million through June 30, 2015. This would leave approximately \$2.5 million in remaining funding for Medi-Cal assistor payments unspent.

Of the \$23.5 million dedicated to county outreach and enrollment grants, as of April 2015, approximately \$3.8 million has been distributed to counties. Under current law, these funds must be fully expended by June 30, 2016.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt the proposed placeholder trailer bill language.

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

1. Please provide an overview of this request.
2. Is there a backlog in Medi-Cal application assistance payments? If so, what is it? How does DHCS plan to address this backlog?

10. Medi-Cal: Ground Emergency Medical Transportation Supplemental Reimbursement Program – Trailer Bill Language

Budget Issue. The May Revision proposes trailer bill language (TBL) to modify the existing ground emergency medical transportation (GEMT) Supplemental Reimbursement Program in order to maximize federal financial participation for public GEMT provider's services, subject to federal approval. This new mechanism would have no impact to the General Fund.

Background. Welfare and Institutions (W&I) Code §14105.94, as enacted on October 2, 2011, authorized the GEMT supplemental reimbursement program. This voluntary Certified Public Expenditure (CPE) based program provides additional funding to eligible governmental entities that provide GEMT services to Medi-Cal beneficiaries. The Centers for Medicare and Medicaid Services (CMS) approved State Plan Amendment (SPA) 09-024 on September 4, 2013, authorizing the federal share of the supplemental reimbursement payments based on uncompensated costs for Medi-Cal fee-for-service (FFS) transports, effective January 30, 2010.

Since its inception, the GEMT supplemental reimbursement program has provided approximately \$45.6 million (federal funds) in additional reimbursements to GEMT providers for their uncompensated care costs.

AB 2577 (Cooley) from the 2014 legislative session would have required DHCS to develop an intergovernmental transfer (IGT) funded program to increase capitation rates to health plans for GEMT services. AB 2577 was vetoed by the Governor; in the veto message the Governor directed DHCS to continue to work on options that would maximize funding for GEMT services in a manner that was operationally possible.

As directed by the Governor's veto message for AB 2577, DHCS indicates it continued to work on potential options for increasing federal funding to public GEMT providers. DHCS determined that the program construct of AB 2577 was not possible to implement and instead is proposing to develop a modified GEMT program in FFS, in collaboration with the GEMT stakeholders.

Under the current GEMT methodology, funded through CPEs, participating providers are limited to supplemental reimbursement up to Medi-Cal allowable costs. These costs may not reflect the GEMT provider's full cost of providing the transport to a Medi-Cal beneficiary. Modifying the existing GEMT supplemental payment methodology to utilize IGTs will allow the providers to receive supplemental reimbursement up to the maximum allowed under federal Medicaid rules, which is generally comparable to the rates they receive from commercial payers, likely higher than the Medi-Cal allowable costs, thus providing additional federal funds to GEMT providers.

SB 534 (Pan), set for hearing in the Senate Appropriations Committee on May 18 requires the DHCS to design and implement an intergovernmental transfer program for public Medi-Cal managed care ground emergency medical transport services in order to increase Medi-Cal capitation payments to Medi-Cal managed care plans for the purpose of increasing Medi-Cal reimbursement to public ground emergency medical transport services providers; permits DHCS to provide supplemental Medicaid reimbursement

for the cost of paramedic services at a rate of payment equal to cost through the use of certified public expenditures. SB 534 is also intended to address the issues raised in the Governor’s veto message.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal.

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

1. Please provide an overview of this request.

11. Major Risk Medical Insurance Program Reconciliation Process

Issue. As discussed at the April 23rd Subcommittee hearing, DHCS is in the process of reconciling Major Risk Medical Insurance Program (MRMIP) and Guaranteed Issue Pilot (GIP) actual plan expenditures and claims with what the state already paid these plans. There is currently a four-year backlog in the reconciliation process. Consequently, it is unknown how much the state may owe plans or how much plans may owe the state. The Administration estimates that on the net of both programs' reconciliations, the state would receive an increase in funding.

Subcommittee staff requested technical assistance from the Administration on methods to facilitate and expedite the reconciliation process. It is important to expedite this process, so that the state has an understanding of the true balance of the Managed Risk Medical Insurance Fund (MRMIF).

In order to expedite this process, the Subcommittee may want to consider trailer bill language that would:

- Specify that DHCS and the plans consult on the reconciliations.
- If DHCS and a plan do not reach an agreement, DHCS has the authority to provide notification to the plan of the final determined amount.
- The plan has 60 days to repay DHCS.
- If the plan does not repay in 60 days:
 - Interest begins to accrue
 - DHCS can offset the repayment amount from other payments to the plan.
 - DHCS can enter into a repayment agreement with the plan and can choose to waive interest.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide a review of the technical assistance provided to the Subcommittee.

12. Health Home Program (DOF ISSUE 522-MR)

Budget Issue. The May Revision proposes trailer bill language (TBL) to provide DHCS with the authority to establish a Health Home Program (HHP) 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 expended upon appropriation by the Legislature, for the purposes of implementing the HHP pursuant to AB 361 (Mitchell), Chapter 642, Statutes of 2013.

Background. The Medicaid Health Home State Plan Option is afforded to states under the federal Affordable Care Act (ACA) allows states to create Medicaid health homes to coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS), and other community-based services needed by beneficiaries with chronic conditions.

AB 361 authorizes DHCS, subject to federal approval, to create an ACA HHP for beneficiaries with chronic conditions. The HHP will serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. Health Homes provide six core services: comprehensive care management; care coordination (physical health, behavioral health, and community-based LTSS); health promotion; comprehensive transitional care; individual and family support; and referral to community and social support services. AB 361 provides that its requirement shall not be implemented unless federal financial participation is available and that the program is cost neutral regarding state General Funds. AB 361 also requires that if DHCS implements the program, DHCS must ensure that an evaluation of the program is completed and that DHCS submits a report to the appropriate policy and fiscal committees of the Legislature two years after implementation of the program.

Federal matching funds at 90 percent would be available for eight quarters. Federal matching funds would be available for staffing and contractor services at 50 percent. Foundation funding would be available to provide the non-federal share during the first eight quarters of HHP. Any unexpended funds within the HHP Account, within the Special Deposit Fund from a local government, foundation or other organization will be returned to the entity.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt this placeholder trailer bill language to ensure DHCS has the ability to receive foundation funding to support this program.

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

1. Please provide a review of this proposal, including a description of the targeted population, the total funding and how it will be allocated.
2. Has DHCS secured non-General Fund funding for this program?
3. Please provide a review of the proposed timeline and implementation of the Health Home Program?
4. Please describe the stakeholder process used in the development of this program.

0530 California Health and Human Services Agency

4260 Department of Health Care Services

4265 Department of Public Health

1. High Cost Drug Proposal (DOF ISSUE 521-MR and 400)

Budget Issue. The May Revision proposes to allocate funding for the treatment of Hepatitis C (HCV) to various state departments as noted in the table below. The May Revision also proposes to eliminate the \$300 million General Fund reserve that was proposed in the January budget for HCV treatment and eliminate Budget Bill Control Section 8.75 that provided for this reserve.

Tables: Summary of Hepatitis C Treatment Costs in Various State Departments

2015-16 Budget Year			
Departments	General Fund @ GB	General Fund @ MR	Difference
Health Care Services	65.3	126.0	60.7
Corrections & Rehabilitation	10.0	70.6	60.6
State Hospitals	0.0	6.3	6.3
Public Health (ADAP)	0.0	0.0	0.0
CS 8.75/Org 5209	200.0	0.0	-200.0
Total	275.3	202.9	-72.4

2014-15 Current Year			
Departments	General Fund @ GB	General Fund @ MR	Difference
Health Care Services	65.3	113.7	48.4
Corrections & Rehabilitation	10.0	61.7	51.7
State Hospitals	0.0	0.0	0.0
Public Health (ADAP)	0.0	0.0	0.0
CS 8.75/Org 5209	100.0	0.0	-100.0
Total	175.3	175.4	0.1

Additionally, the May Revision indicates that the agency will convene two workgroups with state departments and local entities to discuss clinical and procurement issues with the goal of developing a proposal for inclusion in the 2016-17 budget.

Department of Health Care Services (DHCS) – Revised HCVC Clinical Guidelines. The May Revision indicates that DHCS plans to update its HCV policy to include newly FDA-approved drugs and include people with less advanced stages of the disease (including State 2). The new policy will include HCV patients, regardless of stage, who also have diabetes, HIV, Hepatitis B, debilitating fatigue,

a desire to become pregnant, and other co-morbid conditions. The May Revision includes \$13.4 million (\$6.7 million General Fund) for the increased costs to account for this expansion of clinical guidelines.

Department of Public Health – Revised HCV Clinical Guidelines. The Office of AIDS (OA) proposes to expand access to HCV medications to include all HCV co-infected ADAP clients, regardless of liver disease stage. According to DPH, this policy is in alignment with the federal Health and Human Services guidelines for treating HCV co-infection among HIV-infected persons and the revised Department of Veteran Affairs’ HCV clinical guidelines, which recommend that all HIV/HCV co-infected patients be treated. HIV co-infection accelerates liver disease progression among HCV-infected persons.

For the January budget, OA estimated that 12 percent of ADAP clients are co-infected with HCV, 32.4 percent of the co-infected clients have F3 or F4 liver disease, and 10 percent of ADAP’s co-infected sub-population with F3 or F4 disease would be treated for HCV each FY. However, due to low utilization of the new HCV drugs in 2014-15 to date, this revised estimate is based on actual utilization data pro-rated for the remainder of the current year. Therefore, the 2014-15 estimate is based on providing treatment to clients with F3 or F4 disease only, since OA expects that the transition to providing treatment for all co-infected clients will require a ramp-up time period beginning 2015-16. The updated estimate for 2015-16 is based on the earlier methodology, except that the restriction on treating only patients with F3 or F4 disease was removed, and OA estimates that only five percent of ADAP’s co-infected sub-population will be treated for HCV each fiscal year; all HCV co-infected ADAP clients were considered eligible for treatment. Additionally, OA expects to implement preferential utilization of lower cost treatment regimens (e.g., Viekira Pak™) among eligible patients when such regimens are equally effective and no medical contraindications to their use exist; this was included in the estimate calculations.

- 2014-15: OA estimates that 13 clients with F3 or F4 disease will be treated for HCV during FY 2014-15, with an estimated \$1.4 million in program expenditures and \$107,402 in rebate revenue. The estimated net cost is \$1.3 million.
- 2015-16: OA estimates that access to HCV treatment for all ADAP clients will result in 199 clients being treated with \$9.9 million in program expenditures and \$3.4 million in rebate revenue, for a net cost of \$6.5 million.

Subcommittee Staff Recommendation—Approve. It is recommended to approve the adjustments to the Department of Health Care Services and Department of Public Health’s budgets reflected above and delete Budget Bill Control Section 8.75.

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

1. Please provide a review of this proposal.
2. DHCS: Have you released the updated clinical guidelines to the public? If not, when will these guidelines be released? Will stakeholders have an opportunity to comment on these guidelines?

3. DHCS: How many Medi-Cal individuals will receive HCV treatment under the new clinical guidelines?

4265 Department of Public Health

1. AIDS Drug Assistance Program (DOF ISSUE 007-MR)

Budget Issue. The May Revision proposes a decrease of \$5.7 million in federal funds and \$20.2 million in ADAP Rebate Fund due to a larger number of ADAP clients transition to Medi-Cal and fewer ADAP clients accessing new Hepatitis C treatment than originally estimated.

Additionally, the May Revision proposes to reallocate \$1.5 million Ryan White (RW) base funding to local health jurisdictions and/or community-based organizations to support targeted efforts to re-engage HIV-infected minority clients in medical care and treatment. Both in California and nationwide, minority populations are at a greater risk of not being linked to care and treatment shortly after HIV diagnosis and becoming disengaged from medical care and treatment services. Because HIV-infected persons who have an undetectable viral load due to appropriate treatment have a close to zero risk of transmitting HIV to their partner(s), the greater risk of minority populations being untreated leads to health disparities in HIV viral load suppression, survival, and infection rates. In 2012, only 75 percent of HIV-diagnosed African American Californians in care had a suppressed viral load, as compared with 83 percent of Latinos and 88 percent of non-Hispanic Whites. Linking and re-engaging clients in HIV care and treatment services both improves individual health outcomes and prevents new HIV infections.

Enrollment Workers. Although the addition of health care coverage assistance programs are providing the opportunity for more individuals to obtain health coverage, these programs are complicated and the success of enrollment into these programs is often dependent on enrollment workers who can direct individuals to coverage programs that meet each person's unique needs.

Concerns have been raised that local health jurisdictions and the state Office of AIDS (OA) are not sufficiently funded to ensure enrollment into the various ADAP programs and that the expansion of ADAP programs, such as when the OA-Health Insurance Premium Payment program begins paying medical out-of-pockets costs in 2016, will add to this workload.

Local health jurisdictions (LHJ) are currently allocated \$2 million for costs associated with the administration of ADAP enrollment. This funding is allocated based on the number of ADAP clients the LHJ enrolled in the previous year.

Subcommittee Staff Comment and Recommendation. It is recommended to do the following:

- **Approve** the revised ADAP May Revision estimate, including the proposal to reallocate \$1.5 million RW base funding to local health jurisdictions and/or community-based organizations to support targeted efforts to re-engage HIV-infected minority clients in medical care and treatment.
- **Augment** the allocation to the local health jurisdictions for ADAP enrollment by \$2 million (rebate fund) to be allocated according to the existing formula (the number of ADAP clients enrolled in the previous year).
- **Augment** OA's budget by \$1 million (rebate fund) to support efforts to work with enrollment workers, provide technical assistance on improving the ADAP enrollment process, increase

capacity due to the projected changes in the program, and develop quality metrics for the ADAP program.

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

1. Please provide an overview of the May Revision Proposal.

2. Licensing and Certification Program (DOF ISSUE 201-MR)

Budget Issue. As previously discussed in Subcommittee on March 5th, the Governor proposes:

1. **L&C Workload** - An increase of \$19.8 million in 2015-16 for 173 permanent positions and 64 two-year, limited-term positions, for a total of 237 positions (123 positions will become effective July 1, 2015 and 114 positions will begin on April 1, 2016), and an increase in expenditure authority of \$30.4 million in 2016-17 from the L&C Special Fund to address the licensing and certification workload. This request attempts to address the L&C's past failures to complete its survey workload and close/complete complaint investigations.
2. **L&C Quality Improvement Projects** – An increase of \$2 million in 2015-16 from the Internal Departmental Quality Improvement Account to implement quality improvement projects recommended by Hubbert Systems Consulting for the Licensing and Certification Program.
3. **Los Angeles County Contract** - An increase in expenditure authority of \$9.5 million from the L&C Special Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County. This proposal includes \$2.6 million to fully fund the current contract positions at current Los Angeles County salary rates, and \$6.9 million to fund 32 additional Los Angeles County positions to enable the county to address long-term care facility complaints and entity-reported incidents, and investigate aging long-term care complaints and entity-reported incidents (Tier 1 and Tier 2 federal workload).
4. **Los Angeles County Contract Monitoring** – An increase of \$378,000 from the L&C Special Fund and three 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. In order to begin the on-site oversight immediately, the department plans to administratively establish three positions in 2014-15.

May Revision. As part of the May Revision, the Governor proposes to increase the Los Angeles County Contract Proposal (number three above) by \$5.3 million to fund (1) a 2-percent salary increase that became effective in October 2014; (2) a 2-percent salary increase that became effective in April 2015; (3) an increase to the fringe benefit rate; (4) an increase to the indirect cost rate; (5) a productive workload adjustment based on 1,760 hours per full-time equivalent position; and (6) consistency with state staff ratios for county field staff. (The total projected contract amount is \$36,489,046.) DPH notes that due to the timing of the Governor's budget and ongoing negotiations with Los Angeles County the January budget proposal did not include funding for the above specified purposes.

Subcommittee Staff Comment and Recommendations. The following actions are recommended:

1. **Approve the budget change proposals and make the 64 limited-term positions proposed under "L&C Workload" permanent.** The state makes a significant investment in the training of health facility evaluator nurses (HFENs) and acknowledges that it takes 12 to 14 months for HFEN to complete the training necessary to become proficient and work independently. Consequently, these positions would only be available to actively complete workload for one year, since these positions

are authorized for only two years. Given that L&C’s problem is not just closing a backlog of complaints, but also timely investigation and completion of new complaints and surveys and monitoring for compliance with state health facility licensing requirements (which are generally more stringent than the federal requirements), these positions should be permanent. Once the backlog is addressed, these trained and skilled surveyors could be directed to address other workload activities that are not the focus of this Governor’s proposal.

2. Adopt placeholder trailer bill language to establish timeframes to complete complaint investigations at long-term care facilities. Specifically, this placeholder language would specify that department would be required to:

- a. For A¹ and AA² complaints received on or after July 1, 2016, the department shall complete the investigation within 90 days of receipt. This time period may be extend up to an addition 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department shall notify the facility of this extension and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation shall be issued and served within thirty days of the completion of the complaint investigation.
- b. For all other categories of complaints received on or after July 1, 2017, the department shall complete the investigation within 90 days of receipt. This time period may be extend up to an addition 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department shall notify the facility of this extension and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation shall be issued and served within thirty days of the completion of the complaint investigation.
- c. Report on an annual basis (in the Licensing and Certification Fee report) data on the department’s compliance these new timelines.

3. Adopt placeholder trailer bill language allowing for an extension of the 45-day complaint investigation for hospitals due to extenuating circumstances. The department would be required to document the circumstances in its final determination and provide written notice to the facility and complainant of the basis of the extension and the anticipated completion date.

4. Increase funding (by \$1.4 million) to the Long Term Care (LTC) Ombudsman Program at the Department of Aging to facilitate an increase in skilled nursing facility (SNF) complaint investigations and quarterly visits by:

¹ Class “AA” violations are violations that meet the criteria for a class “A” violation and that the state department determines to have been a direct proximate cause of death of a patient or resident of a long-term health care facility.

² Class “A” violations are violations which the state department determines present either (1) imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom.

- a. **Directing \$1 million (one-time) from the State Health Facilities Citation Penalties Account to the LTC Ombudsman Program in 2015-16.**
- b. **Increasing the licensing and certification fee for skilled nursing facilities to generate \$400,000 to support the LTC Ombudsman Program on an ongoing-basis.**

As shown in the table below, since the reduction in funding for the LTC Ombudsman Program in 2008-09, there has been a reduction in the number of SNF complaint investigations and SNF quarterly visits by the LTC Ombudsman Program. As previously discussed by the Subcommittee, it is reasonable to assume that the ombudsman program’s presence and advocacy on behalf of SNF residents improves quality of life for these residents and improves a SNF’s compliance with state and federal laws. This is because the ombudsman is often able to intervene on behalf of a resident and investigate and resolve complaints before they result in more serious and costly cases of abuse and neglect.

Consequently, in an effort to address L&C problems from another perspective, it is recommended augment funding for the LTC Ombudsman Program in regard to its work at SNFs. While the \$1.4 million augmentation does not equal the projected unmet need, the LTC Ombudsman Program also uses volunteers and this infusion of new funding can be used to train and support new volunteers to meet this workload.

Table: Long-Term Care Ombudsman Program Skilled Nursing Facility Workload

	2008-09	2013-14	Difference	Average Hours to Complete	Average Hourly Wage	Cost
SNF Complaints	36,516	24,968	11,548	8	30	\$2,425,080
SNF Quarterly Visits	1,280	884	396	7	30	\$83,160
						\$2,508,240

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

- 1. Please provide an overview of the May Revision proposal.
- 2. Please provide a review of the technical assistance provided to the Subcommittee regarding establishing timelines for complaint investigations and funding for the Long Term Care Ombudsman Program.

3. Genetic Disease Screening Program Prenatal Screening Trailer Bill Language

Budget Issue. The May Revision proposes trailer bill language (TBL) to clarify that private health insurance plans cannot consider the Genetic Disease Screening Program (GDSP) Prenatal Screening Program to be an out-of-network provider. Currently, some private health plans have considered the Prenatal Screening Program to be treated as an out-of-network provider even though it is the sole provider of these services in California. This has resulted in some health plans either denying prenatal services claims or reimbursing only a portion of a total claim, resulting in lower than anticipated collections. GDSP has also been informed by the Department of Managed Care that they cannot balance bill patients.

The GDSP budget reflects a revenue increase of \$837,215 in revenue as a result of this proposed TBL.

GDSP is able to collect approximately 98 percent of all fees owed on behalf of Medi-Cal clients (which is approximately 45 percent of the total caseload), and approximately 81 percent of the fees owed by individuals with private insurance. In an effort to increase the collection rate from non-Medi-Cal payers CDPH is introducing the attached Trailer Bill Language (TBL). If this TBL is adopted, GDSP anticipates an increase in the non-Medi-Cal fee collection rate to from 81 percent to 83 percent in 2015-16.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt this proposed trailer bill language to facilitate GDSP’s collection of prenatal screening fees from private health plans.

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

1. Please provide an overview of the May Revision proposal.

4. California Clinical Laboratory Testing

Issue. Stakeholders have raised a concern that changes to the federal Clinical Laboratory Improvement Amendments (CLIA) will no longer allow medical laboratories in California to use the federal quality control option known as the Equivalent Quality Control (EQC). Stakeholders have requested state law be amended to allow for EQC to be used until December 31, 2015. CLIA will prohibit EQC after January 1, 2016.

Background. The Centers for Medicare and Medicaid Services (CMS) regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total, CLIA covers approximately 251,000 laboratory entities. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

DPH's Laboratory Field Services ensures compliance with state and federal clinical laboratory laws and regulations by performing biannual onsite inspections to ensure accuracy and reliability of laboratory test results and conducting review of laboratory performed proficiency testing results.

Both federal and state laws require laboratories to meet certain quality standards when performing laboratory tests. Among them are standards to ensure the accuracy and reliability of the testing no matter where the testing is performed or what type of testing instrument is used.

Quality control consists of the procedures used to detect errors that occur due to test system failure, adverse environmental conditions and variance in operator performance, as well as the monitoring of the accuracy and precision of the test performance over time.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff has requested technical assistance on this issue. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of this issue and the technical assistance provided to the Subcommittee.

4800 California Health Benefit Exchange

1. Emergency Regulations and Rulemaking Authority

Budget Issue. The California Health Benefit Exchange (Covered California) proposes trailer bill language in the May Revision to:

- a. Extend its current emergency regulations and the exchange board’s rulemaking authority for an additional year until January 1, 2017, extends its ability to readopt emergency regulations until January 1, 2020 for emergency regulations adopted prior to the effective date of the Budget Act of 2015, and
- b. Provide limited statutory exemptions from the Administrative Procedure Act’s (APA) rulemaking requirements for (i) standard plan designs, and (ii) having separate regulations for each procurement.

Background. In 2010, Covered California was granted authority to adopt emergency regulations through January 1, 2016. Emergency regulations must be made permanent within one year, or else they expire. A provision in a 2014-15 budget trailer bill provided a one-year extension of the board’s emergency regulations before those regulations needed to be made permanent. However, according to Covered California, changes in federal regulations and marketplace implementation issues continue to require timely adjustments in Covered California’s rules and regulations.

Covered California indicates that this proposal will enable Covered California to account for new federal regulations and to continue implementing and updating current policies to respond to market needs. An example of continuing changes in federal regulations is the final federal 2016 Notice of Benefit and Payment Parameters rule, which requires:

- Changes to special enrollment periods and expanded triggering events allowing consumers to select a plan through an exchange during special enrollment periods;
- Changes to termination of coverage provisions, allowing a retroactive termination; and
- Changes to eligibility standards for exemptions.

According to Covered California, failure to extend Covered California’s emergency rulemaking authority could lead to inconsistency between federal, state and Covered California regulations, risk litigation, and create uncertainties in eligibility and enrollment for Covered California and Medi-Cal.

Even where federal policy is established, Covered California indicates that it is continuously updating—and in many instances still developing—its implementation policies to account for lessons learned from its first renewal period. With emergency rulemaking authority, Covered California plans to quickly revise its policies to respond to market needs.

Additionally, Covered California is seeking limited statutory exemption from the APA for standard plan designs and from having separate regulations for each procurement.

Covered California is authorized to establish standard benefit plan designs, including copays and deductibles, to allow consumers to compare health care plans on an “apples to apples” basis. To develop its standard plan design, Covered California is required to rely on federal regulations that are updated annually. These updates include changes in the Final Notice of Benefit and Payment Parameters and the Actuarial Value Calculator (AV Calculator). These annual changes result in significant challenges to Covered California’s ability to adopt permanent regulations within the necessary timeline. For example, the permanent rulemaking process can take up to a year to complete. However, in 2014, rates for standard plan designs were due May 1, 2014, less than two months after the final AV Calculator was released.

Without an exemption from the permanent rulemaking process, Covered California argues that it would be highly problematic for Covered California to implement policies to standardize insurance products in the individual and small group markets. Therefore, Covered California proposes to remove standard plan designs from the formal rulemaking process. Under this proposal, the standard plan designs would be subject to approval of the board, and must be publicly noticed and discussed during at least two board meetings.

In its enacting legislation, Covered California was granted certain exceptions from the Public Contract Code and from Department of General Services (DGS) oversight in an effort to provide it with flexibility in its contracting and procurements processes. Unlike agencies that are under DGS oversight, Covered California’s contracting and procurements processes are not exempt from the rulemaking requirements of the APA.

According to Covered California, one unanticipated consequence of this is that once Covered California’s emergency regulation authority ends, it would be required to adopt its competitive solicitations and some of its contracts as permanent regulations before its contracts could be executed. This would create an administrative burden on Covered California because of the excessive amount of time it would take to contract for necessary services.

As an alternative, Covered California proposes a process that would provide it the flexibility of being exempt from the APA’s permanent rulemaking requirements, while also promoting transparency in its contracting and procurements processes. Under this proposal, the board would adopt a contracting manual incorporating procurement and contracting policies and procedures that must be followed by Covered California.

Subcommittee Staff Recommendation Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this proposal.

Questions. The Subcommittee has requested Covered California to respond to the following:

1. Please provide a review of this proposal and the need for these extensions.
2. How did Covered California work with stakeholders on this proposal?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

**OUTCOMES: Senate Subcommittee #3 on Health & Human Services
 Thursday, May 18 (Room 113)**

ISSUES RECOMMENDED FOR VOTE ONLY

VOTE ONLY

0530 Office of Systems Integration

1. CalHEERS Adjustment

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve adjustments and modified budget bill language.

0977 California Health Facilities Financing Authority (CHFFA)

1. Investment in Mental Health Wellness Act of 2013

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt the placeholder trailer bill language below to allow CHFFA to use up to \$3 million in unencumbered Mental Health Wellness Grant funds for peer respite programs.

Current law requires that these remaining unencumbered funds be used for crisis residential and crisis stabilization services. This language would provide CHFFA with the flexibility to allow this grant funding to be used to support peer respite programs if CHFFA finds that peer respite programs meet the intent of the Investment in Mental Health Wellness Act’s goal to improve access to and capacity for mental health crisis services in California.

Proposed Placeholder Trailer Bill Language:

For the 2015-16 fiscal year, the California Health Facilities and Financing Authority (CHFFA) may authorize up to \$3 million in unencumbered funds as appropriated in Item 0977-101-0001 for Mental Health Wellness Grants, Chapter 20 (AB 110), Statutes of 2013, to develop peer respite sites.

Any grant awards authorized by CHFFA for peer respite sites shall be used to expand local resources for the development, capital, equipment acquisition, and applicable program startup or expansion costs to increase bed capacity for peer respite support services. This may include, but not be limited to, the purchase of property, purchase of equipment, and the remodeling or construction of housing for the purpose of operating a peer respite site.

Any recipient of a grant to develop peer respite sites shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

CHFFA may adopt emergency regulations relating to grants for peer respite sites, including emergency regulations that define eligible costs, and determine minimum and maximum grant amounts. The adoption of these regulations shall be in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) and shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare.

4260 Department of Health Care Services

1. May 2015 Medi-Cal Estimate (DOF Issue 501 and 502)

- Vote to approve staff recommendation: 2-0 (Senator Stone not voting.)

Subcommittee Staff Recommendation— Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken. This is a technical adjustment.

2. Eliminate Cost-of-Living Adjustment for County Eligibility Administration

- Held open.

3. Child Health and Disability Prevention (CHDP) Program Dental Referral

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language.

4. Health Care Reform – Workload Extension

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

5. Medi-Cal Annual Open Enrollment Period

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Recommendation—Reject. The Legislature has denied similar proposals in the last few years because it found that it is important to ensure that Medi-Cal enrollees have the ability to

change health plans at any time to ensure that his or her health needs are met. Although this proposal includes the ability for someone to switch plans if they have “good cause,” having to demonstrate this and go through this process could be a barrier to ensuring timely treatment.

6. CalHEERS Electronic MAGI Determination Trailer Bill Language

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language.

7. Health Care Reform Financial Reporting Resources

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Recommendation—Approve.

8. Hospital Quality Assurance Fee Resources

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

9. Martin Luther King Jr. Hospital Resources

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

10. MEDS and Securing Medi-Cal Eligibility Information Resources

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

11. Intergovernmental Transfer Program Resources

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

12. Drug Medi-Cal Provider Enrollment

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

13. Drug Medi-Cal Provider Monitoring

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

14. Substance Abuse – Recovery and Treatment Services (AB 2374, 2014)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

15. Performance Outcomes System for EPSDT Medi-Cal Specialty Mental Health Services

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

16. Family Health Programs Adjustments (DOF Issue 505, 505-MR, 506-MR)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

17. Modify Major Risk Medical Insurance Program

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Comment and Recommendation--Reject proposed trailer bill language. As previously discussed, the proposal gives DHCS broad authority to redesign MRMIP without any input from stakeholders and it eliminates a safety-net option whereby individuals could purchase health coverage throughout the year if they missed the open enrollment period for commercial coverage or do not qualify for Medi-Cal. For these reasons, it is recommended to reject this proposal.

4265 Department of Public Health

1. Genetic Disease Screening Program Update & AB 1559 (2014) (DOF ISSUE 010-MR)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve Genetic Disease Screening Program Estimate and Budget Change Proposal.

2. Office of AIDS: ADAP Client Eligibility Verification Resources

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

3. ADAP Modernization

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt placeholder trailer bill language to modernize ADAP as specified above.

4. May Revision Estimate Updates (DOF ISSUE 400-MR, 009-MR, 010-MR, 400-MR)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation—Approve.

ITEMS FOR DISCUSSION

4260 Department of Health Care Services

1. 2011 Realignment Behavioral Health Growth Account Allocation

- Held open.

2. Drug Medi-Cal Waiver Implementation (DOF ISSUE 001-MR)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to only approve six of the 13 requested positions as the workload justification for these positions appears exaggerated. For example, DHCS proposes that it would take 25 days (200 hours) to prepare for each quarterly Waiver Advisory Group meetings. DHCS has also used the assumption that all 53 counties that have expressed interest will apply and fails to account for its own phased-in approach. Additionally, many of the proposed workload activities are one-time in nature, such as the review and approval of county implementation plans, which would only occur once. It is recommended to approve the proposed budget bill language.

3. Drug Medi-Cal Residential Treatment Services

- Held open.

4. Medi-Cal: Caseload Update

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the May Revision caseload estimate, with any changes to conform as appropriate to other actions taken by the Subcommittee.

5. Medi-Cal: County Administration Augmentation (DOF ISSUE 515-MR)

- Held open.

6. Medi-Cal: Impact of President’s Executive Order (DOF ISSUE 521-MR)

- Held open.

7. Coordinated Care Initiative: Multipurpose Senior Services Program Transition Timeline

- Held open.

8. Medi-Cal: Behavioral Health Treatment (DOF ISSUE 524-MR)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Comment and Recommendation—Approve Placeholder Budget Bill Language (BBL). It is recommended to approve the revised cost estimates related to providing BHT in Medi-Cal. Additionally, it is recommended to modify the proposed BBL to require the departments to provide more information about the transfer amount. The modified BBL is noted below:

Add the following provision to Item 4260-101-0001:

X. The Department of Finance may authorize the transfer of expenditure authority from Item 4300-101-0001 Schedule (2) 4140019 Purchase of Services to this item to support the transition of current Medi-Cal eligible regional center clients receiving Behavioral Health Treatment services upon completion of the statewide transition plan.

The Director of Finance shall provide notification to the Joint Legislative Budget Committee of any transfer of expenditure authority approved under this provision not less than 30 days prior to the effective date of the approval. The 30-day notification shall include a description of the transfer, including the number of children per regional center affected, the cost difference per regional center client compared to the cost per Medi-Cal enrollee, and assumptions used in calculating the amount of expenditure authority to be transferred.

Item 4300-101-0001

X. The Department of Finance may authorize the transfer of expenditure authority from Schedule (2) 4140019-Purchase of Services to Item 4260-101-0001 to support the transition of current Medi-Cal eligible regional center clients receiving Behavioral Health Treatment services upon completion of the statewide transition plan.

The Director of Finance shall provide notification to the Joint Legislative Budget Committee of any transfer of expenditure authority approved under this provision not less than 30 days prior to the effective date of the approval. The 30-day notification shall include a description of the transfer, including the number of children per regional center affected, the cost difference per regional center client compared to the cost per Medi-Cal enrollee, and assumptions used in calculating the amount of expenditure authority to be transferred.

9. Medi-Cal: Enrollment Application Assistance Payments

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt the proposed placeholder trailer bill language.

10. Medi-Cal: Ground Emergency Medical Transportation Supplemental Reimbursement Program – Trailer Bill Language

- Held open.

11. Major Risk Medical Insurance Program Reconciliation Process

- Held open.

12. Health Home Program (DOF ISSUE 522-MR)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language.

It is recommended to adopt this placeholder trailer bill language to ensure DHCS has the ability to receive foundation funding to support this program.

0530 California Health and Human Services Agency

4260 Department of Health Care Services

4265 Department of Public Health

1. High Cost Drug Proposal (DOF ISSUE 521-MR and 400)

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Recommendation--Approve. It is recommended to approve the adjustments to the Department of Health Care Services and Department of Public Health's budgets reflected above and delete Budget Bill Control Section 8.75.

4265 Department of Public Health

1. AIDS Drug Assistance Program (DOF ISSUE 007-MR)

- See below for votes.

Subcommittee Staff Comment and Recommendation. It is recommended to do the following:

- **Approve** the revised ADAP May Revision estimate, including the proposal to reallocate \$1.5 million RW base funding to local health jurisdictions and/or community-based organizations to support targeted efforts to re-engage HIV-infected minority clients in medical care and treatment.

- Vote to approve staff recommendation: 3-0

- **Augment** the allocation to the local health jurisdictions for ADAP enrollment by \$2 million (rebate fund) to be allocated according to the existing formula (the number of ADAP clients enrolled in the previous year).
 - Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)
- **Augment** OA’s budget by \$1 million (rebate fund) to support efforts to work with enrollment workers, provide technical assistance on improving the ADAP enrollment process, increase capacity due to the projected changes in the program, and develop quality metrics for the ADAP program.
 - Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)

2. Licensing and Certification Program (DOF ISSUE 201-MR)

- See below for votes.

Subcommittee Staff Comment and Recommendations. The following actions are recommended:

- **A. Approve the budget change proposals and make the 64 limited-term positions proposed under “L&C Workload” permanent.** The state makes a significant investment in the training of health facility evaluator nurses (HFENs) and acknowledges that it takes 12 to 14 months for HFEN to complete the training necessary to become proficient and work independently. Consequently, these positions would only be available to actively complete workload for one year, since these positions are authorized for only two years. Given that L&C’s problem is not just closing a backlog of complaints, but also timely investigation and completion of new complaints and surveys and monitoring for compliance with state health facility licensing requirements (which are generally more stringent than the federal requirements), these positions should be permanent. Once the backlog is addressed, these trained and skilled surveyors could be directed to address other workload activities that are not the focus of this Governor’s proposal.

- Vote to approve staff recommendation: 3-0

B. May Revision Proposal Regarding Los Angeles County Contract—Approve.

- Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)
- **Adopt placeholder trailer bill language to establish timeframes to complete complaint investigations at long-term care facilities.** Specifically, this placeholder language would specify that department would be required to:

- For A¹ and AA² complaints received on or after July 1, 2016, the department shall complete the investigation within 90 days of receipt. This time period may be extended up to an additional 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department shall notify the facility of this extension and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation shall 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 shall complete the investigation within 90 days of receipt. This time period may be extended up to an additional 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department shall notify the facility of this extension and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation shall 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.
 - Vote to approve staff recommendation: 3-0
-
- **Adopt placeholder trailer bill language requiring DPH to notify the facility and complainant if an investigation regarding hospital complaints is not completed in the required timeframe. This notification shall document the extenuating circumstances as to why the investigation has not been completed and provide notice to the parties on the basis for not meeting the timeframe and the anticipated completion date.**
 - Vote to approve staff recommendation: 3-0
 - **Increase funding (by \$1.4 million) to the Long Term Care (LTC) Ombudsman Program at the Department of Aging to facilitate an increase in skilled nursing facility (SNF) complaint investigations and quarterly visits by:**
 - **Directing \$1 million (one-time) from the State Health Facilities Citation Penalties Account to the LTC Ombudsman Program in 2015-16.**

¹ Class "AA" violations are violations that meet the criteria for a class "A" violation and that the state department determines to have been a direct proximate cause of death of a patient or resident of a long-term health care facility.

² Class "A" violations are violations which the state department determines present either (1) imminent danger that death or serious harm to the patients or residents of the long-term health care facility would result therefrom, or (2) substantial probability that death or serious physical harm to patients or residents of the long-term health care facility would result therefrom.

- **Increasing the licensing and certification fee for skilled nursing facilities to generate \$400,000 to support the LTC Ombudsman Program on an ongoing-basis.**
- Vote to approve staff recommendation: 3-0

3. Genetic Disease Screening Program Prenatal Screening Trailer Bill Language

- Vote to approve staff recommendation: 3-0

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt this proposed trailer bill language to facilitate GDSP’s collection of prenatal screening fees from private health plans.

4. California Clinical Laboratory Testing

- Held open.

4800 California Health Benefit Exchange

1. Emergency Regulations and Rulemaking Authority

- Held open.

Chair, Senator Holly J. Mitchell
Senator Jeff Stone, Pharm. D.
Senator William W. Monning



May 19, 2015
10:30 a.m.
John L. Burton Hearing Room 4203

PART A

Staff: Peggy Collins

4300 Department of Developmental Services (DDS)

PROPOSED VOTE ONLY

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PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the agenda unless otherwise directed by the Chair.

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OUTCOMES

**May 19, 2015
10:30 a.m.
John L. Burton Hearing Room 4203**

PART A

Staff: Peggy Collins

PROPOSED VOTE ONLY ISSUES

Developmental Centers

Issue 1: Foster Grandparent and Senior Companion Program Transfer from Developmental Centers Program to the Community Services Program – May Revision Adjustment

Staff recommendation: Approve May Revision.

Vote: 3-0

Issue 2: Lanterman Developmental Center Community State Staff Program – Issue 509-MR, 609-MR

Staff Recommendation: Approve May Revision.

Vote: 3-0

Issue 3: DC Population Staffing Adjustments - Issue 507-MR, 508 MR, 608-MR

Staff Recommendations: Approve May Revision.

Vote: 3-0

Issue 5: Sonoma Creek Pump Station Project – January Budget Proposal

Staff Recommendation: Reject the January proposal.

Vote: 3-0

Community Services

Issue 1: Sick Leave – Governor’s Proposal – Issues 515-MR, 616-MR

Staff Recommendation: Approve May Revision and proposed trailer bill language. Adopt LAO recommendation for supplemental report language to require DDS to provide the actual general fund costs for these proposals.

Vote: 3-0

Issue 2: Minimum Wage Increase – Issues 511-MR, 611-MR

Staff recommendation: Approve May Revision. Adopt LAO recommended supplemental report language.

Vote: 3-0

Issue 3: Early Start Program – Restoration of Eligibility Criteria; GF Backfill for Reduced Federal Grant – Issues 520-MR, 516-MR, 525-MR

Staff Recommendation: Approve May Revision.

Vote: 3-0

Issue 4: Behavioral Health Treatment – Issues 517-MR, 617-MR

Staff recommendation: Approve May Revision. The subcommittee took action yesterday in the Department of Health Care Services budget to modify the proposed provision language in order to ensure that the departments to provide more information about the transfer amount.

Vote: 3-0

PROPOSED DISCUSSION ISSUES

Proposed Developmental Center Closures

Issue 1: May Revision Overview

Staff Recommendation: Adopt the LAO recommendations as supplemental reporting language.

Vote: 3-0

Issue 2: Community Placement Plan (CPP) Funding – Headquarters –Issue 521-MR; BCP MR 1

Staff Recommendation: Approve May Revision.

Vote: 3-0

Issue 3: Additional Community Placement Plan (CPP) Funding for the Closure of Sonoma Developmental Center – Issues 519-MR, 619-MR

Staff Recommendation: Approve May Revision. Approve a technical correction to schedule \$46.7 million GF in the purchase-of-services budget and \$1.3 million in the regional center operations budget.

Vote: 3-0

Issue 4: Extension of Lanterman Developmental Center (LDC) Positions-Governor’s January Proposal

Staff Recommendation: Approve as budgeted.

Vote: 3-0

Issue 5: Developmental Center Closures: May Revision Trailer Bill Proposal

Staff Recommendation: Adopt proposed May Revision language, with additions described in staff comments, at placeholder trailer bill language.

Vote: 3-0

Issue 6: Enhanced Behavioral Supports Homes – May Revision Trailer Bill Proposal

Staff recommendation: Approve May Revision as placeholder trailer bill.

Vote: 3-0

Issue 7: Delayed Egress/Secured Perimeter Homes – May Revision Trailer Bill Proposal

Staff Recommendation: Adopt placeholder trailer bill language and direct subcommittee staff to work with the Administration, policy committee staff and advocates on additional language, as described in staff comments.

Vote: 2-0 (Stone not voting)

Issue 8: Statewide Self-Determination Program – Governor’s January Proposal and Legislative Proposal

Staff Recommendation: Approve the Administration’s proposed provisional language, modified to require notice to the Joint Legislative Budget Committee 30 days prior to the transfer of funds. Approve placeholder trailer bill language to require the Administration, upon approval

of the self-determination program waiver, to seek an amendment to the waiver to expand participant slots for up to 250 additional slots so that up to half of the total slots are reserved for persons moving to the community.

Vote: 3-0

DEVELOPMENTAL CENTERS

Issue 1: Expansion of Secured Treatment Program (STP) at Porterville Developmental Center (PDC) – Issue 503-MR

Staff Recommendation: Staff recommends the subcommittee approve half of the requested funding and positions for the budget year - \$9 million GF and 92.3 positions, as a placeholder amount; and direct subcommittee staff to work with the Administration, stakeholders and policy committee staff to make recommendations for the appropriate number of beds in the secure treatment program and transitional beds in the general treatment program, and other statutory changes that would reduce the demand on STP and transitional beds, including but not limited to alternative locations for the provision of IST services, improving the delivery of services in the STP and transitional beds, and other strategies for reducing placements and the length of stay in the STP and transitional beds.

Vote: 3-0

Issue 2: Sonoma Developmental Center Four Intermediate Care Facilities (ICF) Units - General Fund Backfill – Issues 505-MR, 605-MR

Staff Recommendation: Adopt placeholder budget bill language to require the department to provide the Joint Legislative Budget Committee, and the appropriate legislative budget and policy committees, within 5 days of receipt, a copy of any communication from CMS regarding federal Medicaid funding for the developmental center relative to the eligibility status of developmental center residents or certification status of any housing unit. This notice shall include the amount of federal Medicaid funding that must be repaid as a result of decertification. Approve supplemental report language that requires DDS to provide, within 90 days of a determination that federal funding will not be continued for ICF units in state developmental centers, a discussion of any PIP components that may be discontinued without risk to resident care or safety, in order to reduce the General Fund impact; and how the loss of federal funding will impact the crisis homes at Sonoma and Fairview developmental centers.

Vote: 2-1 (Stone voting no)

Issue 3: Staffing Adjustments for Acute Crisis Units – Issue 607-MR

Staff Recommendation: Approve May Revision. The previous action includes a requirement that DDS report to the Legislature regarding the potential discontinuation of federal funding.

Vote: 2-0 (Stone not voting)

Issue 4: Program Improvement Plans for Fairview and Porterville Developmental Centers – Issues 506-MR, 606-MR

Staff Recommendations: Approve May Revision. The previous action includes a requirement that DDS report to the Legislature regarding the potential discontinuation of federal funding.

Vote: 2-1 (Stone voting no)

Issue 5: Lanterman Developmental Center Land Transfer – Legislative Proposal

Staff Recommendations: Staff recommends that the subcommittee communicate to Senate Budget Subcommittee No. 4 that the transfer should require a minimum of 20 percent of any housing developed by the CSU or one of its affiliates, auxiliaries, or other party through transfer, lease or sale, shall be available and affordable to individuals with developmental disabilities served by a regional center pursuant to WIC 4500 et al.

Vote: 3-0

Issue 6: Fire Alarm System Upgrade at Porterville Developmental Center - Capital Outlay Project – January Budget Proposal

Staff Recommendation: Given the announced intent of the Administration to close the general treatment area of Porterville Developmental Center, staff recommends the subcommittee approve this request but limit the project to the Secure Treatment Program and the administration building.

Vote: 3-0

Issue 7: Deferred Maintenance Projects – January Budget Proposal

Staff Recommendation: Staff recommends the subcommittee make a recommendation to Senate Budget Subcommittee No. 4 and the Joint Legislative Budget Committee, that the boiler retrofit not be approved.

Vote: 3-0

Issue 4: Fairview Developmental Center – Shannon’s Mountain Development – May Revision Proposed Trailer Bill

Staff Recommendation: Approve May Revision, as modified, as placeholder language.

Vote: 3-0

COMMUNITY SERVICES

Issue 1: Current Year Deficiency and Budget Year Increase – May Revision – Issues 510 MR, 610-MR

Staff Recommendation: Approve May Revision, adjusted for any actions adopted elsewhere in the agenda. Request that DDS and LAO report back to the subcommittee next year on the issue of the federal matching funds estimate methodology.

Vote: 3-0

Issue 2: Continuation Costs for Residents Transitioning from a Developmental Center into the Community - Issues 512-MR, I612-MR

Staff Recommendation: Approve May Revision.

Vote: 3-0

Issue 3: General Fund Offset Due to Reduction in Revenues from the Program Development Fund (PDF) – Issue 513-MR

Staff Recommendation: Approve the May Revision. Ask DDS to report back at 2016 budget hearings on the status of its implementation of the State Auditor’s recommendations.

Vote: 3-0

Issue 4: Federal Overtime Changes – Issues 514-MR, 614-MR

Staff Recommendation: Adopt trailer bill language that, in the event the FLSA regulation is implemented in California, DDS shall work with legislative staff, providers and advocate organizations, and the Association of Regional Centers to establish and implement a strategy for monitoring the impact of the regulation on consumers and providers and present the findings of the monitoring during the 2016 budget subcommittee process.

Vote: 2-1 (Stone voting no)

Issue 5: Prior Years General Fund Shortfall – Issue 518-MR

Staff Recommendations: Approve May Revision.

Vote: 2-0 (Stone not voting)

Issue 6: Stability of Community-Based Services and Supports System - Legislative Proposal

Staff Recommendation: Hold open.

Issue 7: Disparities in Service Delivery – Legislative Proposal

Staff Recommendation: Adopt placeholder trailer bill language to accomplish the following:

- **Clarify that the written list of agreed upon services that is provided to consumers or families at the end of an IPP meeting, be provided in a language the consumer or family understands.**
- **Provide a deadline of 45 days, by which a copy of the IPP in the consumer or family member’s native language must be provided.**
- **Specify that consumers and family members be provided a list of services, including information about the appeal and complaint process, in their native language at the start of an IPP meeting.**
- **Require the Health and Human Services Agency to convene a workgroup to review existing data on service disparities and make recommendations to the Legislature on ways to reduce them.**
- **Require the department to include in regional center performance contracts, guidelines and measurements to reduce disparity in regional center POS expenditure.**

Vote: 3-0

SUBCOMMITTEE #3: Health & Human Services

Chair, Holly J. Mitchell
Senator Jeff Stone, Pharm.D.
Senator William W. Monning



May 19, 2015
10:30 AM
Room 4203, State Capitol

Part B

Consultant: Samantha Lui

ISSUES RECOMMENDED FOR VOTE-ONLY

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PLEASE NOTE. Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. 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. Thank you.

ISSUES RECOMMENDED FOR VOTE-ONLY

5160 Department of Rehabilitation

1. Increase Funding for Vocational Rehabilitation Program

(Issue 001)

May Revision. The Administration proposes to increase by \$155,000 the non-federal match of the 2014 Federal Workforce Innovation and Opportunity Act (WIOA) for the Vocational Rehabilitation program. Although previous versions of the WIOA did not require a state match, the 2014 WIOA does; this \$155,000 reflects a ten percent non-federal match.

Staff Recommendation. Approve as requested. No concerns have been raised.

5175 Department of Child Support Services

1. Enrollment Caseload Population Estimate for Local Assistance

(Issue 004)

May Revision. The Administration proposes to decrease the amount in the department's state operations funding by \$46,000, and to offset the reduction with a corresponding increase in federal funds by \$46,000 to reflect a projected increase in Federal Performance Basic Incentive Funds.

Background. There are federal incentives tied to a list of performance measures that apply to the process of establishing parentage, the collection of child support, the overall cost of collecting child support, the establishments of cases with support orders, and collection on arrears. Gains made in these areas have led to an increase in Federal Performance Basic Incentive funds.

Staff Recommendation. Approve as requested. No concerns have been raised.

5180 Department of Social Services - CalWORKs

1. CalWORKs General Fund Offset

(Issue 705)

May Revision. The Administration requests a decrease of \$43,724,000 General Fund to reflect an increase in Family Support Subaccount funds, associated with the redirection of 1991 health realignment funds for CalWORKs expenditures, thereby offsetting General Fund costs in the program.

Background. Pursuant to AB 85 (Budget Committee), Chapter 24, Statutes of 2013, county indigent health savings are redistributed to counties, via a redirection of 1991 health realignment funds, for CalWORKs expenditures, to offset General Fund costs in the program.

Staff Recommendation. Approve as requested. No concerns have been raised.

5180 Department of Social Services – Child Welfare Services**1. Interagency Child Abuse and Neglect Reporting (ICAN)**

January Budget. The Administration includes a \$4 million grant program to fund county welfare and probation departments' ICAN activities, for counties that choose to participate.

Staff Comment and Recommendation. Approve as proposed. The subcommittee considered this proposal on April 9, 2014. Subcommittee No. 4 on State Administration and General Government approved the Administration's proposal to suspend the ICAN mandate on May 7, 2015. According to the department and the Department of Finance, the amount of the grant is based on claims currently received by the State Controller's Office. Staff recommends that the department evaluate the appropriate level of funding needed for ICAN activities in the budget year and provide an update to the fiscal committees next year.

5180 Department of Social Services - Community Care Licensing**1. Next Phase Quality Enhancement**

January Budget. The January budget includes a budget change proposal and accompanying trailer bill language. Specifically, the Administration requests 136 permanent positions (eight position authority) to strengthen enforcement; 13 two-year limited-term positions to improve the timeliness of complaint investigations; nine positions to expand technical assistance and establish a Southern California training unit; and \$2.8 million for infrastructure costs (hardware/software, network, and telecommunication costs) for the budget year through 2019-20 and \$588,701 in ongoing costs. The Administration also requests a corresponding \$859,000 for FY 2016-17 through 2019-20 for the Office of Administrative Hearing (OAH) and other hearing-related costs, and \$397,000 in ongoing costs.

In addition, the Administration proposes to increase the frequency of inspections from the current level of at least once every five years, to once every three years for child care facilities; once every two years for children's residential facilities; and annual inspections for adult and senior care facilities.

Proposed trailer bill language seeks to implement provisions related to increased inspection frequency, as determined by facility type.

Staff Comment and Recommendation. Approve BCP as proposed; adopt placeholder trailer bill language. The subcommittee considered this issue during its April 30, 2015 hearing. Staff notes the Legislature's intent to receive information, on an ongoing basis, to monitor, the department's commitment to increase inspection frequency by facility type. The Legislature may also wish to express its desire to evaluate the appropriateness of the inspection frequency by facility type at next year's budget hearings, after considering the March 2016 State Plan deadline, which will outline how the state intends to comply with new federal Child Care Development Block Grant requirements.

2. Licensing Costs Related to Sonoma Developmental Center Closure

(Issue 726)

May Revision. The Administration proposes an increase of \$188,000 GF and one position to support initial licensing activities associated with the proposed closure of the Sonoma Developmental Center (SDC). It is anticipated that two additional positions will be needed, starting 2016-17. For more information about the proposed SDC closure, please see Agenda A of today's hearing.

Staff Comment and Recommendation. Approve request as proposed. Staff notes that a similar staffing request was approved for the Agnews closure.

ISSUES FOR DISCUSSION

4700 Department of Community Services and Development

1. BCP #2: Migrant & Seasonal Farmworkers Drought Assistance Program

May Revision. The Administration requests \$7.5 million General Fund in the budget year to provide emergency relief and support services to specified populations, including those who are low-income and migrant and seasonal farmworkers (MSFWs), within the state’s most drought impacted counties. Services could include rental and utility assistance, transportation, and basic necessities, including access to food resources. The \$7.5 million GF will augment existing federal Community Services Block Grant funding to support core funding for four local non-profit organizations.¹ Approximately 3,200 MSFWs and low-income individuals will be served, with an average benefit of \$2,000 per person.

Background. The federal Department of Health and Human Services provides funding for the Department of Community Services and Development (CSD) through the Community Services Block Grant (CSBG). CSD distributes CSBG funding to a network of local, CSBG-eligible entities, which are comprised of private, non-profit, and local government organizations. CSD provides core funding to four local non-profit organizations that administer programs serving farmworkers and other low-income populations.

In calendar year 2015, \$5.9 million CSBG funds were allocated to MSFW organizations. MSFW organizations serve all 58 counties in California. Services include: vocational education, remedial education, English language instruction, emergency food youth employment, health care acquisition, child care services, housing assistance, and energy payment assistance. Program services are determined by a mandatory biennial community needs assessment, which identifies local needs. Currently, MSFW organizations serve 24² of the most drought-affected counties, which are defined as those that have high unemployment; a high share of agricultural workers; and “exceptional” drought conditions, according to the U.S. Drought Monitor Classification System.

Justification. The current \$5.9 million federal CSBG grant is not sufficient to meet needs of MSFWs and low-income populations impacted by the drought. According to the department, “MSFWs’ persistent low wages and their dependence on seasonal work will cause immediate financial crisis with the loss of jobs.” CSD’s proposal includes the following implementation plan:

Timeframe	Activity
July to August 2015	<ul style="list-style-type: none"> • Receive funding • Develop program plan and service model with MSFW providers • Begin contract process
September 2015	Implement program
July to August 2016	<ul style="list-style-type: none"> • Final report • Program evaluation • Program closeout

¹ The four MSFW agencies are: California Human Development Corporation (Santa Rosa); Proteus, Inc.(Visalia); Central Valley Opportunity Center, Inc. (Winton); and the Center for Employment Training (San Jose).

² Amador, Butte, Colusa, Fresno, Glenn, Kern, Kings, Lake, Lassen, Madera, Monterey, San Benito, San Joaquin, Santa Cruz, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Tulare, Yolo, and Yuba counties.

Staff Comment and Recommendation. Hold open. Staff notes that the proposed implementation plan anticipates the program to close out by August 2016. However, effects of the drought may continue to impact California's economy beyond one year. In addition, a \$400,000 one-time surplus of CSBG state operations funding was re-directed in January 2015 for the four MSFW organizations; to date, all funds have been expended. Staff recommends holding the item open for further discussion.

Questions

1. CSD: Please provide an overview of the proposal.
2. CSD: Please present the implementation timeline. Does the department foresee the need to have the requested funding be available for longer than one year? Or does it anticipate full expenditure of the \$7.5 million GF within one budget year?
3. CSD: Does the department anticipate these services to also expand to the five new counties added to the list of counties that will receive drought food assistance boxes?
4. CSD: How often does the U.S. Drought Monitor Classification System update which counties experience "exceptional drought" conditions? Will the department re-allocate funding to include new counties that may have not been previously identified?

5180 Department of Social Services**1. BCP #86, TBL 610: Federal Immigration Assistance and Associated Impact**

(Issue 704, 724, 725)

The May Revision includes three components and revised caseload and funding estimated, related to the federal immigration assistance:

1. Funding for the department to contract with qualified legal services organizations to provide application assistance for specified persons;
2. Provisional budget bill language to extend the liquidation period for encumbered amounts; and,
3. Proposed trailer bill language to implement these provisions.

May Revision. The Administration requests \$5 million General Fund³ for the department to contract with qualified nonprofit legal services organizations to provide application assistance to persons residing in California who are eligible for, or to renew, Deferred Action for Childhood Arrivals (DACA) or Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) status. Legal services will include culturally and linguistically appropriate services provided by attorneys, paralegals, interpreters and other support staff for assistance in applying for DACA or DAPA status or renewal of that status with the United States Citizenship and Immigration Services.

In addition, the May Revision includes revised caseload estimates for several social services programs that may be impacted, as a result of the President's Immigration Accountability Executive Orders. The Administration provides that these estimates do not reflect an eligibility change for any of these programs; instead, the figures reflect an assumed increase in the take-up rate. Specifically, the May Revision reflects anticipated impacts to the following programs with a six-month phase-in:

- CalWORKs and CalFresh (Issue 704). As a result of DAPA eligible individuals seeking benefits for citizen children who currently are not receiving benefits, the CalWORKs and CalFresh caseload may increase from 8,800 to 12,152 children, and from 1,040 to 1,400 children, respectively, by the end of the budget year. The May Revision requests an increase in \$19.2 million GF for CalWORKs; Item 5180-141-0001 be increased by \$38,000 General Fund and Item 5180-141-0890 be increased by \$54,000 Federal Trust Fund to reflect increased benefit and administrative costs in the CalFresh program.
- Cash Assistance Payments for Immigrants (CAPI). The department estimates that the caseload will increase by 250 individuals, resulting in a \$1.4 million GF cost in the budget year.

³ Of the \$5 million GF, \$191,000 General Fund (GF) will fund the establishment of a Staff Services Manager I position and a Career Executive Assignment Level A position. This funding supplements the \$100,000 GF previously provided for state operations costs associated with the Unaccompanied Undocumented Minors (UUM) program. \$4,809,000 General Fund for DSS to provide grants for the provision of legal and application services to individuals eligible for deferred action under the President's November 2014 Executive Order on immigration.

- In-Home Supportive Services Residual caseload (Issue 704). The department estimates that the caseload will increase by 2,034 individuals. The Administration requests an additional \$13.9 million GF.

Trailer Bill. The May Revision includes trailer bill language that includes the following provisions:

1. Requires the department to contract with qualified nonprofit legal services organizations to provide application assistance to persons eligible to apply for, or renew, DACA or DAPA status based on the guidelines issued by the Department of Homeland Security.
2. Sets forth contract requirements for eligible nonprofit legal services organizations that provide application assistance for DACA or DAPA status or renewal of that status.
3. Authorizes the department to implement or interpret proposed law without taking any regulatory action.

Provisional Language to Budget Bill Item 5180-151-0001. Provisional language is also proposed to extend the liquidation period for encumbered amounts until June 30, 2021. The proposed language is as follows:

X. Funds appropriated in this item shall be available for legal and application services to individuals eligible for deferred action under the President's November 2014 Immigration Accountability Executive Order shall be available for liquidation until June 30, 2021.

Background. On June 15, 2012, the Secretary of Homeland Security announced that certain individuals, who came to the United States as children and met several guidelines, may request consideration of deferred action for a period of two years, subject to renewal. On November 20, 2014, President Obama issued executive orders that expanded the population eligible for DACA program, and to include new Deferred Action for Parents of Americans (DAPA).

- The Deferred Action for Parents for Americans and Lawful Permanent Residents (DAPA)⁴ authorizes undocumented immigrants, who have lived in the United States since 2010 and are parents of U.S. citizens and lawful permanent residents to apply for deferred action and employment authorization for a three year, renewable work permit. The program will be administered on a case-

⁴ To be considered for the DAPA program, a person must meet the following criteria:

- Have lived in the U.S. continuously since January 1, 2010, up to the present time;
- Have been physically present in the U.S. on November 20, 2014 and at the time of making a request for consideration of DAPA with USCIS;
- Had no lawful status on November 20, 2014;
- Had on November 20, 2014, a son or daughter, of any age or marital status, who is a U.S. citizen or lawful permanent resident; and,
- Have not been convicted of a felony, significant misdemeanor, or three or more misdemeanors; do not otherwise pose a threat to national security; and are not an enforcement priority for removal.

by-case basis for individuals that meet specific guidelines, including a thorough background check.

- Expansion of the Deferred Action for Childhood Arrivals (DACA)⁵ program for youth who came to the United States as children. The action expanded eligibility to undocumented immigrants who entered the country before 2010 (rather than 2007), eliminated a requirement that applicants be younger than 31 years old, and extended the duration of renewable work permits from two years to three years.

Currently, the U.S. Citizenship and Immigration Services (USCIS) is not accepting applications for the expanded DACA and the DAPA. A federal district court in Texas issued an order that temporarily blocks DAPA and the expanded DACA from being implemented. USCIS continues to accept renewal applications or initial applications from people who qualify under the initial DACA announcement in 2012.

The May Revision assumes the suspension will be lifted and the USCIS will be accepting applications for DACA and DAPA program in the near future. As such, the May Revision anticipates impacts to several social services programs beginning October 1, 2015.

Justification. The department provides the following justification for the position requests:

The 2014 Budget Act provided \$3 million GF for the implementation of the undocumented unaccompanied minors (UUM) program. This program provides legal services to UUMs with their immigration status in federal and state court proceedings, through 17 contracted non-profit legal services organizations. No position authority was provided for this program. The 2015-16 Governor's budget continues an annual \$3 million allocation for this program. Of the annual funding provided, \$100,000 is available for state operations costs, and although no position authority was established, 2014-15 funding largely was spent for staff overtime costs, mailings to UUMs released to sponsors, and associated program implementation costs.

LAO Comments and Recommendations. The LAO makes the following comments and recommendations related to federal immigration:

⁵ To be considered for the DACA program a person must meet the following criteria:

- Was under the age of 31 as of June 15, 2012;
- Have entered the U.S. before the age of 16;
- Have lived in the U.S. continuously since June 15, 2007;
- Born before June 15, 1981;
- Have been physically present in the U.S. on June 15, 2012, and at the time of making a request for consideration of deferred action with the United States Citizenship and Immigration Services (USCIS);
- Not have lawful status as of June 15, 2012;
- Be currently in school, have graduated or obtained a certificate of completion from high school, have obtained a general education development (GED) certificate, or is a honorably discharged veteran of the Coast Guard or Armed Forces of the U.S.; and,
- Have not been convicted of a felony, significant misdemeanor or three or more other misdemeanors, and do not otherwise pose a threat to national security or public safety.

- Significant Legal Uncertainty Creates Challenge in Estimating If and When President’s Executive Actions May Be Implemented. In response to the lawsuit filed by officials in 26 states who contend the President’s executive actions are an overreach of executive power, a federal district court judge issued an injunction preventing the actions from being implemented pending the result of the underlying litigation. The federal government subsequently appealed this injunction and on April 17, 2015, oral arguments were heard in the 5th Circuit Court of Appeals (hereafter referred to as the “5th Circuit”). The 5th Circuit has not yet issued a decision on the appeal. If the 5th Circuit lifts the injunction, then the federal government may proceed with implementing the President’s executive actions even though the underlying litigation still remains to be resolved. However, if the 5th Circuit does not lift the injunction, the President’s executive actions may be implemented no sooner than the time when the underlying litigation is resolved, which may not be before several years should appeals in the underlying litigation be made all the way to the United States Supreme Court.
- Eligible Individuals Would Also Have to Proactively Apply for State-Funded Programs. In addition to applying for deferred action status, individuals would need to take the additional step of applying for health and human services programs before receiving benefits from these programs. It is uncertain how many newly eligible individuals with DACA and DAPA status would apply for health and human services programs. However, there are reasons to suggest that enrollment could be low, such as government avoidance and language barriers.
- Estimated General Fund Expenditures Likely Overstated, particularly in CalWORKs. On the whole, we find the Administration’s estimated General Fund expenditures resulting from the potential implementation of the President’s executive actions are likely overstated for two main reasons: (1) enrollment phase-in will likely take longer than expected; and (2) it is difficult to predict the effect this has on CalWORKs and CalFresh enrollment. The LAO recommends reducing the Governor’s estimates. Specifically, the LAO recommends:
 - Reducing the DSS estimated costs (for IHSS, CAPI, CalWORKS, and CalFresh) to account for a twelve-month phase-in period rather than a six-month phase-in period. This will likely reduce the DSS costs by roughly 50 percent (\$17 million in General Fund savings).
 - Requiring DSS to provide the Legislature with an updated estimate of costs based on a twelve-month phase-in period.

Staff Comment. The Federal Immigration Assistance program for DAPA and DACA is structured nearly identically to the existing \$3 million GF program for unaccompanied undocumented minors, but targeted to a different population of eligible individuals. The Legislature may wish to consider the following in evaluating this proposal.

- Other legal services that assist immigrants. From 1998-2008, the Naturalization Services Program (NSP) within the Department of Community Services and Development (CSD) provided assistance to legal permanent residents in obtaining citizenship, subject to Budget Act funding. The Legislature appropriated funds to support the program, which were distributed through contracts with community-based organizations for services such as: outreach, intake,

referrals, citizenship application assistance, citizenship testing, interview preparation, and follow up activities. In the last several years of the NSP, through the 2007-08 fiscal year, CSD received a \$3 million General Fund appropriation, which supported contracts with 23 community based organizations around the state. In 2008, 9,743 clients were served, and 5,502 received certificates of naturalization. Over ten years, a total of 118,488 clients were served. Since 2008, the program has not been funded. The Legislature may wish to consider: (1) whether it is appropriate to re-authorize funding for CSD to provide legal services to assist in naturalization; (2) whether it should authorize the use of the \$5 million for contracts to include naturalization services under DSS; (3) if additional organizations, specified to certain qualifications, that provide assistance to immigrants should be authorized; and/or, (4) if there is another program structure that would otherwise provide additional services and supports to immigrants with naturalization.

- Coordination for programs aimed to assist immigrants. With the recent passage of federal and state actions, including the Department of Social Services’ UUM and the Department Housing and Community Development’s housing and support services for migrant farmworkers, the Legislature may wish to ask whether DSS will coordinate efforts to assist immigrants in navigating various programs and services offered by the state and federal governments, or to contemplate another structure that may be better equipped to coordinate resources and integration supports across various organizations.

Staff Recommendation. Hold open for further discussion and review.

Questions

1. DSS: Please briefly summarize the proposal and accompanying trailer bill language.
2. DSS: Does the department intend to coordinate services or information for immigrant populations, now that there a UUM and proposed Federal Immigration Assistance program?
3. DSS/DOF: Would legal service organizations be authorized to provide naturalization services? Why are naturalization services deemed to be ineligible for this funding?

2. May Revision Caseload and Estimates Update

(Issue 700, 701)

The May Revision proposes a net increase of \$176,635,000 (increases of \$218,155,000 General Fund, \$12,366,000 Children’s Health and Human Services Special Fund, \$7,777,000 reimbursements, \$532,000 Child Support Collections Recovery Fund, \$12,000 Emergency Food Assistance Program Fund, partially offset by a decrease of \$62,207,000 Federal Trust Fund) primarily resulting from updated caseload estimates since the Governor’s budget. Realigned programs are displayed for the purpose of federal fund adjustments and other technical adjustments. Caseload and workload changes since the Governor’s budget are displayed in the following table:

Program	Item	Change from Governor’s Budget
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Program	Item	Change from Governor's Budget
California Work Opportunity and Responsibility to Kids (CalWORKs)	5180-101-0001	\$88,034,000
	5180-101-0890	-\$162,005,000
	Reimbursements	-\$95,000
Kinship Guardianship Assistance Payment	5180-101-0001	-\$2,210,000
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	5180-111-0001	-\$22,776,000
In-Home Supportive Services (IHSS)	5180-111-0001	\$172,325,000
	5180-111-3156	\$12,366,000
	Reimbursements	-\$39,960,000
Other Assistance Payments	5180-101-0001	-\$1,416,000
	5180-101-0122	\$12,000
	5180-101-0890	\$671,000
County Administration and Automation Projects	5180-141-0001	-\$17,084,000
	5180-141-0890	-\$23,210,000
	Reimbursements	\$25,551,000
Community Care Licensing	5180-151-0001	\$1,264,000
	5180-151-0890	-\$27,000
Realigned Programs		
Adoption Assistance Program	5180-101-0890	\$61,000
	5180-151-0890	\$88,000
Foster Care	5180-101-0001	-\$17,000
	5180-101-0890	\$6,148,000
	5180-101-8004	\$532,000
	5180-141-0890	\$558,000
Child Welfare Services (CWS)	5180-151-0001	-\$2,981,000
	5180-151-0890	\$114,945,000
	Reimbursements	\$11,268,000
Title IV-E Waiver	5180-153-0001	\$3,016,000
	5180-153-0890	\$564,000
Adult Protective Services	Reimbursements	\$11,013,000

The updated caseload estimates for the largest programs are summarized below:

Program⁶	January estimate	May Revision
CalWORKs	533,335	525,189
SSI/SSP	1,310,977	1,307,789
IHSS	462,648	467,000

Additionally, the Administration notes the following local assistance adjustments:

- Local assistance expenditures for DSS are estimated to increase by a net amount of \$726,799,000. This is comprised of increases of \$238,202,000 General Fund, \$477,264,000 Federal Trust Fund, \$12,366,000 Children’s Health and Human Services Special Fund, \$532,000 Child Support Collections Recovery Fund, \$12,000 Emergency Food Assistance Program Fund, partially offset by a decrease of \$1,577,000 reimbursements.

LAO Comments. In response to the May Revision, the LAO makes the following comments:

- Estimated Total CalWORKs Spending in 2015-16 Is Down Slightly. Total projected spending in CalWORKs for the budget year is down by a net amount of \$31 million (total funds) relative to the January budget, reflecting various changes in estimated caseloads and about \$20 million in increased grant costs related to the potential implementation of the President’s executive action on immigration. For additional LAO comments on the President’s executive action, please refer to pages 11-12 of the agenda.
- Total CalWORKs Caseload Estimates Appear Reasonable. The May Revision estimate of total CalWORKs cases shows a declining trend, which is expected given the improvement in the labor market. Based on more recent actuals, the May Revision projects a slightly more rapid caseload decline than in January.
- Employment Services Caseload Estimate Likely Overstated. When the Administration’s January caseload estimates were prepared, actual employment services caseloads were increasing rapidly (from mid-2013 through mid-2014), and estimates assumed that these increases would continue through 2014-15 and into 2015-16. However, since July 2014, the employment services caseload has reversed direction and mostly declined. The Administration’s May Revision estimates continue to show a significant increase in the employment services caseload into 2015-16. However, more recent actuals made available since DSS prepared its May Revision estimate make it likely that the employment services caseload will be at least 1,600 cases lower than estimated in 2014-15 and 2015-16, resulting in revised estimated caseloads of 227,577 and 238,273 cases, respectively.

⁶ Total average caseload, by program

If the Legislature accepts the May estimates, the Legislature could (1) reduce the county single allocation by roughly \$8 million in 2015-16, freeing up General Fund resources for other purposes, or (2) leave the otherwise freed-up resources in the single allocation, which would allow counties to flexibly use the funds to provide incrementally better service for a smaller caseload.

- CalFresh Caseload Estimates Are Reasonable. The Governor's May Revision proposes \$692 million General Fund for CalFresh administrative costs, approximately \$29 million General Fund less than in the January budget. This is primarily because the Governor's May Revision estimates that the non-assistance CalFresh caseload will continue to increase, but at a slower rate than previously expected. Specifically, the May Revision assumes that the CalFresh caseload will increase by eight percent in 2015-16 over the prior year, to an average of 1,949,066 households per month. The LAO attributes slower caseload growth to the: (1) continual improvements in the labor market so that fewer households are eligible; and (2) the temporary increase in individuals applying for assistance because of outreach related to the Affordable Care Act is winding down.

Staff Comment and Recommendation. Hold open May Revision caseload estimate changes, subject to additional conforming changes made by other legislative actions.

Questions

1. DSS: Please provide an overview of the May Revision estimates.
2. DSS/LAO: Please explain the fluctuations in the employment services caseload estimates.
3. LAO: Are the estimates reasonable?

5180 Department of Social Services - CalWORKs**1. Temporary Assistance for Needy Families (TANF) Transfer to CA Student Aid Commission**

(Issue 703)

May Revision. The Administration requests an increase in the department's federal funding by \$533,646,000 Federal Trust Fund to reflect an increase in the amount of federal TANF block grant funds available to offset General Fund costs in the Cal Grant program administered by the California Student Aid Commission (CSAC). Of this amount, \$286,320,000 reflects a technical correction.

Background. The proposed Budget erroneously did not include the transfer amount assumed in the Governor's budget. The remaining increase of \$247,326,000 is primarily attributable to shifting of long-term sanctioned CalWORKs cases from the federal TANF program to a solely state-funded non-TANF maintenance-of-effort program (see Item 6980-101-0001, Issue 214-MR).

Staff Comment and Recommendation. Hold open. Staff recommends a conforming action to Subcommittee No. 1 on Education.

Question

1. DSS: Please provide a summary of the proposal.

2. TBL 611: Child Support Pass-Through for Long-Term Sanction Cases

May Revision. The Administration proposes trailer bill to shift Temporary Assistance for Needy Families (TANF) funds in FY 2014-15 to carry forward to the budget year. These TANF funds will be transferred to the Student Aid Commission in the budget year to offset GF. According to the Administration, this funding shift is cost neutral.

Background. Effective March 1, 2015, adults who have been in long-term sanction status (12 consecutive months or more) for not complying with Welfare-to-Work requirements, are receiving benefits and services with state General Fund that does not count towards the maintenance of effort. This fund shift is estimated to increase the state's Work Participation Rate by 0.93 percent in federal fiscal year 2015, and 1.59 percent ongoing.

Approximately 14,550 CalWORKs cases are in long-term sanction status. This proposal changes how child support is treated for these cases. Since funding for these cases is now switched to non-MOE GF, these cases will no longer assign their child support to the state, and the Department of Child Support Services will no longer be required to track these cases. If this child support income can be reasonably anticipated, it could be factored into recipients' grant calculations.

Budget Act 2014. Last year, SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, enacted a child support pass-through for safety-net and certain child-only cases. This language sought to resolve a conflict in federal and state laws by exempting Safety Net and Drug and Fleeing Felon child-only cases from assigning their child and spousal support rights to the state/county, cooperating with DCSS, and requiring these cases be referred to DCSS for child support enforcement/collection services. In

2013, when implementing the move-out of Safety Net and Drug/Fleeing Felon child-only cases out of the Temporary Assistance for Needy Families (TANF) program to exclude them from the federal TANF Program work participation requirement, DSS and the Department of Child Support Services (DCSS) discovered a conflict between federal law and California state law with regard to child support requirements. DCSS cited federal law that prohibited them from passing collected child support through to the state on behalf of non-TANF families, and instead, required that payments be made directly to the families. State law, on the other hand, required that all CalWORKs applicants and/or recipients assign support rights and cooperate with child support enforcement requirements, as a condition of eligibility, and requires counties to refer these families to the Local Child Support Agencies.

Staff Recommendation. Hold open for further discussion.

Question

1. DSS: Please provide an overview of the proposal and need for the language.

3. TBL 612: Previous Drug Felony Reporting Requirement

January Budget. The department estimates that approximately 400 persons with a prior felony drug conviction will be added to an existing CalFresh household, and approximately 1,100 households will become newly eligible for CalFresh. In addition, DSS estimates that around 3,900 CalWORKs child-only cases per month are anticipated to include an adult with a previous felony drug conviction that will become eligible for CalWORKs. The 2015-16 budget provides \$23.4 million (\$1 million General Fund) for this policy.

May Revision. The Administration proposes trailer bill language that deletes a mid-period reporting requirement that is no longer applicable. Existing law previously required a CalWORKs recipient to report a drug felony conviction, as specified, within ten days. This proposed trailer bill eliminates this requirement and makes the code consistent with current law.

Background. Senate Bill 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, expands eligibility for adults who were previously ineligible for benefits due to a prior felony drug conviction, effective April 1, 2015.

Staff Recommendation. Hold open. The subcommittee previously considered the January budget during its March 26, 2015 hearing. Staff notes that no concerns have been raised.

Question

1. DSS: Please provide a summary of the proposal and the need for trailer bill language.

4. TBL 613 and BBL: Housing Support Program and Extension of Liquidation Period
--

(Issue 706)

May Revision. The Administration proposes trailer bill language that contains the following provisions:

1. Requires the department to award funds, according to criteria developed by the department in consultation with the County Welfare Directors Association, to provide CalWORKs housing support to recipients who are experiencing homelessness or housing instability.
2. Authorizes counties to continue providing housing support under the CalWORKs Housing Support Program to a recipient who may no longer be income eligible for CalWORKs.
3. Other technical, non-substantive changes.

In addition, the Administration proposes budget bill language to extend the availability of funds appropriated in the 2014 Budget Act to allow counties to liquidate Housing Support Program expenditures that occurred in fiscal year 2014-15 but will be paid in 2015-16. The proposed language is below:

5180-492—Reappropriation, Department of Social Services. The balances of the appropriations provided in the following citations are reappropriated for expenditure pursuant to Provision 1 and shall be available for encumbrance or expenditure until June 30, 2016:

0001—General Fund

(1) Item 5180-101-0001, Budget Act of 2014 (Ch. 25, Stats. 2014)

Provisions:

1. Funds allocated to counties pursuant to Provision 10 of Item 5180-101-0001 for housing support for those families in receipt of CalWORKs but unexpended as of June 30, 2015, shall be reappropriated for encumbrance or expenditure for services provided by a county in fiscal year 2014-15 that are claimed by the county in fiscal year 2015-16.

Background. SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, established the CalWORKs Housing Support Program and provides \$20 million (\$12 million General Fund) to be awarded to 20 counties to provide evidence-based interventions to families receiving CalWORKs who are at risk for homeless or are homeless. Services could include landlord outreach, housing search and placement, legal services, and housing barrier assessment.

Justification. According to the Administration, “Because counties budget on a cash basis, expenditures are claimed against allocations in the year they are paid. As such, language is proposed to extend the liquidation period for 2014-15 expenditures until June 30, 2016.”

Staff Comment and Recommendation. Hold open for further consideration.

Question

1. DSS: Please summarize the proposal.
2. DSS/DOF: How much of last year’s HSP funds have been encumbered?

5. Welfare to Work 24-Month Clock

January Budget. The Governor's budget assumed \$6.4 million (\$500,00 General Fund) in associated savings for cases that will receive a grant reduction for not meeting the federal participation requirements after using 24 months of welfare-to-work (WTW) services. The March estimate projected 2,600 cases would experience a grant reduction by June 2016.

May Revision. The Administration estimates \$1 million (\$100,000) in savings for cases that will receive a grant reduction for not meeting federal requirements after 24 months of WTW services. The department also updates its estimate that after 24 months of WTW services and the conciliation process, approximately 1,500 cases will have the adult's portion of the grant removed by June 2016.

Background. SB 1041 (Budget and Fiscal Review Committee), Chapter 47, Statutes of 2012, created a differentiation between welfare-to-work participation rules that apply before expiration of a 24-month time limit. A county may provide extensions of up to six months, after a review at least every six months, of the more flexible rules for up to 20 percent of participants. Recognizing the significant program changes, AB 74 also established several early engagement strategies, such as subsidized employment, family stabilization, and online CalWORKs appraisal tool.

The first 24-months provide flexibility for CalWORKs clients to participate in activities, such as education and barrier-removal services. After 24-months, clients must participate in activities that satisfy federal work participation requirements. If clients do not meet the federal participation requirements following the 24-months of flexibility, then they may receive a grant reduction for the adult portion of the grant.

According to the department, although the 24-month clock was effective January 1, 2013, "it is assumed that the clock did not fully implement statewide until April 2013." The department projects that no clients will receive a grant reduction in the current year, but at least 9,000 cases may experience a grant reduction by June 2017.

Staff Recommendation. Informational; no action needed at this time. For additional information on the subcommittee's oversight of welfare-to-work requirements, SB 1041, and the implementation of early engagement strategies, please see the March 10, 2015, and March 26, 2015 hearing agendas.

Question

1. DSS: Please present the updated estimate, compared to the January budget and the March 10 estimates, regarding the number of recipients anticipated to reach the 24-month clock and who could potentially receive a grant reduction.

5180 Department of Social Services – Child Welfare Services**1. Case Record Reviews**

(Issue 720)

May Revision. The Administration requests Item 5180-151-0001 be increased by \$2,346,000 General Fund; Item 5180-151-0890 be increased by \$2,472,000 Federal Trust Fund; and Item 5180-153-0001 be increased by \$614,000 General Fund to provide additional funding to counties for the preparation and completion of upcoming federal child welfare case reviews. The May Revision projects 155 full-time equivalents in the budget year, with an annual statewide cost of \$129,074 per social worker full-time equivalent. The May Revision estimates approximately 125,339 child welfare and probation cases in case review.

In addition, the May Revision outlines the number of full time equivalents that will be funded by county, depending on the number of cases to be reviewed.

No. of cases in a county	No. of Full-time equivalents (FTE)t funded
0-100	1 FTE
101-500	2 FTE
500-1,500	3 FTE
1,500	4 FTE

Background. The federal Administration on Children and Families memo 12-07⁷ provides states title with information to establish and maintain Continuous Quality Improvement (CQI) systems and to provide information on claiming allowable federal financial participation costs for CQI. Funds are needed to comply with federal requirements for a state CQI and for conducting ongoing case reviews to measure the quality of casework provided by county welfare departments.

Similar to the federal CFRS process, the new CWS case record review includes online processes and interviews with children, parents, social workers, foster parents, and service providers. Each county welfare department and county probation department performs reviews on an ongoing basis – at least monthly for child welfare, and at least quarterly for probation.

Justification. After counties started implementing caseworker reviews, the department determined that the funding level included in the Governor’s budget [\$10.3 million total funds (\$3.6 million GF)] is insufficient to complete all of the federally-required activities. Additional resources will assist in the state’s and counties’ efforts to achieve and maintain the necessary level of quality assurance and compliance with federal requirements under Titles IV-B and IV-E.

Staff Comment and Recommendation. Hold open for further consideration.

Question

1. DSS: Please provide an overview of the federal requirement for a state CQI. How will this proposal help the state meet federal requirements?

⁷ <https://www.acf.hhs.gov/sites/default/files/cb/im1207.pdf>

2. Child Welfare Training Program

(Issue 721)

January Budget. The January budget includes \$26 million (\$10.8 million GF) to provide a statewide coordinated training program to meet the needs of county social workers assigned to emergency response, family maintenance, family reunification, permanent placement, and adoption responsibilities.

May Revision. The May Revision requests that Item 5180-151-0001 be increased by \$474,000 General Fund and Item 5180-151-0890 be increased by \$1,828,000 Federal Trust Fund to fund general cost increases associated with the provision of child welfare training for social workers.

Background. The Child Welfare Training Program includes training for public agencies, including county probation departments, who provide child welfare case management services. The training includes crisis intervention, investigative techniques, rules of evidence, indicators of abuse and neglect, assessment criteria, intervention strategies, family-based services, legal requirements of child protection, indicators of mental health needs, case management, and the use of community resources.

The May Revision reflects a \$2.3 million (\$474,000 GF) increase to cover the cost of a ten percent indirect cost rate for UC San Diego, Fresno State University, and UC Berkeley to continue providing the training.

Justification. According to the department, “If the partnership with the universities ends precipitously, it will have negative consequences for the state related to federal compliance. Should the increase not be approved, DSS will have to reduce current contract deliverables to the counties to cover these additional expenses.”

Staff Comment and Recommendation. Hold open.

Questions

1. DSS: Please briefly summarize the proposal.
2. DSS: What types of “indirect costs” incurred by the university does this proposal seek to cover?

3. Strengthening Families Act

(Issue 722)

May Revision. The Administration requests an increase of \$1,350,000 General Fund to Item 5180-151-0890; an increase of \$1,422,000 in Federal Trust Fund; and, Item 5180-153-0001 to be increased by \$1,333,000 General Fund to support newly identified requirements and components necessary to ensure compliance with the federal Preventing Sex Trafficking and Strengthening Families Act of 2014.

Background. Three of the top ten highest trafficking areas in the nation are in California: San Francisco, Los Angeles, and San Diego. Last year, the budget included \$14 million to enable county child welfare agencies to serve victims of commercial sexual exploitation (CSE) through prevention and intervention strategies, and direct services (e.g., safe shelter, enhanced supervision, protection). New

federal requirements include notification to relatives upon removal of a foster child from placement, data collection on pregnant minors and non-minor dependents, credit report checks for foster youth ages 14 and 15, increased documentation for youth in certain planned permanent living arrangements, and new policies, procedures, and protocols for missing youth, runaways, and children at risk of commercial or sexual exploitation.

Budget Act 2014. SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, established the county opt-in CSEC program and appropriated \$5 million General Fund for:

- Training foster youth and other youth on how to recognize and avoid being exploited (\$750,000);
- Statewide training for county social workers, probation officers, out-of-home caregivers, and group home staff (\$1.75 million); and,
- Protocol development and capacity building (\$2.5 million).

Funds have been provided via several contracts to train social workers; and a new agreement is under development with the Community College Chancellor's Office to provide training to caregivers through the community colleges. In addition, the federal Preventing and Addressing Child Trafficking (PACT) grant provides \$1.25 million over five years for consultation and training support to ten counties for developing multi-disciplinary teams.

Related Budget Issue for Commercial Sexual Exploitation of Children. The Governor's budget includes \$17.8 million (\$14 million GF) for: development and implementation of case management and services, employing local multidisciplinary teams including mandated partner service providers, such as law enforcement, mental health, probation, and others.

Advocate concerns. The County Welfare Directors Association (CWDA) is opposed to the Administration's proposal that "diverts \$3.25 million of the \$14 million General Fund intended for services to victims of child sex trafficking in the budget to meet new federal mandates under P.L. 113-183, Strengthening Families Act." CWDA request that the funds, separate from, and in addition to, the existing \$14 million GF, for the new federally required CSEC activities be moved back in the Strengthening Families budget items (\$3.25 million SGF), or that new funding be added to the CSEC premise on top of the \$14 million GF. CWDA would like to ensure that proposed funds are sufficient for counties to meet the new federal mandates in 2015-16.

Staff Comment and Recommendation. Hold open. At an April 9, 2015 hearing, the subcommittee conducted oversight on the Commercial Sexual Exploitation of Children program; at which time, the department noted the likelihood of a May Revision request, stating "Work continues to define the requirements that overlap between the state CSEC program and federal HR 4980 legislation. This will ensure a consistent program and federal reimbursement for eligible activities."

Staff notes ongoing conversations between legislative staff, counties representatives, and the department to ensure that the budget request approved last year is better understood within the context of new federal requirements.

Questions

1. DSS: Please provide a summary of the proposal, including a walk-through of the new federal requirements.
2. DSS: How does this May Revision amend the \$14 million that was allocated through the Budget Act last year?
3. DSS: The new federal law contains new mandates that implement in the budget year and other requirements that implement FY 2016-17. What type of activities will the \$3.25 million fund?

4. Performance Data on Psychotropic Medication for Children in Foster Care

(Issue 723)

May Revision. The Administration proposes \$149,000 (\$100,00 GF)⁸ for the department to contract with the University of California, Berkeley, for the purpose of matching Medi-Cal pharmacy claims data collected by the Department of Health Care Services (DHCS) with foster care data at regular intervals. This data matching effort will improve DSS' ability to identify and monitor psychotropic drug use in the foster care system. In addition, this control will allow for data analysis, including case specific information that can be shared with counties.

Background. Federal law requires that a state's health care oversight plan includes an outline of protocols for the appropriate use and monitoring of psychotropic medications. To meet the federal requirements (Public Law 112-34), DSS and DHCS have conducted cross-system data matching to inform policy decisions for effective oversight and monitoring. Currently, both departments do not have the capacity to produce data required by federal regulations.

Staff Comment and Recommendation. Hold open for further consideration. For additional information regarding psychotropic medication,

Questions

1. DSS: Please summarize the proposal.
2. DSS/DHCS: What types of analysis can UC Berkeley conduct that the two departments are not able to?
3. DSS: How frequent are "regular intervals" for data matching? Monthly? Quarterly?
4. DSS: If this proposal is approved, what is the earliest date for when the Legislature can expect to see performance data from UC Berkeley?

⁸ An increase of \$100,000 in Item 5180-151-0001, and an increase in \$49,000 Federal Trust Fund.

5. Extension of Liquidation Period for Unaccompanied Minors Funding

(Issue 724)

May Revision. The Administration proposes budget bill language to extend the liquidation period for encumbered amounts in 2014-15 to June 30, 2012, for the provision of legal services provided to unaccompanied undocumented minors. The proposed language is as follows:

Addition of Budget Bill Item 5180-493:

5180-493—Reappropriation, Department of Social Services. Notwithstanding any other provision of law, the period to liquidate encumbrances appropriated for services to unaccompanied undocumented minors in the following citations are extended to June 30, 2021:

0001-General Fund

(1) Item 5180-151-0001, Program 25.35-Special Programs, Budget Act of 2014 (Ch. 25, Stats. 2014)

Background. As of March 2014, the federal government indicated that 5,831 UUMs were released to California sponsors prior to October 2014, and 1,120 since that date.⁹ Senate Bill 873 (Budget and Fiscal Review), Chapter 685, Statutes of 2014, recognized this humanitarian crisis and authorized the department to contract with qualified nonprofit legal service organizations to provide legal services to Unaccompanied Undocumented Minors (UUMs). An UUM is eligible to receive state-funded legal services if s/he is in California, either in the physical custody of the federal Office of Refugee Resettlement (ORR) or residing with a family member or sponsor.

The 2014 Budget Act provides \$2.9 million General Fund for these legal services. Funds only may be expended for new client representation agreements signed after execution of each contract with a legal services organization. 17 contracts were awarded to qualified legal service providers throughout California in early December 2014. As of April 2, 2015, the department has received 24 invoices; totaling 201 clients. The immigration cases of the clients represented to-date include Asylees (107), T-Visa (1), U-Visa (21) and Special Immigrant Juveniles (72).

Justification. Qualified nonprofit organizations only receive 50 percent of awarded funding up front and the remaining 50 percent is paid when the minor's case is closed. According to the department, closing a case could take several years.

Staff Comment and Recommendation. Approve; adopt placeholder budget bill language, as no concerns have been raised.

Question

1. DSS: Please briefly summarize the need for the budget bill language.

⁹ This data periodically is updated, available here: <http://www.acf.hhs.gov/programs/orr/programs/ucs/state-bystate-uc-placed-sponsors>

6. TBL 609: Intensive Treatment Foster Care (ITFC) Rate Extension

May Revision. The Administration proposes trailer bill language that includes the following provisions:

1. Extends, from June 30, 2015 to December 31, 2016, the applicable interim period for specified modified serve and rate levels, which support modified in-home support counselor hours per month, apply.
2. Extends, from June 30, 2015 to December 31, 2016, the interim period for which specified modified serve and rate levels, that support the modified standard rate schedule, apply.
3. Requires the rate for the modified standard rate be adjusted for the California Necessities Index on July 1, 2015, and on July 1, 2016.

Background. ITFC offers an alternative, family-like setting for foster children who would otherwise be placed in group homes at a higher cost.. SB 1380 (Steinberg), Chapter 486, Statutes of 2008, expanded the number of children eligible for the ITFC program by including youth with serious behavioral problems who would otherwise require placement into group homes Rate Classification Level (RCL) 9 through 11. SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, authorized the Continuum of Care Reform (CCR) effort to develop recommendations related to the state's current rate setting system, and to services and programs that serve children and families in the continuum of Aid to Families with Dependent Children-Foster Care (AFDC-FC) eligible placement settings. In particular, the Legislature expressed its intent for recommended reforms, including reforms related to the use of group homes, changes to the rate systems, and changes to the assessment of children's needs, and to outcome measurement, to promote positive outcomes for children and families.

SB 1013 also provided for an interim increase in rates, including a California Necessities Index increase, intended to ensure providers keep pace with the costs of providing care, recruitment, and retaining qualified foster caregivers for children needing intensive treatment in a home-based setting. The ITFC placement addresses the needs of the *Katie A.* subclass population, pending development of the therapeutic foster home and implementation of the continuum of care for foster children.

Related Budget Issue: Continuum of Care Reform. The budget includes \$9.6 million (\$7 million General Fund) to fund two of the 19 recommendations outlined in the Continuum of Care Reform Report: increase foster parent recruitment, retention, and training efforts (\$3.8 million [\$2.8 million GF]); and increase foster family agency social worker rates (\$5.8 million [\$4.2 million GF]) by fifteen percent.

On January 9, 2015, DSS released the report¹⁰ concurrently with the release of the Governor's budget. The report provided 19 recommendations with the expressed goal to:

Reduce reliance on group homes as a long-term placement setting by narrowly defining the purpose of group care, and by increasing the capacity of home-based family care to better address the individual needs of all children, youth, and caregivers.

¹⁰ Please see http://www.cdss.ca.gov/cdssweb/entres/pdf/CCR_LegislativeReport.pdf for the full legislative report and list of recommendations.

According to the department, the recommendations “represent a paradigm shift from traditional group homes as a long-term placement to Short-Term Residential Treatment Centers (STRTC) as an intervention.” The list of 19 recommendations seeks to improvement assessment of child and families to make more appropriate initial placement decisions; emphasize home-based family care; support placement with available services; change the goals for group home care placement; and, increase transparency for child outcomes. Some of the recommendations include:

- Accreditation. Require STRTCs and Foster Family Agencies to be accredited by a national body, as a condition of receiving a foster care rate.
- Foster Family Agencies (FFA). Allow public agencies to be licensed to operate an FFA. Strengthen resource family recruitment (such as relative caregivers and foster and adoptive families), training, and retention strategies.
- Short-Term Residential Treatment Centers (STRTCs). STRTC programs will provide services and support for children and youth who need short-term, intensive treatment. Placements must be reviewed at six-month intervals or less.
- Rate structures. Replace the group home Rate Classification Level system with a statewide residential rate for all STRTCs. Revise the FFA rate structure to account for two types of FFAs – those that provide core services, and those that function as home-finding agencies.
- Residential treatment. Phase-out county-operated children’s shelters. Educationally-based boarding schools for foster youth must adapt and align their programs to meet CCR goals.
- Performance and outcomes. Use a client satisfaction survey to capture children and their families’ perceptions regarding services received from STRTC and FFA treatment providers. Develop a method to increase transparency of a provider’s performance.

Justification for the May Revision proposal. The ITFC’s rate is due to sunset June 30, 2015. ITFC’s will be an integral part of the overall continuum of care reform anticipated to begin implementation January 1, 2017. In order to ensure continuity of care, it is imperative that there be an extension of the ITFC rate. According to the department, “This proposal extends the interim increase to the ITFC foster care rates based on the original recommendations of the ITFC workgroup which was established as a result of SB 1380. The County Welfare Directors Association and the Children and Family Services Alliance support extending the interim increase for this much needed placement model. Retaining the increase and the cost of living adjustments to the rate will ensure that the providers will continue to provide a valuable level of care that will maintain the placements and not force the children to be displaced and/or moved to group home care.”

Staff Comment and Recommendation. Hold open for further consideration.

Question

1. DSS: Please summarize the proposal, including how this ITFC rate extension fits into the timing of the continuum of care reform.

5180 Department of Social Services In-Home Supportive Services**1. Implementation of Federal Overtime Regulations for 2015-16**

(Issue 710, 711)

May Revision. It is requested that Item 5180-111-0001 be increased by \$18,260,000 General Fund and reimbursements be decreased by \$9,354,000 to reflect updated IHSS caseload-related increases and a shift of one-time administrative costs from 2014-15 to 2015-16 due to the delayed implementation of Fair Labor Standards Act (FLSA) regulations. These adjustments reflect an overall increase in budget year funding for FLSA implementation, as updated for caseload and a shift in one-time administrative costs from current year to budget year.

Background. Due to increases in caseload, hours per case, and costs per hour, the May Revision increases funding for the program by \$147.6 million General Fund in current year and \$179.1 million General Fund in budget year.

In addition, the May Revision proposes to use one-time, unspent \$184 million General Fund – the amount included in the current year for implementation of the Fair Labor Standards Act – to offset increasing IHSS costs. The remainder of the unspent FLSA-related funding appropriated in 2014-15 will be used to partially offset the overall increase in IHSS costs since the Governor’s budget.

Staff Comment and Recommendation. Hold open for further discussion.

Question

1. DSS: Please briefly summarize the proposal.

2. Increase General Fund Loan Authority for the IHSS Program

(Issue 714)

May Revision. It is requested that Provision 2 of Item 5180-111-0001 be amended to increase loan authority from \$385 million to \$650 million to alleviate cash flow complications resulting from delayed reimbursement of federal funds from the Department of Health Care Services (DHCS).

Staff Comment and Recommendation. Hold open for further discussion. Staff notes the that there is a typical delay in receiving federal reimbursement for costs associated with the Coordinate Care Initiative and the enhanced federal funding for Community First Choice Option (CFCO). As a result, the department, often, makes payments to IHSS providers but may run low on cash flow towards the end of the budget year. This proposal anticipates this delay in federal reimbursements for CCI and seeks to ensure that DSS have the funding available until federal reimbursements arrive.

Question

1. DSS: Please briefly summarize the proposal.

SUBCOMMITTEE #3: Health & Human Services

Chair, Holly J. Mitchell
Senator Jeff Stone, Pharm.D.
Senator William W. Monning



May 19, 2015
10:30 AM
Room 4203, State Capitol

Part B

OUTCOMES IN RED

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ISSUES FOR DISCUSSION

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5180 Department of Social Services

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Senate Budget and Fiscal Review – Mark Leno, Chair
SUBCOMMITTEE #3 on
Health & Human Services

Chair, Senator Holly J. Mitchell

Senator William W. Monning
Senator Jeff Stone, Pharm. D.



May 21, 2015

10:00 a.m.

Room 4203, State Capitol

Agenda
Part A
(Michelle Baass)

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PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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. Thank you.

VOTE ONLY

Multiple Departments

1. Health-Related General Fund Investments

As discussed at the March 19th and May 7th Subcommittee hearings, the Subcommittee has received multiple requests for General Fund augmentations for health-related programs.

Subcommittee Staff Recommendation—Approve. Given the state’s fiscal situation and the Senate’s desire to help lift more people out of poverty, it is recommended to approve the following General Fund augmentations and to adopt placeholder trailer bill language to effectuate these proposals:

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
1. Medi-Cal: Restore Full Adult Dental Benefits	The 2009 budget eliminated several Medicaid optional benefits from the Medi-Cal program. The 2013-14 budget partially restored adult dental benefits. It is proposed to fully restore these benefits effective October 1, 2015.	\$67.5 million
2. Medi-Cal: Expand to Cover Remaining Uninsured Regardless of Immigration Status	Provide Medi-Cal coverage to undocumented immigrants.	\$40 million
3. Medi-Cal: Eliminate AB 97 Reductions for Dental Providers	Given the growing concerns of access to dental services in Medi-Cal, it is recommended to eliminate the AB 97 payment reduction for dental providers.	\$30 million

<p>4. Medi-Cal: Restore Optional Benefits</p>	<p>The 2009 budget eliminated several Medicaid optional benefits from the Medi-Cal program. These benefits were eliminated for budgetary, not policy, reasons in response to the fiscal crisis. The following benefits are proposed to be restored:</p> <ul style="list-style-type: none"> • Acupuncture • Audiology • Incontinence Cream and Washes • Optician / Optical Lab • Podiatry • Speech Therapy <p>Chiropractic services are not proposed to be restored.</p>	<p>\$15.1 million</p>
<p>5. Public Health: Hepatitis C and HIV Prevention</p>	<p>In effort to prevent Hepatitis C (HCV) and HIV, funding for the following proposals is recommended:</p> <ul style="list-style-type: none"> • State Syringe Exchange Program (\$3 million) • HCV Rapid Testing Kits (\$600,000) • HCV Linkage & Retention in Care Demonstration Projects (\$2.2 million) • Pre-Exposure Prophylaxis (PrEP) Access & Affordability Program (\$2.2 million) 	<p>\$8 million</p>
<p>6. Medi-Cal: AB 97 Payment Claw back for Distinct-Part Nursing Facilities</p>	<p>Provide one-time funding to exempt one-half of the collection of AB 97 retroactive recoupments for Distinct-Part Nursing Facilities in the budget year. Budget year recoupment amount is \$13.9 million General Fund and total retroactive recoupment from these facilities is \$114 million General Fund.</p>	<p>\$7 million (one-time)</p>
<p>7. Medi-Cal: Dental Anesthesia Rate</p>	<p>Increase the dental anesthesia rate to provide rate parity between general anesthesia and dental anesthesia providers. (The cost of equalizing facility fees and anesthesia to medical rate.)</p>	<p>\$4.3 million</p>
<p>8. Robert F. Kennedy Health Plan</p>	<p>In order to ensure the continuation of the United Farmworkers Union's Robert F. Kennedy Health Plan, it is proposed to provide one-time \$2.5 million to this plan to purchase stop-loss coverage insurance.</p>	<p>\$2.5 million (one-time)</p>

4260 Department of Health Care Services

1. Medi-Cal: Impact of President's Executive Order (DOF ISSUE 521-MR)

Budget Issue. The May Revision includes \$33.1 million (\$27.8 million General Fund) to reflect the costs of providing Medi-Cal to newly qualified individuals as a result of the President's Executive Order on immigration. However, this number has been revised by the Administration and the estimated cost for this proposal is \$41.5 million (\$33.2 million General Fund) in 2015-16 and \$206 million (\$165.2 million General Fund) on an ongoing basis. These numbers were revised to include dental and managed care carve-outs in the per member per month rate (revised from \$242.09 to \$274.54).

This issue was heard at the May 18^h Subcommittee hearing.

Subcommittee Staff Comment and Recommendation—Approve. As the LAO noted at the Subcommittee hearing, there are significant uncertainties with regard to when and if the President's actions may be implemented, how many eligible individuals will enroll in this immigration program, and then the number of these individuals who would proactively enroll into Medi-Cal. For this reason, it is recommended to approve the Administration's estimate.

2. Medi-Cal: Skilled Nursing Facility Quality Assurance Fee Extension

Budget Issue. DHCS requests trailer bill language (TBL) to:

- a. Extend the sunset date for the skilled nursing facility rate-setting methodology established under AB 1629 (Frommer), Chapter 875, Statutes of 2004, as well as the Quality Assurance Fee (QAF) and Quality/Accountability Supplemental Payment (QASP) programs, from July 31, 2015, to July 31, 2020.
- b. Specify that beginning 2015-16, the annual increase in the weighted average Medi-Cal reimbursement rate for skilled nursing facilities would be 3.62 percent. (The rate increase for 2013-14 and 2014-15 was three percent.)
- c. Set Quality Accountability Supplemental Payment Program (QASP) payments at the same level as existed for 2014-15 (approximately \$90 million per year).
- d. Extends the DHCS Administrative Procedure Act (APA) exemption through July 31, 2020, and the California Department of Public Health (CDPH) Public Contract Code exemption through December 31, 2020.

This issue was heard at the April 23rd Subcommittee hearing.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt the above placeholder trailer bill language and to add provisions to require

DHCS to (1) include direct care staff retention in the QASP and (2) require DHCS to report to the Legislature on the QASP, including if the level of QASP payments are adequate to sustain the program.

3. Medi-Cal: Financial Audits Workload

Budget Issue. DHCS requests 21 positions (nine permanent and 12.0 two-year limited term) and expenditure authority of \$3,094,000 (\$844,000 General Fund, \$1,544,000 federal funds and \$706,000 reimbursements) to address new audit workload associated with Intermediate Care Facilities for the Developmentally Disabled Nursing/Habilitative (ICF-DDN/H) and AB 959 (Frommer), Chapter 162, Statutes of 2006, public clinics.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

4. Medi-Cal: Allied Dental Professionals Enrollment

Budget Issue. DHCS proposes to include allied dental professions employed by a public health program (registered dental hygienists, registered dental hygienists in extended functions, and registered dental hygienists in alternative practice) in the Medi-Cal dental services program. A State Plan Amendment is under development to implement this change.

The May Revision assumes annual costs of \$1.6 million (\$761,850 General Fund) for the increase in dental services as a result of these professionals providing services.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Approve.

5. Medi-Cal: Ground Emergency Medical Transportation - Trailer Bill Language

Budget Issue. The May Revision proposes trailer bill language (TBL) to modify the existing ground emergency medical transportation (GEMT) Supplemental Reimbursement Program in order to maximize federal financial participation for public GEMT provider's services, subject to federal approval. This new mechanism would have no impact to the General Fund.

This issue was heard at the May 18^h Subcommittee hearing.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language.

6. Medi-Cal: Eliminate Cost-of-Living Adjustment for County Eligibility Administration

Budget Issue. DHCS proposes trailer bill language to suspend the county administration cost-of-living adjustment (COLA) on a permanent basis.

This issue was heard at the March 19th Subcommittee hearing.

Subcommittee Staff Recommendation—Modify Trailer Bill Language. It is recommended to modify the proposed placeholder trailer bill language by suspending the county COLA for the budget year only and not on a permanent basis. The May Revision proposes increased funding for county eligibility administration.

7. Medi-Cal: County Administration Augmentation (DOF ISSUE 515-MR)

Budget Issue. The May Revision proposes to increase Medi-Cal county administration funding by \$150 million (\$48.8 million General Fund) due to ongoing implementation issues related to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) information technology system built to implement the federal Affordable Care Act (ACA). This augmentation would fund county administration at the current year level for ACA-related workload at \$390 million (\$195 million General Fund).

This issue was heard at the May 18th Subcommittee hearing.

Subcommittee Staff Comment and Recommendation. Since Monday’s hearing, the Administration and counties have worked to identify alternative funding sources for this workload. It is estimated that current year CalFresh caseload will be lower than anticipated and it is proposed to reappropriate this unused funding (for current year caseload) to Medi-Cal county administration in the budget year. This would provide a \$95.3 million increase for this county administration workload, including \$31 million General Fund that would be reappropriated and would be used to draw down approximately \$64.3 million in federal funds. To implement this, it is recommended to adopt the following placeholder budget bill language:

Reappropriation Item in 5180

5180-XXX – Reappropriation, Department of Social Services. Notwithstanding any other provision of law, \$31,000,000 from the General Fund for the appropriations provided in the following citations are reappropriated for expenditure pursuant to Provision 1 and are available for encumbrance or expenditure or transfer until June 30, 2016.

0001–General Fund

(1) Item 5180-141-0001, Budget Act of 2014 (Chs. 25 and 663, Stats. 2014)

Provisions:

1. For the 2015-16 fiscal year only, \$31,000,000 from the General Fund shall be reappropriated to provide funds for counties to implement the county administration efforts necessary to

implement the federal Patient Protection and Affordable Care Act P.P. 111-148). These funds shall be transferred to Schedule (1) of Item 4260-101-0001 for the purpose noted above.

Provisional Language for Item 4260-101-0001

X. For the 2015-16 fiscal year only, notwithstanding any other provision of law, pursuant to Provision 1 of Item 5810-XXX, \$31,000,000 from the General Fund in Schedule (1) of this item is available for the purpose of funding county administration efforts to support the federal Patient Protection and Affordable Care Act (P.L. 111-148).

8. CCI: Multipurpose Senior Services Program Transition Timeline

Budget Issue. Current statute authorizing the Coordinated Care Initiative (CCI) states that the Multipurpose Senior Services Program (MSSP) will transition from a federal waiver to a managed care benefit after 19 months of MSSP beneficiary enrollment into managed care. This proposal will extend the transition deadline to December 31, 2017, but would allow an earlier transition in a county or region when the MSSP sites and managed care plans mutually agree they are ready to transition and want to transition early; in addition both the MSSP sites and managed care plans would have to demonstrate that they have met readiness criteria that is developed by DHCS, California Department of Aging (CDA), MSSP providers, managed care plans and stakeholders. Additionally, the proposed trailer bill language specifies that if CCI is terminated that MSSP will revert to a waiver benefit.

This issue was heard at the May 18th Subcommittee hearing.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language.

9. Drug Medi-Cal Residential Treatment Services

Budget Issue. The May Revision includes \$47 million (\$14.8 million General Fund) for the provision of residential treatment services in Drug Medi-Cal. This estimate assumes the approval of the Drug Medi-Cal Waiver by June 30, 2015 and that 22 counties will begin providing residential treatment services in the budget year, with 11 counties starting in September.

Subcommittee Staff Comment and Recommendation—Reduce by \$5 million General Fund (and by appropriate federal funds). It is recommended to reduce this item by \$5 million General Fund because it is highly unlikely that this service will be available in 11 counties in September. The Administration's timeline does not reflect that CMS has not yet approved this waiver amendment, counties have not submitted their implementation plans (and DHCS has not approved these plans), DHCS has not developed an American Society of Addiction Medicine (ASAM) designation program, and residential treatment providers do not yet have the ASAM designation. This reduction amount reflects that some counties may be able to start in the November-December time period, which is still uncertain.

10. Pediatric Palliative Care Waiver Pilot Project Expansion

Budget Issue. DHCS proposes to expand the Pediatric Palliative Care Waiver Pilot Project. This expansion is expected to result in net savings of \$1,356,000 (\$857,500 General Fund) in 2015-16.

The Administration is proposing an expansion to the program in light of both the fiscal savings and positive satisfaction ratings found in the independent evaluation. Currently the pilot program operates in nine counties, serving approximately 150 children. This proposal is to expand the pilot to up to seven additional counties, potentially increasing caseload to approximately 270 participants.

Subcommittee Staff Recommendation—Approve.

11. Major Risk Medical Insurance Program Reconciliations Trailer Bill Language

Issue. As discussed at the April 23rd Subcommittee hearing, DHCS is in the process of reconciling Major Risk Medical Insurance Program (MRMIP) and Guaranteed Issue Pilot (GIP) actual plan expenditures and claims with what the state already paid these plans. There is currently a four-year backlog in the reconciliation process. Consequently, it is unknown how much the state may owe plans or how much plans may owe the state. The Administration estimates that on the net of both programs' reconciliations, the state would receive an increase in funding.

Subcommittee staff requested technical assistance from the Administration on methods to facilitate and expedite the reconciliation process. It is important to expedite this process, so that the state has an understanding of the true balance of the Managed Risk Medical Insurance Fund (MRMIF).

This issue was heard at the May 18^h Subcommittee hearing.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. In order to expedite this reconciliation process, it is recommended to adopt placeholder trailer bill language that specifies the following:

- DHCS and the plans consult on the reconciliations.
- If DHCS and a plan do not reach an agreement, DHCS has the authority to provide notification to the plan of the final determined amount.
- The plan has 60 days to repay DHCS.
- If the plan does not repay in 60 days:
 - Interest begins to accrue
 - DHCS can offset the repayment amount from other payments to the plan.
 - DHCS can enter into a repayment agreement with the plan and can choose to waive interest.

Additionally, given that the Subcommittee rejected the Administration's proposed modifications to the MRMIP program, it is recommended to adopt placeholder trailer bill language to extend the period of time to reconcile payments for the GIP program from six to 18 months which is more consistent with historical timelines.

12. Suicide Prevention Hotlines – Supplemental Report Language

Issue. CalMHSA, a joint powers authority, and the County Behavioral Health Directors Association request Proposition 63 state administrative funds for suicide hotlines. These efforts are currently supported with county funding from Proposition 63. The county funding structure is coming to an end; and, consequently, counties are seeking state funding. (Nothing prohibits counties from continuing to fund these efforts.)

Subcommittee Staff Recommendation—Adopt supplemental report language. It is recommended to adopt Supplemental Report Language regarding DHCS to assess suicide hotlines in the state. The report shall cover the accessibility of suicide hotlines throughout the state, deficiencies in accessibility or quality of the hotlines, an overview of the funding history of the hotlines, and information on potential future funding strategies. In the development of this report, DHCS shall confer with the Mental Health Services Oversight & Accountability Commission, the Office of Emergency Services, and counties. This report would be due January 10, 2016.

4265 Department of Public Health

1. AIDS Drug Assistance Program (ADAP) – Increase in Federal Authority

Issue. At its May 18th hearing, the Subcommittee adopted proposals to use ADAP rebate funds to increase funding for ADAP enrollment (\$2 million for local health jurisdictions and \$1 million for the Office of AIDS). These proposals were ongoing investments.

Subsequent to this hearing, DPH and the Department of Finance identified the possibility of available federal funding for these purposes. Using these federal funds for these purposes would ensure that the state does not return unused federal funds for ADAP.

Subcommittee Staff Recommendation—Increase federal fund authority. It is recommended to augment federal fund authority for these purposes, to ensure that federal funds are used, if available, to fund these proposals before rebate special funds are used.

2. California Clinical Laboratory Testing

Issue. Stakeholders have raised a concern that changes to the federal Clinical Laboratory Improvement Amendments (CLIA) will no longer allow medical laboratories in California to use the federal quality control option known as the Equivalent Quality Control (EQC). Stakeholders have requested state law be amended to allow for EQC to be used until December 31, 2015. CLIA will prohibit EQC after January 1, 2016.

This issue was heard at the May 18th Subcommittee hearing.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to authorize laboratories to use the federally approved quality control testing approach until December 31, 2015. Proposed placeholder trailer bill language:

Business and Professions Code Section 1220(d)(2)(B): A quality control program, *may include the laboratory's use of an alternative quality control testing procedure recognized by the Centers for Medicare and Medicaid Services (CMS). The program shall meet the requirements of CLIA in Subpart K (commencing with Section 493.1201 493.1200) of Title 42 of the Code of Federal Regulations (in effect as of 2003–2014). The following alternative quality control testing procedures recognized by CMS pursuant to this section may be used:*

- (i) Equivalent Quality Control procedures may be used until December 31, 2015.
- (ii) An Individualized Quality Control Plan may be used as of January 1, 2016 according to Appendix C of the State Operations manual as adopted by CMS.

3. Licensing and Certification Fee Augmentation for LTC Ombudsman Program

Budget Issue. At the May 18th Subcommittee hearing, the Subcommittee adopted the proposal to increase the licensing and certification fee for skilled nursing facilities to generate \$400,000 to support the Long Term Care (LTC) Ombudsman Program on an ongoing-basis.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to implement this proposal and allow the revenue generated by this fee increase to be directed to the Long Term Care Ombudsman Program.

4560 Mental Health Services Oversight and Accountability Commission (OAC)

1. Competitive Bid Contracts for Mental Health Advocacy

Budget Issue. As was discussed at the April 9th Subcommittee hearing, multiple groups have requested contract augmentations for mental health advocacy using Proposition 63 state administration funds.

Subcommittee Staff Comment and Recommendation. The May Revision estimates that there could be about \$2 million in available Proposition 63 state administration funds in 2015-16. It is recommended to augment the OAC's budget by \$1 million in state administration funds for competitive bid contracts to support mental health advocacy on behalf of youth, veterans, and racial and ethnic minorities and adopt placeholder budget bill language to allow these funds to be made available provided that there is availability in the state administration cap.

4800 California Health Benefit Exchange

1. Emergency Regulations and Rulemaking Authority

Budget Issue. The California Health Benefit Exchange (Covered California) proposes trailer bill language in the May Revision to:

- a. Extend its current emergency regulations and the exchange board's rulemaking authority for an additional year until January 1, 2017, extends its ability to readopt emergency regulations until January 1, 2020 for emergency regulations adopted prior to the effective date of the Budget Act of 2015, and
- b. Provide limited statutory exemptions from the Administrative Procedure Act's (APA) rulemaking requirements for (i) standard plan designs, and (ii) separate regulations for each procurement.

This issue was heard at the May 18th Subcommittee hearing.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language.

Michelle Baass 651-4103
 Senate Budget & Fiscal Review

**OUTCOMES: Senate Subcommittee #3 on Health & Human Services
 Thursday, May 21 (Room 4203)
 Agenda Part A**

VOTE ONLY

Multiple Departments

1. Health-Related General Fund Investments

Subcommittee Staff Recommendation—Approve. Given the state’s fiscal situation and the Senate’s desire to help lift more people out of poverty, it is recommended to approve the following General Fund augmentations and to adopt placeholder trailer bill language to effectuate these proposals:

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
1. Medi-Cal: Restore Full Adult Dental Benefits	The 2009 budget eliminated several Medicaid optional benefits from the Medi-Cal program. The 2013-14 budget partially restored adult dental benefits. It is proposed to fully restore these benefits effective October 1, 2015. Vote: 3-0	\$67.5 million
2. Medi-Cal: Expand to Cover Remaining Uninsured Regardless of Immigration Status	Provide Medi-Cal coverage to undocumented immigrants. Vote: 2-1 (Senator Stone voting no.)	\$40 million
3. Medi-Cal: Eliminate AB 97 Reductions for Dental Providers	Given the growing concerns of access to dental services in Medi-Cal, it is recommended to eliminate the AB 97 payment reduction for dental providers. Vote: 3-0	\$30 million

<p>4. Medi-Cal: Restore Optional Benefits</p>	<p>The 2009 budget eliminated several Medicaid optional benefits from the Medi-Cal program. These benefits were eliminated for budgetary, not policy, reasons in response to the fiscal crisis. The following benefits are proposed to be restored:</p> <ul style="list-style-type: none"> • Acupuncture • Audiology • Incontinence Cream and Washes • Optician / Optical Lab • Podiatry • Speech Therapy <p>Chiropractic services are not proposed to be restored.</p> <p>Vote: 3-0</p>	<p>\$15.1 million</p>
<p>5. Public Health: Hepatitis C and HIV Prevention</p>	<p>In effort to prevent Hepatitis C (HCV) and HIV, funding for the following proposals is recommended:</p> <ul style="list-style-type: none"> • State Syringe Exchange Program (\$3 million) • HCV Rapid Testing Kits (\$600,000) • HCV Linkage & Retention in Care Demonstration Projects (\$2.2 million) • Pre-Exposure Prophylaxis (PrEP) Access & Affordability Program (\$2.2 million) <p>Vote: 3-0</p>	<p>\$8 million</p>
<p>6. Medi-Cal: AB 97 Payment Claw back for Distinct-Part Nursing Facilities</p>	<p>Provide one-time funding to exempt one-half of the collection of AB 97 retroactive recoupments for Distinct-Part Nursing Facilities in the budget year. Budget year recoupment amount is \$13.9 million General Fund and total retroactive recoupment from these facilities is \$114 million General Fund.</p> <p>Vote: 3-0</p>	<p>\$7 million (one-time)</p>
<p>7. Medi-Cal: Dental Anesthesia Rate</p>	<p>Increase the dental anesthesia rate to provide rate parity between general anesthesia and dental anesthesia providers. (The cost of equalizing facility fees and anesthesia to medical rate.)</p> <p>Vote: 3-0</p>	<p>\$4.3 million</p>

<p>8. Robert F. Kennedy Health Plan</p>	<p>In order to ensure the continuation of the United Farmworkers Union’s Robert F. Kennedy Health Plan, it is proposed to provide one-time \$2.5 million to this plan to purchase stop-loss coverage insurance.</p> <p>Vote: 2-1 (Senator Stone voting no.)</p>	<p>\$2.5 million (one-time)</p>
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4260 Department of Health Care Services

1. Medi-Cal: Impact of President’s Executive Order (DOF ISSUE 521-MR)

- **Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)**

Subcommittee Staff Comment and Recommendation—Approve. As the LAO noted at the Subcommittee hearing, there are significant uncertainties with regard to when and if the President’s actions may be implemented, how many eligible individuals will enroll in this immigration program, and then the number of these individuals who would proactively enroll into Medi-Cal. For this reason, it is recommended to approve the Administration’s estimate.

2. Medi-Cal: Skilled Nursing Facility Quality Assurance Fee Extension

- **Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)**

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt the placeholder trailer bill language and to add provisions to require DHCS to (1) include direct care staff retention in the QASP and (2) require DHCS to report to the Legislature on the QASP, including if the level of QASP payments are adequate to sustain the program.

3. Medi-Cal: Financial Audits Workload

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Recommendation—Approve.

4. Medi-Cal: Allied Dental Professionals Enrollment

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Recommendation—Approve.

5. Medi-Cal: Ground Emergency Medical Transportation - Trailer Bill Language

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language.

6. Medi-Cal: Eliminate Cost-of-Living Adjustment for County Eligibility Administration

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Recommendation—Modify Trailer Bill Language. It is recommended to modify the proposed placeholder trailer bill language by suspending the county COLA for the budget year only and not on a permanent basis. The May Revision proposes increased funding for county eligibility administration.

7. Medi-Cal: County Administration Augmentation (DOF ISSUE 515-MR)

- **Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)**

Subcommittee Staff Comment and Recommendation. Since Monday’s hearing, the Administration and counties have worked to identify alternative funding sources for this workload. It is estimated that current year CalFresh caseload will be lower than anticipated and it is proposed to reappropriate this unused funding (for current year caseload) to Medi-Cal county administration in the budget year. This would provide a \$95.3 million increase for this county administration workload, including \$31 million General Fund that would be reappropriated and would be used to draw down approximately \$64.3 million in federal funds. To implement this, it is recommended to adopt the following placeholder budget bill language:

5180-495—Reversion, Department of Social Services. As of June 30, 2015, the balances specified below, of the appropriations provided in the following citations shall revert to the balances in the funds from which the appropriations were made.

0001—General Fund

(1) Item 5180-141-0001, Budget Act of 2014 (Ch. 25, Stats. 2014). \$31,000,000 appropriated for CalFresh administration in Program 16.75—County Administration and Automation Projects.

Provisional Language for Item 4260-101-0001

X. For the 2015-16 fiscal year only, notwithstanding any other provision of law, pursuant to Provision 1 of Item 5810-XXX, \$31,000,000 from the General Fund in Schedule (1) of this item

is available for the purpose of funding county administration efforts to support the federal Patient Protection and Affordable Care Act (P.L. 111-148).

8. CCI: Multipurpose Senior Services Program Transition Timeline

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language.

9. Drug Medi-Cal Residential Treatment Services

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Comment and Recommendation—Reduce by \$5 million General Fund (and by appropriate federal funds). It is recommended to reduce this item by \$5 million General Fund because it is highly unlikely that this service will be available in 11 counties in September. The Administration’s timeline does not reflect that CMS has not yet approved this waiver amendment, counties have not submitted their implementation plans (and DHCS has not approved these plans), DHCS has not developed an American Society of Addiction Medicine (ASAM) designation program, and residential treatment providers do not yet have the ASAM designation. This reduction amount reflects that some counties may be able to start in the November-December time period, which is still uncertain.

10. Pediatric Palliative Care Waiver Pilot Project Expansion

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Recommendation—Approve.

11. Major Risk Medical Insurance Program Reconciliations Trailer Bill Language

- **Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)**

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. In order to expedite this reconciliation process, it is recommended to adopt placeholder trailer bill language that specifies the following:

- DHCS and the plans consult on the reconciliations.
- If DHCS and a plan do not reach an agreement, DHCS has the authority to provide notification to the plan of the final determined amount.

- The plan has 60 days to repay DHCS.
- If the plan does not repay in 60 days:
 - Interest begins to accrue
 - DHCS can offset the repayment amount from other payments to the plan.
 - DHCS can enter into a repayment agreement with the plan and can choose to waive interest.

Additionally, given that the Subcommittee rejected the Administration’s proposed modifications to the MRMIP program, it is recommended to adopt placeholder trailer bill language to extend the period of time to reconcile payments for the GIP program from six to 18 months which is more consistent with historical timelines.

12. Suicide Prevention Hotlines – Supplemental Report Language

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Recommendation—Adopt supplemental report language. It is recommended to adopt Supplemental Report Language regarding DHCS to assess suicide hotlines in the state. The report shall cover the accessibility of suicide hotlines throughout the state, deficiencies in accessibility or quality of the hotlines, an overview of the funding history of the hotlines, and information on potential future funding strategies. In the development of this report, DHCS shall confer with the Mental Health Services Oversight & Accountability Commission, the Office of Emergency Services, and counties. This report would be due January 10, 2016.

4265 Department of Public Health

1. AIDS Drug Assistance Program (ADAP) – Increase in Federal Authority

- **Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)**

Subcommittee Staff Recommendation—Increase federal fund authority. It is recommended to augment federal fund authority for these purposes, to ensure that federal funds are used, if available, to fund these proposals before rebate special funds are used.

2. California Clinical Laboratory Testing

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to authorize laboratories to use the federally

approved quality control testing approach until December 31, 2015. Proposed placeholder trailer bill language:

Business and Professions Code Section 1220(d)(2)(B): A quality control program, may include the laboratory's use of an alternative quality control testing procedure recognized by the Centers for Medicare and Medicaid Services (CMS). The program shall meet the requirements of CLIA in Subpart K (commencing with Section 493.1204 493.1200) of Title 42 of the Code of Federal Regulations (in effect as of 2003–2014). The following alternative quality control testing procedures recognized by CMS pursuant to this section may be used:

- (i) Equivalent Quality Control procedures may be used until December 31, 2015.
- (ii) An Individualized Quality Control Plan may be used as of January 1, 2016 according to Appendix C of the State Operations manual as adopted by CMS.

3. Licensing and Certification Fee Augmentation for LTC Ombudsman Program

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to implement this proposal and allow the revenue generated by this fee increase to be directed to the Long Term Care Ombudsman Program.

4560 Mental Health Services Oversight and Accountability Commission (OAC)

1. Competitive Bid Contracts for Mental Health Advocacy

- **Vote to approve staff recommendation: 3-0**

Subcommittee Staff Comment and Recommendation. The May Revision estimates that there could be about \$2 million in available Proposition 63 state administration funds in 2015-16. It is recommended to augment the OAC's budget by \$1 million in state administration funds for competitive bid contracts to support mental health advocacy on behalf of youth, veterans, and racial and ethnic minorities and adopt placeholder budget bill language to allow these funds to be made available provided that there is availability in the state administration cap.

4800 California Health Benefit Exchange

1. Emergency Regulations and Rulemaking Authority

- **Vote to approve staff recommendation: 2-1 (Senator Stone voting no.)**

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language.

Senate Budget and Fiscal Review—Mark Leno, Chair
SUBCOMMITTEE No. 3

AGENDA

Chair, Senator Holly J. Mitchell
Senator Jeff Stone, Pharm. D.
Senator William W. Monning



May 21, 2015
10:00 a.m.
John L. Burton Hearing Room 4203

PART B

Staff: Peggy Collins

4300 Department of Developmental Services (DDS)

PROPOSED VOTE ONLY

Issue 1	Stability of Community-Based Services and Supports System	2
Issue 2	Clean-up to Address Services for Individuals in IMDs.	4
Issue 3	Technical Correction - Additional CPP Funding for the Closure of Sonoma Developmental Center	5

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the agenda unless otherwise directed by the Chair.

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. Thank you.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)**Issue 1: Stability of Community-Based Services and Supports System - Legislative Proposal**

Background: At earlier hearings, the subcommittee discussed at length, and took extensive public comment on, the growing lack of stability of community-based services and supports due to the lack of significant rate adjustments for most community-based service providers since 2006. The 2014 budget approved by the Legislature included budget bill language to require DDS to work with stakeholders to develop a proposal relative to rate-setting methodologies for community-based services and supports, as well as make recommendations for improvements to the core staffing formula for regional centers. However, the Governor vetoed this language and instead directed the Health and Human Services Agency to convene a work group to review these issues. The agency convened its first Developmental Services Work Group meeting in December 2014. Concurrently, a Home and Community-Based Services Advisory Group was established by the Administration, and first met on February 17, 2015, to analyze issues, identify steps and processes, and develop policy recommendations involved with implementing federal home and community-based settings requirements.

May Revision: The May Revision includes no proposed increases in provider rates or adjustments for regional centers.

Staff Comments: In both the legislative and policy committee arenas, members have expressed deep concerns about the impact of a prolonged rate freeze on the quality, stability, and accessibility of services and supports in the community; and the impact on consumer services due to the outdated regional center core staffing formula. While the agency-led advisory and work group process is underway and commendable, it is not clear when this will result in tangible recommendations. Additionally, Legislators and advocates have expressed interest in tying the savings achieved from the closure of developmental centers to new investments in the community-based system that serves persons with developmental disabilities.

Staff Recommendation: Adopt the following augmentations to the Governor's May Revision, for a total new investment of \$100,941,000 (\$63,623,000 GF), and trailer bill language to 1) require the Administration to submit a plan for further rate reform, based on the work of their existing task forces, and, 2) express the Legislature's intent that the savings achieved from the closure of developmental centers be used for new investments in the community system.

Regional Center Purchase-of-Services – Rate Increases

Supported Living Services - 10% rate increase	\$46,273,000 (\$29,615,000 GF)
Supported Employment- Individual – 10% rate increase	\$1,836,000 (\$1,188,000 GF)
Supported Employment-Group – 10% rate increase	\$7,422,000 (\$4,509,000 GF)
Respite (in/out-of-home) – 10% rate increase	\$27,609,000 (\$17,670,000 GF)
Transportation – 5% rate increase	\$13,043,000 (\$8,348,000 GF)

Regional Center Operations – Targeted Enhancements

Dental Coordinators (21)	\$1,967,000 (\$521,000 GF)
Forensic Coordinators (21)	\$2,111,000 (\$1,245,000 GF)
Client Rights Contract with DRC – 10% increase	\$680,000 (\$527,000 GF)

Placeholder TBL #1:

Utilizing the work of the secretary’s Developmental Services Task Force and the department’s Home and Community-Based Services Advisory Group, the department shall make recommendations to the Legislature on January 10, 2016 for revisions to existing rate-setting methodologies for community-based services and supports for persons with developmental disabilities, and to regional center operations budget core staffing formulas, that accomplish the following:

- Support maximum federal funding participation.
- Meet the current and future needs of persons with developmental services, including those moving from developmental centers.
- Ensure that services and supports provided are cultural competent.
- Maximize consumer choice, person-centered planning, and integration in all aspects of community life.
- Reflect appropriate state and federal law and regulation requirements for caseload ratios, staffing levels, staffing competencies and qualifications, prudent auditing requirements, and other quality control measures.
- Reflect reasonable costs necessary to sustainably provide quality services and supports, including but not limited to, federal, state and local mandates regarding employee wages and benefits.

In making the recommendations required by this section, the department may propose an incremental approach based on priorities that maximize federal funding participation; assist programs in becoming compliant with new federal regulations; support persons moving from developmental centers or to

avoid institutionalization; and, ensure a sufficient complement of services and supports to meet the needs identified in individual program plans.

The department shall report to the Legislature annually, on January 10th, on its progress toward implementation of the recommendations.

Placeholder TBL #2:

It is the intent of the Legislature that General Fund savings derived from the closure of state developmental centers, including any proceeds from the sale or lease of developmental center lands, benefit persons with developmental disabilities living in the community.

The department shall display annually in their January and May budget documents, for any year in which it is applicable, all the following:

1. All General Fund savings or gains reasonably associated with the downsizing or closure of a developmental center, including proceeds from the sale or lease of developmental center lands.
2. All General Fund community investments reasonably associated with the downsizing or closure of a developmental center, including the costs associated with the development and provision of services and supports for persons moving from a developmental center or at risk of institutionalization.

Issue 2: Clean-up to assist persons in IMDs

Background: Disability Rights California is the federally-mandated protection and advocacy organization for California. Client rights advocacy services for persons receiving services through a regional center are provided through a contract with Disability Rights California through their Office of Client Rights Advocates (OCRA). Among its other duties, OCRA is charged with assisting individuals move to a less-restrictive setting.

Current law limits the length of time a consumer may be placed in an Institute for Mental Disease (IMD) and required regional centers to take certain actions relative to planning for, and providing, the services and supports a person will need in order to move from an IMD. According to OCRA, some regional centers take the view that these provisions do not apply when the regional center is not responsible for placing the individual in the IMD.

Staff Recommendation: Adopt the placeholder trailer bill language to ensure that the regional center remains responsible regardless of who makes the initial IMD placement.

Issue 3: TECHNICAL CORRECTION: Additional Community Placement Plan (CPP) Funding for the Closure of Sonoma Developmental Center – Issues 519MR and 619MR

May Revision Request: The May Revision proposes an augmentation of \$46.7 million (total funds) for start-up and placement costs; of that, \$1.3 million is for regional center operational costs to coordinate activities and placements.

Staff Comments: This action corrects a technical error on the May 19th agenda, the change is underlined in the staff recommendation and distinguishes the General Fund. The subcommittee previously approved this issue on a 3-0 vote.

Staff Recommendation: Approve May Revision. Approve a technical correction to schedule \$46.7 million (\$44.4 million GF) in the purchase-of-services budget and \$1.3 million in the regional center operations budget.

OUTCOMES

Senate Budget and Fiscal Review—Mark Leno, Chair
SUBCOMMITTEE No. 3

Chair, Senator Holly J. Mitchell
Senator Jeff Stone, Pharm. D.
Senator William W. Monning



May 21, 2015

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

Issue 1: Stability of Community-Based Services and Supports System - Legislative Proposal

Staff Recommendation: Adopt the following augmentations to the Governor’s May Revision, for a total new investment of \$100,941,000 (\$63,623,000 GF), and trailer bill language to 1) require the Administration to submit a plan for further rate reform, based on the work of their existing task forces, and, 2) express the Legislature’s intent that the savings achieved from the closure of developmental centers be used for new investments in the community system.

VOTE: 3-0

Regional Center Purchase-of-Services – Rate Increases

Supported Living Services - 10% rate increase	\$46,273,000 (\$29,615,000 GF)
Supported Employment-Individual – 10% rate increase	\$1,836,000 (\$1,188,000 GF)
Supported Employment-Group – 10% rate increase	\$7,422,000 (\$4,509,000 GF)
Respite (in/out-of-home) – 10% rate increase	\$27,609,000 (\$17,670,000 GF)
Transportation – 5% rate increase	\$13,043,000 (\$8,348,000 GF)

Regional Center Operations – Targeted Enhancements

Dental Coordinators (21)	\$1,967,000 (\$521,000 GF)
Forensic Coordinators (21)	\$2,111,000 (\$1,245,000 GF)
Client Rights Contract with DRC – 10% increase	\$680,000 (\$527,000 GF)

Placeholder TBL #1:

Utilizing the work of the secretary's Developmental Services Task Force and the department's Home and Community-Based Services Advisory Group, the department shall make recommendations to the Legislature on January 10, 2016 for revisions to existing rate-setting methodologies for community-based services and supports for persons with developmental disabilities, and to regional center operations budget core staffing formulas, that accomplish the following:

- Support maximum federal funding participation.
- Meet the current and future needs of persons with developmental services, including those moving from developmental centers.
- Ensure that services and supports provided are cultural competent.
- Maximize consumer choice, person-centered planning, and integration in all aspects of community life.
- Reflect appropriate state and federal law and regulation requirements for caseload ratios, staffing levels, staffing competencies and qualifications, prudent auditing requirements, and other quality control measures.
- Reflect reasonable costs necessary to sustainably provide quality services and supports, including but not limited to, federal, state and local mandates regarding employee wages and benefits.

In making the recommendations required by this section, the department may propose an incremental approach based on priorities that maximize federal funding participation; assist programs in becoming compliant with new federal regulations; support persons moving from developmental centers or to

avoid institutionalization; and, ensure a sufficient complement of services and supports to meet the needs identified in individual program plans.

The department shall report to the Legislature annually, on January 10th, on its progress toward implementation of the recommendations.

Placeholder TBL #2:

It is the intent of the Legislature that General Fund savings derived from the closure of state developmental centers, including any proceeds from the sale or lease of developmental center lands, benefit persons with developmental disabilities living in the community.

The department shall display annually in their January and May budget documents, for any year in which it is applicable, all the following:

1. All General Fund savings or gains reasonably associated with the downsizing or closure of a developmental center, including proceeds from the sale or lease of developmental center lands.
2. All General Fund community investments reasonably associated with the downsizing or closure of a developmental center, including the costs associated with the development and provision

of services and supports for persons moving from a developmental center or at risk of institutionalization.

Issue 2: Clean-up to assist persons in IMDs

Staff Recommendation: Adopt the placeholder trailer bill language to ensure that the regional center remains responsible regardless of who makes the initial IMD placement.

VOTE: 3-0

Issue 3: TECHNICAL CORRECTION: Additional Community Placement Plan (CPP) Funding for the Closure of Sonoma Developmental Center – Issues 519MR and 619MR

Staff Recommendation: Approve May Revision. Approve a technical correction to schedule \$46.7 million (\$44.4 million GF) in the purchase-of-services budget and \$1.3 million in the regional center operations budget.

VOTE: 3-0

SUBCOMMITTEE #3: Health & Human Services

Chair, Holly J. Mitchell
Senator Jeff Stone, Pharm.D.
Senator William W. Monning



May 21, 2015
10:00 AM
Room 4203, State Capitol

Part C

Consultant: Samantha Lui

ISSUES RECOMMENDED FOR VOTE-ONLY

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PLEASE NOTE. Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. 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. Thank you.

ISSUES RECOMMENDED FOR VOTE-ONLY

4700 Department of Community Services and Development

1. BCP #2: Migrant & Seasonal Farmworkers Drought Assistance Program

May Revision. The Administration requests \$7.5 million General Fund to provide emergency relief and support services to specified populations, including those who are low-income and migrant and seasonal farmworkers (MSFWs), within the state’s most drought impacted counties. Services could include rental and utility assistance, transportation, and basic necessities, including access to food resources. The \$7.5 million GF will augment existing federal Community Services Block Grant funding to support core funding for four local non-profit organizations. Approximately 3,200 MSFWs and low-income individuals will be served, with an average benefit of \$2,000 per person. Currently, MSFW organizations serve 24¹ of the most drought-affected counties, which are defined as those that have high unemployment; a high share of agricultural workers; and “exceptional” drought conditions, according to the U.S. Drought Monitor Classification System.

Staff Comment and Recommendation. Approve. This issue was considered on May 19, 2015. As effects of the drought may continue to impact California’s economy beyond the one year this budget request proposes, and staff recommends that department provide periodic updates and provide additional information, including, but not limited to overall met need, program outcomes, number of individuals served, and types of services provided, at future budget committee hearings and throughout its implementation.

5160 Department of Rehabilitation

1. Legislative Proposal: Supported Employment Program

Background. The Supported Employment Program provides activities and services, including ongoing support services, needed to support and maintain an individual with a significant disability in an integrated employment setting. Persons with developmental disabilities who wish to participate in supported employment, enter the program through DOR. DOR services are typically limited to 18 months, after which the person typically shifts to the Department of Developmental Services (DDS)-funded supported employment program. Under the Part B agenda today, the committee approved a ten percent rate increase for the DDS-funded supported employment program.

Staff Comment and Recommendation. To correspond with the actions taken in the DDS budget, provide a 10 percent rate increase for supported employment programs funded through DOR, staff recommends approving \$264,000 GF for this purpose..

¹ Amador, Butte, Colusa, Fresno, Glenn, Kern, Kings, Lake, Lassen, Madera, Monterey, San Benito, San Joaquin, Santa Cruz, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Tulare, Yolo, and Yuba counties.

5180 Department of Social Services**1. May Revision Caseload and Estimates Update**

(Issue 700, 701)

The May Revision proposes a net increase of \$176,635,000 (increases of \$218,155,000 General Fund, \$12,366,000 Children's Health and Human Services Special Fund, \$7,777,000 reimbursements, \$532,000 Child Support Collections Recovery Fund, \$12,000 Emergency Food Assistance Program Fund, partially offset by a decrease of \$62,207,000 Federal Trust Fund) primarily resulting from updated caseload estimates since the Governor's budget. Realigned programs are displayed for the purpose of federal fund adjustments and other technical adjustments. Caseload and workload changes since the Governor's budget are displayed in the following table:

Staff Recommendation. Approve May Revision caseload estimate changes, subject to additional conforming changes made by other legislative actions.

2. BCP #86, TBL 610: Federal Immigration Assistance and Associated Impact

(Issue 704, 724, 725)

The May Revision includes the following components and revised caseload and funding estimates, related to the federal immigration assistance:

1. \$4.8 million General Fund for the department to contract with qualified legal services organizations to provide application assistance for specified persons;
2. \$191,000 GF to establish a position at DSS;
3. Provisional budget bill language to extend the liquidation period for encumbered amounts until June 30, 2021; and,
4. Proposed trailer bill language to implement these provisions.

May Revision. The Administration requests \$5 million General Fund for the department to contract with qualified nonprofit legal services organizations to provide application assistance to persons residing in California who are eligible for, or to renew, Deferred Action for Childhood Arrivals (DACA) or Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) status. Legal services will include culturally and linguistically appropriate services provided by attorneys, paralegals, interpreters and other support staff for assistance in applying for DACA or DAPA status or renewal of that status with the United States Citizenship and Immigration Services.

In addition, the May Revision includes revised caseload estimates for several social services programs that may be impacted, as a result of the President's Immigration Accountability Executive Orders. The Administration provides that these estimates do not reflect an eligibility change for any of these programs; instead, the figures reflect an assumed increase in the take-up rate.

Background. On November 20, 2014, President Obama issued executive orders that expanded the population eligible for DACA program, and to include new Deferred Action for Parents of Americans (DAPA). Currently, the U.S. Citizenship and Immigration Services (USCIS) is not accepting applications for the expanded DACA and the DAPA. A federal district court in Texas issued an order

that temporarily blocks DAPA and the expanded DACA from being implemented. USCIS continues to accept renewal applications or initial applications from people who qualify under the initial DACA announcement in 2012. The May Revision assumes the suspension will be lifted and the USCIS will be accepting applications for DACA and DAPA program in the near future. As such, the May Revision anticipates impacts to several social services programs, beginning October 1, 2015.

Staff Recommendation. Amend Governor's May Revision to reflect the following language to be included, in addition to what was proposed in May Revision, in trailer bill language:

- Augment the \$5 million proposed May Revision with an additional \$15 million General Fund, for a total of \$20 million for the proposal;
- Require that the department must contract with, and provide grants to, subject to available funding in the Budget Act, qualified non-profit organizations to provide legal services or legal training and technical assistance to non-profit legal organizations;
- Expand the list of organizations who may be eligible for contracts and grants, to include labor unions or central labor bodies;
- Expand the types of legal services that may be provided to include:
 - Other legal remedies for people receiving DACA or DAPA application assistance ;
 - Services to assist with the application process for naturalization; and
 - Services to provide legal training and technical assistance to non-profit legal service organizations, labor unions, or central labor bodies.
- Define the services that can be provided that assist the application process to include:
 - Outreach, workshop presentations, document review, Freedom of Information Act requests, and screening services to assist individuals with DACA, DAPA, naturalization, or other legal remedies.
- Define "legal training and assistance" to include:
 - Webinars, in-person trainings, technical assistance through e-mail, fax, or phone from non-profit legal organizations, labor unions, or labor bodies, their staff, and/or volunteers.
- Require that contracts and grants awarded through this program must fulfill specified criteria, including:
 - Legal services organizations that provide legal training and technical assistance must have at least ten years of experience conducting immigration legal services and technical assistance, and must be a Trust Fund Program administered by the State Bar of California
- Exempt specified organizations that provide legal training and technical assistance from providing legal services on a fee-per-case basis.
- Require the department, no later than March 1, 2016, to report to the fiscal legislative committee, the timeline for implementation.
- Require the department, no later than March 1, 2017, to provide information to the Legislature, including:
 - Participating entities awarded contracts and grants;
 - Number of applications submitted;
 - Identification of further barriers and challenges to immigration assistance and legal services related to naturalization and deferred action.
- Require the department, subject to available Budget Act funding, to contract with stakeholders that can demonstrate the ability to reach key communities eligible for DACA, DAPA, and naturalization.

- Define the terms “education” and “outreach” to include referrals to educational or legal services that support an applicant’s eligibility for citizenship or deferred action, and the importance of participating in civic engagement as a naturalized citizen. Education and outreach activities are prohibited from including representation as legal counsel that assists in the application process.

5180 Department of Social Services - CalFresh**1. State Emergency Food Assistance Program**

Budget Issue. The California Association of Food Banks (CAFB) requests a \$5 million General Fund appropriation for the State Emergency Food Assistance Program (SEFAP). Currently, there is no on-going General Fund dedicated for this use. In the 2013-14 fiscal year, the state Assembly donated \$1 million for one-time use. The \$5 million SEFAP request would be distributed to all counties based on the established formula for the distribution of Emergency Food Assistance Program, currently funded with federal dollars.

Background. The SEFAP funds provide additional flexibility to food banks, as they can purchase the items that they need to complement the types of foods that are currently available to them.

Staff Comment and Recommendation. Approve \$2.5 million GF in the budget year for this program. This item was considered at the subcommittee's April 30, 2015, hearing.

2. Nutrition Incentive Program/Market Match

Budget Issue. Advocates, including Roots of Change, Latino Coalition for a Healthy California, Ecology Center, and the Public Health Institute, proposed \$5 million General Fund annually to establish a statewide nutrition incentive program for purchasing California-grown fruits, nuts and vegetables (i.e. specialty crops), benefiting low-income families and California's economy.

Background. California's Market Match, beginning in 2009, doubles the purchasing power of nutrition assistance benefits (e.g. CalFresh) when spent on specialty crops at participating farmers' markets.

Staff Comment and Recommendation. Approve \$2.5 million GF in the budget year to establish a statewide nutrition incentive program and associated placeholder trailer bill to enact this action. This item was considered at the subcommittee's April 30, 2015, hearing.

5180 Department of Social Services - CalWORKs**1. Temporary Assistance for Needy Families (TANF) Transfer to CA Student Aid Commission**

(Issue 703)

May Revision. The Administration requests an increase in the department's federal funding by \$533,646,000 Federal Trust Fund to reflect an increase in the amount of federal TANF block grant funds available to offset General Fund costs in the Cal Grant program administered by the California Student Aid Commission (CSAC). Of this amount, \$286,320,000 reflects a technical correction.

Background. The proposed budget erroneously did not include the transfer amount assumed in the Governor's budget. The remaining increase of \$247,326,000 is primarily attributable to shifting of long-term sanctioned CalWORKs cases from the federal TANF program to a solely state-funded non-TANF maintenance-of-effort program (see Item 6980-101-0001, Issue 214-MR).

Staff Recommendation. Approve as requested, as no concerns have been raised.

2. TBL 611: Child Support Pass-Through for Long-Term Sanction Cases

May Revision. The Administration proposes trailer bill to allow the Temporary Assistance for Needy Families (TANF) funds in FY 2014-15 to carry forward to the budget year. These TANF funds will be transferred to the Student Aid Commission in the budget year to offset GF. According to the Administration, this funding shift is cost neutral.

Background. Approximately 14,550 CalWORKs cases are in long-term sanction status. This proposal changes how child support is treated for these cases. Since funding for these cases is now switched to non-MOE GF, these cases will no longer assign their child support to the state, and the Department of Child Support Services will no longer be required to track these cases. If this child support income can be reasonably anticipated, it could be factored into recipients' grant calculations.

Staff Recommendation. Approve as requested, as no concerns have been raised.

3. TBL 612: Previous Drug Felony Reporting Requirement

January Budget. The department estimates that approximately 400 persons with a prior felony drug conviction will be added to an existing CalFresh household, and approximately 1,100 households will become newly eligible for CalFresh. In addition, DSS estimates that around 3,900 CalWORKs child-only cases per month are anticipated to include an adult with a previous felony drug conviction that will become eligible for CalWORKs. The 2015-16 budget provides \$23.4 million (\$1 million General Fund) for this policy.

May Revision. The Administration proposes trailer bill language that deletes a mid-period reporting requirement that is no longer applicable. Existing law previously required a CalWORKs recipient to report a drug felony conviction, as specified, within ten days. This proposed trailer bill eliminates this requirement and makes the code consistent with current law.

Background. Senate Bill 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, expands eligibility for adults who were previously ineligible for benefits due to a prior felony drug conviction, effective April 1, 2015.

Staff Recommendation. Approve as requested. The subcommittee previously considered the January budget during its March 26, 2015 hearing.

4. TBL 613 and BBL: Housing Support Program and Extension of Liquidation Period

(Issue 706)

May Revision. The Administration proposes trailer bill language that contains the following provisions:

1. Requires the department to award funds, according to criteria developed by the department in consultation with the County Welfare Directors Association, to provide CalWORKs housing support to recipients who are experiencing homelessness or housing instability.
2. Authorizes counties to continue providing housing support under the CalWORKs Housing Support Program to a recipient who may no longer be income eligible for CalWORKs.
3. Other technical, non-substantive changes.

In addition, the Administration proposes budget bill language to extend the availability of funds appropriated in the 2014 Budget Act to allow counties to liquidate Housing Support Program expenditures that occurred in fiscal year 2014-15 but will be paid in 2015-16.

Background. SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, established the CalWORKs Housing Support Program and provides \$20 million (\$12 million General Fund) to be awarded to 20 counties to provide evidence-based interventions to families receiving CalWORKs who are at risk for homelessness or are homeless. Services could include landlord outreach, housing search and placement, legal services, and housing barrier assessment.

Staff Comment and Recommendation. Adopt placeholder trailer bill and budget bill language, as requested.

5. Welfare to Work 24-Month Clock

January Budget. The Governor's budget assumed \$6.4 million (\$500,00 General Fund) in associated savings for cases that will receive a grant reduction for not meeting the federal participation requirements after using 24 months of welfare-to-work (WTW) services. The March estimate projected 2,600 cases would experience a grant reduction by June 2016.

May Revision. The Administration estimates \$1 million (\$100,000) in savings for cases that will receive a grant reduction for not meeting federal requirements after 24 months of WTW services. The department also updates its estimate that after 24 months of WTW services and the conciliation process, approximately 1,500 cases will have the adult's portion of the grant removed by June 2016.

Background. SB 1041 (Budget and Fiscal Review Committee), Chapter 47, Statutes of 2012, created a differentiation between welfare-to-work participation rules that apply before expiration of a 24-month time limit. A county may provide extensions of up to six months, after a review at least every six months, of the more flexible rules for up to 20 percent of participants. Recognizing the significant program changes, AB 74 also established several early engagement strategies, such as subsidized employment, family stabilization, and online CalWORKs appraisal tool.

The first 24-months provide flexibility for CalWORKs clients to participate in activities, such as education and barrier-removal services. After 24-months, clients must participate in activities that satisfy federal work participation requirements. If clients do not meet the federal participation requirements following the 24-months of flexibility, then they may receive a grant reduction for the adult portion of the grant.

According to the department, although the 24-month clock was effective January 1, 2013, “it is assumed that the clock did not fully implement statewide until April 2013.” The department projects that no clients will receive a grant reduction in the current year, but at least 9,000 cases may experience a grant reduction by June 2017.

Staff Recommendation. In recognition of the delays in rolling out the early engagement pieces, adopt placeholder trailer bill language to delay the effect of the 24-month clock policy for clients who were not afforded the benefits of program change, thereby ensuring that these clients do not receive a grant reduction in 2015-16. Approve \$1 million GF to continue to serve clients who will, as a result of this action, not be receiving a grant reduction. Staff recommends that the department provide relevant and updated data and information, throughout the interim and at legislative hearings, that will assess and determine the long-term impacts of the 24-month clock policy, including a) the utilization of supportive services, like child care; b) the participation in specified work or education related activities; c) the sanction rate, by county and statewide, as point-in-time and longitudinally.

6. Repeal of the Maximum Family Grant

Budget Issue. Advocates request to repeal the Maximum Family Grant (MFG).

Background. AB 473 (Brulte), Chapter 196, Statutes of 1994, prohibits an increase in CalWORKs aid based on an increase in the number of needy persons in a family due to the birth of an additional child, if the family has received aid continuously for the ten months prior to the birth of the child, as specified, or for longer than the gestational period of the new baby. Based on information provided by the Department of Social Services (DSS) from data collected from the county consortia, 13.3 percent of total children in CalWORKs families are currently subject to the MFG rule, or approximately 131,400 children. Approximately 58.2 percent of those children are under the age of six.

Staff Recommendation. Effective October 1, 2015, repeal the Maximum Family Grant, with the inclusion of \$158 million GF for the policy.

5180 Department of Social Services – Child Welfare Services**1. Continuum of Care Reform**

Budget Issue. The budget includes \$9.6 million (\$7 million General Fund) to fund two of the 19 recommendations outlined in the Continuum of Care Reform Report: increase foster parent recruitment, retention, and training efforts (\$3.8 million [\$2.8 million GF]); and increase foster family agency social worker rates (\$5.8 million [\$4.2 million GF]) by fifteen percent.

Background. SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, authorized the Continuum of Care Reform (CCR) effort to develop recommendations related to the state's current rate setting system, and to services and programs that serve children and families in the continuum of Aid to Families with Dependent Children-Foster Care (AFDC-FC) eligible placement settings. In particular, the Legislature expressed its intent for recommended reforms, including reforms related to the use of group homes, changes to the rate systems, and changes to the assessment of children's needs, and to outcome measurement, to promote positive outcomes for children and families.

Staff Comment. Adopt as proposed; adopt placeholder trailer bill language that will include additional detail and specifications for how the \$3.8 million for foster parent outreach, recruitment and support will be used, as well as what outcomes should be expected; as well as additional guidance per legislative interest. The LAO noted, during the subcommittee's hearing on April 9, 2015, that the proposal also does not include detail for how funding will be distributed and whether all counties will have access to these funds. Staff recommends that proposed trailer bill language and further conversations with the department and stakeholders will identify this answer.

2. TBL 608: Child Near Fatality Public Disclosure

January Budget. The Administration proposes the following trailer bill language:

SECTION 1. It is the intent of the Legislature that California comply with the requirements set forth in the federal Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 et seq; 42 U.S.C. 5116 et seq.) relating to the public disclosure of information pertaining to child near fatalities that are the result of child abuse or neglect.

Background. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states receiving funds under CAPTA must disclose to the public findings and information about child abuse and neglect cases that result in fatalities or near fatalities. A September 15, 2008, letter from the federal Department of Health and Human Services, Administration on Children, Youth, and Families found that the state's disclosure practice for fatalities is more extensive than that released for near fatalities. The federal Child Welfare Policy Manual (CWPM) clarifies that states must develop procedures for the release of information including, but not limited to, the following items:

- Cause of and circumstances regarding the fatality or near fatality;
- Age and gender of the child;
- Information describing any previous reports of child abuse and/or neglect investigations; that are pertinent to the child abuse and/or neglect that led to the fatality or near fatality;

- Result of any such investigations; and,
- Services provided by and actions of the state on behalf of the child pertinent to the child abuse and/or neglect that led to the fatality or near fatality.

Senate Bill 39 (Migden), Chapter 468, Statutes of 2007, requires that once the cause of death from abuse or neglect has been substantiated, the child welfare agency must, within five days of a request, release specified records (age, gender, date of death of the child; whether an investigation is being conducted; whether the child was in foster care or in the home of his/her parent or guardian), subject to redaction of confidential information. The bill did not make any provision for the release of information for cases of near fatalities.

The CAPTA grant averages slightly more than \$3 million annually.

Staff Comment and Recommendation. Staff recommends rejecting the Governor’s January trailer bill proposal, without prejudice. This item was heard at the subcommittee’s April 9, 2015, hearing and held open to allow for additional time to refine language with stakeholders. The April 9 agenda reflected extensive trailer bill language that was previously posted online, but was rescinded prior to the hearing date. To date, (a) no additional, developed language --beyond the intent language stated above --is posted publicly; and (b) no consensus, across multiple stakeholders (County Welfare Directors Association, Child Advocacy Institute, NYCL, and the California Newspaper Publishers Association) has been reached. The inclusion and development of any language beyond this point would require extensive review not afforded by the May Revision process. Staff recognizes the department’s commitment to identify language and practices to reach compliance with federal requirements, but recommends that the department do so through the policy process, to ensure that lengthier time of discussion is provided and that the proposed language does not represent a retreat from, or complicates, existing practice.

3. Case Record Reviews

(Issue 720)

May Revision. The Administration requests Item 5180-151-0001 be increased by \$2,346,000 General Fund; Item 5180-151-0890 be increased by \$2,472,000 Federal Trust Fund; and Item 5180-153-0001 be increased by \$614,000 General Fund to provide additional funding to counties for the preparation and completion of upcoming federal child welfare case reviews. The May Revision projects 155 full-time equivalents in the budget year, with an annual statewide cost of \$129,074 per social worker full-time equivalent. The May Revision estimates approximately 125,339 child welfare and probation cases in case review.

Staff Recommendation. Approve as proposed, as no concerns have been raised.

4. Child Welfare Training Program

(Issue 721)

January Budget. The January budget includes \$26 million (\$10.8 million GF) to provide a statewide coordinated training program to meet the needs of county social workers assigned to emergency response, family maintenance, family reunification, permanent placement, and adoption responsibilities.

May Revision. The May Revision reflects a \$2.3 million (\$474,000 GF) increase to cover the cost of a ten percent indirect cost rate for UC San Diego, Fresno State University, and UC Berkeley to continue providing the training.

Background. The Child Welfare Training Program includes training for public agencies, including county probation departments, who provide child welfare case management services. The training includes crisis intervention, investigative techniques, rules of evidence, indicators of abuse and neglect, assessment criteria, intervention strategies, family-based services, legal requirements of child protection, indicators of mental health needs, case management, and the use of community resources.

Staff Recommendation. Approve as proposed, as no concerns have been raised.

5. Strengthening Families Act

(Issue 722)

May Revision. The Administration requests an increase of \$1,350,000 General Fund to Item 5180-151-0890; an increase of \$1,422,000 in Federal Trust Fund; and, Item 5180-153-0001 to be increased by \$1,333,000 General Fund to support newly identified requirements and components necessary to ensure compliance with the federal Preventing Sex Trafficking and Strengthening Families Act of 2014.

Background. SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, established the county opt-in CSEC program and appropriated \$5 million General Fund for:

- Training foster youth and other youth on how to recognize and avoid being exploited (\$750,000);
- Statewide training for county social workers, probation officers, out-of-home caregivers, and group home staff (\$1.75 million); and,
- Protocol development and capacity building (\$2.5 million).

Funds have been provided via several contracts to train social workers; and a new agreement is under development with the Community College Chancellor's Office to provide training to caregivers through the community colleges. In addition, the federal Preventing and Addressing Child Trafficking (PACT) grant provides \$1.25 million over five years for consultation and training support to ten counties for developing multi-disciplinary teams.

Related Budget Issue for Commercial Sexual Exploitation of Children. The Governor's budget includes \$17.8 million (\$14 million GF) for: development and implementation of case management and services, employing local multidisciplinary teams including mandated partner service providers, such as law enforcement, mental health, probation, and others.

Advocate concerns. The County Welfare Directors Association (CWDA) is opposed to the Administration’s proposal that “diverts \$3.25 million of the \$14 million General Fund intended for services to victims of child sex trafficking in the budget to meet new federal mandates under P.L. 113-183, Strengthening Families Act.” CWDA request that the funds, separate from, and in addition to, the existing \$14 million GF, for the new federally required CSEC activities be moved back in the Strengthening Families budget items (\$3.25 million SGF), or that new funding be added to the CSEC premise on top of the \$14 million GF. CWDA would like to ensure that proposed funds are sufficient for counties to meet the new federal mandates in 2015-16.

Staff Comment and Recommendation. Approve proposal, with direction for staff to continue working with advocates and the department to identify any possible technical problems associated with the relationship between prior funding and new proposal. At an April 9, 2015 hearing, the subcommittee conducted oversight on the Commercial Sexual Exploitation of Children program; at which time, the department noted the likelihood of a May Revision request, stating “Work continues to define the requirements that overlap between the state CSEC program and federal HR 4980 legislation. This will ensure a consistent program and federal reimbursement for eligible activities.”

6. Performance Data on Psychotropic Medication for Children in Foster Care

(Issue 723)

May Revision. The Administration proposes \$149,000 (\$100,00 GF)² for the department to contract with the University of California, Berkeley, for the purpose of matching Medi-Cal pharmacy claims data collected by the Department of Health Care Services (DHCS) with foster care data at regular intervals. This data matching effort will improve DSS’ ability to identify and monitor psychotropic drug use in the foster care system. In addition, this control will allow for data analysis, including case specific information that can be shared with counties.

Background. To meet the federal requirements that a state’s health care oversight plan must include an outline of protocols for the appropriate use and monitoring of psychotropic medications (Public Law 112-34), DSS and DHCS have conducted cross-system data matching to inform policy decisions for effective oversight and monitoring.

Staff Comment and Recommendation. Approve, as proposed. Staff notes the movement of proposes policies through the legislative process that pertain to the subject.

7. TBL 609: Intensive Treatment Foster Care (ITFC) Rate Extension

May Revision. The Administration proposes trailer bill language that includes the following provisions:

1. Extends, from June 30, 2015 to December 31, 2016, the applicable interim period for specified modified service and rate levels, which support modified in-home support counselor hours per month, apply.
2. Extends, from June 30, 2015 to December 31, 2016, the interim period for which specified modified serve and rate levels, that support the modified standard rate schedule, apply.

² An increase of \$100,000 in Item 5180-151-0001, and an increase in \$49,000 Federal Trust Fund.

3. Requires the rate for the modified standard rate be adjusted for the California Necessities Index on July 1, 2015, and on July 1, 2016.

Background. ITFC offers an alternative, family-like setting for foster children who would otherwise be placed in group homes at a higher cost. SB 1380 (Steinberg), Chapter 486, Statutes of 2008, expanded the number of children eligible for the ITFC program by including youth with serious behavioral problems who would otherwise require placement into group homes Rate Classification Level (RCL) 9 through 11. SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, authorized the Continuum of Care Reform (CCR) effort to develop recommendations related to the state's current rate setting system, and to services and programs that serve children and families in the continuum of Aid to Families with Dependent Children-Foster Care (AFDC-FC) eligible placement settings. In particular, the Legislature expressed its intent for recommended reforms, including reforms related to the use of group homes, changes to the rate systems, and changes to the assessment of children's needs, and to outcome measurement, to promote positive outcomes for children and families.

SB 1013 also provided for an interim increase in rates, including a California Necessities Index increase, intended to ensure providers keep pace with the costs of providing care, recruitment, and retaining qualified foster caregivers for children needing intensive treatment in a home-based setting. The ITFC placement addresses the needs of the *Katie A.* subclass population, pending development of the therapeutic foster home and implementation of the continuum of care for foster children.

Related Budget Issue: Continuum of Care Reform. The budget includes \$9.6 million (\$7 million General Fund) to fund two of the 19 recommendations outlined in the Continuum of Care Reform Report: increase foster parent recruitment, retention, and training efforts (\$3.8 million [\$2.8 million GF]); and increase foster family agency social worker rates (\$5.8 million [\$4.2 million GF]) by fifteen percent.

Staff Comment and Recommendation. Approve as proposed. Staff notes the ongoing conversations related to

5180 Department of Social Services In-Home Supportive Services**1. Fair Labor Standards Act**

January Budget. The Administration includes \$721 total funds (\$335 million GF) for a full-year of program and administrative activities, related to the implementation of FLSA overtime, as specified in SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014.

Staff Comment and Recommendation. Amend Governor's estimates to reflect a timeline that would ensure safe and expedient implementation of overtime. Based on estimates of the amount of time to make CMIPS II changes to enable the implementation of FLSA rules, the subcommittee may wish to consider directing staff to work with the Legislative Analyst's Office to identify the timeline.

2. BCP #1: IHSS CMIPS II and Overtime Implementation for FLSA

January Budget. The department requests \$1 million (\$513,000 GF) for associated operating expenses and for four new positions. The department is also seeking a two-year extension of the following four existing limited-term positions, associated with the Case Management, Information and Payrolling System II through the maintenance and operation phase. The department notes that existing backlogs and additional workload related to FLSA activities, such as incorporating workweek limitations and payment for providers who travel between two recipients in the CMIPS II system, have placed "some of the normal operational activities on hold and has resulted in time-consuming tasks for staff to research and identify the issues."

Staff Comment and Recommendation. Approve as proposed. The subcommittee first considered this proposal at its March 26, 2015 hearing. Staff notes the criticality of CMIPS II in implementing overtime payment and tracking.

3. Implementation of Federal Overtime Regulations

May Revision (Issue 710, 711). It is requested that Item 5180-111-0001 be increased by \$18,260,000 General Fund and reimbursements be decreased by \$9,354,000 to reflect updated IHSS caseload-related increases and a shift of one-time administrative costs from 2014-15 to 2015-16, due to the delayed implementation of Fair Labor Standards Act (FLSA) regulations.

Background. The Budget Act of 2014 recognized these new regulations, thought to be effective January 1, 2015, and provided \$405.6 million (\$183.6 million GF) to cover implementation of federal requirements, including the creation of a new workweek system, automation changes for the Case Management Information and Payrolling System II (CMIPS II), and payment for overtime, travel time between two clients, and medical accompaniment wait time. On December 31, 2014, a federal district court determined that a portion of the regulations exceeded the Department of Labor's authority and delayed implementation of the regulations. California's implementation of FLSA, such as limiting providers to a 61-hour workweek (66-hour workweek minus the current seven-percent reduction in service hours), is delayed pending further action by the federal court.

Due to increases in caseload, hours per case, and costs per hour, the May Revision increases funding for the program by \$147.6 million General Fund in current year and \$179.1 million General Fund in budget year. In addition, the May Revision proposes to use one-time, unspent \$184 million General Fund – the amount included in the current year for implementation of the Fair Labor Standards Act – to offset increasing IHSS costs. The remainder of the unspent FLSA-related funding appropriated in 2014-15 will be used to partially offset the overall increase in IHSS costs since the Governor’s budget.

Staff Recommendation. Approve the Governor’s May Revision request.

4. Increase General Fund Loan Authority for the IHSS Program

(Issue 714)

May Revision. The Administration proposes to increase loan authority from \$385 million to \$650 million to alleviate cash flow complications resulting from delayed reimbursement of federal funds from the Department of Health Care Services (DHCS).

Staff Recommendation. Approve, as no concerns have been raised.

5. Restoration of the Seven Percent Reduction

January Budget. The Governor’s budget includes a proposal to create a new managed care organization (MCO) tax, which is projected to raise an additional \$215.6 million GF in revenues (to be matched with federal funds) to fully restore the seven percent reduction in IHSS hours.

Background. A settlement agreement repealed previous reductions and replaced them with an eight percent across-the-board cut, effective July 1, 2013, which will become a seven percent across-the-board cut on July 1, 2014. The settlement agreement also included a provision to “trigger off” the ongoing reduction of up to seven percent—in whole or in part—as a result of enhanced federal funding received pursuant to an “assessment” (likely a fee or tax) on home care services, including IHSS. On August 28, 2014, the Administration sent a letter to the Legislature indicating that it had worked in good-faith to develop a federally-compliant proposal authorizing an assessment but, given the new federal guidance on health care related taxes, it would not be able to meet the October 1, 2014 deadline. The letter indicated that the Administration would work with all parties on viable legislation early in the 2015-16 Legislative Session.

Staff Recommendation. Approve \$228 million General Fund to restore the across-the-board seven-percent reduction in service hours.

5180 Department of Social Services – Adult Protective Services**1. APS Position Codification**

Budget Issue. The California Elder Justice Coalition, the California Commission on Aging, and the County Welfare Directors Association, request the following trailer bill language be included:

WIC 15753 is added, to read:

The department shall, to the extent funding for this purpose remains with the department, establish one full-time position which reports to the director to assist counties with the following functions in their operation of the adult protective services system:

- A. Facilitating the review and update of state policies and procedures to promote best casework practices throughout the state, and providing technical assistance to local programs to promote consistent statewide adherence to these policies.
- B. Developing recommended program goals, performance measures, and outcomes for the adult protective services system, and a strategic plan to accomplish these recommended goals, performance measures, and outcomes.
- C. Collaborating with other state departments and local communities that provide or oversee elder justice services to address the needs of elders and adults with disabilities and improve coordination and effectiveness of adult protective services.
- D. Exploring the development of a state data collection system that builds on existing statewide data and additionally tracks outcomes that will align with national data collection efforts.
- E. Participating in national, statewide and regional discussions on adult protective services and elder justice issues and providing information on California’s adult protective services programs.
- F. Participating in the development of federal and state policy that responds to new and emergent needs and develops suggested quality assurance measures to be implemented at the local level.
- G. Facilitating the development of a regionally based, ongoing, comprehensive and consistent statewide adult protective services training program that responds to new and emerging trends .
- H. In collaboration with experts in the field, developing guidelines for local adult protective services programs that will make recommendations for local practice in following areas:
 - a. Caseload levels for adult protective services workers
 - b. Availability of tangible services for local programs
 - c. Educational and professional development of adult protective services workers
 - d. Structure for 24 hour adult protective services response

Staff Comment and Recommendation. Adopt as proposed. As of May 12, 2015, the one position at the department has been filled. Staff notes that advocates request this language to ensure that the department retains dedicated staff related to APS issues.

SUBCOMMITTEE #3: Health & Human Services

Chair, Holly J. Mitchell
Senator Jeff Stone, Pharm.D.
Senator William W. Monning



May 21, 2015
10:00 AM
Room 4203, State Capitol

Part C

Consultant: Samantha Lui

ISSUES RECOMMENDED FOR VOTE-ONLY

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PLEASE NOTE. Only those items contained in this agenda will be discussed at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. 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. Thank you.

ISSUES RECOMMENDED FOR VOTE-ONLY

4700 Department of Community Services and Development

1. BCP #2: Migrant & Seasonal Farmworkers Drought Assistance Program

May Revision. The Administration requests \$7.5 million General Fund to provide emergency relief and support services to specified populations, including those who are low-income and migrant and seasonal farmworkers (MSFWs), within the state’s most drought impacted counties. Services could include rental and utility assistance, transportation, and basic necessities, including access to food resources. The \$7.5 million GF will augment existing federal Community Services Block Grant funding to support core funding for four local non-profit organizations. Approximately 3,200 MSFWs and low-income individuals will be served, with an average benefit of \$2,000 per person. Currently, MSFW organizations serve 24¹ of the most drought-affected counties, which are defined as those that have high unemployment; a high share of agricultural workers; and “exceptional” drought conditions, according to the U.S. Drought Monitor Classification System.

Staff Comment and Recommendation. Approve. This issue was considered on May 19, 2015. As effects of the drought may continue to impact California’s economy beyond the one year this budget request proposes, and staff recommends that department provide periodic updates and provide additional information, including, but not limited to overall met need, program outcomes, number of individuals served, and types of services provided, at future budget committee hearings and throughout its implementation. **Approve (3-0)**

5160 Department of Rehabilitation

1. Legislative Proposal: Supported Employment Program

Background. The Supported Employment Program provides activities and services, including ongoing support services, needed to support and maintain an individual with a significant disability in an integrated employment setting. Persons with developmental disabilities who wish to participate in supported employment, enter the program through DOR. DOR services are typically limited to 18 months, after which the person typically shifts to the Department of Developmental Services (DDS)-funded supported employment program. Under the Part B agenda today, the committee approved a ten percent rate increase for the DDS-funded supported employment program.

Staff Comment and Recommendation. To correspond with the actions taken in the DDS budget, provide a 10 percent rate increase for supported employment programs funded through DOR, staff recommends approving \$264,000 GF for this purpose. **Approve (3-0)**

¹ Amador, Butte, Colusa, Fresno, Glenn, Kern, Kings, Lake, Lassen, Madera, Monterey, San Benito, San Joaquin, Santa Cruz, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Tulare, Yolo, and Yuba counties.

5180 Department of Social Services**1. May Revision Caseload and Estimates Update**

(Issue 700, 701)

The May Revision proposes a net increase of \$176,635,000 (increases of \$218,155,000 General Fund, \$12,366,000 Children's Health and Human Services Special Fund, \$7,777,000 reimbursements, \$532,000 Child Support Collections Recovery Fund, \$12,000 Emergency Food Assistance Program Fund, partially offset by a decrease of \$62,207,000 Federal Trust Fund) primarily resulting from updated caseload estimates since the Governor's budget. Realigned programs are displayed for the purpose of federal fund adjustments and other technical adjustments. Caseload and workload changes since the Governor's budget are displayed in the following table:

Staff Recommendation. Approve May Revision caseload estimate changes, subject to additional conforming changes made by other legislative actions. **Approve (3-0)**

2. BCP #86, TBL 610: Federal Immigration Assistance and Associated Impact

(Issue 704, 724, 725)

The May Revision includes the following components and revised caseload and funding estimates, related to the federal immigration assistance:

1. \$4.8 million General Fund for the department to contract with qualified legal services organizations to provide application assistance for specified persons;
2. \$191,000 GF to establish a position at DSS;
3. Provisional budget bill language to extend the liquidation period for encumbered amounts until June 30, 2021; and,
4. Proposed trailer bill language to implement these provisions.

May Revision. The Administration requests \$5 million General Fund for the department to contract with qualified nonprofit legal services organizations to provide application assistance to persons residing in California who are eligible for, or to renew, Deferred Action for Childhood Arrivals (DACA) or Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) status. Legal services will include culturally and linguistically appropriate services provided by attorneys, paralegals, interpreters and other support staff for assistance in applying for DACA or DAPA status or renewal of that status with the United States Citizenship and Immigration Services.

In addition, the May Revision includes revised caseload estimates for several social services programs that may be impacted, as a result of the President's Immigration Accountability Executive Orders. The Administration provides that these estimates do not reflect an eligibility change for any of these programs; instead, the figures reflect an assumed increase in the take-up rate.

Background. On November 20, 2014, President Obama issued executive orders that expanded the population eligible for DACA program, and to include new Deferred Action for Parents of Americans (DAPA). Currently, the U.S. Citizenship and Immigration Services (USCIS) is not accepting applications for the expanded DACA and the DAPA. A federal district court in Texas issued an order

that temporarily blocks DAPA and the expanded DACA from being implemented. USCIS continues to accept renewal applications or initial applications from people who qualify under the initial DACA announcement in 2012. The May Revision assumes the suspension will be lifted and the USCIS will be accepting applications for DACA and DAPA program in the near future. As such, the May Revision anticipates impacts to several social services programs, beginning October 1, 2015.

Staff Recommendation. Amend Governor's May Revision to reflect the following language to be included, in addition to what was proposed in May Revision, in trailer bill language:

Approve (2-1, Sen. Stone voting no)

- Augment the \$5 million proposed May Revision with an additional \$15 million General Fund, for a total of \$20 million for the proposal;
- Require that the department must contract with, and provide grants to, subject to available funding in the Budget Act, qualified non-profit organizations to provide legal services or legal training and technical assistance to non-profit legal organizations;
- Expand the list of organizations who may be eligible for contracts and grants, to include labor unions or central labor bodies;
- Expand the types of legal services that may be provided to include:
 - Other legal remedies for people receiving DACA or DAPA application assistance ;
 - Services to assist with the application process for naturalization; and
 - Services to provide legal training and technical assistance to non-profit legal service organizations, labor unions, or central labor bodies.
- Define the services that can be provided that assist the application process to include:
 - Outreach, workshop presentations, document review, Freedom of Information Act requests, and screening services to assist individuals with DACA, DAPA, naturalization, or other legal remedies.
- Define "legal training and assistance" to include:
 - Webinars, in-person trainings, technical assistance through e-mail, fax, or phone from non-profit legal organizations, labor unions, or labor bodies, their staff, and/or volunteers.
- Require that contracts and grants awarded through this program must fulfill specified criteria, including:
 - Legal services organizations that provide legal training and technical assistance must have at least ten years of experience conducting immigration legal services and technical assistance, and must be a Trust Fund Program administered by the State Bar of California
- Exempt specified organizations that provide legal training and technical assistance from providing legal services on a fee-per-case basis.
- Require the department, no later than March 1, 2016, to report to the fiscal legislative committee, the timeline for implementation.
- Require the department, no later than March 1, 2017, to provide information to the Legislature, including:
 - Participating entities awarded contracts and grants;
 - Number of applications submitted;
 - Identification of further barriers and challenges to immigration assistance and legal services related to naturalization and deferred action.

- Require the department, subject to available Budget Act funding, to contract with stakeholders that can demonstrate the ability to reach key communities eligible for DACA, DAPA, and naturalization.
- Define the terms “education” and “outreach” to include referrals to educational or legal services that support an applicant’s eligibility for citizenship or deferred action, and the importance of participating in civic engagement as a naturalized citizen. Education and outreach activities are prohibited from including representation as legal counsel that assists in the application process.

5180 Department of Social Services - CalFresh**1. State Emergency Food Assistance Program**

Budget Issue. The California Association of Food Banks (CAFB) requests a \$5 million General Fund appropriation for the State Emergency Food Assistance Program (SEFAP). Currently, there is no on-going General Fund dedicated for this use. In the 2013-14 fiscal year, the state Assembly donated \$1 million for one-time use. The \$5 million SEFAP request would be distributed to all counties based on the established formula for the distribution of Emergency Food Assistance Program, currently funded with federal dollars.

Background. The SEFAP funds provide additional flexibility to food banks, as they can purchase the items that they need to complement the types of foods that are currently available to them.

Staff Comment and Recommendation. Approve \$2.5 million GF in the budget year for this program. This item was considered at the subcommittee's April 30, 2015, hearing. **Approve (3-0).**

2. Nutrition Incentive Program/Market Match

Budget Issue. Advocates, including Roots of Change, Latino Coalition for a Healthy California, Ecology Center, and the Public Health Institute, proposed \$5 million General Fund annually to establish a statewide nutrition incentive program for purchasing California-grown fruits, nuts and vegetables (i.e. specialty crops), benefiting low-income families and California's economy.

Background. California's Market Match, beginning in 2009, doubles the purchasing power of nutrition assistance benefits (e.g. CalFresh) when spent on specialty crops at participating farmers' markets.

Staff Comment and Recommendation. Approve \$2.5 million GF in the budget year to establish a statewide nutrition incentive program and associated placeholder trailer bill to enact this action. This item was considered at the subcommittee's April 30, 2015, hearing. **Approve (3-0).**

5180 Department of Social Services - CalWORKs**1. Temporary Assistance for Needy Families (TANF) Transfer to CA Student Aid Commission**

(Issue 703)

May Revision. The Administration requests an increase in the department's federal funding by \$533,646,000 Federal Trust Fund to reflect an increase in the amount of federal TANF block grant funds available to offset General Fund costs in the Cal Grant program administered by the California Student Aid Commission (CSAC). Of this amount, \$286,320,000 reflects a technical correction.

Background. The proposed budget erroneously did not include the transfer amount assumed in the Governor's budget. The remaining increase of \$247,326,000 is primarily attributable to shifting of long-term sanctioned CalWORKs cases from the federal TANF program to a solely state-funded non-TANF maintenance-of-effort program (see Item 6980-101-0001, Issue 214-MR).

Staff Recommendation. Approve as requested, as no concerns have been raised. **Approve (2-1, Sen Stone voting no.).**

2. TBL 611: Child Support Pass-Through for Long-Term Sanction Cases

May Revision. The Administration proposes trailer bill to allow the Temporary Assistance for Needy Families (TANF) funds in FY 2014-15 to carry forward to the budget year. These TANF funds will be transferred to the Student Aid Commission in the budget year to offset GF. According to the Administration, this funding shift is cost neutral.

Background. Approximately 14,550 CalWORKs cases are in long-term sanction status. This proposal changes how child support is treated for these cases. Since funding for these cases is now switched to non-MOE GF, these cases will no longer assign their child support to the state, and the Department of Child Support Services will no longer be required to track these cases. If this child support income can be reasonably anticipated, it could be factored into recipients' grant calculations.

Staff Recommendation. Approve as requested, as no concerns have been raised. **Approve (3-0).**

3. TBL 612: Previous Drug Felony Reporting Requirement

January Budget. The department estimates that approximately 400 persons with a prior felony drug conviction will be added to an existing CalFresh household, and approximately 1,100 households will become newly eligible for CalFresh. In addition, DSS estimates that around 3,900 CalWORKs child-only cases per month are anticipated to include an adult with a previous felony drug conviction that will become eligible for CalWORKs. The 2015-16 budget provides \$23.4 million (\$1 million General Fund) for this policy.

May Revision. The Administration proposes trailer bill language that deletes a mid-period reporting requirement that is no longer applicable. Existing law previously required a CalWORKs recipient to report a drug felony conviction, as specified, within ten days. This proposed trailer bill eliminates this requirement and makes the code consistent with current law.

Background. Senate Bill 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, expands eligibility for adults who were previously ineligible for benefits due to a prior felony drug conviction, effective April 1, 2015.

Staff Recommendation. Approve as requested. The subcommittee previously considered the January budget during its March 26, 2015 hearing. **Approve (3-0).**

4. TBL 613 and BBL: Housing Support Program and Extension of Liquidation Period

(Issue 706)

May Revision. The Administration proposes trailer bill language that contains the following provisions:

1. Requires the department to award funds, according to criteria developed by the department in consultation with the County Welfare Directors Association, to provide CalWORKs housing support to recipients who are experiencing homelessness or housing instability.
2. Authorizes counties to continue providing housing support under the CalWORKs Housing Support Program to a recipient who may no longer be income eligible for CalWORKs.
3. Other technical, non-substantive changes.

In addition, the Administration proposes budget bill language to extend the availability of funds appropriated in the 2014 Budget Act to allow counties to liquidate Housing Support Program expenditures that occurred in fiscal year 2014-15 but will be paid in 2015-16.

Background. SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, established the CalWORKs Housing Support Program and provides \$20 million (\$12 million General Fund) to be awarded to 20 counties to provide evidence-based interventions to families receiving CalWORKs who are at risk for homelessness or are homeless. Services could include landlord outreach, housing search and placement, legal services, and housing barrier assessment.

Staff Comment and Recommendation. Adopt placeholder trailer bill and budget bill language, as requested. **Approve (3-0).**

5. Welfare to Work 24-Month Clock

January Budget. The Governor's budget assumed \$6.4 million (\$500,00 General Fund) in associated savings for cases that will receive a grant reduction for not meeting the federal participation requirements after using 24 months of welfare-to-work (WTW) services. The March estimate projected 2,600 cases would experience a grant reduction by June 2016.

May Revision. The Administration estimates \$1 million (\$100,000) in savings for cases that will receive a grant reduction for not meeting federal requirements after 24 months of WTW services. The department also updates its estimate that after 24 months of WTW services and the conciliation process, approximately 1,500 cases will have the adult's portion of the grant removed by June 2016.

Background. SB 1041 (Budget and Fiscal Review Committee), Chapter 47, Statutes of 2012, created a differentiation between welfare-to-work participation rules that apply before expiration of a 24-month time limit. A county may provide extensions of up to six months, after a review at least every six months, of the more flexible rules for up to 20 percent of participants. Recognizing the significant program changes, AB 74 also established several early engagement strategies, such as subsidized employment, family stabilization, and online CalWORKs appraisal tool.

The first 24-months provide flexibility for CalWORKs clients to participate in activities, such as education and barrier-removal services. After 24-months, clients must participate in activities that satisfy federal work participation requirements. If clients do not meet the federal participation requirements following the 24-months of flexibility, then they may receive a grant reduction for the adult portion of the grant.

According to the department, although the 24-month clock was effective January 1, 2013, “it is assumed that the clock did not fully implement statewide until April 2013.” The department projects that no clients will receive a grant reduction in the current year, but at least 9,000 cases may experience a grant reduction by June 2017.

Staff Recommendation. In recognition of the delays in rolling out the early engagement pieces, adopt placeholder trailer bill language to delay the effect of the 24-month clock policy for clients who were not afforded the benefits of program change, thereby ensuring that these clients do not receive a grant reduction in 2015-16. Approve \$1 million GF to continue to serve clients who will, as a result of this action, not be receiving a grant reduction. Staff recommends that the department provide relevant and updated data and information, throughout the interim and at legislative hearings, that will assess and determine the long-term impacts of the 24-month clock policy, including a) the utilization of supportive services, like child care; b) the participation in specified work or education related activities; c) the sanction rate, by county and statewide, as point-in-time and longitudinally. **Approve (2-1, Sen Stone voting no.).**

6. Repeal of the Maximum Family Grant

Budget Issue. Advocates request to repeal the Maximum Family Grant (MFG).

Background. AB 473 (Brulte), Chapter 196, Statutes of 1994, prohibits an increase in CalWORKs aid based on an increase in the number of needy persons in a family due to the birth of an additional child, if the family has received aid continuously for the ten months prior to the birth of the child, as specified, or for longer than the gestational period of the new baby. Based on information provided by the Department of Social Services (DSS) from data collected from the county consortia, 13.3 percent of total children in CalWORKs families are currently subject to the MFG rule, or approximately 131,400 children. Approximately 58.2 percent of those children are under the age of six.

Staff Recommendation. Effective October 1, 2015, repeal the Maximum Family Grant, with the inclusion of \$158 million GF for the policy. **Approve (2-1, Sen Stone voting no.).**

5180 Department of Social Services – Child Welfare Services**1. Continuum of Care Reform**

Budget Issue. The budget includes \$9.6 million (\$7 million General Fund) to fund two of the 19 recommendations outlined in the Continuum of Care Reform Report: increase foster parent recruitment, retention, and training efforts (\$3.8 million [\$2.8 million GF]); and increase foster family agency social worker rates (\$5.8 million [\$4.2 million GF]) by fifteen percent.

Background. SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, authorized the Continuum of Care Reform (CCR) effort to develop recommendations related to the state's current rate setting system, and to services and programs that serve children and families in the continuum of Aid to Families with Dependent Children-Foster Care (AFDC-FC) eligible placement settings. In particular, the Legislature expressed its intent for recommended reforms, including reforms related to the use of group homes, changes to the rate systems, and changes to the assessment of children's needs, and to outcome measurement, to promote positive outcomes for children and families.

Staff Comment. Adopt as proposed; adopt placeholder trailer bill language that will include additional detail and specifications for how the \$3.8 million for foster parent outreach, recruitment and support will be used, as well as what outcomes should be expected; as well as additional guidance per legislative interest. The LAO noted, during the subcommittee's hearing on April 9, 2015, that the proposal also does not include detail for how funding will be distributed and whether all counties will have access to these funds. Staff recommends that proposed trailer bill language and further conversations with the department and stakeholders will identify this answer. **Approve (3-0).**

2. TBL 608: Child Near Fatality Public Disclosure

January Budget. The Administration proposes the following trailer bill language:

SECTION 1. It is the intent of the Legislature that California comply with the requirements set forth in the federal Child Abuse Prevention and Treatment Act (42 U.S.C. 5101 et seq; 42 U.S.C. 5116 et seq.) relating to the public disclosure of information pertaining to child near fatalities that are the result of child abuse or neglect.

Background. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states receiving funds under CAPTA must disclose to the public findings and information about child abuse and neglect cases that result in fatalities or near fatalities. A September 15, 2008, letter from the federal Department of Health and Human Services, Administration on Children, Youth, and Families found that the state's disclosure practice for fatalities is more extensive than that released for near fatalities. The federal Child Welfare Policy Manual (CWPM) clarifies that states must develop procedures for the release of information including, but not limited to, the following items:

- Cause of and circumstances regarding the fatality or near fatality;
- Age and gender of the child;

- Information describing any previous reports of child abuse and/or neglect investigations; that are pertinent to the child abuse and/or neglect that led to the fatality or near fatality;
- Result of any such investigations; and,
- Services provided by and actions of the state on behalf of the child pertinent to the child abuse and/or neglect that led to the fatality or near fatality.

Senate Bill 39 (Migden), Chapter 468, Statutes of 2007, requires that once the cause of death from abuse or neglect has been substantiated, the child welfare agency must, within five days of a request, release specified records (age, gender, date of death of the child; whether an investigation is being conducted; whether the child was in foster care or in the home of his/her parent or guardian), subject to redaction of confidential information. The bill did not make any provision for the release of information for cases of near fatalities.

The CAPTA grant averages slightly more than \$3 million annually.

Staff Comment and Recommendation. Staff recommends rejecting the Governor’s January trailer bill proposal, without prejudice. This item was heard at the subcommittee’s April 9, 2015, hearing and held open to allow for additional time to refine language with stakeholders. The April 9 agenda reflected extensive trailer bill language that was previously posted online, but was rescinded prior to the hearing date. To date, (a) no additional, developed language --beyond the intent language stated above --is posted publicly; and (b) no consensus, across multiple stakeholders (County Welfare Directors Association, Child Advocacy Institute, NYCL, and the California Newspaper Publishers Association) has been reached. The inclusion and development of any language beyond this point would require extensive review not afforded by the May Revision process. Staff recognizes the department’s commitment to identify language and practices to reach compliance with federal requirements, but recommends that the department do so through the policy process, to ensure that lengthier time of discussion is provided and that the proposed language does not represent a retreat from, or complicate, existing practice. **Approve (3-0).**

3. Case Record Reviews

(Issue 720)

May Revision. The Administration requests Item 5180-151-0001 be increased by \$2,346,000 General Fund; Item 5180-151-0890 be increased by \$2,472,000 Federal Trust Fund; and Item 5180-153-0001 be increased by \$614,000 General Fund to provide additional funding to counties for the preparation and completion of upcoming federal child welfare case reviews. The May Revision projects 155 full-time equivalents in the budget year, with an annual statewide cost of \$129,074 per social worker full-time equivalent. The May Revision estimates approximately 125,339 child welfare and probation cases in case review.

Staff Recommendation. Approve as proposed, as no concerns have been raised. **Approve (3-0).**

4. Child Welfare Training Program

(Issue 721)

January Budget. The January budget includes \$26 million (\$10.8 million GF) to provide a statewide coordinated training program to meet the needs of county social workers assigned to emergency response, family maintenance, family reunification, permanent placement, and adoption responsibilities.

May Revision. The May Revision reflects a \$2.3 million (\$474,000 GF) increase to cover the cost of a ten percent indirect cost rate for UC San Diego, Fresno State University, and UC Berkeley to continue providing the training.

Background. The Child Welfare Training Program includes training for public agencies, including county probation departments, who provide child welfare case management services. The training includes crisis intervention, investigative techniques, rules of evidence, indicators of abuse and neglect, assessment criteria, intervention strategies, family-based services, legal requirements of child protection, indicators of mental health needs, case management, and the use of community resources.

Staff Recommendation. Approve as proposed, as no concerns have been raised. **Approve (3-0).**

5. Strengthening Families Act

(Issue 722)

May Revision. The Administration requests an increase of \$1,350,000 General Fund to Item 5180-151-0890; an increase of \$1,422,000 in Federal Trust Fund; and, Item 5180-153-0001 to be increased by \$1,333,000 General Fund to support newly identified requirements and components necessary to ensure compliance with the federal Preventing Sex Trafficking and Strengthening Families Act of 2014.

Background. SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, established the county opt-in CSEC program and appropriated \$5 million General Fund for:

- Training foster youth and other youth on how to recognize and avoid being exploited (\$750,000);
- Statewide training for county social workers, probation officers, out-of-home caregivers, and group home staff (\$1.75 million); and,
- Protocol development and capacity building (\$2.5 million).

Funds have been provided via several contracts to train social workers; and a new agreement is under development with the Community College Chancellor's Office to provide training to caregivers through the community colleges. In addition, the federal Preventing and Addressing Child Trafficking (PACT) grant provides \$1.25 million over five years for consultation and training support to ten counties for developing multi-disciplinary teams.

Related Budget Issue for Commercial Sexual Exploitation of Children. The Governor's budget includes \$17.8 million (\$14 million GF) for: development and implementation of case management and services, employing local multidisciplinary teams including mandated partner service providers, such as law enforcement, mental health, probation, and others.

Advocate concerns. The County Welfare Directors Association (CWDA) is opposed to the Administration’s proposal that “diverts \$3.25 million of the \$14 million General Fund intended for services to victims of child sex trafficking in the budget to meet new federal mandates under P.L. 113-183, Strengthening Families Act.” CWDA request that the funds, separate from, and in addition to, the existing \$14 million GF, for the new federally required CSEC activities be moved back in the Strengthening Families budget items (\$3.25 million SGF), or that new funding be added to the CSEC premise on top of the \$14 million GF. CWDA would like to ensure that proposed funds are sufficient for counties to meet the new federal mandates in 2015-16.

Staff Comment and Recommendation. Approve proposal, with direction for staff to continue working with advocates and the department to identify any possible technical problems associated with the relationship between prior funding and new proposal. At an April 9, 2015 hearing, the subcommittee conducted oversight on the Commercial Sexual Exploitation of Children program; at which time, the department noted the likelihood of a May Revision request, stating “Work continues to define the requirements that overlap between the state CSEC program and federal HR 4980 legislation. This will ensure a consistent program and federal reimbursement for eligible activities.” **Approve (3-0).**

6. Performance Data on Psychotropic Medication for Children in Foster Care

(Issue 723)

May Revision. The Administration proposes \$149,000 (\$100,00 GF)² for the department to contract with the University of California, Berkeley, for the purpose of matching Medi-Cal pharmacy claims data collected by the Department of Health Care Services (DHCS) with foster care data at regular intervals. This data matching effort will improve DSS’ ability to identify and monitor psychotropic drug use in the foster care system. In addition, this control will allow for data analysis, including case specific information that can be shared with counties.

Background. To meet the federal requirements that a state’s health care oversight plan must include an outline of protocols for the appropriate use and monitoring of psychotropic medications (Public Law 112-34), DSS and DHCS have conducted cross-system data matching to inform policy decisions for effective oversight and monitoring.

Staff Comment and Recommendation. Approve, as proposed. Staff notes the movement of proposed policies through the legislative process that pertain to the subject. **Approve (3-0).**

7. TBL 609: Intensive Treatment Foster Care (ITFC) Rate Extension

May Revision. The Administration proposes trailer bill language that includes the following provisions:

1. Extends, from June 30, 2015 to December 31, 2016, the applicable interim period for specified modified service and rate levels, which support modified in-home support counselor hours per month, apply.
2. Extends, from June 30, 2015 to December 31, 2016, the interim period for which specified modified serve and rate levels, that support the modified standard rate schedule, apply.

² An increase of \$100,000 in Item 5180-151-0001, and an increase in \$49,000 Federal Trust Fund.

3. Requires the rate for the modified standard rate be adjusted for the California Necessities Index on July 1, 2015, and on July 1, 2016.

Background. ITFC offers an alternative, family-like setting for foster children who would otherwise be placed in group homes at a higher cost. SB 1380 (Steinberg), Chapter 486, Statutes of 2008, expanded the number of children eligible for the ITFC program by including youth with serious behavioral problems who would otherwise require placement into group homes Rate Classification Level (RCL) 9 through 11. SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, authorized the Continuum of Care Reform (CCR) effort to develop recommendations related to the state's current rate setting system, and to services and programs that serve children and families in the continuum of Aid to Families with Dependent Children-Foster Care (AFDC-FC) eligible placement settings. In particular, the Legislature expressed its intent for recommended reforms, including reforms related to the use of group homes, changes to the rate systems, and changes to the assessment of children's needs, and to outcome measurement, to promote positive outcomes for children and families.

SB 1013 also provided for an interim increase in rates, including a California Necessities Index increase, intended to ensure providers keep pace with the costs of providing care, recruitment, and retaining qualified foster caregivers for children needing intensive treatment in a home-based setting. The ITFC placement addresses the needs of the *Katie A.* subclass population, pending development of the therapeutic foster home and implementation of the continuum of care for foster children.

Related Budget Issue: Continuum of Care Reform. The budget includes \$9.6 million (\$7 million General Fund) to fund two of the 19 recommendations outlined in the Continuum of Care Reform Report: increase foster parent recruitment, retention, and training efforts (\$3.8 million [\$2.8 million GF]); and increase foster family agency social worker rates (\$5.8 million [\$4.2 million GF]) by fifteen percent.

Staff Comment and Recommendation. Approve as proposed. **Approve (3-0).**

5180 Department of Social Services In-Home Supportive Services**1. Fair Labor Standards Act**

January Budget. The Administration includes \$721 total funds (\$335 million GF) for a full-year of program and administrative activities, related to the implementation of FLSA overtime, as specified in SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014.

Staff Comment and Recommendation. Amend Governor's estimates to reflect a timeline that would ensure safe and expedient implementation of overtime. Based on estimates of the amount of time to make CMIPS II changes to enable the implementation of FLSA rules, the subcommittee may wish to consider directing staff to work with the Legislative Analyst's Office to identify the timeline. **Approve (2-1, Sen. Stone voting no).**

2. BCP #1: IHSS CMIPS II and Overtime Implementation for FLSA

January Budget. The department requests \$1 million (\$513,000 GF) for associated operating expenses and for four new positions. The department is also seeking a two-year extension of the following four existing limited-term positions, associated with the Case Management, Information and Payrolling System II through the maintenance and operation phase. The department notes that existing backlogs and additional workload related to FLSA activities, such as incorporating workweek limitations and payment for providers who travel between two recipients in the CMIPS II system, have placed "some of the normal operational activities on hold and has resulted in time-consuming tasks for staff to research and identify the issues."

Staff Comment and Recommendation. Approve as proposed. The subcommittee first considered this proposal at its March 26, 2015 hearing. Staff notes the criticality of CMIPS II in implementing overtime payment and tracking. **Approve (3-0).**

3. Implementation of Federal Overtime Regulations

May Revision (Issue 710, 711). It is requested that Item 5180-111-0001 be increased by \$18,260,000 General Fund and reimbursements be decreased by \$9,354,000 to reflect updated IHSS caseload-related increases and a shift of one-time administrative costs from 2014-15 to 2015-16, due to the delayed implementation of Fair Labor Standards Act (FLSA) regulations.

Background. The Budget Act of 2014 recognized these new regulations, thought to be effective January 1, 2015, and provided \$405.6 million (\$183.6 million GF) to cover implementation of federal requirements, including the creation of a new workweek system, automation changes for the Case Management Information and Payrolling System II (CMIPS II), and payment for overtime, travel time between two clients, and medical accompaniment wait time. On December 31, 2014, a federal district court determined that a portion of the regulations exceeded the Department of Labor's authority and delayed implementation of the regulations. California's implementation of FLSA, such as limiting providers to a 61-hour workweek (66-hour workweek minus the current seven-percent reduction in service hours), is delayed pending further action by the federal court.

Due to increases in caseload, hours per case, and costs per hour, the May Revision increases funding for the program by \$147.6 million General Fund in current year and \$179.1 million General Fund in budget year. In addition, the May Revision proposes to use one-time, unspent \$184 million General Fund – the amount included in the current year for implementation of the Fair Labor Standards Act – to offset increasing IHSS costs. The remainder of the unspent FLSA-related funding appropriated in 2014-15 will be used to partially offset the overall increase in IHSS costs since the Governor’s budget.

Staff Recommendation. Approve the Governor’s May Revision request. **Approve (3-0).**

4. Increase General Fund Loan Authority for the IHSS Program

(Issue 714)

May Revision. The Administration proposes to increase loan authority from \$385 million to \$650 million to alleviate cash flow complications resulting from delayed reimbursement of federal funds from the Department of Health Care Services (DHCS).

Staff Recommendation. Approve, as no concerns have been raised. **Approve (3-0).**

5. Restoration of the Seven Percent Reduction

January Budget. The Governor’s budget includes a proposal to create a new managed care organization (MCO) tax, which is projected to raise an additional \$215.6 million GF in revenues (to be matched with federal funds) to fully restore the seven percent reduction in IHSS hours.

Background. A settlement agreement repealed previous reductions and replaced them with an eight percent across-the-board cut, effective July 1, 2013, which will become a seven percent across-the-board cut on July 1, 2014. The settlement agreement also included a provision to “trigger off” the ongoing reduction of up to seven percent—in whole or in part—as a result of enhanced federal funding received pursuant to an “assessment” (likely a fee or tax) on home care services, including IHSS. On August 28, 2014, the Administration sent a letter to the Legislature indicating that it had worked in good-faith to develop a federally-compliant proposal authorizing an assessment but, given the new federal guidance on health care related taxes, it would not be able to meet the October 1, 2014 deadline. The letter indicated that the Administration would work with all parties on viable legislation early in the 2015-16 Legislative Session.

Staff Recommendation. Approve \$228 million General Fund to restore the across-the-board seven-percent reduction in service hours. **Approve (2-1, Sen. Stone voting no).**

5180 Department of Social Services – Adult Protective Services**1. APS Position Codification**

Budget Issue. The California Elder Justice Coalition, the California Commission on Aging, and the County Welfare Directors Association, request the following trailer bill language be included:

WIC 15753 is added, to read:

The department shall, to the extent funding for this purpose remains with the department, establish one full-time position which reports to the director to assist counties with the following functions in their operation of the adult protective services system:

- A. Facilitating the review and update of state policies and procedures to promote best casework practices throughout the state, and providing technical assistance to local programs to promote consistent statewide adherence to these policies.
- B. Developing recommended program goals, performance measures, and outcomes for the adult protective services system, and a strategic plan to accomplish these recommended goals, performance measures, and outcomes.
- C. Collaborating with other state departments and local communities that provide or oversee elder justice services to address the needs of elders and adults with disabilities and improve coordination and effectiveness of adult protective services.
- D. Exploring the development of a state data collection system that builds on existing statewide data and additionally tracks outcomes that will align with national data collection efforts.
- E. Participating in national, statewide and regional discussions on adult protective services and elder justice issues and providing information on California’s adult protective services programs.
- F. Participating in the development of federal and state policy that responds to new and emergent needs and develops suggested quality assurance measures to be implemented at the local level.
- G. Facilitating the development of a regionally based, ongoing, comprehensive and consistent statewide adult protective services training program that responds to new and emerging trends .
- H. In collaboration with experts in the field, developing guidelines for local adult protective services programs that will make recommendations for local practice in following areas:
 - a. Caseload levels for adult protective services workers
 - b. Availability of tangible services for local programs
 - c. Educational and professional development of adult protective services workers
 - d. Structure for 24 hour adult protective services response

Staff Comment and Recommendation. Adopt as proposed. As of May 12, 2015, the one position at the department has been filled. Staff notes that advocates request this language to ensure that the department retains dedicated staff related to APS issues. **Approve (3-0).**