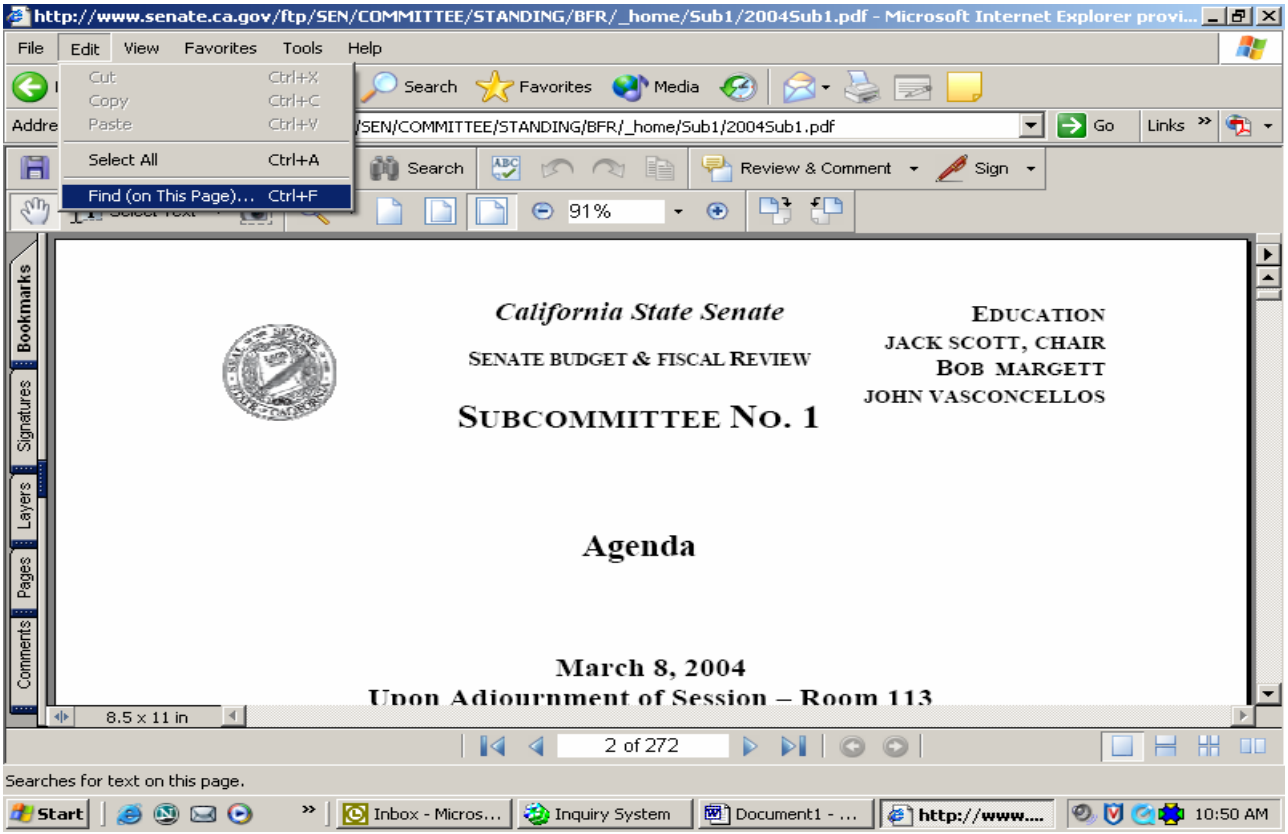
Senate Budget and Fiscal Review

Subcommittee No. 3 2014 Agendas

Complete year 2014 Subcommittee No. 3 agendas in PDF format. They are archived in Adobe to make them more accessible by subject. Please use "Edit" then "find" from the Menu to access information. Use "Bookmarks" from side menu To access agendas by date.



SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Bill Monning
Senator Mimi Walters

March 6, 2014

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

Room 4203, State Capitol

Agenda

(Michelle Baass)

4120 Emergency Medical Services Authority 3
1. Overview 3
2. Epinephrine Auto Injector Training 4

4140 Office of Statewide Health Planning and Development 6
1. Overview 6
1. Peer Personnel Support – Investment in Mental Health Wellness Act of 2013 7
2. Health Care Reform Health Workforce 8
3. Hospital Inpatient Discharge Data Audit 10
4. Song-Brown Primary Care Residency 12
5. Mental Health Services Act – Unspent Workforce Education Training Funds 15

0530 California Health and Human Services Agency (CHHSA) 16
1. Office of Systems Integration (OSI) – CHHSA Governance 16

0530 CHHSA & 4265 Department of Public Health 20
1. Transfer of Medical Privacy Breach Program to Department of Public Health 20

4265 Department of Public Health 22
1. Overview 22
2. Drinking Water Program Transfer to State Water Resources Control Board 25
3. Licensing and Certification (L&C) Program 28
4. L&C: Program Evaluation Contract 34
5. L&C: Licensing Standards for Chronic Dialysis, Rehabilitation, & Surgical Clinics 36
6. L&C: Oversight on Nursing Home Referrals to Community-Based Services 37
7. Office of AIDS (OA): AIDS Drug Assistance Program (ADAP) 38

8. OA: ADAP – Wrap for Out-of-Pocket Medical Expenses 41
9. OA: Cross Match of ADAP Data with Franchise Tax Board 44
10. Genetic Disease Screening Program – Prenatal Screening Fee Increase 45
11. Women, Infant, and Children Program 47
12. Nutrition Education and Obesity Prevention Branch – Contract Conversion 50
13. Infant Botulism Treatment and Prevention Program 52

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.

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 $28.4 million ($6.8 General Fund and $2.7 million federal funds) and 65.2 positions for EMSA. See table below for more information.

Table: EMSA Budget Overview

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed
General Fund	$6,692,000	$6,771,000	$6,771,000
Federal Trust Fund	1,511,000	2,625,000	2,678,000
Reimbursements	11,276,000	14,801,000	14,801,000
Special Funds	3,351,000	3,972,000	4,132,000
Total Expenditures	**$22,830,000**	**$28,169,000**	**$28,382,000**
Positions	**67.4**	**64.2**	**65.2**

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. Epinephrine Auto Injector Training

Budget Issue. EMSA requests one two-year limited-term position and $135,000 Specialized First Aid Training Approval (SFA) Fund expenditure authority, beginning July 1, 2014, to address the new workload associated with the development and implementation of the Epinephrine Auto Injector training and certification program resulting from the passage of SB 669 (Huff), Chapter 725, Statutes of 2013.

Since training program and certification revenues are not estimated to be collected until July 1, 2015, EMSA is requesting authority for a $135,000 loan from the Emergency Medical Services Personnel (EMSP) Fund for initial costs. Budget bill language to provide for this loan is requested.

EMSA proposes the following timeline to implement this new program:

- January 1, 2014 – June 30, 2014
    - Recruit and hire one position.
- July 1, 2014 – June 30, 2015
    - Convene taskforce to develop training standards and draft regulations.
- July 1, 2015 – June 30, 2016
    - Open and complete rulemaking process through the Office of Administrative Law.
    - Seek approval of the Office of Administrative Law and EMSA.
    - Begin to review and approve training programs and sell certification cards.

Background. The passage of SB 669 authorizes off-duty pre-hospital emergency medical care personnel and lay rescuers to obtain and use an epinephrine auto-injector (Epi-Pen) in emergency situations after receiving certification and training. SB 669 requires EMSA to approve authorized training providers and to establish and approve minimum standards for training and certification on the use and administration of epinephrine auto-injectors as specified by the bill.

SB 669 permits the EMSA to impose a reasonable fee on training providers for the review, approval, and certification of their training programs but does not expect the collection of fees to begin until July 1, 2015. EMSA estimates a training program review cost of $500 per program, with 10 programs to be reviewed throughout the entire state every year. The estimated revenue generated will be $5,000. Estimating an EMSA certification card and sticker cost of $15 per card for 9,000 individuals per year receiving or renewing their training will generate annual estimated revenues of $135,000. According to EMSA, given that there are approximately 80,000 EMTs and EMT-Paramedics currently licensed throughout the State, an estimate of 9,000 individuals who will seek training and renewals of certification every year is a very conservative number, as EMTs and EMT-Paramedics are not the only individuals who may reasonably have the responsibility to care for others. Other individuals throughout the

state may include camp counselors, park and forest rangers, wilderness guides, team coaches, and lifeguards.

California law authorizes school districts to provide epinephrine auto-injectors to trained personnel for the provision of emergency medical aid to students experiencing anaphylactic shock. School personnel first must complete an EMSA-approved training course covering characteristics and method of assessment and treatment of anaphylactic reactions and the use of epinephrine. These laws are consistent with laws adopted across the nation reflecting the understanding that the timely administration of epinephrine is essential to avoiding serious injury or death in cases of anaphylaxis, and that epinephrine auto-injectors, which contain carefully metered doses of this life-saving medication, are safe to administer by properly trained individuals.

Prior to the enactment of SB 669, it was illegal for first responders to possess or carry an epinephrine auto-injector to save lives for anyone suffering anaphylaxis. SB 669 expands the use of epinephrine auto-injectors by authorizing additional qualified personnel who have successfully completed a certified training course to obtain and use them to provide life-saving first aid in the event of anaphylaxis and provides immunity to properly certified individuals from civil liability, except in cases of gross negligence.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal as no concerns have been raised.

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

1. Please provide a brief overview of this proposal and the timeline to implement this new program.

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 $145.7 million ($74,000 General Fund) and 479.6 positions for OSHPD.

Table: OSHPD Budget Overview

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change
General Fund	$0	$74,000	$74,000	$0
Federal Trust Fund	1,434,000	1,504,000	1,444,000	-$60,000
Reimbursements	363,000	8,153,000	7,860,000	-$293,000
Mental Health Services Fund	20,957,000	52,350,000	26,291,000	-$26,059,000
Other Special Funds	69,044,000	114,156,000	110,066,000	-$4,090,000
Total Expenditures	**$91,798,000**	**$176,237,000**	**$145,735,000**	**-$30,502,000**
Positions	**445.1**	**476.6**	**479.6**	**-4**

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. 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.

OSHPD released the Peer Personnel Support Request for Proposal (RFP) on December 27, 2013, and held two bidders' conferences on January 23, 2014 and February 10, 2014. The final date for proposal submission is March 7, 2014. OSHPD expects to award four contracts.

Generally, the goal of this RFP is to enter into a contract, or contracts, to:

A. 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).

B. Recruit Peer Personnel for participation in the defined career pathway.

C. Establish/Expand educational or training programs for Peer Personnel.

D. 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.

Subcommittee Staff Comment. This is an informational item. It is requested that OSHPD keep the Subcommittee up-to-date on the implementation of this item.

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

1. Please provide an overview of this issue and present how this RFP meets the goals outlined in the Investment in Mental Health Wellness Act of 2013.

2. Did OSHPD work with stakeholders to develop this RFP? Please explain.

3. Health Care Reform Health Workforce

Budget Issue. OSHPD requests to make permanent the three limited-term positions responsible for proactive Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA) and Medically Underserved Population (MUP) designation. These positions proactively seek to make these designations to improve access to care in underserved communities.

Additionally, OSHPD requests to make permanent one position responsible for continuing the implementation of the Health Care Reform work plan.

These two requests result in an increase in the California Health Data and Planning Fund (CHDPF) expenditure authority of $355,000 in 2014-15 and ongoing.

Background. OSHPD has traditionally processed HPSA, MUA, and MUP applications in a reactive fashion; community clinics or stakeholders submit their application to OSHPD and staff validates the information in the HPSA, MUA, and MUP applications and makes a recommendation to the federal government.

The 2011-12 budget authorized three positions to perform these designations on a proactive basis. The proactive process allows OSHPD to prepare the aforementioned applications by identifying which areas of the state meet the federal criteria for designation and preparing designation applications on behalf of communities. However, OSHPD was unable to fill these four positions until February 2012. The 2013-14 budget reauthorized these positions through June 2014 on a one-year extension.

According to OSHPD, permanency for these positions is necessitated by the complexity of implementing Affordable Care Act (ACA) healthcare workforce provisions such as upcoming rule changes to the method of shortage designations, increasing demand to designate underserved areas, maximizing federal program and funding opportunities, developing policy recommendations on health workforce issues that promote employer health workforce diversity programs and invest in pipeline efforts, and developing workforce education and training programs that increase the health care workforce in underserved areas.

Additionally, the ACA includes provisions on health workforce. OSHPD has assumed the role of leading the state's efforts to ensure maximum funding for California for healthcare workforce development. This includes applying for grants that expand OSHPD programs , developing new programs and increasing awareness and providing technical assistance to grant applicants. OSHPD has been involved in guiding the implementation of health workforce provisions of the ACA and developed a health care reform implementation work plan. One of the limited-term positions requested to be extended is responsible for continuing the implementation of the healthcare reform work plan.

In the 2012 calendar year, California received almost $1.7 billion in federal, state, local, and private funding for programs in which one of the pre-requisites for participation is a HPSA,

MUA, or MUP designation. Given the myriad of programs whose funding status relies on its designation status, this number will increase considerably. The $1.7 billion represented an increase of nearly $200 million in funds leveraged from the 2011 calendar year. Of the 2013 total, $1.6 billion was awarded to Federally Qualified Health Centers (FQHC), FQHC Look-Alikes, and Rural Health Clinics (RHC). Both FQHC and RHC funds require the sites to be located in either a Primary Care HPSA/MUA/MUP or serve in a MUA/MUP designation.

During 2012-13, the federal government approved 21 new communities as Primary Care HPSAs through the efforts of these three positions, which resulted in an additional 1.7 million Californians benefiting from these designations.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this request. Granting permanency to these positions enables OSHPD to continue to proactively designate shortage areas and secure additional funding for California.

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

1. Please provide an overview of this proposal.

2. Please highlight the results in California of the proactive designation.

4. Hospital Inpatient Discharge Data Audit

Budget Issue. OSHPD requests two positions, $652,000 in 2014-15, and $636,000 ongoing in California Health Data and Planning Fund authority to conduct periodic audits of hospital discharge data that is related to any report that OSHPD publishes.

OSHPD requests two positions:

1. Research Scientist III –This position would utilize statistical techniques to analyze hospital discharge records to identify the hospitals most likely to have serious coding issues and recommend hospitals to be audited. This position would create, maintain, and update the data mining and analysis system for targeted hospital audits.

2. Associate Governmental Program Analyst – This position would communicate with hospitals, provide training interventions with facilities that have performed poorly on the audits, and provide technical assistance.

As part of this proposal, $400,000 would be used to contract with a vendor to conduct audits of medical records to assess data quality issues onsite at hospitals across the state. This would allow for reabstraction of 4,000 charts annually at 10 hospitals.

Background. OSHPD annually publishes the following 12 medical conditions or procedures:

- Acute Stroke [including hemorrhagic]
- Acute Myocardial Infarction [heart attack including transfers between healthcare facilities]
- Heart Failure
- Gastrointestinal Hemorrhage [intestinal bleeding]
- Hip Fracture
- Pneumonia
- Abdominal Aortic Aneurism Repair [for bulging abdominal aorta]
- Carotid Endarterectomy [surgery on the carotid artery in neck]
- Craniotomy [operation through the skull, including brain surgery]
- Esophageal Resection [removal of all or part of the esophagus]
- Pancreatic Resection [removal of all or part of the pancreas]
- Percutaneous Coronary Intervention (PCI) [non-surgical coronary artery disease treatment, including insertion of a stent]

OSHPD states that funding was not initially requested to fulfill the mandate (Health and Safety Code Section 128745(e)) to create outcome reports because the number of outcome measures OSHPD produced at that time was small, but it has since greatly expanded. Between 2008 and 2010, the number of reports grew 500 percent (from three to 15), making additional resources for data auditing necessary. The need for timely, accurate, and actionable healthcare information has been well documented in legislative mandates, national

healthcare reform efforts, and consumer initiatives as well as by business and healthcare industry representatives and the public health community.

Increasingly, health provider outcomes data are being used in programs that link payers' reimbursement levels with performance, such as the Center for Medicare and Medicaid Service's hospital performance-based incentive programs. OSHPD states that this proposal will support those programs and ensure more accurate reporting of hospital performance in the areas of risk-adjusted mortality, hospital-acquired infections, surgical and medical complications, rates of hospital readmissions, treatment errors, and patient safety incidents.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this request as it is important for reliable data to be used in OSHPD's reports. No issues have been raised with this proposal.

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

1. Please provide an overview of this proposal.

5. Song-Brown Primary Care Residency

Budget Issue. OSHPD requests the following:

a. $2.84 million per year for three years in California Health Data Planning Fund (CHDPF) expenditure authority to expand its Song-Brown Health Care Workforce Training Program to fund primary care residency programs via the Song-Brown Program. This expansion will increase the number of primary care residents specializing in internal medicine, pediatrics as well as obstetrics and gynecology (OB/GYN).

b. To expand eligibility for Song-Brown residency program funding to teaching health centers. Song-Brown's focus on areas of unmet need (AUN) results in residents' exposure to working with underserved communities, providing culturally competent care and learning to practice in an inter-disciplinary team.

c. One three-year limited-term Staff Services Analyst position and $106,000 in CHDPF spending authority to develop and implement the program. This position would, for example, draft regulations; seek stakeholder feedback; develop key program components such as eligibility criteria; work with OSHPD's e-application vendors to modify the grants management system to include the additional primary care residency programs; develop and implement an outreach and marketing campaign; administer the contract process; collect and maintain program data to prepare progress, final reports, and summaries; and evaluate the outcomes of the expansion program.

The funding source for this proposal will be the CHDPF which will receive a $12 million repayment from a loan to the General Fund in 2014-15.

Statutory changes are needed to implement this proposal. For example, statutory language is necessary to expand the Song-Brown program criteria to include residencies in Teaching Health Centers as the Song-Brown program is currently limited to medical school-based residency programs. Teaching health centers are community-based ambulatory patient care settings (e.g., clinics) that operate a primary care medical residency program.

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.

Funding is provided to family practice residency programs via capitation funding. Each training program funded by Song-Brown must meet the accreditation standards set forth by their specific discipline. Song-Brown funds do not replace existing resources but are used to support and augment primary care training. Family practice residency programs are funded in increments of $51,615 per capitation cycle ($17,205 per year for three years). The funding level per capitation cycle has remained the same since the program's inception in 1974 and only covers a portion of a resident's training cost which has been estimated to exceed $150,000 per year.

There are 110 primary care residencies in the state and of these, 44 are family practice programs that currently apply for Song-Brown funds. The remaining 66 residencies include 31 internal medicine, 18 OB/GYN, and 17 pediatric programs. Based on the number of primary care residency programs in California, the $2.84 million would be allocated into an annual 50/25/25 split at a capitation rate of $51,615 per resident for a maximum request of 2 residents per applicant. See below for tables on how these funds are proposed to be used.

Internal Medicine – Projected Outcomes by Fiscal Year

	2014-15	2015-16	2016-17
Requests received	31	31	31
Grants awarded	13	13	13
Residents/students supported	27	27	27
Funds awarded	$1,420,000	$1,420,000	$1,420,000

Obstetrics/Gynecology – Projected Outcomes by Fiscal Year

	2014-15	2015-16	2016-17
Estimate of possible applications	18	18	18
Estimate of possible application awards	6	6	6
Possible residents/students supported	13	13	13
Funds to be awarded	$710,000	$710,000	$710,000

Pediatrics – Projected Outcomes by Fiscal Year

	2014-15	2015-16	2016-17
Estimate of possible applications	17	17	17
Estimate of possible application awards	6	6	6
Possible residents/students supported	13	13	13
Funds to be awarded	$710,000	$710,000	$710,000

In the third year, OSHPD proposes that Song-Brown staff will engage in an extensive review of the expansion program to evaluate outcomes and impact. This will include documenting the number of primary care resident slots funded, exposure to primary care curricula and didactic clinical training in underserved areas, retention of residents in those areas, etc. Based on the evaluation of the program, permanent funding for the expansion program may be considered.

This proposal will be funded by the CHDPF. The CHDPF is supported by annual assessments on California's hospitals and skilled nursing facilities. Health and Safety Code Section 127280(h) provides for a maximum assessment rate of .035 percent of a hospital or skilled nursing facilities annual gross operating expenses. The current assessment rate for hospitals and skilled nursing facilities is .027 percent and .025 percent, respectively. In 2008, the CHDPF made a $12 million loan to the General Fund. This loan is scheduled to be repaid in 2014-15. The loan repayment will provide for the initial 3-year funding for this expansion program. If after evaluation of the first three years, on-going funding is supported, the assessment fee could be raised within the existing statutory limit to provide on-going support for this expansion program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open to continue discussions with the Administration on this proposal and how the statutory changes would be enacted.

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

1. Please provide an overview of this proposal.

6. Mental Health Services Act – Unspent Workforce Education Training Funds

Budget Issue. OSHPD requests that $102,000 in unexpended Mental Health Services Act (MHSA) Workforce, Education, and Training (WET) funds be appropriated through 2017-18 for mental health WET Programs.

Background. The 2012 budget transferred the Mental Health Services Act (MHSA) workforce education and training (WET) component to OSHPD (from the eliminated Department of Mental Health). The MHSA WET targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.

The 2013-14 budget includes the reappropriation of $7.8 million in unexpended WET funds through 2017-18 for WET programs. The $7.8 million included $1.6 million in unexpended WET contract funds from 2010-11 and 2011-12. Since this unspent balance was not from OSHPD appropriations (as it was originally appropriated when the program was at the Department of Mental Health), OSHPD could not request a reappropriation of funds through 2017-18 as it did with all other WET appropriations in SB 68, amending the Budget Act of 2012 (Chapter 21, Statutes of 2012). Thus, OSHPD requested a new appropriation in 2013-14 via a May Revision budget request.

During year-end closing exercises, after the May Revision budget request was submitted to the Legislature, OSHPD received new information regarding unexpended balances for two vendors. As such, those unexpended balances could not be included in the 2013 May Revision proposal. This budget proposal captures those unexpended balances and requests reappropriation.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this request. No issues have been raised with this proposal.

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

1. Please provide a brief overview of this proposal.

0530 California Health and Human Services Agency (CHHSA)

1. Office of Systems Integration (OSI) – CHHSA Governance

Budget Issue. The California Health and Human Services Agency (CHHSA) requests three permanent positions and $431,000 in reimbursement authority to provide dedicated staffing for the establishment of formalized governance, project assessment, and strategic enterprise architecture functions within the Office of the Agency Information Officer (OAIO).

The Administration states that the requested resources will greatly enhance information technology planning throughout the CHHSA by dedicating resources to prioriting information technology (IT) investments through early assessments and ensuring maximum investment in interoperable, highly adaptive systems that can be leveraged throughout the agency.

One of the requested positions would focus on strategic enterprise architecture and the other two positions would share responsibility for governance and program assessment, with one position taking a management role and the other position taking a staff analyst role. The requested positions would replace the redirected staff used sporadically in the past for these efforts.

CHHSA is also requesting to add provisional budget bill language to Item 0530-001-9745 that is intended to enhance the Office of Systems Integration's (OSI) ability to timely provide requested subject matter expertise on an as-needed basis to departments that have requested technical assistance for information technology projects or have been referred by the CHHSA or the California Department of Technology as having projects that are at-risk. The provisional language exempts augmentations to Reimbursements within this Item from Section 28.50 and requires the Finance Director to provide written notice to the Legislature within 30 days when the increase to Reimbursements exceeds $200,000. Proposed budget bill language:

0530-001-9745--For support of Secretary of California Health and Human Services, payable from the California Health and Human Services Automation Fund ……. 246,655,000
Schedule:
(1) 30-Office of Systems Integration ……. 247,086,000

(2) Reimbursements ……. -431,000

Provisions:
4. Augmentations to reimbursements in this item are exempt from Section 28.50. The Director of Finance shall provide written notification within 30 days to the Joint Legislative Budget Committee describing the nature of these augmentations when the amount received exceeds $200,000.

Background. CHHSA is the largest agency in state government with a total of 13 departments and three offices, with a current active IT project portfolio estimated at $1.8 billion. See table below for a list of these projects.

Table: CHHSA Active IT Project Portfolio Summary (Major Projects)

Department	IT Project Name	Total Cost
DSS/OSI	LEADER Replacement System (LRS)	$472,373,213
DHCS	CA Medicaid Management Information System (CA-MMIS)	$458,591,056
	CalHEERS	$416,332,107
DSS/OSI	Child Welfare Services New System Project (CWS-NS)	$351,800,000
DSH	Personal Duress Alarm System (All facilities: Atascadero (ASH), Coalinga (CSH), Metropolitan (MSH), Patton (PSH)) PDAS	$47,888,223
DHCS	Health Insurance Portability and Accountability (HIPAA) II	$30,777,467
DSH	Automated Staff Scheduling Information Support Tool (ASSIST)	$8,903,016
DSS	County Expense Claim Reporting Information System (CECRIS)	$7,740,594
CDPH	California Immunization Registry (CAIR) 2.0	$6,996,699
DSH	Active Directory Restructuring (AD)	$2,210,380

Acronyms: DSS – Department of Social Services, DHCS – Department of Health Care Services, DSH – Department of State Hospitals, CDPH – California Department of Public Health, OSI – Office of Systems Integration

Historically, the functions peformed by the OAIO have been conducted primarily through staff redirections and work teams derived from various departments. According to agency, this approach has resulted in limited success in ensuring agency-wide coordination of its information technology investments. As technologies continue to emerge toward systems that offer interoperable, multi-departmental opportunities, it is necessary to have full time staff dedicated to coordinating the IT investments at the Agency level.

Office of the Agency Information Officer (OAIO). Legislation enacted in 2007 vested broad responsibilities to improve the governance and strategic planning of IT with an agency Chief Information Officer. The CHHSA's Chief Information Officer was established as the OAIO—an office of the Secretary. It is charged with (1) overseeing the IT portfolio of CHHSA departments, (2) ensuring that all CHHSA departments are in compliance with state IT policy,

and (3) developing an "enterprise architecture"—the organization of IT infrastructure to reflect integration, consolidation, and standardization of requirements. Historically, the OAIO has not had dedicated staff; instead, its functions have been performed primarily through the sporadic redirection of staff from various CHHSA departments.

OSI. OSI—also an office of the Secretary—was established in 2005 to provide—under contract with CHHSA departments—project management, oversight, procurement, and support services to a portfolio of large, complex, and high criticality health and human services IT projects. (Outside CHHSA, departments are responsible for their own project management, unless project management services are contracted out to a third–party vendor.) Although there is collaboration between OAIO and OSI, typically OSI begins its project management role once the strategic planning is competed by OAIO. OSI's funding and staffing is project–specific. Therefore, OSI does not have the ability to redirect staff resources to provide technical assistance to projects not under contract with OSI.

Top Priorities for New Staff. According to the Administration, the top five initial priorities for the requested positions and formalized governance structure are:

1. Create an IT strategic plan for CHHSA and its departments – To ensure development of flexible IT solutions which eliminates silos and fosters interoperability and data sharing.

2. Review IT projects - Identify opportunities for multiple departments with similar IT needs to leverage a single system fostering collaboration and reuse.

3. Prioritize initiatives - Ensure the highest programmatic goals are the focus.

4. Collaborate with departments (once the project concept is approved) – Ensure alignment with project management best practices and CHHSA goals.

5. Review of projects (prior to Feasibility Study Report approval) - Verify that projects are appropriately resourced and if timelines and cost projections are accurate.

LAO Findings and Recommendations. The LAO finds that (1) the OAIO has limited capacity for IT strategic planning, (2) that additional strategic planning could eliminate duplicative projects, improve system interoperability, and lead to enhanced customer services, and (3) additional guidance during the planning phase could improve project success and potential cost savings. Consequently, the LAO supports the concept of the proposal; however, it recommends that the three positions be approved on a three-year limited-term basis and that a status report to the Legislature on the effects of the proposal be required. Additionally, the LAO does not recommend approval of the proposed budget bill provisional language as it finds that the exemption does not address what appears to be delays in the Administration's own internal review processes.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on how to ensure that the resources requested in

this proposal add value and achieve the intended and worthy goals of better agency-wide planning and coordination of IT projects.

Questions. Please respond to the following questions:

1. Please provide a brief overview of this proposal.

2. Please describe the top priorities to be accomplished through this proposal.

3. What is your response to the LAO's finding that the proposed budget bill provisional language does not address what appears to be delays in the Administration's internal review processes for augmentations to OSI's budget?

0530 CHHSA & 4265 Department of Public Health

1. Transfer of Medical Privacy Breach Program to Department of Public Health

Budget Issue. The Administration proposes to combine the authority and resources of two existing programs charged with enforcing medical privacy violations in order to increase efficiency. To do this, the Administration requests to transfer three investigator positions and associated workload and responsibilities from the Health and Human Services Agency California Office of Health Information Integrity (CalOHII) to the Department of Public Health (DPH).

According to the Administration, this proposal would allow current DPH and CalOHII staff to conduct concurrent investigations of violations by health facilities and individuals and eliminate or reduce redundancy and inefficiencies.

This transfer requires statutory changes.

Background. In 2008, legislation was enacted to improve patient privacy laws and their enforcement. The resulting laws established two law enforcement responsibilities as follows:

- ***Department of Public Health.*** Health and Safety Code Section 1280.15 requires health facilities, clinics, hospices, and home health agencies to prevent unlawful or unauthorized access to, and use or disclosure of, a patient's medical information. DPH, after investigation, may assess an administrative penalty of up to $25,000 per patient for a violation of these provisions, and up to $17,500 per patient for each subsequent occurrence. DPH may refer violations of this section to CalOHII for further follow-up enforcement actions.

- ***CalOHII.*** Health and Safety Code Division 109 (Sections 130200 through 130205) established CalOHII to ensure the enforcement of state law mandating the confidentiality of medical information and to impose administrative fines for the unauthorized use of medical information. Upon receipt of a referral from DPH, CalOHII may assess an administrative fine against any person or provider of health care, for any violation of this division. CalOHII may also recommend further action be taken by various agencies or entities to impose administrative fines, civil penalties, or other disciplinary actions against persons or entities that violate state confidentiality of medical information laws.

Since 2009, DPH and CalOHII have established and maintained two distinct enforcement programs, one focusing on medical privacy violations by health facilities and the other focusing on violations by healthcare providers and other individuals. The Licensing and Certification (L&C) Program of DPH is primarily responsible for regulating licensed healthcare facilities and ensuring their compliance to minimum standards of care and patient safety requirements. Since 2009-10, the number of deliberate breaches reported by healthcare facilities has nearly tripled and is expected to further increase**.**

Currently, licensed health facilities, clinics, hospices, and home health agencies report breaches of patients' confidential medical information to the L&C Program. DPH conducts an

investigation into the breach and may assess an administrative penalty for substantiated violations against the reporting entity. When a violation is substantiated, DPH refers the violation to CalOHII for enforcement actions against individuals and other involved entities**.** This requires subsequent visits to the facilities by these investigators, resulting in additional travel time and costs. CalOHII conducts its own investigation after DPH, often requiring interviews with the same individuals questioned by DPH. Furthermore, because CalOHII may only conduct an investigation after the DPH's referral, time lapses occur that often make it difficult for CalOHII to locate and contact individuals including victims, witnesses and subjects of violations. Finally, separate administrative and legal resources are necessary to support both functions. This proposal would improve efficiency by eliminating redundant investigations and related travel, improving timeliness, and by consolidating administrative and legal resources.

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

Questions. Please respond to the following questions:

1. Please provide an overview of this proposal.

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 billion ($110.6 million General Fund) for the DPH as noted in the Table below and 3,541.4 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 $683.3 million for state operations and $2.3 billion for local assistance. The budget reflects a net decrease of $472.5 million as compared to the revised 2013-14 budget primarily as a result of transferring the drinking water program to the State Water Resources Control Board. See tables below for more information on the proposed budget.

Table: DPH Budget Overview

Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change
General Fund	$129,474,000	$115,182,000	$110,629,000	-$4,553,000
Federal Trust Fund	1,785,473,000	1,888,068,000	1,732,974,000	-$155,094,000
Reimbursements	211,051,000	194,086,000	237,947,000	$43,861,000
Other Special Funds	943,815,000	1,286,301,000	929,615,000	-$356,686,000
Total Expenditures	**$3,069,813,000**	**$3,483,637,000**	**$3,011,165,000**	**-$472,472,000**
Positions	**3493.2**	**3795.7**	**3541.4**	**-254**

Table: DPH Program Funding Summary

Program	2012-13 Actual	2013-14 Projected	2014-15 Proposed
Public Health Emergency Preparedness	$87,891	$98,015	$97,598
Chronic Disease Prevention and Health Promotion	272,326	310,420	294,244
Infectious Diseases	624,053	597,508	592,727
Family Health	1,600,095	1,675,208	1,691,936
Health Statistics and Informatics	23,967	28,154	28,031
County Health Services	13,729	16,685	17,078
Environmental Health	279,559	554,768	83,507
Licensing and Certification	158,836	189,443	192,773
Laboratory Field Services	9,357	13,436	13,271
Administration	27,733	34,158	33,798
Distributed Administration	-27,733	-34,158	-33,798
Total Expenditures (All Programs)	**$3,069,813**	**$3,483,637**	**$3,011,165**

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. Drinking Water Program Transfer to State Water Resources Control Board

Budget Issue. The Administration proposes to transfer the Drinking Water Program (DWP) from DPH to the State Water Resources Control Board (SWRCB). The budget proposes to shift 291 positions and $202 million ($5 million GF) from DPH to the SWRCB, and includes an additional $1.8 million (General Fund) for one-time funds for technology and facility costs.

The proposal shifts all programs (described below) and combines certain financial assistance programs:

- **Regulatory Program.** The proposal seeks to consolidate all water quality regulation within one state agency. The DWP would be organized as a separate division under the State Water Board. Program regulatory staff would remain in locally-based offices and would not be integrated with the regional water quality control boards. The division would be overseen by a deputy director who would be required to have public health expertise and who would report directly to the executive director. The deputy director would have the authority to grant or deny water system permit applications. These decisions would not be subject to Board review, nor would permit issuance and enforcement be delegated to the regional water boards. The proposal does not include a proposal to extend statutorily-mandated minimum penalties for waste discharge violations to drinking water violations.

- **Maximum Contaminant Level (MCL)-Setting.** MCLs are currently adopted as regulations by DPH. These are the health protective drinking water standards to be met by public water systems. MCLs take into account chemicals' health risks; factors, such as their detectability and treatability; and, costs of treatment. The MCLs would continue to be established through the regular rulemaking process under the Administrative Procedures Act. The deputy director would follow existing rulemaking procedures and the SWRCB would act on the proposed regulations in a public meeting, after which they would be subject to Office of Administrative Law review.

- **Recycled Water.** As a result of this reorganization, the DPH functions related to recycled water would be coordinated through the SWRCB permit process. The Board does not propose to change how these permits are issued, but proposes to seek opportunities for more efficient and effective permitting of recycled water.

- **Emergency Response.** The proposal plans to maintain the existing local emergency response structure of the DWP, including rotating district office duty officers, under the new division. The division would become part of the Cal-EPA Emergency Response Management Committee, which is Cal-EPA's coordinating body that assists in emergencies requiring cross-department or cross-agency solutions. For emergencies affecting water quality, such as sewage or chemical spills, the DWP would coordinate with the Regional Water Boards.

- **Operator Certification.** The SWRCB plans to jointly manage both Operator Certification Programs within the Division of Financial Assistance (already existing at SWRCB). This will allow the DWP to take advantage of the SWRCB's new web-based data management system for wastewater operators and would expand this system to include drinking water operators.

- **Financial Assistance Programs**. The proposal plans for the SWRCB to jointly manage the Clean Water and Drinking Water State Revolving Funds (SRFs) and both bond programs (Propositions 50 and 84) within the Division of Financial Assistance. This proposal will likely require statutory and regulatory changes to harmonize the programs. The division would combine the programs to streamline water quality infrastructure financing, in particular for application assistance for disadvantaged communities.

As a precursor to this proposal, the Administration hosted a series of stakeholder meetings and convened a reorganization task force to solicit feedback on the proposal. The Administration plans to prepare a transition plan in February 2014 that will take into account the efforts to date.

Objectives of Transfer. The Administration intends for the transfer to achieve several objectives. First, it believes consolidating the state's drinking water and water quality programs would result in more integrated water quality management. It considers that consolidating responsibilities for drinking water oversight and regulation with SWRCB's water quality and water rights regulatory activities could allow a single department to address interrelated water issues more comprehensively. For example, there could be a more coordinated focus on the sources of water pollution and their effects on drinking water. In addition, there may be opportunities to coordinate permitting processes for entities that are currently regulated by both DPH and SWRCB.

The Administration also believes this consolidation would improve the state's ability to provide financial assistance to small disadvantaged communities. A SWRCB–administered drinking water program may be more likely to have the expertise and administrative resources required to adequately run the program and get financial assistance out the door in a timely manner. For example, the SWRCB has significant expertise in financial management, including recent experience leveraging their revolving fund to increase the amount of loans the fund is able to offer. This expertise could be extended to Safe Drinking Water State Revolving Fund (SDWSRF).

Finally, the Administration believes the transfer would enhance accountability and transparency on drinking water issues because SWRCB's board structure with regular hearings provides a process for the public and stakeholders to offer comments on proposed rules or other issues. This could improve the ability of the public to hold decision–makers accountable for drinking water outcomes.

Background. DPH administers the federal Safe Drinking Water Act (and the parallel state statute). The DPH's overall programs are involved in a broad range of health-related activities, such as chronic disease prevention, communicable disease control, regulation of

environmental health (including drinking water quality), and inspection of health facilities. The department's drinking water program (DWP) regulates 5,700 public water systems serving more than 15 service connections or 25 people. The department also oversees water-recycling projects, permits water treatment devices; and provides various technical assistance and financial assistance programs for water system operators—including bond and federally-funded programs for infrastructure improvements in public water systems—to meet state and federal safe drinking water standards. The department administers a revolving loan fund for water treatment infrastructure improvements that is funded by the U.S. Environmental Protection Agency (US EPA). The department responds to drinking water emergencies and provides oversight, technical assistance, and training for local water agencies.

The State Water Resources Control Board (SWRCB) and the nine semi-autonomous regional boards, administer the federal Clean Water Act (and the parallel state statute). Specifically, the board regulates the overall quality of the state's waters, including groundwater, to protect the beneficial uses of water by permitting waste discharges into water and enforcing water quality standards. The board administers the state's system of water rights and provides financial assistance to fund wastewater system improvements, underground storage cleanups, and other improvements to water quality. The board also administers a similar revolving loan fund for wastewater infrastructure improvements that is funded by the US EPA.

LAO Findings and Recommendation. The LAO finds that the proposed transfer is likely to improve the effectiveness and efficiency of state water policy. However, it also finds that specific aspects of the transfer that warrant legislative consideration, including: (1) the continuation of some potential enforcement concerns; (2) coordination between SWRCB and DPH in responding to emergencies and protecting public health; and, (3) statutory changes to the administration of Safe Drinking Water State Revolving Fund.

Consequently, the LAO recommends that the Legislature: (1) approve the proposed transfer of DWP to SWRCB; (2) require the Administration to report at budget hearings on the details of the transition plan and progress made by DPH and SWRCB on coordinating implementation of the transfer; and, (3) require reports on the outcomes of the transfer, including its effects on permitting, enforcement, and emergency response.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open in order to continue discussions on this proposal. Additionally, it should be noted that Senate Budget Subcommittee No. 2 (which covers SWRCB) will discuss this issue in more detail at its April 20th Subcommittee hearing.

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

1. Please provide an overview of this proposal.

2. How has the Administration reached out to and involved public health stakeholders in the development of this proposal? How has the Administration addressed public health stakeholder concerns?

3. Licensing and Certification (L&C) Program

Issue. There are significant concerns regarding the Licensing and Certification (L&C) program's ability to complete its mission to promote the highest quality of medical care in community settings and facilities.

The Governor's budget does nothing to address these concerns and does not put forth a proposal to immediately address the inconsistent and untimely enforcement of federal and state laws regarding the health facilities it licenses.

Background. The Licensing and Certification (L&C) Program develops and enforces state licensure standards, conducts inspections to assure compliance with federal standards for facility participation in Medicare and/or Medi-Cal, and responds to complaints against providers licensed by the DPH. L&C contracts with Los Angeles County to license and certify health facilities in Los Angeles County.

L&C Fee Report. 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.

The DPH Fee Report utilizes the requirements of existing statute for the fee calculations, and makes certain "credit" adjustments. The DPH notes that these "credits" are most likely one-time only and that fees are calculated based solely on the statutorily prescribed workload methodology as contained in statute.

The "credits" are applied to offset fees (e.g., hold the fee stable or reduce the fee) for 2014-15 and total $15.3 million. They are as follows:

- $3.8 million credit for miscellaneous revenues for change in ownerships and late fees.
- $11.5 million credit from the program reserve which is applied to each facility type to prevent fees from increasing "on the natural" and placing a cap of 20 percent on fees that would have decreased "on the natural."

***Background on L&C Fee Methodology*.** 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 based on the following activities:

- Combines information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital).
- Calculates the state workload rate percentage of each facility type to the total state workload.

- Allocates the baseline budget costs by facility type based on the state workload percentages.
- Determines the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.
- Divides 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 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/fiscalrep/Documents/LicCertAnnualReport2014.pdf

The DPH Fee Report of February 2014 proposes to generally keep fees at the same level as the current year and to slightly decrease certain fees as shown in the table below.

Table: Proposed Health Facility License Fees

License Fees by Facility Type			
Facility Type	Fee Per Bed or Facility	FY 2013-14 Fee Amounts	FY 2014-15 Proposed Fee Amounts
Acute Psychiatric Hospitals	Bed	$ 266.58	$ 266.58
Adult Day Health Centers	Facility	$ 4,164.92	$ 4,164.92
Alternative Birthing Centers	Facility	$ 2,380.19	$ 2,380.19
Chemical Dependency Recovery Hospitals	Bed	$ 191.27	$ 191.27
Chronic Dialysis Clinics	Facility	$ 2,862.63	$ 2,862.63
Community Clinics	Facility	$ 718.36	$ 718.36
Congregate Living Health Facilities	Bed	$ 312.00	$ 312.00
Correctional Treatment Centers	Bed	$ 573.70	$ 573.70
District Hospitals Less Than 100 Beds	Bed	$ 266.58	$ 266.58
General Acute Care Hospitals	Bed	$ 266.58	$ 266.58
Home Health Agencies	Facility	$ 3,452.38	$ 2,761.90
Hospice Facilities *	Bed	$ 312.00	$ 312.00
Hospices (2-Year License Total)	Facility	$ 3,713.56	$ 2,970.86
ICF - DD Habilitative	Bed	$ 580.40	$ 580.40
ICF - DD Nursing	Bed	$ 580.40	$ 580.40
ICF - Developmentally Disabled	Bed	$ 580.40	$ 580.40
Intermediate Care Facilities	Bed	$ 312.00	$ 312.00
Pediatric Day Health/Respite Care	Bed	$ 150.41	$ 150.41
Psychology Clinics	Facility	$ 1,476.66	$ 1,476.66
Referral Agencies	Facility	$ 3,494.41	$ 2,795.53
Rehab Clinics	Facility	$ 259.35	$ 259.35
Skilled Nursing Facilities	Bed	$ 312.00	$ 312.00
Special Hospitals	Bed	$ 266.58	$ 266.58
Surgical Clinics	Facility	$ 2,487.00	$ 2,487.00

* Pursuant to SB 135 (Hernandez), Chapter 673, Statutes of 2012, a new Hospice Facility licensure category was established. In the first year of licensure, the fee shall be equivalent to the license fee for Congregate Living Health Facilities.

L&C Estimate. In addition to the fee report, the L&C program develops a budget estimate that details all L&C programmatic, fiscal, and workload factors that it uses to develop its budget. The 2014-15 estimated L&C budget is $188.8 million, which is an increase of $1.9 million from the current year. This increase is a result of two budget proposals discussed later in the agenda.

There are about 800 positions in the L&C field operations, these positions conduct and support licensing surveys and complaint investigations.

According to the L&C estimate, updated workload factors show a decrease of overall surveyor workload hours and staffing needs and projects that 70 less L&C field operations staff would be needed. However, L&C notes that it is undergoing a comprehensive program evaluation to improve the reliability of the estimate; consequently, it proposes to maintain the current year level of funding (with the addition of $1.9 million for specific budget proposals).

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 for DPH to attain and is requiring quarterly updates from DPH on its work plans and progress on meeting these benchmarks.

Recent Legislative Oversight Hearings on L&C. Multiple recent legislative oversight hearings by the Assembly Committee on Aging and Long-Term Care, Assembly Committee on Health, Senate Committee on Business, Professions and Economic Development, and Senate Committee on Health and media reports have highlighted significant gaps in state oversight of health facilities and certain professionals that work in these facilities. These gaps include a backlog of complaint investigations against certified nurse assistants and untimely health facility complaint investigations.

Long-Standing Problems with Complaint Investigations. There has been long-standing concerns about L&C's ability to investigate and close complaints in a timely manner. The LAO (in 2006) and the Bureau of State Audits (in 2007) found that L&C had a backlog of complaints and that complaint investigations were not investigated or closed in a timely manner.

These concerns still exist today. See tables below for the number of skilled nursing facility and hospital complaints. At the time of this agenda, the department has been unable to indicate how many reports were investigated in a timely manner (within 10 days per state law for complaints that do not pose imminent danger and 24 hours for those that pose imminent danger) nor a count of how many investigations are currently open.

Table: Skilled Nursing Facility Complaints Summary

Complaints Received per Quarter CY 2012 and 2013		Complaints Investigated and Closed within 60 Days of Investigation in CY 2012 and 2013		Complaints with Departmental Action Taken (deficiency issued) in CY 2012 and 2013	
QUARTERS	TOTAL	QUARTERS	TOTAL	QUARTERS	TOTAL
2012 Q1	1,447	2012 Q1	613	2012 Q1	401
2012 Q2	1,503	2012 Q2	760	2012 Q2	415
2012 Q3	1,534	2012 Q3	771	2012 Q3	365
2012 Q4	1,443	2012 Q4	806	2012 Q4	352
2013 Q1	1,465	2013 Q1	885	2013 Q1	292
2013 Q2	1,386	2013 Q2	993	2013 Q2	278
2013 Q3	1,531	2013 Q3	1,352	2013 Q3	257
2013 Q4 YTD	545	2013 Q4 YTD	404	2013 Q4 YTD	33

NOTE: Numbers in Table 2 and 3 will not add to Table 1 because either a complaint was not completed within 60 days or did not have a deficiency or a combination of both.

Table: Non-Deemed Hospital Complaints Summary

Complaints Received per Quarter CY 2012 and 2013		Complaints Investigated and Closed within 60 Days of Investigation in CY 2012 and 2013		Complaints with Departmental Action Taken (deficiency issued) in CY 2012 and 2013	
QUARTERS	Total	QUARTERS	Total	QUARTERS	Total
2012 Q1	32	2012 Q1	12	2012 Q1	3
2012 Q2	24	2012 Q2	7	2012 Q2	6
2012 Q3	42	2012 Q3	22	2012 Q3	3
2012 Q4	36	2012 Q4	19	2012 Q4	5
2013 Q1	43	2013 Q1	23	2013 Q1	6
2013 Q2	37	2013 Q2	26	2013 Q2	12
2013 Q3	38	2013 Q3	33	2013 Q3	6
2013 Q4 YTD	10	2013 Q4 YTD	1	2013 Q4 YTD	1

NOTE: Numbers in Table 2 and 3 will not add to Table 1 because either a complaint was not completed within 60 days or did not have a deficiency or a combination of both.

Subcommittee Staff Comment and Recommendation—Hold Open. There are major concerns with L&C's ability to meet its mandate to ensure that health facilities and certain individuals who work in these facilities provide quality care in safe environments. Specific concerns include:

- ***L&C Not Meeting CMS Benchmarks.*** As discussed above, DPH must report quarterly to CMS regarding its progress in meeting benchmarks. In its fourth quarter report for 2013 to CMS, DPH did not meet the benchmark to investigate and close 95 percent of hospital and nursing home complaints within 60 days of the investigation. It only closed 64 percent. Subcommittee staff has requested the most recent benchmark report, but it has not been provided.

- ***Unclear if L&C is Enforcing State Laws.*** In addition to conducting *federal* surveys of health facilities, L&C is responsible for enforcing *state* laws regarding health facilities. Generally, these state laws are more stringent than federal requirements. L&C is not able to explain whether or not it is enforcing state laws and has no mechanism to evaluate this workload factor.

- ***Unable to Understand Workload and Staffing Needs.*** The Administration has admitted that its current methodology to assess workload demands and needs is flawed. For this reason, it is proposing no change to its budget even though it estimates that it would need 70 less staff. It notes that it is undertaking an evaluation and making an effort to develop a better timekeeping system and workload forecast.

- ***Credit to Health Facilities vs. Investment in Workforce.*** For the second year in a row, L&C proposes to credit health facilities with over $11 million from the program reserve instead of using these funds to address the problems with this program. L&C fees are to be used to support the work associated with enforcing state laws and requirements. Since it is clear that L&C has not been able to enforce these mandates, it should evaluate how these reserve funds could be used to ensure that laws are enforced.

DPH indicates that it understands these concerns and is in the process of conducting a complete evaluation of its program (see next agenda item for more information). While this evaluation is warranted, the findings and recommendations from this evaluation would not be implemented for at least two more years. Consequently, Subcommittee staff has requested technical assistance from L&C on developing short-term solutions to address the concerns regarding this program on a more immediate basis.

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 health facility fees, including the key credits and adjustments.

2. Please explain what efforts DPH is currently taking to address the concerns with the L&C program.

3. Please explain what steps DPH is taking to monitor its enforcement of state laws.

4. L&C: Program Evaluation Contract

Budget Issue. DPH requests one-time funding of $1.4 million from the Internal Departmental Quality Improvement Account (IDQIA) to further expand the work being conducted by the current contractor related to the Licensing and Certification (L&C) Program Evaluation project.

Background. In a letter dated June 20, 2012, CMS informed DPH that the L&C Program was not adequately meeting the federal survey and certification workload required in accordance with the U. S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) Mission and Priority Document. In addition to laying out benchmark goals in this letter, CMS required DPH to:

> "Conduct a comprehensive assessment of DPH's entire survey and certification operations at not only its headquarters, but also at each of the District Offices and the offices covered by its contractual agreement with Los Angeles County…The assessment must identify concerns, issues, and barriers related to DPH's difficulty in meeting performance expectations."

A previous letter dated May 4, 2012, withheld $1,565,384 from CDPH's 2012 federal grant allocation, pending demonstrated performance improvement.

In order to fulfill the CMS requirement, the L&C Program contracted with an external organizational improvement contractor in 2013-14 to pursue three deliverables: (1) preliminary program assessment, (2) organizational gap analysis, and (3) develop preliminary recommendations. These deliverables are scheduled to be presented to the L&C Program by the current contractor by spring 2014.

According to DHP, the approval of this budget proposal will allow implementation of the preliminary remediation plan proposed by the contractor.

The completion of this project will assist the L&C Program in identifying performance indicators and benchmarks to measure its compliance with state and federal regulations, in terms of both quality and quantity. It will help resolve challenges as follows:

1. Maintain and effectively manage its resources to meet statutory survey and certification responsibilities while successfully accomplishing other CMS workload mandates.
2. Ensure adequate CMS training activities are provided for the effective utilization and adherence to federal survey and enforcement processes.
3. Identify and eliminate barriers preventing the L&C Program from ensuring timely and accurate completion of mandated state and federal workload as outlined in existing state law and regulations.

The current contractor is performing high-level workload assessments and developing six scopes of work for improvements in the following areas: (1) workload assignment and workload management processes; (2) the Time Entry and Activity Management system

(TEAM); (3) allocation of staff and funding resources; (4) best practices; (5) program efficiencies; and (6) quality improvement activities.

Subcommittee Staff Comment and Recommendation—Hold Open. As discussed in the previous agenda item, there is significant concern that L&C is not able to meet federal and state mandates and that a complete program evaluation is warranted. This proposal presents an opportunity to develop a long-term solution to challenges facing L&C. It is recommended to hold this item open as discussions continue on short-term solutions to improve L&C's ability to complete its mandate to ensure individuals are safe and receive quality care in California's health care facilities.

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

1. Please provide an overview of this proposal.

2. Please provide a high-level overview of some of the preliminary findings from this assessment.

3. As this program evaluation is primarily a result of CMS concern with meeting federal mandates, please explain how DPH plans to utilize the findings to ensure compliance with state mandates as well.

5. L&C: Licensing Standards for Chronic Dialysis Clinics, Rehabilitation Clinics, and Surgical Clinics

Budget Issue. DPH requests one-time special fund (Internal Departmental Quality Improvement Account) expenditure authority of $201,000 to contract with the University of California, Davis (UCD) for an independent research analysis and report that describes the extent to which the federal certification standards are or are not sufficient as a basis for state licensing standards, as required by SB 534 (Hernandez), Chapter 722, Statutes of 2013.

DPH has contacted the Institute for Population Health Improvement at UCD to perform independent research and analysis and produce the required report on the sufficiency of the federal regulations. The analysis and report will consist of: (1) a review of the various certification, accreditation, and other relevant performance standards currently used to evaluate chronic dialysis clinics, surgical clinics, and rehabilitation clinics in other states, comparing requirements of the federal standards with these alternate standards; and (2) a systematic literature review of the peer-reviewed and grey literature on experiences with the implementation of those standards, including identification of areas in need of additional regulatory oversight. The projected cost is $200,000 for the required study.

Background. DPH licenses health care facilities and agencies in California through its Licensing and Certification (L&C) Program. Licensing is a state mandated and controlled function to assure that facilities providing health care services meet standards regarding qualifications and training of staff, the physical layout and condition of facilities, and systems governing the appropriateness and quality of the services provided.

L&C licenses approximately 30 different types of health care facilities including chronic dialysis clinics, rehabilitation clinics, and surgical clinics. L&C is also the state entity designated by the federal CMS to verify that health care facilities meet minimum certification standards to protect patient health and safety and qualify for Medicare and/or Medicaid reimbursement.

L&C develops regulatory standards for health care facilities and conducts periodic on-site inspections and investigations in response to complaints filed by the public. A longstanding policy has been to use federal certification standards to meet licensure requirements. SB 534 authorizes the DPH to continue this practice by formally adopting the federal certification standards for chronic dialysis clinics, surgical clinics, and rehabilitation clinics for a period of four years while the efficacy of the federal standards is evaluated.

Subcommittee Staff Comment and Recommendation—Hold Open. No issues have been raised regarding this proposal; however, it is recommended to hold this item open as discussions continue regarding L&C.

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

1. Please provide an overview of this proposal.

6. L&C: Oversight on Nursing Home Referrals to Community-Based Services

Oversight Issue. AB 1489 (Committee on Budget), Chapter 631, Statutes of 2012, requires the Department of Health Care Services, in collaboration with DPH, to provide the Legislature an analysis of the appropriate sections of the Minimum Data Set, Section Q and nursing facilities referrals made to designated local contact agencies (LCA) by April 1, 2013. This analysis should also document the LCA's response to referrals from nursing facilities and the outcomes of those referrals.

The Legislature has not yet received this report; it is almost one year overdue.

Background. On October 1, 2010, CMS required certified nursing facilities to begin using a new iteration of the Minimum Data Set (MDS 3.0). MDS is part of the federally mandated process for assessing nursing facility residents upon admission, quarterly, annually, and when there has been a significant change in status. Under Section Q of MDS 3.0, nursing facilities must now ask residents directly if they are "interested in learning about the possibility of returning to the community." If a resident indicates "yes," a facility is required to make the appropriate referrals to state designated local community organizations.

The state's California Community Transitions (CCT) project (funded with a federal Money Follows the Person grant) targets Medi-Cal enrollees with disabilities who have continuously resided in hospitals, nursing facilities, and intermediate care facilities for persons with developmental disabilities for three months or longer. The goal of this program is to offer a menu of social and medically necessary services to assist these individuals to remain in their home or community environments. By providing participants long-term services and supports in their own homes for one full-year after discharge from a health care facility, the state receives an 87 percent federal fund match.

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature has not yet received this report. Subcommittee staff has continually checked on the status of this report.

Given the state's efforts, with CCT and other initiatives, to provide services in home- and community-based settings, and the opportunity to receive enhanced federal funding for certain nursing home residents who transition to receiving services in the community, it is important to understand how and when nursing homes are making referrals to local agencies.

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

1. Please provide an overview of this issue.

2. What is the status of the report? When will the Legislature receive this report?

3. How does the Administration ensure that nursing facilities make the appropriate referrals to local contact agencies?

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

AIDS Drug Assistance Program (ADAP) Update

ADAP is a subsidy program for low- and moderate-income persons living with HIV/AIDS who could not otherwise afford drug therapies. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the ADAP Pharmacy Benefit Manager (PBM).

Comparison of Current Year & Budget Year. The Office of AIDS (OA) estimates that 36,687 people living with HIV/AIDS will receive drug assistance through ADAP in 2014-15. The budget estimates expenditures of $409.6 million which reflects a *net* decrease of $9.4 million as compared to the revised current year. See tables below for more information.

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

Fund Source	2013-14 Budget Act	2013-14 Revised	2014-15 Proposed
General Fund	$0	$0	$0
AIDS Drug Rebate Fund	$260.8	$307.2	$259.8
Federal Funds – Ryan White	$79.1	$103.5	$98.7
Reimbursements from Medicaid Waiver (Safety Net Care Pool Funds)	$66.3	$8.3	$51.1
Total	**$406.3**	**$419**	**$409.6**

Table: Estimated ADAP Clients by Coverage Group

	2013-14		2014-15	
Coverage Group	**Clients**	**Percent**	**Clients**	**Percent**
ADAP-only	17,674	48.92%	17,441	47.54%
Medi-Cal	686	1.90%	708	1.93%
Private Insurance	7,714	21.35%	8,163	22.25%
Medicare	10,053	27.83%	10,375	28.28%
Total	36,127	100%	36,687	100%

Major changes from the 2013-14 Budget Act include:

- For 2013-14, an increase in ADAP Drug Rebate Fund expenditure authority of $46.4 million primarily due to the federal requirement to spend rebate funds prior to federal funds.
- For 2013-14, an increase in federal funds of $24.3 million due to additional grant awards.
- For 2013-14, a decrease in the use of reimbursements from the Medicaid Waiver (Safety Net Care Pool Funds) of $58 million due in part to the federal requirement to spend all rebate revenue first.

ADAP Eligibility and Current Cost-Sharing. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the Pharmacy Benefit Manager (PBM). 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.

The current cost-sharing formula is based on twice the client's individual income tax liability, minus any health insurance premiums paid by the individual. The final amount due can vary greatly depending on the client's tax deductions, that are used to reach their final income tax liability (based on tax return). This amount is then split into 12 equal monthly payments which are collected at the pharmacy at the time the client picks up their medication.

The client's payment is then credited and the amount the pharmacy bills the ADAP Pharmacy Benefits Manager is adjusted to account for this credit.

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 65 cents in rebates. This 65 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 HRSA requires states to have HIV-related non-HRSA expenditures. California's 2013 HRSA match requirement for 2013-14 funding is $65.3 million. OA will meet the match requirement by using General Fund expenditures from the California Department of Corrections and Rehabilitation, and the University of California's California HIV/AIDS Research Program ($8.753 million), for example.

Impact of Federal Health Care Reform on ADAP. As a result of the federal Affordable Care Act, many ADAP clients have or are projected to transition to Medi-Cal (expansion) or Covered California starting January 1, 2014. See table below for the projected caseload transitions.

Table: Impact of Federal Health Care Reform on ADAP

Transition	2013-14		2014-15	
	Clients	ADAP Savings	Clients	ADAP Savings
Medi-Cal Expansion	5,401	$74 million	9,502	$131 million
Covered California	237	$1.2 million	552	$10 million

ADAP Savings include drug expenditure savings and premium payment savings.

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

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.

8. OA: ADAP – Wrap for Out-of-Pocket Medical Expenses

Issue. The Office of AIDS (OA) has a number of programs to help people move into and retain comprehensive health coverage, such as the OA-Health Insurance Premium Payment (OA-HIPP) program. However, it does not have a program to pay for the out-of-pocket medical expenses (copays, coinsurance, and deductibles) associated with comprehensive health coverage for eligible persons with HIV/AIDS.

A program to pay for these out-of-pocket medical expenses could ensure that persons with HIV/AIDS can enroll in and receive comprehensive health coverage and could result in AIDS Drug Assistance Program (ADAP) savings as HIV/AIDS-related medications would be paid for by the primary health coverage (e.g., coverage purchased privately or through Covered California). Fifteen other states have ADAP programs that pay for these out-of-pocket medical expenses.[1]

This is not a proposal from the Administration.

Background. Nationally, ADAPs traditionally have provided access to medications through direct distribution to eligible clients. However, as the health care landscape has changed and more ADAP clients have been able to access public and private insurance coverage, ADAP's activities have also changed. Today, ADAPs are increasingly assisting clients with purchasing insurance, which is more cost-effective for ADAPs than direct provision of medications. Purchasing full insurance coverage also means that clients have access to quality, comprehensive medical care, which can significantly increase retention in care, viral suppression, and, ultimately, decrease rates of HIV transmission.

Currently, the OA-Health Insurance Premium Payment (OA-HIPP) program pays the monthly health insurance premiums for eligible California residents with an HIV/AIDS diagnosis. This program is available to individuals with health insurance who are at risk of losing it, as well as to individuals currently without health insurance who would like to purchase it. The purpose of the OA-HIPP is to get people with HIV comprehensive health coverage because it is better for their health and consequently, save ADAP the costs of covering the drugs (which are more expensive than premiums).

Technical Assistance from DPH. According to DPH, based on ADAP's experience transitioning clients to the Low Income Health Program, OA estimates that between 25 percent and 33 percent of eligible ADAP-only clients would enroll in Covered CA in the first year of implementation of this proposed policy change compared to an estimated 7.2 percent of ADAP-only patients that will enroll in Covered CA in 2015-16 if medical out-of-pocket costs are not covered.

1 National Alliance of State and Territorial AIDS Directors, "Fact Sheet: Insurance Purchasing/Continuation Assistance Provided by ADAPs."

Given these assumptions, OA projects that the cost of paying medical out-of-pocket expenses in this proposal would range from $1.8 to $2.4 million in 2015-16 but would result in a net other fund savings of $6.3 to $9.4 million in 2015-16. These estimates assume the current rebate return rate.

ADAP Special Funds (rebate funds) may be eligible to cover the cost for the Third Party Administrator to operationalize these changes. Also, per federal HRSA requirements, rebate (special) funds would cover the cost of the medical deductibles. If no rebate funds were available, then federal funds could cover these costs – similar to how the state currently pays for ADAP drug costs. The federal Health Resources Services Administration allows ADAP (Ryan White) funds to be used to cover costs associated with a health insurance policy, including co-payments, deductibles, or premiums to purchase or maintain health insurance coverage. Ryan White funds may not be used to pay co-pays or deductibles for inpatient care.

The Administration's estimates assume the payment of medical out-of-pocket expenses would start January 1, 2016. In order to implement this programmatic change, OA would need to develop a request for proposals and enter into a new contract with a third party administrator to pay for premiums and eligible medical out-of-pocket expenses. It is not clear at this time whether additional administrative costs would be incurred for this approach and whether there are other costs to other state programs and departments.

The Administration also notes that this issue is part of a larger discussion of a statewide approach to state-only programs during the implementation of health care reform. There are a number of variables to consider, and its response is based on limited information. Part of the cost depends on how many HIV+ clients have already enrolled in Covered CA compared to how many additional clients would if OA paid the cost of medical expenses. If a relatively low percentage of HIV+ clients have already enrolled, but will now enroll as a result of implementation of this policy proposal, then this proposal would generate savings. However, if a high percentage of HIV+ clients have already enrolled in Covered CA, then this proposal could generate additional costs to the State. The Administration's preliminary data from the first four months of the initial six month Covered California open enrollment period support our estimate in the ADAP November Estimate for the *2014-15 Governor's Budget.*

In order to implement this new program, a statutory change would be needed to clarify that OA has the authority to pay for cost sharing (co-pays) for medical expenses. California Health and Safety Code (HSC) Section 120955(a) authorizes the director to establish and administer a program to provide drug treatments to persons infected with HIV/AIDS. The term drug treatment can be interpreted to mean diagnosis, associated laboratory tests, prescriptions, and follow-up care of a patient. However, the law does not specifically state whether ADAP can pay for medical co-pays (e.g., co-pays for medical office visits, radiologic studies, emergency room visits, inpatient visits, etc.) and deductibles for persons with HIV. HSC 120950(b) also states that the State of California has a compelling interest in ensuring that its citizens infected with the HIV virus have access to drugs used to treat HIV and HIV-related conditions.

The Department was given authority under Health and Safety Code Section 120950(c) to subsidize the cost of these drugs for persons who do not have private health coverage, are not

eligible for Medi-Cal, or cannot afford to purchase the drug privately. Enrolling and maintaining clients in private insurance by paying for cost sharing for medical expenses is a cost effective way for ADAP to subsidize the cost of HIV-related drugs.

Subcommittee Staff Comment and Recommendation—Hold Open. Creating a new ADAP program that covers out-of-pocket medical costs could reduce ADAP expenditures while providing more comprehensive health care coverage to 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. Does the Office of AIDS have any comments on this proposal?

9. OA: Cross Match of ADAP Data with Franchise Tax Board

Budget Issue. The Office of AIDS (OA) proposes to amend statute to provide the State Franchise Tax Board (FTB) with authority to share state tax data with OA. The purpose is for verifying applicant/client income eligibility for OA's federally funded Ryan White HIV/AIDS Program (Ryan White), ADAP.

The proposed trailer bill language:

1. Authorizes DPH to disclose the name and taxpayer identification or social security number to the FTB for the purposes of verifying the adjusted gross income of an applicant or recipient of ADAP.

2. Authorizes FTB to inform DPH of all income information about these individuals.

3. Requires FTB to destroy the information received from DPH after exchanging the data.

Background. OA currently verifies income for Ryan White applicants/clients through a variety of applicant/client-provided documents including: pay stubs, support or self-employment affidavits, bank statements, and/or tax returns. According to OA, often times a client has difficulty providing income documentation. Furthermore, in lieu of providing tax returns, a client may provide pay stubs from only one job, but in fact have a second job that brings their income over the eligibility limit.

FTB has indicated a need for statutory authority in order to provide specified tax data to OA. Currently, FTB is authorized to share tax data with the Department of Social Services (DSS) and Department of Health Care Services (DHCS) for Medi-Cal eligibility determination.

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

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

1. Please provide an overview of this proposal.

2. Please explain how the other departments use this process for their eligibility determination processes.

10. Genetic Disease Screening Program – Prenatal Screening Fee Increase

Budget Issue. DPH proposes total expenditures of $116.9 million (Genetic Disease Testing Fund) for the Genetic Disease Screening Program (GDSP). This reflects a net increase of $8 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

	2013-14	2014-15	BY to CY
	Projected	**Proposed**	**Change**
State Operations	$25,157,000	$28,258,000	$3,101,000
Local Assistance	$83,704,000	$88,654,000	$4,950,000
Total	$108,861,000	$116,912,000	$8,051,000

Included in the GDSP budget estimate are the following proposals:

- **Prenatal Screening Program Fee Increase.** DPH proposes to increase the fee in the Prenatal Screening Program by $45 to bring the total fee to $207, effective July 1, 2014. This fee covers a blood test for participating women and follow-up services offered to women with positive screening results. Although participation in the Prenatal Screening Program is voluntary, providers are required to offer screening to all women in California.

  DPH states that the fee increase is necessary to correct for the historic overstatement of caseload and the resulting inadequate fee revenue in recent years to cover costs. Historically, the Prenatal Screening Program has assumed a caseload of approximately 80 percent of the state's births; however, the caseload has been closer to 73 percent of the annual birth rate. DPH states that this fee increase will stabilize the fund over the next three years.

- **Consolidate Regional Screening Laboratories.** DPH proposes to consolidate the number of regional contract screening laboratories from seven laboratories down to five in order to achieve savings through economies of scale. Contract laboratories perform newborn screening and prenatal screening using state-supplied equipment, reagents, methods, and protocols; the labs provide qualified personnel to do the work for DPH. The savings would be realized primarily through a reduction of testing equipment and the related maintenance, operation, and repair expenses. The estimated one-time upfront moving costs in 2014-15 could range from $200,000 to $800,000, depending on the outcome of the competitive bidding process and how many existing Newborn and Prenatal Screening Labs are successful bidders for the newly consolidated regions. DPH anticipates savings of approximately $1.7 million dollars per year, which would occur no sooner than 2015-16.

- **Refine Algorithm for Detecting Positive Case.** DPH is investigating reducing the false positive rate for certain disorders. This would result in a decrease in reference laboratory services, follow-up diagnostic services, and case management and coordination services.

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 on fees collected from screening participants through the hospital of birth, third party payers, or private parties using a special fund—Genetic Disease Testing Fund.

The Prenatal Screening (PNS) Program provides screening of pregnant women who *consent* to screening for serious birth defects. The current fee paid for this screening is $162. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. This program is expected to screen 371,497 expecting mothers in 2013-14 and 376,249 expecting mothers in 2014-15. DPH estimates that 45 percent of those who receive this screen are in Medi-Cal.

Women who are at high-risk based on the screening test results are referred for follow-up services at state-approved "Prenatal Diagnosis Centers". Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

The Newborn Screening Program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is about $113. Where applicable, this fee is paid by prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees.

The Newborn Screening Program screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis, and many others. Early detection of these conditions can provide for early treatment which mitigates more severe health problems. Informational material is provided to parents, hospitals and other health care entities regarding the program and the relevant conditions and referral information is provided where applicable.

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

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

1. Please provide an overview of this item and the components of the PNS fee increase.

2. Please explain what type of access analysis DPH conducted to evaluate if the proposed PNS fee increase would have a negative impact on access to these services.

11. Women, Infant, and Children Program (WIC)

Budget Issue. DPH requests $1.1 billion in federal trust fund and $248 million in WIC Manufacturer Rebate Special Fund for 2013-14 and $1.2 billion in the federal trust fund and $248 million in the WIC Manufacturer Rebate Special Fund for 2014-15.

Table: WIC Local Assistance Expenditures

Fund Source	2013-14 Projected	2014-15 Proposed	BY to CY Change
Federal Trust Fund	$1,144,932,000	$1,154,051,000	$9,119,000
Manufacturer Rebate Funds	248,000,000	248,100,000	$100,000
Total Expenditures	**$1,392,932,000**	**$1,402,151,000**	**$9,219,000**

Declining Caseload. DPH estimates that about 1,434,096 WIC participants will access food vouchers in 2013-14 and 1,427,552 participants in 2014-15.

Actual participation for federal fiscal year 2013 decreased by 2.26 percent from 2012. DPH indicates that it is currently conducting an analysis to understand the reasons behind the decrease in participation and to evaluate if there are geographic or demographic anomalies.

Background on WIC Funding. DPH states that California's share of the national federal grant appropriation has remained at about 17 percent over the last 5 years. 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. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.
- **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.

  States are to manage the grant, provide client services and nutrition education, and promote and support breastfeeding with NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.

- **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 and/or breastfeeding, and for 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.

CA WIC submitted a plan to the USDA to address price competitiveness, MADR methodology, and cost containment. The final step of this plan will be the adoption of regulations regarding revised peer groups and reimbursement rates for authorized stores. DPH anticipates posting the final regulations by April 1, 2014. It is expected that the regulations would then be effective about 60 days later.

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. WIC is in the process of working with the USDA on the process for lifting the moratorium given that it is expected that the regulations would be in effect by June 2014.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as this estimate will be updated in the May Revise.

Additionally, it is recommended that the Subcommittee request that DPH update the Subcommittee on its analysis of the decrease in WIC participation and identify any geographic or demographic factors that impact participation.

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

1. Please provide a brief summary of the WIC budget.

2. Please provide an update on the status of the peer group and reimbursement rate regulations and the lifting of the WIC vendor moratorium.

3. Please comment on why participation in WIC decreased by 2.26 percent from federal fiscal year 2012 to 2013. What steps is DPH doing to evaluate and understand the reason for the decrease in participation?

4. Please provide an update on the appointment of a WIC Division Chief. (The interim Division Chief was appointed in April 2012.)

12. Nutrition Education and Obesity Prevention Branch – Contract Conversion

Budget Issue. DPH's Nutrition Education and Obesity Prevention Branch (NEOPB) requests authority to convert 70 personal service contract positions to 45 state positions. These positions are federally funded by the United States Department of Agriculture (USDA) through a reimbursement contract with the California Department of Social Services (CDSS). This personal services contract expires on September 30, 2014.

According to DPH, the proposed conversion will align this program with the Governor's directive to reduce reliance on external contracts, and comply with civil service mandate in California Constitution and Government Code (GC) Section 19130.

To implement this proposal, NEOPB requests authority to create 45 new state positions, and authority to fund those positions by shifting $4.2 million in 2014-15 and $5.3 million in 2015-16 from Local Assistance to State Operations.

Additionally, DPH proposes to also shift an additional $1.2 million in 2014-15 and $1.6 million in 2015-16 from Local Assistance to State Operations in order to fund 13 research positions which will be contracted through an interagency agreement with a University of California or a California State University. The combined total for the shift from Local Assistance to State Operations is $5.4 million in 2014-15 and $6.9 million in 2015-16.

In total, 70 of the contract positions would be converted to 58 state positions.

Background. California receives the largest portion of national funding ($136 million) from USDA's Nutrition Education and Obesity Prevention grant program also known as the Supplemental Nutrition Assistance Program for Education (SNAP-Ed). NEOPB manages a statewide obesity prevention initiative comprised of local, state, and national partners collectively working toward improving the health status of low-income Californians through increased fruit and vegetable consumption and daily physical activity.

The NEOPB's SNAP-Ed funded program provides nutrition education and obesity prevention services to qualifying residents. Depending on the type of services provided, it reaches between one million and 12 million Californians each year. These public health interventions are crucial in addressing the obesity epidemic in California. The services provided through this program include: education; training; technical assistance; research and evaluation; advertising; promotion; public relations; consumer empowerment; community development; and public and private partnerships.

NEOPB consists of approximately 147 positions, 70 of which are funded through a personal services contract with the Public Health Institute (PHI). The PHI contract was awarded in November 2009 for a five-year term (October 1, 2009 – September 30, 2014) for approximately $20 million per year for a total of $100 million. PHI has been awarded this contract since 1996. The current contract was approved by the Office of Legal Services and

signed by the Department of General Services (DGS) with a provision that another personal services contract of this nature in the future would not be submitted.

Under the existing contract, PHI provides leadership, local capacity building, services for specialized education, and marketing to California's communities. These efforts include special targeted campaigns for children and you in preschool, school, and after-school and community locations. To do this, PHI provides subcontracts and grants to over 50 community agencies, nonprofits, faith-based organizations, small businesses, and small vendors.

Under this proposal, NEOPB would transition into an entirely new model where the majority of funding will be granted to 61 local health departments. Without the conversion of positions, DPH contends that NEOPB cannot support the new model, provide experienced oversight, sustain needed activities, and continue to be a highly successful nutrition education program. If the NEOPB program is unsuccessful under the new model, it may lose future federal funding.

According to DPH, the conversion and addition of staff will result in $12.7 million in annual savings of USDA federal funds, beginning in 2015-16.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as concerns have been raised by the USDA on this proposal. Specifically, the USDA questions whether a conversion to state staff would produce a program benefit that justifies the administrative costs associated with recruiting, hiring, training, and maintaining new state staff. Additionally, USDA cites concerns about whether the allocation of state staff is sustainable given the projected reduction in federal SNAP-Ed funding by 2018. Finally, Subcommittee staff has requested information on how this proposal achieves $12.7 million in annual savings and has not yet received this information.

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

1. Please provide an overview of this proposal and the rational for the proposal.

2. Please provide an update on the department's discussions with the USDA.

3. Please explain how DPH plans to partner with local community organizations to achieve the goals of this program and build trust with hard-to-reach populations.

13. Infant Botulism Treatment and Prevention Program

Budget Issue. DPH requests:

a. An increase in expenditure authority of $3 million in 2014-15 and $951,000 in 2015-16 in the Infant Botulism Prevention and Treatment Fund to use fee revenue accumulated in the BabyBIG®/Infant Botulism Special Fund, to sustain statutorily-mandated production, distribution, regulatory compliance, and other activities for DPH's public service orphan drug BabyBIG® program. (An orphan drug is a treatment for a rare medical condition, typically developed as a matter of public policy because of insufficient profit motive for drug manufacturers.)

b. Authority to convert contract positions and establish two permanent state positions. The conversion of contract positions to state positions would reduce expenditure authority by $46,000 Infant Botulism Treatment and Prevention Fund (IBTP). Positions will provide the full spectrum of administrative services necessary to the Infant Botulism Treatment and Prevention Program which will significantly reduce the burden on highly-skilled medical staff and/or executive management to perform routine administrative duties to ensure business needs of the program are met.

Background. BabyBIG® [Botulism Immune Globulin Intravenous (Human) (BIG-IV)] is the DPH public service orphan drug for the treatment of infant (infectious) botulism. The drug is distributed nationwide to all patients with infant botulism, as required by the federal Orphan Drug Act and California Health & Safety Code (HSC) §123700-123709. The U.S. Food and Drug Administration (FDA) licensed BabyBIG® to CDPH in 2003; the department is the only entity in the world that produces, tests, and distributes BabyBIG® across the state, the country, and internationally. The drug is also a recognized treatment for any domestic bioterrorist attack that uses botulinum toxin as a weapon.

The program was established as a fee-supported program. Parents of children receiving BabyBIG® and/or their health insurers pay a per-use fee of about $45,000. CDPH collects the medication use fee and deposits it into the Infant Botulism Treatment and Prevention Fund to be used for the purpose of producing and distributing BabyBIG®, performing mandated program activities, and other specified activities.

The conversion from contract to civil service staff, under this proposal, will enable the new state staff to provide a full range of fiscal and management oversight over contracts, budgets, and human resource issues. In addition, this conversion will develop and help retain knowledge and skills within state staff.

External contract staff was initially hired to support the fluctuating workload associated with the development, production, and distribution of the infant botulism treatment and to address new regulatory mandates. However, contract staff is ineligible to fully assume routine administrative responsibilities such as contract development and oversight, personnel training, hiring, or

timekeeping. As a result, civil service staff in medical, and/or executive management positions has absorbed routine administrative duties to ensure business needs of the division were met.

Report Due to the Legislature. AB 82 (Committee on Budget), Chapter 23, Statues of 2013, a budget trailer bill, required DPH to submit a report to the Legislature by October 1, 2013 regarding its plans to address the findings and recommendations described in its "Zero-Based Budgeting (ZBB) Review" report concerning the Infant Botulism Treatment and Prevention Program. The Legislature has not yet received this report.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as the Legislature has not yet received the report outlining findings and recommendations on how to improve the Infant Botulism Treatment and Prevention Program. Information in this report is necessary to evaluate these budget proposals.

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

1. Please provide an overview of these proposals.

2. When will the Legislature receive the ZBB report?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, March 6 (Room 4203)

Senators Corbett and Monning were present. Senator Walters was absent.

4120 Emergency Medical Services Authority (EMSA)

1. Overview

- Informational item

2. Epinephrine Auto Injector Training

- Approved as budgeted (2-0).

4140 Office of Statewide Health Planning and Development (OSHPD)

1. Overview

- Informational item

2. Peer Personnel Support – Investment in Mental Health Wellness Act of 2013

- Informational item

3. Health Care Reform Health Workforce

- Approved as budgeted (2-0).

4. Hospital Inpatient Discharge Data Audit

- Approved as budgeted (2-0).

5. Song-Brown Primary Care Residency

- Held open.

6. Mental Health Services Act – Unspent Workforce Education Training Funds

- Approved as budgeted (2-0).

0530 Health and Human Services Agency – Office of Systems Integration

1. Office of Systems Integration (OSI) – CHHSA Governance

- Held open.

0530 CHHSA & 4265 Department of Public Health

1. Transfer of Medical Privacy Breach Program to Department of Public Health

- Held open.

4265 Department of Public Health (DPH)

1. Overview

- Informational item

2. Drinking Water Program Transfer to State Water Resources Control Board

- Held open.

3. Licensing and Certification (L&C) Program

- Held open.

4. L&C: Program Evaluation Contract

- Held open.

5. L&C: Licensing Standards for Chronic Dialysis Clinics, Rehabilitation Clinics, and Surgical Clinics

- Held open.

6. L&C: Oversight on Nursing Home Referrals to Community-Based Services

- Held open.

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

- Held open.

8. OA: ADAP – Wrap for Out-of-Pocket Medical Expenses

- Held open.

9. OA: Cross Match of ADAP Data with Franchise Tax Board

- Held open.

10. Genetic Disease Screening Program – Prenatal Screening Fee Increase

- Held open.

11. Women, Infant, and Children Program (WIC)

- Held open.

12. Nutrition Education and Obesity Prevention Branch – Contract Conversion

- Held open.

13. Infant Botulism Treatment and Prevention Program

- Held open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Mimi Walters
Senator Bill Monning

March 13, 2014
9:30 a.m. or Upon Adjournment of Session
Room 4203

Consultant: Samantha Lui

Item	Department	Page
4170	**Department of Aging**	**2**
	1. Overview	2
	2. Multi-Purpose Senior Services Program (MSSP) – Update	4
	3. Expanding Capacity to Service Persons with Dementia in Managed Care Plans Grant	6
	4. Aging and Disability Resources Connection Transfer	7
	5. Model Approaches to Statewide Legal Assistance Systems – Phase II Grant	8
5180	**Department of Social Services, Community Care Licensing (CCL)**	**9**
	1. Overview	9
	2. Quality Enhancement and Program Improvement	13
	3. Sacramento County Caseload Transfer	20
	4. Home Care Services Consumer Protection Act	21
5180	**Department of Social Services, Supplemental Security Income / State Supplemental Payment (SSI/SSP)**	**23**
	1. Overview	23
5180	**Department of Social Services, In-Home Supportive Services (IHSS)**	**25**
	1. Overview	25
	2. Coordinated Care Initiative (CCI), IHSS – Update	27
	3. Litigation Settlement Related to Prior Reductions	29
	4. Federal Fair Labor Standards Act (FLSA) – Final Rule	31
5180	**Department of Social Services, In-Home Supportive Services (IHSS)**	**36**
0530	**Health and Human Services Agency: Office of Systems Integration (OSI)**	**36**
	1. Case Management, Information, and Payrolling System II (CMIPS II)	36

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.

4170 Department of Aging

1. Overview

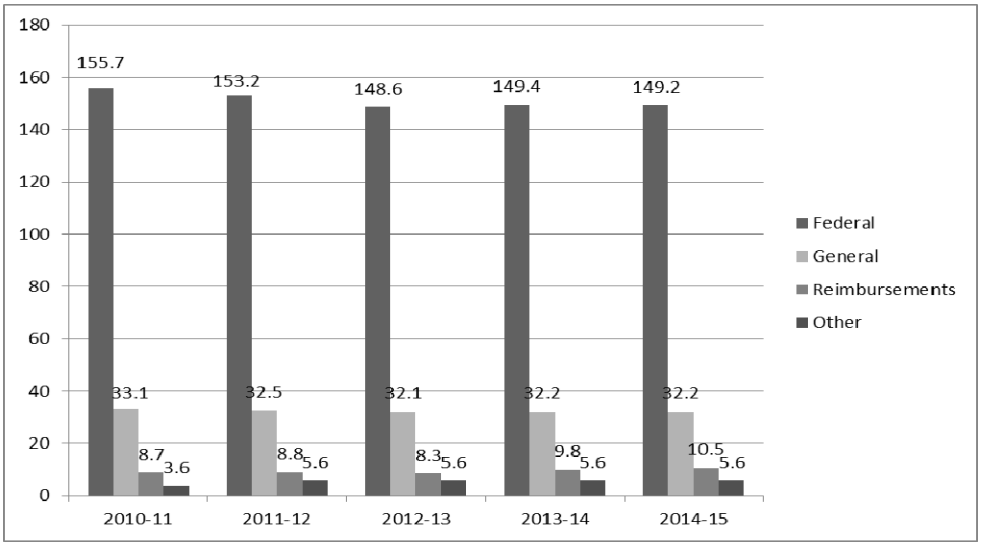
With a proposed 2014-15 budget of $197.47 million ($32.2 million General Fund) and 117.8 authorized positions, the California Department of Aging (CDA) administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities 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. Below is a figure of CDA's funding history for the last five years, starting in fiscal year (FY) 2010-11 to the proposed 2014-15 budget year.

Budget Act Totals by Fund
FY 2010/11 to 2014/15*
(in Millions)



*Amounts above do not include federal sequestration reductions.

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.

Current Competitive Federal Demonstration Grants. CDA has been awarded several competitive federal demonstration grants, which include the following:

- **U.S. Department of Transportation New Freedom Initiative Grant**
  CDA was awarded a $400,000 Department of Transportation New Freedom Grant from June 1, 2011 to December 31, 2013. The grant seeks to increase accessibility and availability of transportation services for older adults and adults with disabilities, and provides mobility management training to California's 33 AAAs.

- **Administration on Aging, Chronic Disease Self-Management Education Grant**
  CDA was awarded a $1.72 million, three-year (September 1, 2012 to August 31, 2015) federal Administration on Aging grant to fund the Empowering Older Adults and Adults with Disabilities through Chronic Disease Self-Management Education (CDSME) grant project. CDA has partnered with the California Department of Public Health (CDPH) to expand the availability of the Chronic Disease Self-Management Program and Diabetes Self-Management Program to individuals who are low-income, limited or non-English speaking, Medi-Cal eligible, and/or veterans. CDA, in partnership with CDPH, will contract with Partners in Care, which will subcontract with the AAAs, or the public health departments, in Los Angeles, Orange, Napa, San Diego, San Francisco, Solano, and Sonoma counties.

Federal Funding for Consumer Counseling. The 2013 budget provided additional expenditure authority to the Department of Aging of $660,000 to reflect a one-time federal grant to provide training for Health Insurance Counseling Program (HICAP) staff and one-on-one dual eligibility health insurance counseling related to Cal MediConnect. HICAP provides free and objective information and counseling about Medicare. Volunteer counselors assist individuals understanding their rights and health care options.

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

Questions

1. Please briefly summarize the department's most critical roles and programs.

2. Please provide an update on the distribution of the federal funds for HICAP for Coordinated Care Initiative.

2. Multi-Purpose Senior Services Program (MSSP) - Update

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

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

MSSP as Part of the Coordinated Care Initiative. The Coordinated Care Initiative (CCI)[1] is intended to integrate medical, behavioral, long-term supports and services (LTSS), and home and community-based services through a single Medi-Cal health plan for persons eligible for both Medicare and Medi-Cal, or "dual eligible," in eight demonstration counties. Under CCI, Medi-Cal beneficiaries will be required to join a participating Medi-Cal managed care health plan to receive their Medi-Cal health benefits, including MSSP. Additionally, CCI will integrate LTSS into Medi-Cal managed care for individuals eligible for Medi-Cal, but not Medicare. For recipients in non-demonstration counties, the MSSP program's current eligibility process and programmatic requirements will continue without changes. The MSSP sites in the CCI counties will continue to provide waiver services to clients for 19 months after the transition to managed care.

The MSSP operates in 48 counties. Fifteen of the 39 MSSP sites are in Coordinated Care Initiative (CCI) demonstration counties. The current MSSP 1915 (c) Home- and Community-Based Services Waiver will expire on June 30, 2014. DHCS and CDA are working together to submit a waiver renewal application which will continue MSSP through June 30, 2019. The waiver renewal addresses transitioning MSSP from a Medi-Cal fee-for-service (FFS) benefit to a managed health care benefit, no earlier than April 1, 2014, in one CCI county (San Mateo), and in the remaining seven CCI counties no sooner than July 1, 2014.

160 MSSP waiver participants will transition into Medi-Cal managed care in San Mateo County, no sooner than April 1, 2014. 5,233 participants will transition into Medi-Cal managed care in Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara Counties, no sooner than July 1, 2014. The remaining 4,047 MSSP waiver participants will continue in the MSSP Waiver under FFS Medi-Cal.

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

[1] For more information, please see the Senate Budget and Fiscal Review Committee and Senate Health Committee's joint oversight hearing of the CCI on February 6, 2014. Background materials may be accessed here: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/02062014SBFR_HealthJointHearingAgendaCCI.pdf

Questions

1. Please briefly describe how the Administration is engaging MSSP sites and staff during CCI implementation.

2. Looking ahead a few years, does the Administration intend for MSSP to continue to be budgeted as a separate LTSS program? Would CDA maintain its programmatic oversight role? How would federal funding potentially change?

3. Expanding Capacity to Service Persons with Dementia in Managed Care Plans Grant

Budget Issue. CDA requests $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.[2] The grant funding will focus 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 will educate care managers to provide person-centered services; and, provide care coordination to individuals and family caregivers, including referrals to services and community support. CDA would work with the California Department of Health Care Services, California Alzheimer's Association Chapters, and interested managed care plans to target patients, family caregivers, and care managers associated with health plans in the Coordinated Care Initiative (CCI) pilot counties. Local Alzheimer's Association Chapters will fully cover the match requirement.

The department indicates that the following seven health plans are scheduled to be involved:

- Health Plan of San Mateo (Year 1)
- Care 1st Health Plan (Year 1)
- Health Net (in the City of Los Angeles) (Years 1 and 2)
- LA Care (Year 2)
- Anthem/CareMore (Year 2)
- Santa Clara Family Health Plan (Year 2)
- Alameda Alliance for Health (Year 2)

In Year 3, CDA seeks to expand the care manager training to interested health plans in Riverside and/or San Bernardino counties.

Background. As the federally designated State Unit on Aging, CDA administers a range of programs, supported by state and federal funds, to provide non-institutional services for older Californians and functionally impaired adults, including the Multipurpose Senior Services Programs (MSSP), Community Based Adult Services (CBAS), and the Alzheimer's Day Care Resource Centers. 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.

Staff Comment & Recommendation. Approve. It is recommended to approve this proposal, as no concerns have been raised.

Questions.

1. Please briefly summarize the proposal, including expected goals and outcomes.

[2] 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

4. Aging and Disability Resource Connection Transfer

Budget Issue. The budget proposes to transfer the Aging and Disability Resource Connection (ADRC) program's administration and oversight from the California Health and Human Services Agency (CHHS) to CDA, and to transfer 2.6 one-year limited-term positions from CHHS to CDA. The budget requests $275,000 in reimbursement authority to fund ADRC program oversight activities. CDA reimbursement authority will be required to collect federal funds from the Department of Health Care Services and State Independent Living Council via interagency agreements.

Background. In 1999, the U.S. Supreme Court's *Olmstead* decision affirmed that the Americans with Disabilities Act applied to individuals with all disabilities, and underscored a person's right to receive community-based long-term services and supports (LTSS) in the most integrated setting as possible. As a result, in 2003, the Administration on Aging (now, called the Administration for Community Living) joined with the Centers for Medicare and Medicaid Services (CMS) to promote and fund ADRC centers and programs.

The ADRC model builds on existing networks and funding to Area Agencies on Aging (AAAs) and Independent Living Centers, and are intended to be a trusted resource for individuals (public and/or private pay) looking for information on the full range of LTSS options. According to the Administration of Community Living's Semi-Annual Report (April 1 to September 30, 2013), ADRCs collectively served more than 33,000 Californians. In California, seven ADRC partnership serve 11 counties (Butte, Colusa, Del Norte, Glenn, Nevada, Orange, Plumas, Riverside, San Diego, San Francisco, and Tehama), and one new ADRC (Alameda County) is in the final planning stages.

In 2007, a CMS demonstration grant, California Community Choices Project, established additional regional ADRCs and state level program support at CHHS, managed by a unit of 2.6 positions. Over the past five years, this effort has been funded by federal grants and limited foundation support.[3] ADRC funding is currently supported with reimbursements from an interagency agreement with the Department of Health Care Services using its remaining 2010 Money Follows the Person (MFP) federal grant funds. That funding, and the authority for the current positions, was approved for one year as part of the 2013-14 budget, and ends June 30, 2014. Federal funding for local ADRCs has, historically, been through opportunities where only a state entity is eligible to apply.

Staff Comment & Recommendation. Approve. Maintaining the State's ADRC program infrastructure allows California's ADRCs to receive future federal funds, as federal funding opportunities require the State to be the applicant. No concerns have been raised with the proposal.

Questions

1. Please briefly explain the Aging and Disability Resource Connection program, including its current service-delivery model, funding sources, and staffing. Why should CDA oversee the ADRC programs?

[3] CHHS ADRC program staff partnered with The SCAN Foundation to select two ADRC partnerships, San Diego and Nevada counties, to work with a team of technical consultants from Mercer. SCAN contracted directly with Mercer to develop innovative models for the delivery and financing of community-based LTSS. Final products were released in February 2014, and posted online at http://communitychoices.info.

5. Model Approaches to Statewide Legal Assistance Systems - Phase II Grant

Budget Issue. CDA requests $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). The Phase II grant project builds upon the prior Phase 1 grant by delivering Older Americans Act (OAA) funded legal services to older adults in greatest need. CDA would continue their partnership with Legal Services of Northern California (LSNC) and the Legal Aid Association of California to implement the grant. The California Model Approaches Advisory Group will monitor project activities and progress. There is no state General Fund impact. CDA's local partners will meet 100 percent of the match requirements.

The project would provide resources for older adults to attend legal education presentations, receive or view online self-help legal education materials, and receive referrals to legal assistance via the statewide aging and disability networks.

Background. As the federally designated State Unit of Aging, CDA receives OAA funding, which it allocates to the 33 local Area Agencies on Aging (AAAs) to provide senior legal services through a network of contracted local providers. In 2009, CDA, in partnership with the Legal Services of Northern California and Legal Aid Association of California, applied for and were awarded a four-year federal Model Approaches to Statewide Leal 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. Also, under the Phase I grant, CDA, LSNC, and the Legal Aid Association of California established the California Model Approaches Advisory Group, comprised of representatives from AAAs, local senior legal services providers, members of the Judicial Council, State Bar Access to Justice Commission, and academia. This Advisory Group prioritized recommendations for future coordination of work, including: increased sharing of tools and resources; increased partnership among legal services and AAAs; and, increased education about legal services.

In May 2013, the Administration of Community Living released a competitive three-year funding opportunity for State Units on Aging to implement a Phase II grant to continue efforts begun under the Phase 1 grant. CDA was awarded the Phase II grant, and will continue to partner with LSNC and the Legal Aid Association of California.

Staff Comment & Recommendation. Approve. It is recommended to approve this proposal, as no concerns have been raised.

Questions

1. Please briefly summarize the Model Approaches Phase II grant. Will findings from the Model Approaches Advisory Group be shared with the Legislature?

2. How will these services be sustained after the Phase II grant expires in FY 2015-16?

5180 Department of Social Services, Community Care Licensing (CCL)

1. Overview

Budget Issue. With a total proposed budget of about $118 million (approximately $36 million GF), 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.

Background. CCL licenses facilities, including childcare centers, family childcare homes, foster family and group homes, adult residential facilities, and residential care facilities for the elderly. 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 figure 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, approximately 200,000 background checks are completed annually, with approximately 1,200 (0.6 percent) individuals denied criminal record clearance or 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 94percent 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

Type of Inspection	Total of Inspections	How many inspections utilized the Key Indicator Tool (KIT)?	How many inspections that utilized the KIT triggered a comprehensive inspection?
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,[4] 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 has 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.[5]

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. Also, civil penalties assessed on licensed facilities are deposited

[4] 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.
[5] 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.

into the Technical Assistance Fund, and are required to be used by the department for technical assistance, training, and education of licensees.

In FY 2013-14 to date, 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.[6]

Training. Licensing managers, who review complaint investigations and administrative actions by licensing analysts, currently receive 80 hours of state mandated, general supervisory training. However, this training does not provide curriculum specific to CCL licensing managers. Currently, licensing program analysts must complete 18 hours of webinar training and 80 hours of in-person training.

Recent Events. Several high-profile cases in child and adult residential facilities recently surfaced, pertaining to the following:

- **2011 Bureau of State Audits Report**.[7] 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.

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

Questions

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

2. Please provide a brief update on 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?

[6] 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.

[7] Full text of the 2011 report can be found at http://www.bsa.ca.gov/pdfs/reports/2011-101.1.pdf.

2. Quality Enhancement and Program Improvement

Budget Issue. The Governor's budget includes $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; and, establish clear fiscal, program, and corporate accountability. Specifically, the budget includes the following components:

- **Additional positions.** The additional 71.5 positions include:
  - Six special investigator assistants;
  - 21 associate governmental program analysts;
  - One office services supervisor and one office technician;
  - One nurse practitioner;
  - Five licensing program managers, of different management levels;
  - Five staff services managers, of different levels;
  - 30.5 licensing program analysts; and,
  - One attorney.

  70.5 positions are requested to be made permanent.

- **Staff training and development.** The budget provides for increased training for new field staff and training for supervisors and managers by expanding the Licensing Program Analyst academy, implementing ongoing training, and strengthening the Administrator Certification Section. Recognizing the changing needs of clients in RCFEs, the Governor's budget proposes that DSS will assist with policy and practice development for medical and mental health conditions in community facilities, as follows:

  - **Establish medical expertise resources.** Although CCL has no staff with medical expertise, DSS licenses facilities that do allow for incidental medical care. Also, DSS has historically maintained a contract with a nurse consultant to provide medical expertise on specific complaint investigations. The Governor's budget proposes to utilize its one Nurse Practitioner position to develop a process and regulations regarding medical conditions and treatments that can be maintained and provided in community care settings, such as chemotherapy.

  - **Create a Mental Health Populations Unit.** With the upcoming Affordable Care Act, and SB 82 (Budget and Fiscal Review Committee), Chapter 34, Statutes of 2013[8], implementation, the Governor proposes to create a Mental Health Populations Unit, which would provide technical assistance to enforcement staff and licensees, as well as to individuals who reside in facilities who have increasing mental health care needs. Specifically, the unit would review and develop bill analyses for proposed legislation on Social Rehabilitation Facilities, coordinate interdepartmental communications, and develop regulations with stakeholders to meet additional program needs.

[8] SB 82 triples the number of social rehabilitation facility (SRF) beds, or crisis stabilization beds, for individuals with higher mental health acuity needs.

- **Establish a Corporate Accountability Unit.** With increased applications for Residential Care Facilities for the Elderly and corporate mergers and acquisitions for facilities, the additional attorney and associate governmental program analyst would perform the following duties: identify and address systemic noncompliance and ensure corrective actions; create management reports that identify patterns and trends; make corrective action recommendations; and, follow-up on corrective action plans to ensure that licensees with poor compliance patterns do not support operational expansions.

- **Increased civil penalties.** According to DSS, because the current civil penalty structure is related to a "per violation" event, the current maximum civil penalty, even in response to serious injury or death of a resident, is $150. The Governor's budget proposes to increase civil penalties for three different types of serious noncompliance, for all facility categories, except foster family homes, specifically:

  - **Zero Tolerance Violations.** Currently, the assessed immediate civil penalty is $150 per day, per violation until corrected. As proposed, an immediate civil penalty assessment[9] would be imposed equal to five times (500 percent) of the facility's annual fee per day, per violation, until and including the day the deficiency is corrected. The budget also adds "any violation that results in the injury, illness, or death of a client" to the list of zero tolerance violations.

  - **Repeat Violations.** The budget proposes to authorize DSS to impose an initial immediate civil penalty assessment on repeat violation equal to three times (300 percent) the facility's annual fee, per violation, in addition to a civil penalty assessment equal to 1.5 times (or 150 percent) the annual license fee per day, per violation, until and including the day the deficiency is corrected.

  - **Failure to Correct.** Currently, the assessed civil penalty is $50 per day, per cited violation, up to a maximum of $150 per day. The budget proposes that if the facility fails to correct a deficiency by the identified due date, a civil penalty equal to 25 percent of the annual fee per day, per violation, until and including the day the deficiency is corrected would be imposed.

  If two or more civil penalties are applicable, the budget proposes to assess the facility, or individual, at the higher penalty rate. In addition, the budget proposes to expand how revenues that are received from civil penalties can be used.

  Below is a chart, which compares current law and the Governor's proposal regarding select CCL civil penalties for serious violation

[9] Examples of violations that would qualify for an immediate civil penalty assessment include: absence of supervision; fire clearance violations; accessible firearms; presence of an excluded person; and, accessible bodies of water.

Selected CCL Civil Penalty Levels for Serious Violations: Current Law and Governor's Proposal

	Current Law			Governor's Proposal		
	Initial	Repeat Within 12 Months		Initial	Repeat Within 12 Months	
Examples of Facilities	(Per Day)	(First Day)	(Each Additional Day)	(Per Day)	(First Day)	(Each Additional Day)
Residential Care Facility for the Elderly (4-6 People)	$150	$150	$50	$2,270	$1,362	$681
Adult Day Program (16-30 Adults)	150	150	50	760	456	228
Family Child Care Center (1-8 Children)	150	150	50	365	219	110
Child Care Centers (31-60 Children)	150	150	50	2,420	1,452	726

Source: Legislative Analyst's Office. *The 2014-15 Budget: Analysis of the Human Services Budget.* Sacramento: 2014. s.v. "Community Care Licensing Quality Enhancement and Program Improvement."

- **Increased licensing fees.** Currently, all facilities, except for foster family homes, must pay application and annual fees set by statute. The budget proposes a ten percent increase in licensing and application fees, which could result in $1 million additional revenues in the first year. The fees would then be adjusted annually with the Consumer Price Index. The proposal requires the department to analyze initial application fees and annual fees, at least every five years, to determine whether the appropriate fee amounts are charged.

Proposed Application Fee and Annual Fee, by Facility Type
(as of March 7, 2014)

Facility Type	Capacity	Initial Application Fee		Annual Fee	
		Current	Proposed	Current	Proposed
Foster Family and Adoption Agencies	N/A	$2,750	$3,025	$1,375	$1,513
Adult Day Programs	1–15	$165	$182	$83	$91
	16–30	$275	$303	$138	$152
	31–60	$550	$605	$275	$303
	61–75	$689	$758	$344	$378
	76–90	$825	$908	$413	$454
	91–120	$1,100	$1,210	$550	$605
	121+	$1,375	$1513	$688	$757
Other Community Care Facilities	1–3	$413	$454	$413	$454
	4–6	$825	$908	$413	$454
	7–15	$1,239	$1,363	$619	$681
	16–30	$1,650	$1,815	$825	$908

Facility Type	Capacity	Initial Application Fee		Annual Fee	
		Current	Proposed	Current	Proposed
	31–49	$2,064	$2,270	$1,032	$1,135
	50–74	$2,477	$2,725	$1,239	$1,363
	75–100	$2,891	$3,180	$1,445	$1,590
	101–150	$3,304	$3,634	$1,652	$1,817
	151–200	$3,852	$4,237	$1,926	$2,119
	201–250	$4,400	$4,840	$2,200	$2,420
	251–300	$4,950	$5,445	$2,475	$2,723
	301–350	$5,500	$6,050	$2,750	$3,025
	351–400	$6,050	$6,655	$3,025	$3,328
	401–500	$7,150	$7,865	$3,575	$3,933
	501–600	$8,250	$9,075	$4,125	$4,538
	601–700	$9,350	$10,285	$4,675	$5,143
	701+	$11,000	$12,100	$5,500	$6,050
Residential Care Facilities For Persons with Chronic Life-Threatening Illness	1–6	$550	$605	$275 plus $10 per bed	$303 plus $11 per bed
	7–15	$689	$758	$344 plus $10 per bed	$378 plus $11 per bed
	16–25	$825	$908	$413 plus $10 per bed	$454 plus $11 per bed
	26+	$964	$1,060	$482 plus $10 per bed	$530 plus $11 per bed
Residential Care Facilities for the Elderly	1–3	$413	$454	$413	$454
	4–6	$825	$908	$413	$454
	7–15	$1,239	$1,363	$619	$681
	16–30	$1,650	$1,815	$825	$908
	31–49	$2,064	$2,270	$1,032	$1,135
	50–74	$2,477	$2,725	$1,239	$1,363
	75–100	$2,891	$3,180	$1,445	$1,590
	101–150	$3,304	$3,634	$1,652	$1,817
	151–200	$3,852	$4,237	$1,926	$2,119
	201–250	$4,400	$4,840	$2,200	$2,420
	251–300	$4,950	$5,445	$2,475	$2,723
	301–350	$5,500	$6,050	$2,750	$3,025
	351–400	$6,050	$6,655	$3,025	$3,328
	401–500	$7,150	$7,865	$3,575	$3,933
	501–600	$8,250	$9,075	$4,125	$4,538

Facility Type	Capacity	Initial Application Fee		Annual Fee	
		Current	Proposed	Current	Proposed
	601–700	$9,350	$10,285	$4,675	$5,143
	701+	$11,000	$12,100	$5,500	$6,050
Family Day Care	1–8	$66	$73	$66	$73
	9–14	$127	$140	$127	$140
Day Care Centers	1–30	$440	$484	$220	$242
	31–60	$880	$968	$440	$484
	61–75	$1,100	$1,210	$550	$605
	76–90	$1,320	$1,452	$660	$726
	91–120	$1,760	$1,936	$880	$968
	121+	$2,200	$2,420	$1,100	$1,210

- **Establish a Temporary Manager and Receivership Process.** The budget authorizes DSS to appoint a temporary manager or receiver to act as the provisional licensee, if DSS determines that residents of a facility are likely to be in danger of serious injury or death, and the immediate relocation of clients is not feasible. The temporary manager or receiver assumes operation of a facility to bring it into compliance; to facilitate a transfer of ownership to a new licensee; or, to assure the transfer of residents, if the facility is required to close. Facilities that serve less than six residents and are also the principal residence of the licensee are exempt. The budget sets forth language which specifies the following:

    - A process to appoint a temporary manger or receiver;
    - A process by which a licensee may contest the appointment of the temporary manager;
    - A temporary manger or receiver's authorized responsibilities;
    - A receiver's salary and length of appointment; and,
    - Circumstances wherein a facility's owner can sell, lease, or close the facility.

- **Specialized complaint hotline.** Currently, 462 LPAs in 26 licensing offices throughout the state review incoming complaints. Depending on workload, a LPA may remain in the office instead of in the field performing licensing visits. Additionally, every LPA must spend two days a month conducting intake and assessing complaints and incidences, as well as respond to general inquiries. The budget establishes a specialized and centralized toll-free public complaint hotline, which can help acquire better initial information, conduct consistent prioritization, and dispatch incoming complaints to regional offices.

- **Centralized application processing.** As of January 10, 2014, 779 Adult and Senior Facility applications for licensure are pending. Applications can take from six months, up to a year or more, to process. The budget proposes centralizing applications for Adult and Senior Care facilities, which is expected to increase inspections of licensed facilities to at least once every two years.

- **Establish a statewide Quality Assurance Unit.** The current information technology system does not allow for documents and reports to track information statewide, including complaints, actions, or performance. It also does not provide aggregate data to review and identify patterns. The budget proposes to establish a Quality Assurance Unit to identify immediate health and safety risks to clients, develop a statewide quality assurance review model, coordinate licensing case file responses to Public Record Act requests, and identify training needs for quality assurance review. The unit will also assist DSS in ensuring that regional offices have the support necessary to ensure that licensed care facilities are monitored, and that systemic noncompliance is detected and addressed at the appropriate organizational level.

- **Establish an Emergency Client/Resident Contingency Account.** The accounts, which would be within the Technical Assistance Fund, would be used at the discretion of the Director of DSS for the care and relocation of clients and residents, when a facility's license is revoked or temporarily suspended. The money in the account must cover costs, such as transportation expenses, expenses incurred in notifying family members, costs associated with providing continuous care and supervision.

The budget provides for an accompanying trailer bill that proposes language to implement the provisions discussed above.

LAO Comments. The LAO makes the following comments and recommendations:

- Changing needs of clients at RCFEs. Due to the changing medical conditions of RCFE residents, and the changing profiles of those applying for licenses to operate RCFEs, the LAO finds merit in the department's proposal to have a public health nurse and the establishment of a mental health populations unit and corporate accountability unit for CCL.

- Increased application and annual licensing fees, and civil penalties. The LAO finds it reasonable to increase the maximum penalty for serious violations. However, citing uncertainty surrounding the appropriate level of civil penalties, and the variations in these levels across states, LAO suggests that the Legislature consider a more gradual ramp up of civil penalty levels to allow evaluation of the appropriateness of the penalties in a year and whether additional increases should be implemented. In addition, the LAO recommends the Legislature require DSS to report annually with information to help evaluate the appropriateness of penalties.

- Centralize specified activities. The LAO finds the proposal in centralizing application processing and complaint intake could increase state oversight and efficiency. By providing a statewide complaint hotline, the public would have one number to call for any complaint and the state could improve consistency in complaint intake and response. Further, LAO notes that by creating a centralized application processing unit, CCL could ensure that a single licensee with multiple applications would get one reviewer and one set of instructions.

- Temporary manager and receivership. The LAO notes that the new enforcement tool makes sense in concept, but recommends the Legislature to ask DSS the differences between the CCL proposal and how DPH currently administers its temporary manager and receivership process for Skilled Nursing Facilities (SNFs).

Staff Comment & Recommendation. Hold open. With demand for health delivery in a home-care, non-institutional setting, the state is at a crossroads to update CCL's current regulatory framework and to ensure that residential care for individuals, including dementia or mental health care, is provided safely. It is recommended to hold this item open to continue discussions with the Administration.

Questions

1. Please briefly summarize the proposal, including the need for the requested positions, the proposed civil penalty structure, the temporary manager and receivership process, and how inspectors can identify widespread problems or patterns across a single licensee

2. Please briefly describe how the KIT will be used within the proposal. Do facilities, which have demonstrated success in meeting the key indicators assessment over time, continue to receive a KIT assessment or a full assessment?

3. How does the proposal address inspection frequency?

4. Please briefly summarize the stakeholder process and involvement.

3. Sacramento County Caseload Transfer

Budget Issue. On September 30, 2013, Sacramento County terminated its contract with DSS and returned the licensing of 1,752 FCCHs to CCL. The Governor's budget requests to redirect funding, from local assistance to state operations, to support 10.5 permanent positions that would manage the workload, specifically:

- Seven licensing program analysts;
- One licensing program manager;
- Two office assistants; and,
- 0.5 associate governmental program analyst.

Background. The CCL Division in DSS oversees the licensure or certification of approximately 66,000 licensed community care facilities, including FCCHs. Staff in CCL regional offices directly license and monitor FCCHs in accordance with mandated minimum licensing standards and Title 22 regulations. For fiscal year 2014-15, CCL projects that it will license and monitor about 29,550 FCCHs, which serve around 297,082 children.

State law authorizes CCL to contract with counties to license FCCHs. Currently, Inyo and Del Norte Counties license FCCHs. If a county chooses to no longer perform the licensing, approval, or consultation responsibilities, the workload is returned to CCL. Last September, Sacramento County terminated its contact with DSS, and returned the licensing of 1,752 FCCHs to CCL. For current budget year, CCL redirected funding from local assistance to state operations to hire temporary staff to handle the workload.

Staff Comment & Recommendation. Approve. It is recommended to approve the requested resources and positions, as no concerns have been raised.

Questions

1. Please briefly summarize the need for the requested positions.

4. Home Care Services Consumer Protection Act

Budget Issue. The budget requests $1,472,000 in General Fund for vendor contract funding ($251,000) and ten positions (seven permanent; two one-year limited-term; and, one two-year limited-term) to establish, and maintain, the operational and administrative components of the Home Care Services Consumer Protection Act (AB 1217, Lowenthal). The positions and related divisions include:

- Community Care Licensing: one staff services manager; two associate governmental program analysts; and, one office technician.
- Legal Division: one attorney.
- Information Systems Division: two staff programmer analysts; two one-year limited term staff programmer analyst; and, one senior information systems analyst.

Initial funding to implement the program will be provided through a General Fund loan, which will be repaid from fees paid by home care organizations and home care aides once the program is operational. The department also intends to submit a FY 2015-16 BCP for resources to ensure that licensing and registration functions are performed.

The Administration also includes a trailer bill, which contains the following provisions:

1. Deletes language that exempts specified individuals from registration requirements for home care aides, and expands the list of individuals and entities that are not considered home care aides or home care organizations.
2. Requires the chief executive officer, or another person serving in a similar capacity, in a home care organization, to consent to a background examination.
3. Prohibits the department from issuing a provisional license to any corporate home care organization applicant that has a member of the board of directors, executive director, or officer who is not eligible for licensure.
4. Revises license renewal requirements, including insurance and workers' compensation policies.
5. Revises a home care organization's licensure requirements to require proof of an employee dishonesty bond.
6. Authorizes the department to cease review on an application if it is determined that the home care applicant was previously issued a license and that license was revoked.
7. Requires home care organization licensees to report suspected or known dependent adult, elder, or child abuse to the department. Upon receipt of these reports, the department must cross-report the suspected or known abuse to local law enforcement and Adult Protective Services or Child Protected Services.
8. Authorizes home care organization applicants and home care aide applicants, who submit applications prior to January 1, 2016, to provide home care services without meeting the tuberculosis examination requirements, provided that those requirements are met by July 1, 2016.

Background. In response to concerns that home care organizations (HCOs) are not required to be licensed, and that home care aides are not required to meet minimum qualifications or screenings, AB 1217 (Lowenthal), Chapter 790, Statutes of 2013, enacted the Home Care Services Consumer Protection Act, effective January 1, 2016, per the Governor's signing message. 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. 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 required that the Administration of the Act be fully supported by fees paid by the HCO and home care aides.

Staff Comment & Recommendation. Hold open. It is recommended to hold this item open to continue discussions on this proposal.

Questions.

1. Please briefly summarize the need for the requested positions.

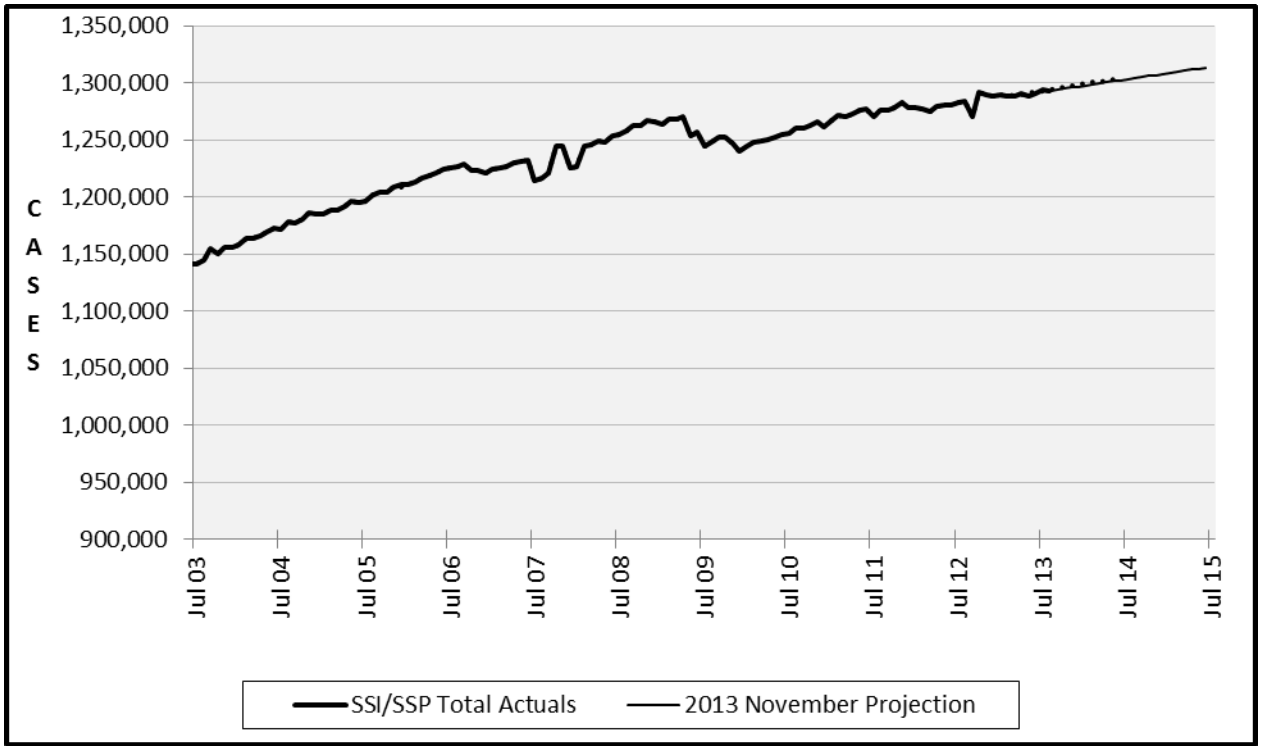
2. How has the Administration involved stakeholders in the development of this proposal?

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, 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, while the state pays SSP, which augments the SSI benefit. The SSI/SSP program is primarily administered by the federal Social Security Administration.

Funding and Caseload. The budget proposes expenditures of $9.6 billion ($2.5 billion General Fund) for SSI/SSP. The state pays administration costs for SSP, around $184 million in for 2014-15. Effective October 2013, the administrative fee is $11.32 per benefit issuance. The budget projects SSI/SSP average monthly enrollment will grow by 0.9 percent, from 1,297,289 in 2013-14 to 1,308,166 in the budget year.



Maximum and Average Grant Amounts. 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 .[10] 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 Food Stamps benefits, due to the state's "cash-out" policy.

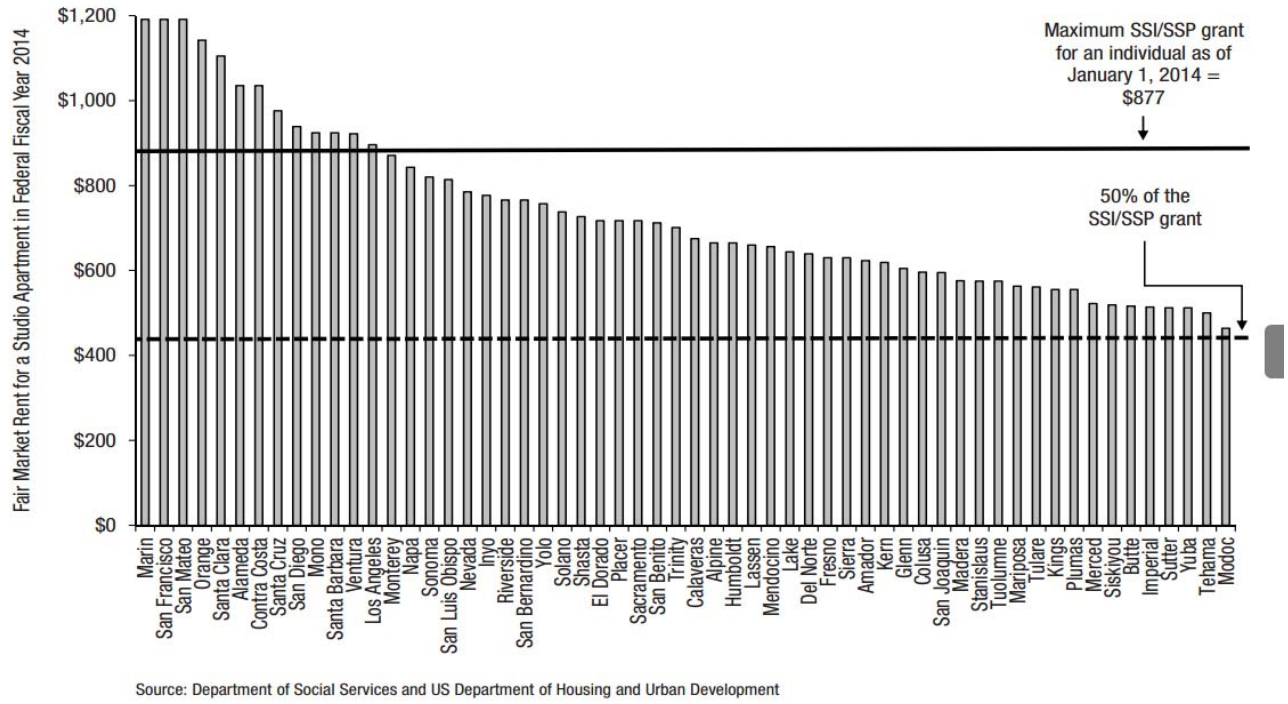
[10] The department projects the 2015 SSI/SSP payment for an individual to be $884.40 (91 percent of FPL); for couples, $1,488.20 (114 percent of FPL).

Average SSI/SSP Grants for Individuals
(as of January 10, 2014)

	SSI	SSP
Individuals aged 65+	$347.93	$159.36
Individuals who are blind	$445.28	$204.24
Individuals with disabilities	$493.69	$157.56

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. Without the COLA, recipients face pressure to reduce spending on food or utilities, as housing costs increase. Below is a figure from the California Budget Project, which demonstrates that fair market rent for a studio apartment exceeds one-half of the current SSI/SSP grant for an individual in all 58 counties, and is higher than the entire grant amount in 13 counties.

Figure 1: Studio Apartment Rent Exceeds One-Half of the SSI/SSP Grant in All 58 Counties and Is Higher Than the Entire Grant in 13 Counties



Source: Department of Social Services and US Department of Housing and Urban Development

Source: California Budget Project. "SSI/SSP in the Governor's Proposed 2014015 Budget: Assistance for Seniors and People with Disabilites is Left Below the Poverty Line." 4 March 2014. http://www.cbp.org/pdfs/2014/140304_SSI_SSP_Governor_Proposed_Budget_BB.pdf

Staff Comment & Recommendation. This is an informational item, and included for discussion. No action is required.

Questions.

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

5180 Department of Social Services, In-Home Supportive Services (IHSS)

1. Overview

Budget Issue. The budget proposes $6.2 billion ($1.8 billion GF) for services and administration, a 4.9 percent increase over expenditures in 2013-14. In response to recent federal labor regulations effective January 1, 2015, (to be discussed further below), the budget increases $209 million ($99 million GF) to comply with new federal regulations. IHSS Basic Services also increases $68 million ($35 million GF) because of a 1.3 percent caseload growth, and higher cost per hour, due to the increase in the hourly minimum wage from $8 to $9, effective July 1, 2014. As a result of implementing the seven percent reduction in IHSS authorized hours (to be discussed further below), the budget estimates $181 million in GF savings.

Background. 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 $13,248 ($1,104.08 per client per month) for 2014-15.

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. The department indicates that the statewide reassessment compliance is around 90 percent through FY 2010-11 to FY 2012-13. 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."

In 2013, IHSS providers' combined hourly wages and health benefits vary by county, and range from $8.00 to $15.38 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 eight counties -- Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara -- participating in Coordinated Care Initiative (CCI) will shift to an IHSS Authority administered by the state (to be discussed further below).

Funding. The average annual cost of services per IHSS client is estimated to be around $12,000 for 2012-13. 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.

Other policies. Several recent policies have also impacted the IHSS program, including:

- **Reductions in IHSS recipient hours.** A legal settlement from *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*, resulted in an 8 percent reduction to authorized hours, effective July 1, 2013. Beginning in July 1, 2014, the reduction in authorized service hours will be reduced to 7 percent.

- **Minimum wage increases.** AB 10 (Alejo), Chapter 351, Statutes of 2013, increased the minimum wage from $8 per hour to $9 per hour in July 2014, with gradual increases until the minimum wage meets $10 per hour by January 2016. 17 counties will be impacted by the minimum wage increase for this fiscal year: Alpine, Amador, Butte, Colusa, Glenn, Humboldt, Lake, Lassen, Modoc, Mono, Nevada, Plumas, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne. All non-federal IHSS provider wage costs will be funded by the General Fund, around $5.7 million total for this year.

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

Questions.

1. Please briefly summarize the IHSS program.

2. Coordinated Care Initiative (CCI), IHSS – Update

Background. As discussed in greater detail during the joint Senate Budget and Fiscal Review Committee and Senate Health Committee hearing on February 6, 2014 (background materials available online at: http://sbud.senate.ca.gov/fullcommitteehearings), the Coordinated Care Initiative, requires Cal Medi-Connect to coordinate medical, behavioral health, long-term institutional, and home and community-based services; and, to administer IHSS according to current program standards and requirements. The intent of CCI is to improve integration of medical and long-term care services through the use of managed health care plans and to realize accompanying fiscal savings. As IHSS becomes a Medi-Cal managed care benefit in the eight counties, the county is responsible for paying a MOE amount, not a percentage of program costs. Approximately 65 percent of IHSS recipients reside in the demonstration counties.

Service delivery. All current regulations pertaining to the governance and operation of IHSS, such as assessments, notices, maintenance of a registry by the county IHSS Public Authority, remains the same. Further, IHSS recipients will continue to hire, fire, and supervise IHSS providers under the self-directed model. Under CCI, managed care plans must include County IHSS social workers in their interdisciplinary team care planning process. Upon their own determination, CCI plan enrollees may also include their IHSS providers in this care coordination team process. This care coordination team is intended to improve the communication, quality of care plans, and coordination among county IHSS eligibility workers, IHSS providers, enrollees' physicians, and other medical and service providers involved in the care of the CCI plan enrollees.

Funding. Related to CCI, a 2012-13 budget trailer bill (Chapter 45, Statutes of 2012) created IHSS Maintenance of Effort (MOE) funding requirements for counties, which replaced the previously existing county share of non-federal funding of 35 percent, and an inflation factor of 3.5 percent beginning this budget year. Under the county MOE financing structure, the GF assumes all nonfederal IHSS costs above a counties' MOE level. As a result, the LAO estimates the county MOE to be $994 million.

Statewide Authority. SB 1036 (Senate Budget and Fiscal Review Committee), Chapter 45, Statutes of 2012, also shifted collective bargaining responsibilities from local county public authorities (PAs), or non-profit consortia in the demonstration counties, to a new California IHSS Authority (Statewide Authority), with specified members and an advisory committee. The department indicates that Statewide Public Authority is to be established after the completion of enrollment of all eligible Medi-Cal beneficiaries in CCI plans. The current schedule of enrollment in managed care plans will be completed by San Mateo by February 2015, and the remaining counties by June 30, 2015.

Universal Assessment Tool. Under CCI, IHSS will continue to be the major home and community based services for seniors and persons with disabilities. The Department of Health Care Services, DSS, and Department of Aging must develop a Universal (or Uniform) Assessment Tool to assess a Medi-Cal beneficiary's need for Home and Community-Based Services. The goal is to enhance personalized care planning under CCI, and create a common tool that can be used by all involved in the care of beneficiaries who need home and community based long-term care services.

DSS indicates that DHCS is working closely with it and CDA, creating a stakeholder workgroup -- comprised of advocates; consumers; county IHSS; CBAS; MSSP; legislative staff; health plans; and UCLA, USC, and UCSF researches -- and a process that facilitates the development of this tool. The workgroup intends to establish a draft tool by 2014-15, to be piloted in no more than four CCI counties in 2015-16 and for adoption in 2016 by providers and health plans.

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

Questions

1. Please briefly summarize the recent changes to IHSS financing and collective bargaining, and the impacts of those changes in 2014-15.

2. Please briefly provide an update on the Universal Assessment Tool, and the department's engagement with stakeholders.

3. Litigation Settlement Related to Prior Reductions

Budget Issue. As summarized in the chart below, several reductions to the IHSS program made in the last four state budgets were enjoined by federal courts from taking effect.

Policy	Name of Lawsuit Under Which Policy Is Enjoined from Taking Effect
Loss of eligibility for individuals with assessed needs below specified thresholds.	*Oster (V.L.) v. Lightbourne, et al. (Oster I)*
Across-the-board cut of 20% of authorized hours, with exceptions (impacts about 300,000 recipients).	*Oster (V.L.) v. Lightbourne, et al. (Oster II)*
Reduction in state participation in provider wages (from maximum of $12.10 to $10.10 per hour).	*Dominguez v. Schwarzenegger, et al.*

In March 2013, the Administration and plaintiffs in those cases (labor unions and disability rights advocates) announced that they had reached a comprehensive settlement agreement. The repeal of the reductions described above and replacement with the policies is described in the chart and summary below:

Policy Included in Settlement	Effective Date
Across-the-board cut of 8% (no exceptions)	July 1, 2013
Across-the-board cut of up to 7% (no exceptions)[11]	July 1, 2014

The settlement agreement also 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" (likely a fee or tax) on home 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.

Appeals and Reassessments under the Settlement. If an IHSS recipient appeals the eight or seven percent reductions on their face, his or her request can be administratively denied. At the same time, the settlement agreement reiterates that IHSS recipients retain their rights under existing law to request a reassessment of service hours based on a change in personal circumstances. For FY 2013-14, the

[11] The department notes that current methodology results in a net impact of 6.41 percent reduction across all IHSS hours. There is no excluded population, and reassessments are only granted for changes in circumstances or health condition. The seven percent reduction is first applied to any documented unmet need, excluding protective supervision.

department estimated that in response to the eight percent reduction proposed, ten percent of IHSS recipients would appeal the reduction itself and have their requests administratively denied. However, the department indicates that appeals submitted for the eight percent reduction were not tied to recent assessments regarding a change in circumstance or health condition; rather, hearings were tied to challenges to the law that required the reduction, not the eight percent reduction impact itself.

Panel. The Subcommittee has requested the following panelists present on the topic:

- Terry Walker-Dampier, Provider in Stanislaus County, Member of UDW/AFSCME
- Michelle Rousey, Consumer in Alameda County, Member of the IHSS Coalition
- Gary Passmore, Vice President, Congress of California Seniors

Staff Comment & Recommendation. This is an information item, and included for discussion. No action is required.

Questions

1. Please briefly summarize the prior reductions at issue and the terms of the settlement agreement.

2. When can we expect to hear more details about the "assessment" on home care services included as part of the settlement agreement? How might it work?

4. Federal Fair Labor Standards Act (FLSA)- Final Rule

Budget Issue. The budget recognizes the new FLSA regulations, effective January 1, 2015, and provides that implementation of federal requirements will cost $208.9 million ($99 million General Fund) in 2014-15 and $327.9 million ($153.1 million General Fund) annually thereafter. The $208.9 million breakdown is as follows:

- Approximately $68.6 million ($32 million GF) for FLSA regulations and creating a provider backup system (around $7.5 million would be allocated to modify CMIPS-II data software to maintain workweek agreements; track provider hours; update policies, instructions, and provider timesheets; and, add new activities, such as wait time during medical accompaniment and mandatory training);[12]
- $87 million ($40 million GF) for FLSA compliance[13] ($81 million [$37 million GF] for medical accompaniment wait time; $6 million [$3 million GF] for travel time; and, mandatory provider training); and,
- $53 million ($27 million GF) to implement overtime restrictions (social workers in county welfare departments work with IHSS recipients to create and review workweek agreements for all recipients).

Prohibits providers from working overtime. The budget prohibits providers from working overtime, except for documented emergency circumstances. Providers who work beyond work week limitations are subject to disciplinary action. After the first instance of overtime claim on a timesheet, the IHSS provider would receive a warning notice. After the second instance, the IHSS provider would be suspended for the program for one year. The budget assumes that unauthorized overtime costs $6.17 per hour.

Establishes a Provider Backup System. The budget assumes that a notification must be mailed to current IHSS providers and recipients, explaining the new policy and workweek agreement. The recipient must monitor his or her workweek agreement, so that IHSS providers do not exceed 40 hours per week. If a recipient's regular provider exceeds, or is approaching, the limitation on hours, a recipient should contact his or her substitute backup provider. If the recipient's substitute backup provider is unavailable, the recipient is authorized to contact the provider Backup System for assistance. Services provided by a backup provider would be deducted from the recipient's authorized hours. The cost of adding providers to the Public Authority registry and backup is $34.50 per provider.

The budget estimate assumes that the cost of compensating the backup provider will be, on average, 25 percent higher than the estimate statewide average cost per hour of $12.33 in 2014-15. This translates into a wage premium of $3.08, and an average wage of $15.41 per hour for backup providers.

[12] Due to a technical budget error, the Administration overestimated the cost associated with paying for authorized services delivered by a backup provider by $22 million GF in 2014-15 and $48 million GF in 2015-16. After correcting the error, the Administration estimates that the proposal to restrict overtime for all IHSS providers, including administrative activities to prevent overtime and maintain the Provider Backup System would cost $52 million ($25 million GF) annually.

[13] The budget provides that 85 percent of recipients will have a provider accompany them to medical visits, where providers will spend three hours per month waiting for recipients to complete their appointments. Each month new providers will attend a two-hour mandatory orientation training.

The budget provides for an accompanying trailer bill that proposes language to implement the provisions discussed above.

Background. FLSA is the primary federal statute dealing with minimum wage, overtime pay, child labor, and related issues. Under current law, some provisions of the FLSA do not apply to certain employees, including the "Companionship Services Exemption" for domestic service employees who: 1) provide babysitting services on a casual basis, or 2) provide "companionship services" to individuals who are unable to care for themselves. Federal regulations define "companionship services" as services that provide fellowship, care, and protection for a person who, because of advanced age or physical or mental disability, cannot care for his or her own needs. These services may include household work, such as meal preparation, bed making, washing of clothes, and other similar services that can be provided through IHSS. General housework may also be included, subject to some limitations. Current regulations exempt employees of third-party agencies and live-in domestic service employees who provide companionship services from overtime regulations in FLSA.

In September 2013, the U.S. Department of Labor (US-DOL) issued a Final Rule, effective January 1, 2015, which redefines "companionship services;" limits exemptions for "companionship services" and "live-in domestic service employees" to the individual, family, or household using the services (not a third party employer); and, requires compensation for activities, such as travel time between multiple recipients, wait time associated with medical accompaniment, and time spent in mandatory provider training. Under the Final Rule, employers must pay at least the federal minimum wage ($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 department estimates that 385,425 individuals will work as IHSS providers in 2014-15. About 49,000 providers (12.7 percent of the workforce), work more than 160 hours per month, and will be impacted by the prohibition on overtime. Further, some providers work for more than one recipient. The department also estimates that 453,417 eligible individuals receive IHSS services. About 37,000 recipients (8.2 percent of the estimated caseload) are expected to receive more than 160 hours per month from a single IHSS provider. About 317,000 recipients (70 percent) receive care from a family member or relative provider; about 222,000 recipients receive care from a live-in provider.

LAO Comments. The LAO makes the following comments and recommendations:

- Consumer choice. For recipients who receive care from a live-in provider, or family member or relative, the restriction and potential to hire a second provider may be undesirable. Some recipients will have to switch to a provider who can accommodate their care, or hire a second provider. Further, for recipients with certain disabilities, there may be challenges in adjusting and finding an appropriate provider to meet needs.

- Back-up provider. Because the Provider Backup System is only intended for unforeseen circumstances, an IHSS recipient who regularly needs more than 40 hours of assistance per week would need to retain at least two providers. It is uncertain if a sufficient number of IHSS providers would be available to meet this demand, and if the Backup System will be able to successfully pair all consumers with providers who meet the consumer's individual needs (e.g., geographically isolated, language other than English) and to preserve the consumers' right to hire a provider of his or her choosing. In addition, the proposed one-year suspension of IHSS providers who claim overtime on two occasions could reduce the pool of available providers.

- Lacks flexibility. By prohibiting all overtime exceeding 40 hours in a week, the proposal could impede consumers' access and disrupt care. The LAO also finds that suspending a provider after claiming two instances of overtime to be unduly punitive to both the provider and recipient. A provider could submit two timesheets in close succession before receiving a warning notice, or may not have received the warning due to a change of address. As such, the LAO recommends adding a suspension of one month, prior to the one-year suspension. A suspension shorter than one-year may produce the same deterrent, and would not force a recipient to go without his or her preferred provider for an extended period.

- Overtime restriction**.** The Governor's proposal to restrict overtime would cost $51 million ($25 million GF) annually. This is significantly less than the estimated cost of paying for the overtime $401 million ($186 million GF) annually.

- Provide targeted exemption**.** The Legislature could consider a targeted exemption for recipients who would be in particularly disruptive situations if the overtime restriction applied to their providers. Examples of a targeted exemption include: individuals with developmental disabilities, who may face challenge in adjusting to a new provider; or, individuals in rural counties who may face difficulty in finding and securing a suitable second provider. Because of federal Medicaid rules, there is significant uncertainty whether this modification would receive approval.

- Provide limited allotment of overtime hours to certain providers. The Legislature could allow a limited allotment – for example, 48 hours in a year (4 overtime hours each month) – to IHSS providers of high-hour recipients, to allow some flexibility to work hours for special circumstances, such as a recipient's fall or a long doctor's visit.

- Authorize overtime when other providers are unavailable. The Legislature may also authorize overtime for a recipient until a second provider, or backup provider, is identified.

- Consider "cash and counseling" model. Under the Cash-and-Counseling Model, consumers receive a monthly sum of available funds, based on the cost of hours of in-home services, to set wage levels, hire a provider, and purchase permissible goods that make it easier to remain at home. A counselor helps the consumer craft spending plans and monitors the use of available funds; and, a financial management services agency assists the consumer with paperwork. The LAO notes that this model could have the effect of classifying the consumer as the sole employer of the live-in provider, which could authorize a consumer to claim the live-in domestic service worker exemption.

Panel. The Subcommittee has requested the following panelists present on the topic:

- Rebecca Malberg, SEIU-UHW
- Earnie Spencer, Provider in Solano County, Member of SEIU-ULTCW
- Mark Beckwith, Consumer in Alameda County, Member of the IHSS Coalition
- Deborah Doctor, Disability Rights California
- Frank Mecca, Executive Director, County Welfare Directors Association

Staff Comment & Recommendation. Hold open. It is recommended to hold the item open for further discussion. In deliberating this proposal, the Legislature may wish to consider the following:

- **Increased workforce.** According to the Department of Finance (DOF), between 30,000 to 40,000 additional providers and workers are needed to meet the needs of the over 160 hours per month population. County workers would help IHSS recipients develop a workweek agreement and would monitor compliance with the agreement. The budget assumes wage cost per hour for social workers of $60.55 per hour, and for clerks, $16.80 per hour. Consistent with the intent of an 8-hour workday/40-hour work week, the new federal regulations attempt to protect the health and safety of providers for IHSS recipients, ensuring that providers are rested and able to care for and supervise the health of IHSS recipients.

- **Impact on family caregivers and providers.** About 37,000 recipients (8.2 percent) of the estimated caseload are expected to receive more than 160 hours per month from a single IHSS provider. About 317,000 recipients (70 percent) receive care from a family member or relative provider. If California were to implement FLSA regulations, as well as fund current allotments, the budget estimates full implementation to cost over $620 million ($288 GF). The Legislature may wish to consider whether limiting overtime is appropriate, as well as the impact of a second provider entering a home on the recipient.

- **Provider Backup System.** Los Angeles County currently operates a Back-Up Attendant Program (BUAP), which matches eligible IHSS recipients with homecare workers to assist on a short-term basis when a recipient's long-term provider and designated substitute provider are unavailable. There are currently 59 providers in the BUAP. The program provides a wage of $12 per hour for providers listed on the registry as backup providers, and $9 per hour for all other providers. The BUAP phone line is available Monday through Friday, 8 a.m. to 5 p.m. When a consumer calls, BUAP operators use a computer database to identify a backup provider who can best meet the consumer's needs. In 2013, only 142 IHSS recipients were enrolled. The phone line received 254 calls, and provided 1,342 backup service hours.

- **A broader perspective.** The IHSS program was created in 1973 to enable elderly, blind, and individuals with disabilities the ability to live independently in the community, not intentionally designed as financial support for caregivers -- though it has evolved as such. Further, as more individuals age in place and prefer home-like, independent, and non-institutional care, the program's recipients and needs continue to change. As more IHSS recipients select in-home care, California's IHSS program may experience a programmatic shift in formalizing care for a family member as employment, as well as a shift in the types of services provided to recipients.

- **Stakeholder process.** The budget proposal assumes a stakeholder process to inform providers and recipients of the impending changes to implement federal regulations, as well as in developing the workweek agreement. The Legislature may wish to consider the timing of conducting a stakeholder process, given the state's required implementation of federal regulations by January 1, 2015.

- **Other states.** Some states, such as New Mexico, Kentucky, and Pennsylvania, have contracted with organizations for counseling services and fiscal agents; and use a "cash and counseling" model, also known as "participant direction." In a Cash-and-Counseling program, the government provides recipients a monthly monetary allowance, based on an assessment of needs. Recipients prepare a plan for spending the allowance on permissible goods and services, hire and pay the providers, and receive counseling to help make decisions about developing back-up plans. The

Legislature may wish to consider whether allocating its resources to create a provider back-up system to comply with FLSA regulations may be better spent on a new delivery system altogether.

Questions.

1. Please briefly summarize the Fair Labor Standards Act Final Rule and how the Governor's proposal responds to the new requirements.

2. Please briefly explain the proposed Provider Backup System and what happens if a provider works over 40 hours per week on at least two occasions.

3. Please briefly describe the "Cash and Counseling" model. Could this model work for California? Why or why not?

4. Please briefly describe the stakeholder process.

5180 Department of Social Services
0530 Health and Human Services Agency: Office of Systems Integration (OSI)

1. Case Management, Information, & Payrolling System II (CMIPS II)

Budget Issue. The budget requests to align the Office of Systems Integration (OSI) spending authority with the CMIPS II system rollout and transition to Maintenance and Operations (M&O) in 2013-14 and 2014-15. Specifically, the budget proposes an increase of $115,000 in OSI spending authority and a corresponding increase of $2.9 million in the DSS Local Assistance for FY 2013-14, and a net decrease in OSI spending authority of $33.7 million for the budget year. The proposal also includes authority for ten new permanent state staff ($1.48 million) and a corresponding decrease of $36.7 million in the DSS Local Assistance.

Correspondingly, the DSS budget requests six permanent positions to support the CMIPS II project in its maintenance and operations (M&O) phase. This proposal has a corresponding reduction to its Local Assistance budget as it was originally budgeted within OSI. DSS will assume the lead role for the service and support activities that were formerly outsourced. Duties in this role include system enhancements, inputting of legislatively mandated changes, validation and testing, data extraction, research, analysis, and reporting. CMIPS II will provide monthly and quarterly system updates during the M&O period that will necessitate DSS oversight, leadership, support and approval.

Background on Case Management, Information, and Payrolling System II (CMIPS II). CMIPS is the automated, statewide system that handles payroll functions for all IHSS providers. The current vendor (formerly Electronic Data Systems, now Hewlett Packard) has operated the CMIPS system since its inception in 1979. The state has been in the process of procuring and developing a more modern CMIPS II system since 1997. The contract was awarded to Hewlett Packard, formerly EDS, in March 2008. Development commenced and in July 2012, Merced and Yolo counties began implementation of CMIPS II. San Diego County joined in September 2012, eight additional counties implemented in March 2013 and Los Angeles County implemented in September 2013. The final counties implemented November 2013, concluding the Design, Development and Implementation (DD&I) phase with associated conclusion activities into 2014.

The CMIPS II system will provide, according to the department, an enhanced Interface system to support the IHSS programs, including the IHSS program transition into managed care. As CMIPS II transitions into the M&O phase, the department will take a management role of the CMIPS operations, in partnership with OSI. The department will assume ongoing service and support activities that were once outsourced to contractors.

The schedule for the CMIPS II roll-out is summarized in the chart below:

Completed Project Milestones

Milestone Phase	End Date
Design, Development, and Implementation (DD&I)	
• Project Initiation Phase	Oct. 2008
• System Requirement Validation Phase	Dec. 2008
• General System Design Phase	Apr. 2009
• Detailed System Design Phase	Jul. 2009
• Coding and Documentation Phase	Jan. 2010
• System Test and Evaluation Phase	Jun. 2012
• Pilot Phase	Sept. 2012
o Pilot 1 go-live	Jul. 2012
o Pilot 2 go-live	Sep. 2012
• Group #1 go-live (8 counties)	Mar. 2013
• Group #2 go-live (22 counties)	May 2013

Rationale for Position Requests. The Administration indicates that the requested budget adjustment in 2013-14 reflects the need for additional infrastructure resources in support of implementation activities. The net decrease in OSI spending authority and DSS Local Assistance for 2014-15 reflects the scheduled completion of system implementation and the commencement of ongoing costs for the M&O phase of CMIPS II. To support ongoing CMIPS II support functions, the OSI budget proposal includes $98,000 for temporary help in 2013-14 and $1.7 million in 2014-15 for new state staff.

Currently, the CMIPS II Project lacks state staff to provide system support activities, such as monitoring and overseeing technical issues, application anomalies, and testing system defects. In the interim, the CMIPS II Project is utilizing contracted resources and loaned county staff. CMIPS II implementation began on July 30, 2012 and will continue through December 2013. CMIPS II M&O will start the following month in January 2014. The temporary help, legal consultant, and additional data center services storage capacity will be implemented in 2013-14 upon release of the Governor's Budget. Additional state positions for 2014-15 will be filled as soon as possible after the Budget Act is enacted. Given the need to ensure the transition of knowledge from consultants and county staff to State staff, CMIPS II plans to begin recruitment activities for these positions as soon as possible to fill the positions in July and August 2014.

OSI's requested ten permanent IT positions for M&O activities will support the program standards, program system enhancements, CMIPS II data sharing requirements, and CMS Medicaid business processes. Further, these staff will ensure that the application is updated with regulatory changes. The department also indicates as the state is now responsible for system analysis and end-user testing of the system, these staff will reduce risk to the state and provide resources to ensure that the system is functioning as designed.

Staff Comment & Recommendation. Hold open. It is recommended to hold this item open.

Questions

1. Please briefly summarize the need for the requested positions, and provide update on the CMIPS II transition.

2. Does this proposal address the adjustments required to implement FLSA overtime regulations?

Samantha Lui
Senate Budget & Fiscal Review
T: (916) 651.4103

OUTCOMES: **Senate Subcommittee #3 on Health & Human Services**
Thursday, March 13 (Room 4203)

All members present: Senator Corbett, Senator Walters, and Senator Monning

4170 Department of Aging

1. Overview

- Information item (no vote).

2. Multi-Purpose Senior Services Program (MSSP) - Update

- Information item (no vote).

3. Expanding Capacity to Service Persons with Dementia in Managed Care Plans Grant

- Approve as budgeted (3-0).

4. Aging & Disability Resource Connection Transfer

- Approve as budgeted (3-0).

5. Model Approaches to Statewide Legal Assistance Systems - Phase II Grant

- Approve as budgeted (3-0).

5180 Department of Social Services, Community Care Licensing (CCL)

1. Overview

- Informational item.

2. Quality Enhancement and Program Improvement

- Held open.

3. Sacramento County Caseload Transfer

- Approve as budgeted (3-0).

4. Home Care Services Consumer Protection Act

- Held open.

5180 Department of Social Services, Supplemental Security Income (SSI)/ State Supplemental Payment (SSP)

1. Overview

- Informational item.

5180 Department of Social Services, In-Home Supportive Services (IHSS)

1. Overview

- Informational item.

2. Coordinated Care Initiative (CCI), IHSS - Update

- Informational item.

3. Litigation Settlement related to Prior Reductions (7% reduction in service hrs.), pg. 29

- Informational item.

4. Federal Fair Labor Standards Act (FLSA)- Final Rule

- Held open.

5180 Department of Social Services, In-Home Supportive Services (IHSS)
0530 Health and Human Services Agency: Office of Systems Integration (OSI)

1. Case Management, Information, & Payrolling System (CMIPS) II, pg. 36

- Held open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Bill Monning
Senator Mimi Walters

March 20, 2014

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

Room 4203, State Capitol

Agenda

ERRATA (see page 45 for changes)

(Michelle Baass)

4150 Department of Managed Health Care 3
1. Overview 3
2. Federal Mental Health Parity Rules 5
3. New Customer Relationship Management System 8
4. AB 1 X1 – Medi-Cal Expansion Workload 10
5. SB 2 X1 – Individual Mandate Workload 16

4280 Managed Risk Medical Insurance Board & 4260 Department of Health Care Services 21
1. Eliminate MRMIB 21

4260 Department of Health Care Services 25
1. Overview 25
2. Restoration of Adult Dental Benefits 28
3. Pregnancy Only Proposal 30
4. AB 85 - County Realignment - Request for Positions 33
5. AB 1 X1 – Medi-Cal Eligibility Under ACA – Request for Positions 37
6. SB 1 X1 – Medi-Cal Eligibility Under ACA, Hospital Presumptive Eligibility 39
7. SB 3 X1 – Health Care Coverage: Bridge Plan – Request for Positions 40
8. ACA - Estimated Savings Due to Claiming Enhanced Federal Funds 42
9. Statewide Outpatient Medi-Cal Contract Drug List 44
10. Impact of Minimum Wage Increase on Medi-Cal 48
11. Fingerprinting and Criminal Background Checks 49
12. Ground Emergency Medical Transportation 52
13. MEDS Modernization 54
14. Breast and Cervical Cancer Treatment Program 56

15. Baseline HIPPA Staffing 58
16. Oversight on Nursing Home Referrals to Community-Based Services 60
17. Medi-Cal – Electronic Health Records Meaningful Use Federal Grant 61

Appendix A - Adult Dental Procedures Not Included in the May 1, 2014 Restoration 62

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 two 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 Health Maintenance Organizations (HMOs) and some Preferred Provider Organizations (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 more than 21 million Californians who are currently enrolled in these types of health plans.

Budget Overview. The budget proposes expenditures of $58.97 million and 397.3 positions for DMHC. See table below for more information.

Table: DMHC Budget Overview

Fund Source	2013-14 Projected	2014-15 Proposed	BY to CY Change
Federal Trust Fund	$1,749,000	$75,000	-$1,674,000
Reimbursements	$3,832,000	$3,412,000	-$420,000
Managed Care Fund	$51,432,000	$55,485,000	$4,053,000
Total Expenditures	**$57,013,000**	**$58,972,000**	**$1,959,000**
Positions	**370.5**	**397.3**	**27**

Subcommittee Staff Comment. This is an informational item.

Questions.

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

2. Federal Mental Health Parity Rules

Issue. The Governor's budget does not include a proposal to implement the new federal rules requiring health plans that offer mental health and substance use disorder benefits do so in a manner comparable to medical and surgical benefits.

Background. The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), expands federal mental health parity protections beyond the limited requirements of the previously enacted federal Mental Health Parity Act of 1996 (MHPA). The MHPAEA requires that group health plans and health insurance coverage offered in connection with group health plans that offer mental health and substance use disorder (MH/SUD) benefits do so in a manner comparable to medical and surgical (med/surg) benefits. For most plans, the MHPAEA became applicable to plan years beginning on or after October 3, 2009.

Final Rules. Because the MHPAEA itself does not explain how health plans are to analyze or achieve parity, the Centers for Medicare and Medicaid Services (CMS), the Department of Labor's Employee Benefits Security Administration, and the Internal Revenue Service (collectively, the Departments) issued the Interim Final Rules on the MHPAEA on February 2, 2010, and the Final Rules on November 13, 2013. These regulations provide an in-depth explanation of what the MHPAEA entails.

The Final Rules provide a framework for application and enforcement of the MHPAEA. The Final Rules explain how health plans must classify benefits, and how they must assess financial requirements and treatment limitations (both quantitative and non-quantitative) for parity purposes. The Final Rules also address the applicability, enforcement, and effective dates of the MHPAEA and regulations.

Under the Final Rules (and Interim Final Rules), parity is not determined under a static "matching" approach that compares similar or analogous treatments. Instead, the Final Rules require that all covered benefits must be sorted into specific classifications, and then the broader classifications are compared and analyzed for parity. The Final Rule provides that if the health plan covers any MH/SUD benefit, it must then provide benefits in any classification for which it provides med/surge coverage. See table below for the classification of benefits.

Table: Final Rules Benefit Classifications

Benefit Classification
Inpatient, In-Network
Inpatient, Out-of-Network
Outpatient, In-Network
Outpatient, Out-of-Network
Emergency Care
Prescription Drugs

Financial Requirements and Quantitative Treatment Limitations. Under the Final Rules, health plans must perform a detailed financial and mathematical analysis to determine "parity" for financial requirements and quantitative treatment limitations. The MHPAEA defines "financial requirements" to include deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes aggregate lifetime and annual limits. "Treatment limitations" are defined to include limits on the scope and duration of treatment; "quantitative treatment limitations" (QTLs) are numerical limits, such as limits on the number of visits, episodes, or days of treatment covered under the plan.

Under the MHPAEA and the Final Rules, the financial requirements and treatment limitations applied to MH/SUD benefits in a classification cannot be more restrictive than the *predominant* (more than one half) requirements or limitations applied to *substantially all* (at least two-thirds) med/surg benefits in the same classification.

Implementation Dates. The MHPAEA has always applied to large group, and the Final Rules for large group apply as of July 1, 2014. For small group, the MHPAEA applies as of January 1, 2014, and the Final Rules apply as of July 1, 2014. For the individual market, the MHPAEA applies as of January 1, 2014. Although, the Final Rules apply as of July 1, 2014, because the individual market in California is now based on the calendar year, the Final Rules will be effective for individual plan contracts as of January 1, 2015.

DMHC's Implementation of the State's Mental Health Parity Laws. DMHC currently enforces the Knox-Keene Act's mental health parity statute, Health and Safety Code section 1374.72, which requires health care service plans to cover nine enumerated severe mental illnesses, as well as serious emotional disturbances of a child, under the same terms and conditions plans apply to medical conditions. DMHC reviews plan Evidences of Coverage for compliance with Section 1374.72, focusing generally on whether services to treat the limited enumerated conditions are covered the same as medical conditions. The DMHC's implementation of California's mental health parity statute has primarily focused on ensuring the mandated benefits are covered and parity for the cost-sharing provisions of the plan benefit designs.

DMHC's Implementation of the New Federal Final Rules. In contrast, the MHPAEA and its associated regulations require a detailed parity analysis whereby plans must: (1) classify all benefits into six federally-mandated classifications, (2) mathematically analyze all benefits to ensure that the financial requirements (such as copayments or coinsurance) and quantitative treatment limitations (such as visit limits or days of treatment) for MH/SUD use disorder benefits are not more restrictive than the predominant requirements or limitations applied to substantially all med/sur benefits in the same classification, and (3) analyze all benefits to ensure that any non-quantitative treatment limitations (such as medical management standards regarding medical necessity) apply comparable processes, strategies, and evidentiary standards for both mental health/substance use disorder and med/sur benefits.

This detailed analysis required by the federal rules requires both clinical and actuarial expertise whereas the implementation of California's mental health parity law was a more straightforward legal analysis. DMHC indicates it has never applied such a clinical/actuarial

analysis of health plan benefit designs and; consequently, it is taking additional time to evaluate how to conduct such an analysis. Moreover, DMHC must correspondingly expand its existing parity compliance review not only to evaluate plans' implementation of the complex mathematical and analytical processes the MHPAEA requires, but also to oversee plans' treatment of the mental health/substance use disorder conditions to which the MHPAEA extends, including all conditions in the Diagnostic and Statistical Manual IV (DSM-IV) (for small group and individual plans, per California's Essential Health Benefit statute) and any conditions large group plans cover beyond those required by Section 1374.72.

Subcommittee Staff Comment and Recommendation—Hold Open. DMHC indicates that it is currently assessing how it will enforce the new federal rules and the workload associated with this new federal requirement. The new federal requirement includes processes and assessments that are different from what DMHC currently performs. For example, the new rules include a "non-quantitative" component to assess parity.

Given that these rules are effective July 1, 2014 and January 1, 2015 (depending on the rule type and plan type), it would be expected that DMHC complete its analysis of (1) the implementation of these rules and (2) the resources that may be needed before the start of the next fiscal year.

Subcommittee staff recommends keeping this item open as discussions continue on implementation and the resources that may be necessary to ensure that millions of Californians, who are suffering from mental health and substance abuse disorders, get the help they need.

Questions.

1. Please provide an overview of the new federal requirements and how these requirements differ from state law.

2. When does DMHC plan to have an assessment of how the state will implement these federal rules and the resources that may be needed?

3. New Customer Relationship Management System

Budget Issue. DMHC requests two positions and a reduction of $50,000 for 2014-15 and ongoing to provide information technology (IT) programming services for the Customer Relationship Management (CRM) system that is currently performed by contracted vendors. This request includes the redirection of existing contract resources to fund the two positions.

Background. DMHC's Office of Technology and Innovation (OTI) provides programming support for all departmental databases, applications, public and internal websites, and secured web portals that deliver mission-critical services to DMHC staff and stakeholders. As part of the DMHC's components of consumer assistance, all interaction between the DMHC's Help Center and consumers is tracked in a CRM database system. This system is the data warehouse for all consumer complaint contact information and provides essential case tracking, workflow, automated correspondence, email notifications, reminders, workload tracking, and customized reporting.

Since 2000, the DMHC has used a CRM system known as Clarify. This system was procured in order to meet legislatively mandated requirements. At that time, the availability of the CRM technology needed to meet these requirements was very limited and the tailored programming necessary for the business and functional requirements was not available through the civil service system. Over the years, the Clarify system has been extensively customized to meet the continuously changing and increasing needs of the DMHC, including the ability to track all forms of consumer contacts, e.g., telephone, email, web forms, US mail and faxed complaints. The CRM system also has been modified to include similar tracking of health care provider complaints. Because the Clarify system requires expert programmer knowledge not found in the civil service system, the DMHC has used contracted consultants to perform all work necessary on Clarify, including ongoing maintenance, database and report customization, and customer support.

The company which owns the Clarify CRM software recently announced it would no longer provide support and maintenance of the Clarify software used by DMHC. The Clarify CRM software utilized by DMHC uses an esoteric programming language (Clear Basic) that requires specialized programming expertise not currently available in the civil service system.

According to DMHC, following a comprehensive review of business and functional requirements, a review and demonstrations of available CRMs, and a comparison of CRM software systems, the DMHC selected an off-the-shelf CRM product, OnContact, as the recommended replacement for Clarify. The OnContact CRM system is compatible with the DMHC's technical environment and programming standards.

DMHC proposes that OnContact be maintained and supported by Senior Programmer Analysts, a civil service classification. Redirection of consultant services to establish two in-house programmers will also comply with Government Code Section 19130(b)(3), which states that contracting is allowed only when the services contracted are not available within civil service.

DMHC is currently working with the OnContact CRM vendor to complete the migration of data and reports from Clarify to OnContact. This migration is scheduled to be completed by June 30, 2014. Once the migration is complete, DMHC will no longer need to contract with a vendor for support of the outdated Clarify system and will fully utilize the OnContact CRM software system.

DMHC plans to build the following customized reports in the OnContact system:

1. Case Audit Field and Grids Combo
2. Complaints Report
3. Independent Medical Review (IMR) Report
4. Aging Case Details, including inquiries
5. Aging Case Details, IMR only
6. Aging Case Details, Reopens
7. Aging Case Summary
8. Aging Case Summary – IMR only
9. Aging Case Summary – Reopens
10. Requested Response Timeliness
11. Activity Case Details – All Case Types (Urgent, Quick Resolution, Complaint, Inquiry)
12. Case Control Sheet
13. Independent Medical Review (IMR) Case Details
14. Closed/Open Cases by Type
15. Consumer Contact Data
16. Incoming Mail
17. IMR Medical Records Report
18. Volume Trending
19. Open Case Volume Report
20. Closed Case Compliance Determinations
21. Global Summary Report
22. Recovered Funds

Subcommittee Staff Comment and Recommendation—Hold Open. No issues have been raised regarding this item; however, it is recommended to hold this item open as discussions continue on DMHC's budget.

Questions.

1. Please provide an overview of this proposal.

4. AB 1 X1 – Medi-Cal Expansion Workload

Budget Issue. DMHC requests 18.0 positions and $2,404,000 for 2014-15 and $2,356,000 for 2015-16 and ongoing, to address increased workload resulting from implementation of AB 1 X1 (Pérez), Chapter 3, Statutes of 2013-14 of the First Extraordinary Session. This request includes $312,000 for 2014-15 and $416,000 for 2015-16 and ongoing for expert witness and deposition costs for enforcement trials.

DMHC states that these positions are necessary to address the increased workload associated with newly-enrolled consumers in Medi-Cal managed care plans licensed by DMHC. This new workload includes answering consumer calls, reviewing and resolving consumer complaints and Independent Medical Review (IMR) applications, resolving urgent nurse cases, and enforcing the managed health care laws that protect this new population.

The requested permanent positions are as follows:

Position	2014-15
Help Center	
Attorney	2.0
Nurse Evaluator II	2.0
Associate Governmental Program Analyst	5.0
Consumer Assistance Technician	6.0
Office of Enforment	
Attorney	1.5
Associate Corporations Investigator	1.5
Total Positions	**18**

Background. AB 1 X1 implements a key provision of the Affordable Care Act (ACA) by expanding the state's Medi-Cal program, effective January 1, 2014, to a new group of adults aged 19 - 64 with incomes up to 138 percent of the federal poverty level and who are not eligible for Medi-Cal today. AB 1 X1 also implements the Medi-Cal expansion by implementing federal rules to simplify and streamline Medi-Cal eligibility determination, enrollment, and renewal.

In addition, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session implements the Medi-Cal expansion by establishing the Medi-Cal benefit package for the expansion population which includes the same benefits all full-scope Medi-Cal enrollees receive. SB 1 X1 also expands the benefit package for the existing Medi-Cal population to include mental health and substance use disorder benefits that mirror those provided under the Essential Health Benefits (EHB) for the individual and small group markets. SB 1 X1 requires Medi-Cal managed care (MCMC) plans that are regulated by the DMHC to provide mental health benefits that are not covered by county mental health plans under the Specialty Mental

Health Services Waiver. AB 1 X1 and SB 1 X1 together implement the Medicaid expansion in California.

The Medi-Cal program is administered by the Department of Health Care Services (DHCS). The DMHC regulates health care service plans under the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended. The KKA provisions apply to Medi-Cal managed care plans, except as specifically exempted. Health plans that arrange for services provided to Medi-Cal beneficiaries through the Medi-Cal managed care program are required to be licensed by the DMHC. Accordingly, Medi-Cal managed care beneficiaries can avail themselves of all the consumer assistance and complaint resolution processes offered by the DMHC. (Except in those in an exempted County Organized Health System.)

DHCS estimates approximately 1,390,000 new beneficiaries will be enrolled in the Medi-Cal managed care program over the next three years as a result of the expansion of Medi-Cal eligibility. As reported by DHCS, the annual breakdown is as follows:

Fiscal Year	Optional Total Enrollees	Mandatory Total Enrollees	Total New Enrollees (Cumulative)
2013-14	326,592	333,372	**659,964**
2014-15	769,069	551,912	**1,320,981**
2015-16	821,634	568,469	**1,390,103**

AB 1 X1 Medi-Cal Expansion Call Data. The Help Center has been able to identify 551 Medi-Cal calls for the period January 1, 2014, to March 10, 2014, see table below for details. The Help Center is unable to confirm the number of Medi-Cal calls that were specifically related to AB 1 X1 as the consumer did not identify the call was related to AB 1 X1. The Help Center is currently discussing methods to specifically identify these consumers.

Table: Medi-Cal-Related Help Center Calls – January 1, 2014 – March 10, 2014

Category	Medi-Cal Managed Care	Medi-Cal Fee For Service/Seniors and Persons with Disabilities
Access	27	3
Appeal of Denial	8	0
Claims/Financial	10	1
Coordination of Care	14	1
Coverage/Benefits	41	4
Covered California	7	6
Enrollment Disputes	35	13
General Inquiry	227	141
Plan Service	9	1
Provider Service	3	0
Total	**381**	**170**

Help Center. Based on the DMHC's historical experience, Medi-Cal populations typically contact the DMHC at a higher rate than the existing commercial managed care population. DMHC anticipates an increase in consumer assistance, complaint resolution, and Independent Medical Review (IMR) workload as approximately 1,390,000 new enrollees enter the Medi-Cal managed care arena. In turn, the DMHC anticipates an increase in enforcement referrals from the Help Center regarding violations of the new law.

The Help Center uses a conservative standard of three percent in increased contact rate when projecting consumer assistance workload for new populations it serves. Based on this percentage and the estimated number of new enrollees provided by the DHCS, the Help Center estimates 39,629 additional contacts resulting from the Medi-Cal expansion.

For 2014-15, these contacts are in the form of:

- 31,703 calls
- 4,755 pieces of correspondence
- 1,189 Quick Resolution cases
- 793 Standard Complaints
- 396 Independent Medical Reviews (IMRs)
- 793 Urgent Nurse cases

For 2015-16, and ongoing, the Help Center estimates 41,703 additional contacts. This is based on the total new enrollment for 2013-14 through 2015-16 as reported by the DHCS. These contacts will generate:

- 33,362 calls
- 5,004 pieces of correspondence
- 1,251 Quick Resolution cases
- 834 Standard Complaints
- 417 IMRs
- 834 Urgent Nurse cases

Office of Enforcement. The Office of Enforcement handles the litigation needs of DMHC, representing DMHC in actions to enforce the managed health care laws including the quality, accessibility, and continuity of care and the denial of treatment and claims in enforcing the managed health care laws. Cases are referred to this office from the Help Center, as well as other DMHC divisions that review the activities of health care service plans for compliance with the managed health care laws.

Based on the projected increased enrollment of 1,390,000, DMHC estimates that the Office of Enforcement will experience a 20 percent annual increase in referrals based on the rate of referrals currently made to Enforcement by the Help Center.

Of the anticipated annual referrals to the Office of Enforcement, DMHC estimates that approximately 10 percent of the enforcement referrals involving this new law will result in a trial. This equates to three trials in 2014-15 and four trials in 2015-16 and ongoing as a result of AB 1 X1 and is based on the current actual percentage of enforcement referrals that typically go to trial. Cases that go to trial require several contracts including those for expert consultants/witnesses, court reporting/deposition and exhibit preparation. Each trial will require two expert consultant/witness contracts at approximately $45,000 per contract (for a total of $90,000 per trial); an average of six administrative discovery depositions at approximately $2,000 per deposition (for a total of $12,000 per trial) and exhibit preparation (i.e. x-rays, large format printing and photos, and 3D models of buildings where illegal solicitation occurred) at approximately $2,000 per trial for a total of $104,000 per trial. The total contract costs for 2014-15 is $312,000 (3 trials x $104,000 = $312,000) and the total contract costs for 2015-16 is $416,000 (4 trials x $104,000 = $416,000.) These estimates are based on actual costs incurred for similar trials the Office of Enforcement has conducted.

Proposed Responsibilities of Requested Positions. DMHC proposes the following responsibilities for the requested positions:

Help Center

- **Attorneys** would review 21 percent of Standard Complaints and five percent of general correspondence (including calls and correspondence) from consumers enrolled in the Medi-Cal managed care. These positions require direct enrollee and health plan contact for case clarification, and to request additional information. Once the requested documentation has been received the attorneys review this information and apply case facts to the KKA and relevant regulations. Once a finding is complete, the attorneys draft correspondence advising of compliance, and discusses complaint findings with the

enrollee, health plan, and/or provider. These positions require documenting progress in the case management database and drafting closing letters to the health plans and enrollees.

- **Nurse Evaluators** would review and respond to the Medi-Cal enrollee Urgent Nurse cases within the mandated timeframes. The Nurse Evaluator receives requests from the Help Center's Call Center staff to review cases where the pre-determined Urgent Nurse case trigger has been noted. Once the Urgent Nurse case has been initiated the nurse reviews the submitted complaint documentation, medical records and other relevant clinical information; confers with Help Center management and legal staff; contacts the consumer, health plan and provider to gather information and documents this research in the case management database. The Nurse Evaluator is responsible for researching Current Procedural Terminology (CPT) codes, emerging medical treatments, standards of care, and health plan contracts. These positions require the information exchange between parties and negotiating resolution with health plan representatives. Once the case has been resolved the Nurse Evaluator is responsible for composing closing letters to the health plans and enrollees.

- **Associate Governmental Program Analysts (AGPAs)** would perform the initial review of incoming Medi-Cal managed care standard complaints and IMR requests, which includes direct contact with enrollees to clarify complaint issues and provide enrollees with additional direction and a review and application of the KKA to determine plan compliance and potential violations.

- **Consumer Assistance Technicians (CATs)** would answer incoming enrollee calls, research and reference policies and procedures, and document pertinent enrollee information in the case management database.

Office of Enforcement

- **Attorneys** would represent DMHC in actions to enforce managed health care laws including the quality, accessibility, continuity of care, and the denial of treatments and claims.

- **Investigators** would investigate complaints, conduct financial reviews, conduct hearing/trial support, and conduct background investigations.

LAO Comment and Recommendation. LAO finds that the estimated workload for this proposal is partially based on a set of assumptions about the increase in the number of additional enrollees in Medi-Cal managed care. LAO finds that there will be more reliable estimates of 2014 Medi-Cal managed care enrollment available with the next couple of months. Consequently, the LAO recommends the Legislature: (1) hold this proposal open, (2) direct the Administration to report on estimates of enrollment in Medi-Cal managed care at the time of the May Revision and (3) direct the Administration to report on how the updated enrollment information affects the estimated workload associated with this proposal.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on DMHC's budget and updated estimates are received at the May Revise.

Questions.

1. Please provide an overview of this proposal.

2. Please describe how the call center responds to questions that are beyond its purview, such as eligibility and general inquiries.

5. SB 2 X1 – Individual Mandate Workload

Budget Issue. DMHC requests 13.5 positions and $1,518,000 for 2014-15 and 19.0 positions and $2,010,000 for 2015-16 and ongoing to address the increased workload resulting from the implementation of SB 2 X1 (Hernandez), Chapter 2, Statutes of 2013-14 of the First Extraordinary Session related to the individual market. These positions will be responsible for providing consumer assistance and resolving consumer complaints.

The requested permanent positions are as follows:

Help Center	2014-15	2015-16
Attorney	2.0	3.0
Nurse Evaluator II	1.5	1.5
Associate Governmental Program Analyst	5.0	7.0
Consumer Assistance Technician	5.0	7.5
Total Positions	**13.5**	**19.0**

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 potentially millions of new enrollees and new health plans and products offered in Covered California.

Based on a November 7, 2012 Covered California report, it is estimated that by the end of 2015-16 approximately 1,701,000 previously uninsured new enrollees will enter the individual market and be enrolled in health plans that are regulated by DMHC.

It is likely that many of these individuals will not have had health care coverage and will be unfamiliar on how to use a health care coverage delivery system. DMHC's Help Center uses a conservative standard increase of three percent in consumer assistance, complaint resolution and Independent Medical Review (IMR) workload as new consumers enroll in health plans that are regulated by the DMHC. The three percent factor is based on historical experience of serving new populations.

SB 2 X1 Help Center Data. The Help Center has been able to identify 1,149 calls (out of 7,288 total calls) related to SB 2 X1 for the period January 1, 2014, to March 10, 2014. DMHC has opened 743 formal complaints from information gained through these 1,149 phone calls. The table below breaks down the categories/issues raised by enrollee's related to SB 2 X1. Enrollee's may have raised more than one issue when contacting DMHC. Because of this, the total number of issues noted in the spreadsheet (1,166) is greater than the total number of calls (1,149) received.

Table: SB 2 X1-Related Help Center Calls – January 1, 2014 – March 10, 2014

Categories/Issues	Number of Issues Identified
Enrollee (EE) did not receive ID cards/enrollment packet	209
EE could not confirm premium payment was received by the Plan	66
Incorrect premium amount on statement	64
EE cannot obtain medication due to lack of enrollment confirmation	112
EE cannot access care due to lack of enrollment confirmation	140
EE cannot confirm enrollment with the Plan/Covered CA	183
EE could not reach the Plan	78
EE could not reach Covered CA	25
EE unsure where to send premium payment	48
EE states their effective date is incorrect	65
EE is requesting premium reimbursement	28
EE states the Plan has incorrect personal data	22
EE states Provider is not accepting Covered CA Plans	51
EE wants to cancel current Covered CA Plan	19
EE states Covered CA Plan was cancelled due to lack of premium payment or personal data confirmation received by the Plan	55
EE states their medications are not on the Plan formulary	1
Total Issues	**1,166**

Projected Workload. For 2014-15, DMHC estimates a total of 37,271 additional contacts. This is based on 1,242,000 new enrollees for 2013-14 and 2014-15.

- 29,808 calls
- 4,471 pieces of correspondence

- 1,129 Quick Resolution cases
- 745 Standard Complaints
- 373 Independent Medical Review (IMR)
- 745 Urgent Nurse cases

For 2015-16, DMHC estimates 51,031 additional contacts. This is based on 1,701,000 new enrollees through 2015-16.

- 40,824 calls
- 6,124 pieces of correspondence
- 1,531 Quick Resolution cases
- 1,021 Standard Complaints
- 510 IMRs
- 1,021 Urgent Nurse cases

Proposed Responsibilities of Requested Positions. DMHC proposes the following responsibilities for the requested positions:

- **Attorneys** would review 21 percent of Standard Complaints and five percent of general correspondence (including calls and correspondence) from consumers enrolled in the individual market. These positions require direct enrollee and health plan contact for case clarification, and to request additional information. Once the requested documentation has been received the attorneys review this information and apply case facts to the KKA and relevant regulations. Once a finding is complete, the attorneys draft correspondence advising of compliance, and discusses complaint findings with the enrollee, health plan, and/or provider. These positions require documenting progress in the case management database and drafting closing letters to the health plans and enrollees.

- **Nurse Evaluators** would review and respond to individual market enrollee Urgent Nurse cases within the mandated timeframes. The Nurse Evaluator receives requests from the Help Center's Call Center staff to review cases where the pre-determined Urgent Nurse case trigger has been noted. Once the Urgent Nurse case has been initiated the nurse reviews the submitted complaint documentation, medical records and other relevant clinical information; confers with Help Center management and legal staff; contacts the consumer, health plan and provider to gather information and documents this research in the case management database. The Nurse Evaluator is responsible for researching Current Procedural Terminology (CPT) codes, emerging medical treatments, standards of care, and health plan contracts. These positions require the information exchange between parties and negotiating resolution with health plan representatives. Once the case has been resolved, the Nurse Evaluator is responsible for composing closing letters to the health plans and enrollees.

- **Associate Governmental Program Analysts (AGPAs)** would perform the initial review of incoming Individual Market Standard Complaints and IMR requests, which includes

direct contact with enrollees to clarify complaint issues and provide enrollees with additional direction and a review and application of the KKA to determine plan compliance and potential violations.

- **Consumer Assistance Technicians (CATs)** would answer incoming enrollee calls, research and reference policies and procedures, and document pertinent enrollee information in the case management database.

LAO Comment and Recommendation. LAO finds that the estimated workload for this proposal is partially based on a set of assumptions about the increase in the number of additional enrollees in DMHC-regulated individual market products under the ACA. The proposal assumes that additional enrollment will be 90 percent of projected Covered California enrollment. The open enrollment period for Covered California will end on March 31 and the LAO expects that there will be more reliable estimates of 2014 enrollment in DMHC-regulated individual market health insurance products available with the next couple of months. Consequently, the LAO recommends the Legislature: (1) hold this proposal open, (2) direct the Administration to report on estimates of enrollment in DMHC-regulated products at the time of the May Revision and (3) direct the Administration to report on how the updated enrollment information affects the estimated workload associated with this proposal.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on DMHC's budget and updated estimates are received at the May Revise.

Questions.

1. Please provide an overview of this proposal.

2. Please provide a highlight of the types of calls the Help Center has been receiving related to SB 2 X1.

4280 Managed Risk Medical Insurance Board & 4260 Department of Health Care Services

1. Eliminate MRMIB

Budget Issue. The Governor's budget proposes to eliminate MRMIB and transfer its programs to the Department of Health Care Services (DHCS). The trailer bill language requests to:

- Transfer the Major Risk Medical Insurance Program (MRMIP), the Access for Infants and Mothers (AIM) program, the County Children's Health Initiative Matching Fund Program (CHIM) to DHCS. The Administration proposes no changes to these programs and states that individuals who are currently in one of these programs would experience no disruption in care or change in coverage, benefits, or eligibility.

- Rename AIM-linked infants program to the Medi-Cal Access Program in order to simplify messaging of subsidized coverage options to solely Medi-Cal and Covered California.

- Transition the responsibility for the close-out activities related to the Healthy Families Program transition to Medi-Cal and the Pre-Existing Conditions Insurance Program (PCIP) transition to the federal government to DHCS.

- Delete reference to adults from the CHIM Program provisions as the program was never expanded to cover parents.

- Transition 27 positions at MRMIB to DHCS.

Background. AB 60, Chapter 1168, Statutes of 1989, established the Major Risk Medical Insurance Board, which was renamed in 1993 to the Managed Risk Medical Insurance Board (MRMIB or Board). MRMIB administers the following programs:

- **Healthy Families Program (HFP).** Established in 1998, the HFP was California's version of the national Children's Health Insurance Program (CHIP) and provided comprehensive health, dental, and vision benefits through participating health plans to children ineligible for Medi-Cal. Pursuant to AB 1494 (Committee on Budget) Chapter 28, Statutes of 2012, as amended by AB 1468 (Committee on Budget), Chapter 438, Statutes of 2012, and in accordance with federal approvals, the HFP transition to Medi-Cal was implemented in four major phases and was completed on November 1, 2013. It is proposed that any remaining close out activities will transfer to DHCS.

- **Access to Infants and Mothers (AIM).** The AIM program, established in 1992, provides medically necessary services to pregnant women with incomes above 200 percent and up to and including 300 percent of the federal poverty level (FPL) through participating health plans. Eligibility for the AIM program requires the pregnant woman

to have no maternity insurance or have health insurance with a high (over $500) maternity-only deductible, and have a family income too high to qualify for no-cost Medi-Cal, up to 300 percent of the FPL. The total cost to eligible women enrolled in AIM is 1.5 percent of the family's adjusted annual household income after applying applicable deductions.

The AIM Program has a monthly statewide enrollment of approximately 6,000 women. The program provides covered services throughout the pregnancy, hospital delivery and through the month of which their 60th day of postpartum care falls. Under the prior HFP statute, infants born to AIM program subscribers, referred to as AIM-linked infants were automatically enrolled into HFP for one year without review of the family's income. Pursuant to AB 82 (Committee on Budget) Chapter 23, Statutes of 2013, AIM-linked infants with incomes above 250 percent and up to and including 300 percent of the FPL transitioned to DHCS beginning on November 1, 2013.

- **Major Risk Medical Insurance Program (MRMIP).** Since 1991, MRMIP has provided health insurance to Californians unable to obtain coverage in the individual health insurance market due to pre-existing conditions. Californians qualifying for the program contribute to the cost of their coverage by paying premiums. The premiums are subsidized through the Cigarette and Tobacco Surtax Fund (Proposition 99). Prior to the ACA, because of funding limitations, MRMIP sometimes developed a waiting list.

  MRMIP provides comprehensive benefits to subscribers and their dependents. Health plan participation in the program is voluntary. One Preferred Provider Organization and three Health Maintenance Organizations participate in the program. The program has statewide coverage and subscribers have a choice of two or more health plans in most urban areas of the State. DHCS will assume responsibility for the program July 1, 2014. See table below for enrollment figures.

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

- **County Health Initiative Matching (CHIM) Program.** AB 495 (Diaz), Chapter 648, Statutes of 2001, created the CHIM program. MRMIB administers this program, which is funded through the use of intergovernmental transfers of local funds. Originally there were four proposed pilot counties – Alameda, Santa Clara, San Francisco and San Mateo, however, prior to federal approval Alameda withdrew its application for program participation. Under this program, local county funds are used as the non-federal share to draw down unused federal State CHIP/Title XXI funds for CHIP-eligible children. Eligible children are uninsured with family incomes above 250 percent and up to 300 percent of the FPL and are otherwise ineligible for Medi-Cal and AIM-linked infants program. Counties have the option of going up to 400 percent.

  In order to ensure compliance with Affordable Care Act (ACA) maintenance-of-effort requirements, the state budget includes approximately $212,000 General Fund for 2013-14 and $424,000 General Fund for 2014-15 for the local match.

  CHIM serves approximately 2,100 children in the three counties and total county expenditures are estimated to be $629,000 in 2013-14 and $509,000 in 2014-15.

- **Pre-Existing Conditions Insurance Program (PCIP).** SB 227 (Alquist), Chapter 31, Statutes of 2010 and AB 1887 (Villines), Chapter 32, Statutes of 2010, authorized MRMIB to establish and administer a new federal high risk pool program, contingent on a contract with the U.S. Department of Health and Human Services and receipt of adequate federal funding for the program.

  California's program, known as PCIP, offered health coverage to medically-uninsurable individuals who live in California. As of July 1, 2013, the federal government took over operations of the PCIP program from MRMIB. MRMIB is required to complete closeout activities of the state-run PCIP program through 2013-14. Any residual closeout activities beyond 2013-14 will transition to DHCS effective July 1, 2014.

Reason for Request. With the transition of HFP to DHCS, the Administration argues that MRMIB has been relieved of most of its workload. It contends that transitioning the remaining MRMIB duties to DHCS makes operational sense and further streamlines California's publicly-financed health care programs. In addition, the Administration finds that it simplifies the enrollment process for consumers applying through Covered California to two options: Medi-Cal or Covered California. This would reduce confusion and the need for branding of a separate program that provides similar benefits and delivery system to traditional Medi-Cal.

Future of MRMIP. MRMIP was designed for a time when individuals could be denied coverage because of a pre-existing health condition. Given the new Affordable Care Act (ACA) prohibition against the denial of coverage for pre-existing health conditions, the purpose of MRMIP has evolved. Most individuals with pre-existing conditions can now seek coverage through Covered California. However, there will still be situations in which individuals may not be eligible for coverage through Covered California, such as when the Covered California open enrollment period is closed.

MRMIB estimates that between 3,000 and 3,200 individuals will remain enrolled in MRMIP in 2014-15. Prior year monthly enrollment was generally around 6,000 (see table on previous page). The Governor's budget includes $41.7 million for MRMIP. This assumes a full caseload of about 7,500 (the MRMIP cap). (The annual cost per MRMIP subscriber is about $5,500.)

AIM and Covered California. CalHEERS, the online enrollment system for Covered California, did not originally include the ability to perform a Modified Adjusted Gross Income (MAGI) determination for AIM, as required by the ACA. Maximus, the AIM administrative vendor, and CalHEERs have developed a workaround to apply the MAGI rules and then transmit the eligibility determination to Maximus. It is anticipated that this functionality will be incorporated into CalHEERs in June.

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

- **Need for Funding for Full Enrollment in MRMIP Unclear.** MRMIB estimates that only about 3,200 individuals (on a monthly basis) would be enrolled in MRMIP, yet the budget includes funding for a caseload of about 7,500. While funding to close-out reconciliation from prior year MRMIP claims may be necessary, it is too soon to estimate for post ACA caseload.

- **No Detailed Transition Plan.** The Administration indicates that it working on a detailed transition plan outlining administrative and operational issues (e.g., the process for transitioning contracts). This plan is not yet ready. It is critical that administrative and operational issues are outlined and worked out prior to any such transition. Although the caseload for these programs is small in comparison to other DHCS-run programs and Covered California, it is important that individuals who may be eligible for these programs are told of the programs and that enrollment into these programs is seamless through CalHEERs and at counties.

Questions.

1. Please provide a brief overview of MRMIB's programs and of this proposal.

2. Please comment on the future of MRMIP and why full year funding is proposed for MRMIP.

3. Please provide an update on integrating AIM into CalHEERs? Please explain the process to enroll women into AIM until this integration occurs. Have all pregnant women who applied through Covered California been evaluated for AIM eligibility?

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 8.3 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 tables for DHCS budget summary information.

Table: DHCS Program Budget Summary (dollars in thousands)

	Program	Actual 2012-13	Estimated 2013-14	Proposed 2014-15
	Health Care Services	$51,947,445	$72,252,490	$76,133,952
	Medi-Cal	49,902,847	70,133,209	73,979,370
	Children's Medical Services	351,581	317,051	299,861
	Primary and Rural Health	1,031	3,086	3,070
	Other Care Services	1,691,986	1,799,144	1,851,651
	Administration	25,109	35,947	35,966
	Distributed Administration	-25,109	-35,947	-35,966
Total Expenditures (All Programs)		**$51,947,445**	**$72,252,490**	**$76,133,952**

Table: DHCS Fund Budget Summary (dollars in thousands)

Fund	Actual 2012-13	Estimated 2013-14	Proposed 2014-15
General Fund	$15,117,724	$16,480,591	$17,212,283
Federal Trust Fund	27,186,874	42,405,766	45,111,444
Special Funds and Reimbursements	9,642,847	13,366,133	13,810,225
Total Expenditures (All Funds)	**$51,947,445**	**$72,252,490**	**$76,133,952**

Medi-Cal. 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 $73.9 billion ($16.9 billion General Fund) which reflects a General Fund increase of $670 million or 4.1 percent above the Budget Act of 2013. Generally, each dollar spent on health care for a Medi-Cal enrollee is matched with one dollar from the federal government.

Caseload is anticipated to increase by about 935,700 for a total of about 10.1 million average monthly eligibles, primarily due to the implementation of federal health care reform.

See following table for a summary of the proposed Medi-Cal budget.

Table: Medi-Cal Local Assistance Funding Summary

	2013-14	2014-15		
	Revised	**Proposed**	**Difference**	**Percent**
Benefits	$65,641,000,000	$69,725,300,000	$4,084,300,000	6.2%
County Administration (Eligibility)	$3,622,500,000	$3,361,900,000	-$260,600,000	-7.2%
Fiscal Intermediaries (Claims Processing)	$414,300,000	$419,300,000	$5,000,000	1.2%
Total	**$69,677,800,000**	**$73,506,500,000**	**$3,828,700,000**	**0.2%**
General Fund	$16,229,900,000	$16,899,500,000	$669,600,000	4.1%
Federal Funds	$43,631,300,000	$45,752,500,000	$2,121,200,000	4.9%
Other Funds	$9,816,700,000	$10,854,500,000	$1,037,800,000	10.6%

LAO Comments. The LAO finds that the baseline Medi-Cal caseload estimate (program caseload absent changes associated with recent major policy changes) is reasonable. Additionally, the LAO finds that the projected Medi-Cal caseload changes resulting from implementation of the Affordable Care Act (ACA) are generally reasonable. The Administration estimates that nearly 1.5 million additional average monthly enrollees in 2014-15. This caseload increase includes additional enrollment associated with the optional expansion, mandatory expansion, hospital presumptive eligibility, and Express Lane enrollment.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide a brief overview of DHCS's programs and major budget proposals.

2. Restoration of Adult Dental Benefits

Oversight Issue. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013 restores partial adult optional dental benefits on May 1, 2014. The goal of this restoration is to enable members, ages 21 and older with full scope Medi-Cal, to be brought up to a basic level of dental health. Basic preventive, diagnostic, and restorative services will be made available to meet this goal, and the program will allow complete dentures and related procedures. DHCS submitted a State Plan Amendment (SPA) regarding this restoration to the federal CMS on December 30, 2013. CMS confirmed receipt of the SPA and is currently reviewing it. For a complete list of services that will not be restored, please see Appendix A.

The budget includes $10.8 million ($3.3 million General Fund and $7.6 million federal funds) in 2013-14 and $239.5 million ($72.9 million General Fund and $166.6 million federal funds) in 2014-15 to restore this benefit and assumes a six month phase-in until full caseload is reached. Additionally, DHCS expects that there is some pent up demand for these services.

Background. Adult Dental Services, with the limited exception of "federally required adult dental services" (FRADS) and dental services to pregnant women and nursing home patients, were eliminated as an "optional" Medi-Cal benefit in 2009 due to the state's fiscal crisis. Generally, FRADS primarily involves the removal of teeth and treating the affected area.

Preparation for Restoration. Beginning mid-January 2014, DHCS began sending notifications directly to Medi-Cal beneficiary heads of households regarding the forthcoming restoration of some adult dental benefits through the department's *Jackson vs. Rank* quarterly mailing for the first quarter of 2014. The department also intends to send a secondary notification to Medi-Cal beneficiaries in the second quarter of 2014. The notification that was sent to the beneficiaries can be found at:

http://www.denti-cal.ca.gov/bene/notice_of_reinstatement_dental_services_12-6-13.pdf

DHCS indicates that it has been working with stakeholder groups and associations regarding the content of notices and informing and working with providers about re-activation into the Denti-Cal program. A streamlined provider enrollment process, known as the Preferred Provisional Provider enrollment, is available to providers who qualify. (This streamlined process was developed during the Healthy Families Program transition to Medi-Cal to expedite the enrollment of Healthy Families Program dentists as Medi-Cal providers.)

The total number of unduplicated providers enrolled in Denti-Cal is 15,549, as of February 2014. However, data is not available to determine whether or not these Denti-Cal providers will accept new enrollment and to what degree.

The dentist-to-beneficiary ratio that DHCS uses to assess the Denti-Cal fee-for-service (FFS) network is 1:2000. This is the standard that is used in counties that provide dental services through managed care (Sacramento and Los Angeles). DHCS adopted this ratio for the purposes of assessing the network for the Healthy Families Program transition.

DHCS states it will monitor utilization of these services based on submitted claims and is working with the federal CMS on how to monitor the utilization of these services.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide an update on DHCS's preparations to implement the partial restoration of adult dental benefits.

2. Please explain how DHCS plans to monitor the implementation of this restoration.

3. Please describe DHCS' plans to measure access and utilization in fee-for-service and managed care. What metrics will be used? Will the data be publically reported? What is the status of the dental dashboard?

4. Has DHCS set targets for utilization?

3. Pregnancy Only Proposal

Budget Issue. DHCS' pregnancy only proposal has two main components:

1. **Provide Full Scope Medi-Cal for Pregnant Women Below 109 percent FPL.** DHCS proposes to provide full-scope coverage—rather than pregnancy-only coverage—to all pregnant women below 109 percent of the federal poverty level (FPL) who receive coverage from Medi-Cal (who are not otherwise eligible for full-scope). DHCS estimates no additional costs associated with providing full-scope coverage instead of pregnancy-only coverage, based on the assumption that there are no significant differences in coverage.

2. **Provide Medi-Cal Cost-Sharing and Benefit Wrap for Pregnant Women between 109 percent and 208 percent FPL.** DHCS also proposes to shift pregnant women between 109 percent and 208 percent of FPL who qualify for Medi-Cal pregnancy-only coverage to plans offered through Covered California. The budget assumes General Fund savings of $17 million in 2014-15 related to this component of the proposal since the federal government (through Covered California) would pick up the costs of comprehensive health coverage for these women. DHCS would implement this provision beginning January 1, 2015 and estimates that 8,100 Medi-Cal enrollees currently receiving pregnancy-only coverage would shift into Covered California.

Background. Beginning January 1, 2104, under the federal Patient Protection and Affordable Care Act (ACA), adults with incomes at or below 138 percent of the FPL who are under 65 years of age, not pregnant, and who meet other eligibility criteria and who are not otherwise eligible can enroll into Medi-Cal and receive full-scope services as a newly-eligible adult.

If the newly-eligible adult is a childless woman and she subsequently becomes pregnant while enrolled in Medi-Cal under this coverage group, she has the ability to remain in this coverage group and can continue with her full scope coverage of Medi-Cal services. However, if the same individual applies for coverage and is pregnant at the time of enrollment, based on her income, she will be ineligible for the new adult group and may only be eligible for the limited scope pregnancy-related services.

Furthermore, individuals with income above applicable Medi-Cal limits but below 208 percent of the FPL can enroll into coverage via the California Health Benefit Exchange, also known as Covered California, and receive applicable premium tax credits and cost sharing reductions, under certain conditions, and are provided with comprehensive health care coverage including pregnancy related care. To the extent individuals enrolled in coverage through Covered California subsequently become pregnant, and become income eligible for Medi-Cal for pregnancy-related services; they will have the option to either remain in coverage through Covered California or can move to Medi-Cal for coverage under the pregnancy-only program.

For purposes of minimum essential coverage (MEC), as required by the ACA, individuals enrolled in limited-benefit programs, such as the pregnancy-only program under Medi-Cal,

would not meet the MEC standard and they would need to seek coverage via Covered California where they may receive premium tax credits to purchase insurance and cost-sharing reductions to meet MEC.

Background--Comprehensive Perinatal Services Program. The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal program that provides women with prenatal care, health education, nutrition services, and psychosocial support for up to 60 days after the delivery of their infants. Over 1,500 Medi-Cal providers are approved as CPSP providers, in both fee-for-service and managed care systems. Providers include physicians, clinics, certified nurse midwives, and family nurse practitioners.

Proposed Medi-Cal Cost-Sharing and Benefit Wrap. For pregnant women with incomes between 109 percent and 208 percent of FPL who qualify for Medi-Cal and who enroll in a qualified health plan offered through Covered California, DHCS would:

- Pay the woman's premium costs minus the woman's premium tax credit.

- Pay for any cost-sharing (e.g., copays) for benefits and services under the Covered California health plan.

- Provide any Medi-Cal benefits (e.g., dental and nonemergency transportation) that are not offered by the Covered California health plan.

- Provide access to Medi-Cal providers who do not contract with the Covered California health plan for services that are not available in the qualified health plan. This may include, but is not limited to perinatal specialists and services in Comprehensive Perinatal Services Program (CPSP).

DHCS indicates that it is currently analyzing how its current Medi-Cal managed care plans provide CPSP services and whether health plans offered in Covered California provider CPSP-like services. For example, according to one qualified health plan that offers products through Covered California, the only Medi-Cal and CPSP benefits that it does not provide are dental benefits and nonemergency medical transportation. This plan contracts with birth centers and utilizes midwives as part of its network.

Additionally, DHCS is in the process of assessing if there is a difference in the outcomes from services if they are provided by certified CPSP providers or non-CPSP certified providers.

LAO Comments and Recommendations. The LAO finds that the Governor's proposal would (1) likely reduce General Fund spending, while potentially providing more generous benefits, (2) full-scope coverage would eliminate coverage inconsistencies for pregnant women, and (3) that certain details of the proposal remain unclear, such the differences in covered services and costs between full-scope and pregnancy-only coverage. The LAO recommends the Administration clarify (1) the differences in covered services between full-scope Medi-Cal and pregnancy-only Medi-Cal and (2) continuity of coverage and plan choice for individuals moving between Medi-Cal and Covered California.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on this proposal and more information is obtained from the Administration.

Some consumer advocates highlight the inequity of the Administration's proposal in that adults, female and male with incomes under 138 percent of the FPL are eligible for full-scope Medi-Cal; however, pregnant women (with incomes under 138 percent of the FPL) who apply and are eligible for Medi-Cal could only receive pregnancy-only Medi-Cal or could choose comprehensive coverage through Covered California, with Medi-Cal providing a cost-sharing and benefit wrap. Additionally, consumer advocates urge the strengthening of the Medi-Cal benefit wrap provisions and consumer protections in the Administration's proposal. Many advocates find that CPSP services must be delivered comprehensively as a program and by CPSP-certified providers and do not think that the success of this program can be duplicated as a "wrap" service.

Questions.

1. Please provide an overview of this proposal.

2. Please provide an update on DHCS' analysis of how Medi-Cal managed care plans provide CPSP services.

3. Please provide an update on DHCS' analysis of whether or not qualified health plans offer CPSP services.

4. What are the differences in benefits and costs between full-scope and pregnancy-only coverage?

5. If the wrap is enacted, pregnant women will have multiple options including, the wrap and pregnancy-only Medi-Cal. How does DHCS propose to inform women of the multiple options?

6. How does DHCS propose to inform Medi-Cal eligible pregnant women of their right to receive services that are not available in their qualified health plan?

7. How does DHCS propose to coordinate pregnancy-related wrap services that may be received outside the Covered California qualified health plan?

4. AB 85 - County Realignment - Request for Positions

Budget Issue. DHCS requests $3,446,000 ($1,723,000 General Fund and $1,723,000 federal funds) in 2014-15 and $3,410,000 ($1,705,000 General Fund and $1,705,000 federal funds) in 2015-16 and ongoing to fund 18 positions and contract funds to implement and maintain the provisions of AB 85 (Committee of Budget), Chapter 24, Statutes of 2013.

The 18 positions requested in this proposal are for the Safety Net Financing Division (SNFD), Audits and Investigations Division (A&I), Office of Legal Services (OLS), Office of Administrative Hearings and Appeals (OAHA), and the Capitated Rates Development Division (CRDD). If the request for these positions is not approved, implementation of the bill requirements will be delayed as current staff cannot absorb this workload and maintain their current workload.

Effective July 1, 2013, DHCS administratively established 12.0 positions and will absorb the costs, in the current year. This proposal requests authorized position and expenditure authority, effective July 1, 2014. DHCS states that resources were redirected in the current year, but that this redirection is not sustainable.

DHCS also requests $1.2 million ($600,000 General Fund and $600,000 federal funds) for consultant contracts:

- $1.0 million for a contract with Mercer (actuarial services). The Mercer contract will fund critical aspects of the program such as rate development and financial reporting.

- $200,000 to contract for a subject matter expert on public hospital data.

Background. Under the Affordable Care Act (ACA), county costs and responsibilities for indigent health care are expected to decrease as more individuals gain access to health care coverage. The state-based Medi-Cal expansion will result in indigent care costs previously paid by counties shifting to the state. AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, modifies 1991 Realignment Local Revenue Fund (LRF) distributions to capture and redirect savings counties will experience from the implementation of federal health care reform effective January 1, 2014.

According to the Administration, county savings are estimated to be $300 million in 2013-14 and $900 million in 2014-15, and those savings will be redirected to counties for CalWORKs expenditures. This redirection mechanism frees up General Fund resources to pay for rising Medi-Cal costs. Counties can either choose a reduction of 60 percent of their health realignment funds, including their maintenance-of-effort, or choose a formula that accounts for the revenues and costs of indigent care programs in their county. Counties have the following options:

- **Option 1** uses a formula that measures actual county health care costs and revenues. The state receives 80 percent of any calculated savings, with the county retaining 20

percent of savings to invest in the local health care delivery system or spend on public health activities.

- **Option 2** transfers 60 percent of a county's health realignment allocation plus the county maintenance-of-effort (MOE) to the state to be captured as savings; the county retains 40 percent of its realignment funding for public health, remaining uninsured, or other health care needs. (To receive health realignment funds, counties are required to meet a MOE. Under this option, a percentage of the MOE is considered in the calculation.)

Counties participating in the County Medical Services Program (CMSP) are subject to an alternative similar to Option 2. Total realignment funding for CMSP consists of a direct allocation that grows over time and $89 million that CMSP counties collectively contribute annually to the CMSP Governing Board. For CMSP counties, AB 85 redirects the $89 million as savings, and the Governing Board will be responsible for covering the remainder of the amount equal to 60 percent of the program's total realignment and MOE funding.

Future year savings for all counties will be estimated in January and May, prior to the start of the year, based on the most recently available data. Further, for counties that choose the formula, reconciliation will occur within two years of the close of each fiscal year. Counties had until January 22, 2014 to adopt a resolution to select Option 1 or Option 2 and inform DHCS of the final decision.

DHCS issued a final determination on the historical percentage spent on indigent health care to each county and it can be found at:
http://www.dhcs.ca.gov/provgovpart/Documents/AB%2085/DHCS_Historical_Determinations.pdf

Counties had until February 28, 2014 to appeal to the County Health Care Funding Resolution Committee (created by AB 85) DHCS' determination on the historical percentage, petition to change options, and petition for an alternative cost calculations. This committee is composed of representatives from the California State Association of Counties, DHCS, and the Department of Finance. Eight counties have submitted appeals to this committee, three of these have been withdrawn.

Details on Proposed Positions. The proposed positions are:

Safety Net Financing Division – 7.0 Positions
5.0 Permanent Positions
1.0 Staff Services Manager (AE)
2.0 Associate Government Program Analyst (AE)
2.0 Health Program Auditor IV

2.0 Limited-Term Positions
2.0 Associate Government Program Analyst

Audits and Investigations – 1.0 Position
1.0 Permanent Position
1.0 Health Program Auditor IV

In the current year, these positions developed and calculated the historical percentages of county indigent care spending, and developed interim calculations for 2013-14 and 2014-15. Staff will also need to develop estimates of redirected amounts to include in the May 2014 Estimate. Throughout the next year, these staff would work with counties to finalize data, develop the final calculation model, and complete final calculations. The final calculations for 2013-14 must be completed by December 31, 2015.

In the budget year and ongoing, these positions would perform interim and final calculations annually until the latter of 2023 or until amounts in the formula are fairly static. The formula looks at all health care costs and revenues and then determines the portion of those costs and revenues spent on Medi-Cal and the uninsured. Different county groups have different kinds of costs and revenues, and counties capture and record data differently. The calculations contain numerous steps, including comparisons of each year's actual data to the historical data for that county, adjustments to data depending on different variables, cost containment limits, weighted trend factors, a low income shortfall calculation, and other steps. This workload will be ongoing.

Office of Legal Services – 3.0 Positions
2.0 Permanent Positions
1.0 Attorney IV (AE)
1.0 Attorney I (AE)

1.0 Limited Term Position
1.0 Legal Analyst (AE)

These positions would be responsible for developing regulations related to AB 85 and represent DHCS on any county appeals of the calculations,

Office of Administrative Hearings and Appeals – 3.0 Positions
3.0 Permanent Positions
1.0 Administrative Law Judge II (AE)
1.0 Administrative Law Judge II
1.0 Legal Analyst (AE)

These positions would process appeals, conduct hearings, and produce proposed decisions related to AB 85.

Capitated Rates Development Division – 4.0 Positions
2.0 Permanent Positions
2.0 Research Program Specialist II (AE)

2.0 Limited Term Positions

2.0 Research Program Specialists I (AE)

These positions will plan, organize, and conduct studies and provide consultation regarding the impact on Medi-Cal managed care plans with the implementation of AB 85, analyze Medi-Cal managed care data and extract data specific to the newly-eligible beneficiaries enrollment to be used by the actuaries in the development of capitation rates; provide analyses to determine the accuracy and reasonableness of the data by specific service type; and develop critical evaluations of AB 85 and develop written narratives (briefing papers, issue memos and policy letters) advising on proposals and alternatives related to the newly-eligible population.

The requested $1.0 million for Mercer Health and Benefits LLC contract for actuarial services (Mercer) would fund two aspects of the program:

- Implementation of AB 85 requires specified percentages of newly-eligible Medi-Cal beneficiaries to be assigned to public hospital health systems in an eligible county until the county public hospital health system meets its enrollment target. Actuarially sound capitation rates need to be calculated to pay the managed care plans at least 75 percent of the rate range available so they can in turn pay county public hospitals at cost for services.

- Managed care plans are to pay the entire rate range as additional payments to county hospitals for providing and making available services to newly-eligible enrollees under the 133 percent Federal Poverty Level (FPL).

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on this proposal and the updated estimates on county savings are included in the May Revise.

Questions.

1. Please provide an overview of this proposal.

2. What county programs and services are funded with health realignment funds? Is there any reporting to the state on how counties use this funding or how counties have changed or propose to change their services as a result of AB 85?

3. Please provide an update on implementation of AB 85 and DHCS' work on calculating the 2014-15 county savings.

5. AB 1 X1 – Medi-Cal Eligibility Under ACA – Request for Positions

Budget Issue. DHCS requests eight positions and expenditure authority of $1,062,000 ($295,000 General Fund and $767,000 federal funds) in 2014-15 and $1,046,000 ($290,000 General Fund and $756,000 federal funds) in 2015-16 needed to implement the various statutory requirements of AB 1 X1 (Pérez), Chapter 3, Statutes of 2013-14 of the First Extraordinary Session. Specifically, AB 1 X1 authorizes DHCS to implement various Medicaid provisions of the Affordable Care Act (ACA).

Background. AB 1 X1 authorizes the DHCS to implement various Medicaid provisions of the ACA. Specifically, AB 1 X1 1implements the new "adult group" in California; transitions Low Income Health Program (LIHP) beneficiaries to Medi-Cal beginning January 1, 2014; implements the use of the Modified Adjusted Gross Income (MAGI) methodology; simplifies the annual renewal and change in circumstances processes for Medi-Cal beneficiaries; requires DHCS to use electronic verifications of eligibility criteria both at initial application and redeterminations of eligibility; permits Covered California to make Medi-Cal eligibility determinations in limited situations; and establishes performance standards for DHCS, Covered California, and the Statewide Automated Welfare Systems (SAWS).

Details on Proposed Positions. Of the requested positions, the Medi-Cal Eligibility Division requests four two-year limited-term, full-time positions as follows:

- Two Health Program Specialists II
- Two Associate Governmental Program Analysts

The Medi-Cal Eligibility Division (MCED) is responsible for the planning, development, coordination, and implementation of Medi-Cal regulations, policies, and procedures to ensure accurate and timely determination of Medi-Cal eligibility for applicants and beneficiaries. These positions would provide extensive technical program consultation on the implementation requirements of the legislation; assist in the development of policies in the form of All County Welfare Director Letters, Medi-Cal Eligibility Division Information Letters, and regulations in support of the policy changes mandated by the legislation; conduct ongoing policy reviews and analyses of the eligibility requirements; review and interpret ongoing federal guidance; and obtain stakeholder and county perspectives.

The Information Technology Division requests four two-year limited-term positions as follows:

- One Senior Information Systems Analyst Specialist
- One Staff Information Systems Analyst
- One Senior Programmer Analyst Specialist
- One System Software Specialist III

The Information Technology Division (ITSD) provides a secure, reliable information technology environment to support program and administrative objectives of DHCS, the California Department of Public Health (DPH), and the California Health and Human Services Agency.

These positions would provide requirements definition, design, development, implementation and ongoing support of the various Medicaid provisions of the ACA. This work includes provisions contained in AB 1 X1, and will require system enhancements to Medi-Cal Eligibility Data System (MEDS) and related systems including the Statewide Client Index (SCI), and interfaces in the following major areas: eligibility, enrollment, systems integration, and the establishment of performance standards for DHCS, Covered California and SAWS.

LAO Findings and Recommendations. The LAO finds that based on the timelines provided the proposal, it appears most of the activities that will be performed by the requested positions are scheduled to be complete by June 2015, with many of them completed even earlier. Currently, it is unclear why the department is requesting positions through June 30, 2016 when the activities are scheduled to be completed by June 2015. The LAO recommends the Legislature direct the department to report on the activities these positions will be performing after June 2015, at which point it appears most of the workload associated with this request is scheduled to be complete.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open as discussions continue on this proposal and implementation of federal health care reform.

Questions.

1. Please provide an overview of this proposal.

2. Please comment on the LAO's findings that justification for these positions in 2015-16 is unclear. What will these positions perform after June 2015?

6. SB 1 X1 – Medi-Cal Eligibility Under ACA, Hospital Presumptive Eligibility

Budget Issue. DHCS requests funding for the information technology consultant costs associated with enhancing the business functionalities and reporting requirements of the Medi-Cal Eligibility Determination System (MEDS) to create a Hospital Presumptive Eligibility gateway and implement the Hospital Presumptive Eligibility (PE) program, as set forth in the Affordable Care Act (ACA) and enacted in SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session.

The costs associated with the implementation is estimated at $1,583,000 ($396,000 General Fund, $1,187,000 Federal Fund) with an on-going cost of $239,000 ($60,000 General Fund, $179,000 Federal Fund) per year. The contracted vendor will assist DHCS to develop the Hospital PE gateway and enhance MEDS, including developing requirements, validation, training, and user ownership.

Background. On July 5, 2013, the federal Centers for Medicare and Medicaid Services (CMS) released Part 2 of the Medicaid Final Rule regulations to implement various provisions of the Affordable Care Act. The Part 2 packet provided final regulations on the implementation of the Hospital PE program established by the ACA at 42 Code of Federal Regulations (CFR) Section 435.1110.

To implement the Hospital PE program, California enacted Welfare & Institutions Code Section 14011.66, as prescribed in SB 1 X1. The Hospital PE program provides temporary no share-of-cost Medi-Cal benefits during a presumptive period to individuals determined eligible by a qualified hospital, on the basis of preliminary information. The Hospital PE program is effective as of January 1, 2014. To ensure compliance with the Hospital PE program's effective date of January 1, 2014, DHCS enhanced the MEDS by leveraging the system functionalities established for the Child Health and Disability Prevention (CHDP) Gateway program. However, this strategy was a short-term approach to meet the mandate; the enhancements do not provide the means to meet critical program requirements on oversight and monitoring, performance standards development, and program integrity and compliance with applicable state and federal policies, statutes, and regulations.

To date, 124 hospitals are providing Hospital PE and 11,000 individuals have been approved to receive Medi-Cal under the Hospital PE program.

Subcommittee Staff Recommendation and Comment—Approve. It is recommended to approve this item. No issues have been raised. DHCS developed short-term solutions to ensure that this program was implemented quickly and, as a result, over 11,000 individuals have qualified for Medi-Cal Hospital PE. This proposal will provide for a long-term technology solution to support the Hospital PE program.

Questions.

1. Please provide an overview of this proposal.

7. SB 3 X1 – Health Care Coverage: Bridge Plan – Request for Positions

Budget Issue. DHCS requests four three-year limited-term positions and $460,000 ($229,000 General Fund and $231,000 Federal Trust Fund) to implement the provisions of SB 3 X1 (Hernandez), Chapter 5, Statutes of 2013-14 of the First Extraordinary Session. The bill requires DHCS to ensure that its contracts with Medi-Cal managed care health plans meet various requirements, including providing coverage in bridge plans to Medi-Cal managed care enrollees and other specified individuals.

DHCS states that these positions are necessary to provide legal advice, litigation support and regulation development. Additionally, the positions would be needed to address managed care bridge plan policy implementation and to avoid potential negative consequences including noncompliance with state and federal mandates, the loss of federal funding, and litigation.

Background. SB 3 X1 requires the California Health Benefits Exchange (known as Covered California) to enter into contracts with and certify as a qualified health plan (QHP) Medi-Cal managed care plans that offer "bridge plan" products meeting specified requirements; specify the populations that would be eligible to purchase a bridge plan product; and require DHCS to ensure its contracts with Medi-Cal managed care plans meet specified requirements. A bridge plan product is the individual health benefit plan offered by a licensed health care service plan or health insurer that contracts with Covered California.

The bill requires Covered California to submit an evaluation to the Legislature of the bridge plan program in the fourth year following federal approval and would sunset the bridge plan program five years after federal approval, unless a later enacted statute deletes or extends the dates of operation. The purpose of SB 3 X1 is to improve continuity of coverage for Medi-Cal enrollees and their families, and provide more affordable coverage to low-income individuals.

SB 3 X1 establishes a bridge health insurance plan for low-income individuals, the parents of Medi-Cal and Healthy Families Program-eligible individuals, and individuals moving from Medi-Cal coverage to subsidized coverage through Covered California. The purpose of the bridge is to promote continuity of care, provide an additional low-cost coverage choice to hard-working Californians, and reduce the negative effects of "churning" back and forth between systems of coverage where individuals are required to shift health plans and health coverage programs because of changes in their household income. By allowing individuals to remain within their current health plan when they shift health subsidy programs, SB 3 X1 prevents disruptions in individuals' provider networks and improves continuity of care.

LAO Findings and Recommendations. The LAO finds that the workload appears to be based on an assumption that a significant number of Medi-Cal managed care plans will be offering a Bridge Plan product. The federal government has yet to approve the state's Bridge Plan proposal and—even assuming the proposal is approved by the federal government—it is unclear how many Medi-Cal plans will offer Bridge Plan products. If very few Medi-Cal plans offer Bridge products, the workload for this proposal may be overstated. Second, the authorizing statute (SB 3 X1) gives DHCS the authority to delegate much of the

implementation responsibility to Covered California. Currently, it is unclear why DHCS chose to implement these activities rather than delegate these activities to Covered California. The LAO recommends the Legislature direct DHCS to report on the following: (1) how many Medi-Cal plans they expect to offer Bridge Plan products, (2) the degree to which the number of plans offering Bridge Plan products affects the workload associated with this proposal, (3) which Bridge Plan implementation activities are being delegating to Covered California, and (4) why the department is requesting resources to implement the activities described in this proposal, rather than delegating the activities to Covered California.

Subcommittee Staff Recommendation and Comment—Hold Open. It is recommended to hold this item open. The federal CMS has not yet approved the state's proposal to create a bridge plan and it is unclear if any health plans will apply to become bridge plans. Additionally, DHCS' proposed role in implementing the bridge plan program does not appear consistent with SB 3 X1, as SB 3 X1 envisioned that Covered California would be primarily responsible for implementation.

Questions.

1. Please provide an overview of this proposal and rationale for DHCS' request for four staff to implement this program.

8. ACA - Estimated Savings Due to Claiming Enhanced Federal Funds

Budget Issue. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, requires DHCS to report to the Legislature, each January and May, the projected General Fund savings attributable to claiming enhanced federal funding for previously eligible Medi-Cal beneficiaries. The law also required DHCS to confer with applicable fiscal and policy staff of the Legislature by no later than October 1, 2013 regarding the potential content and attributes of the information provided in its savings estimate.

This information was not included in the Governor's January budget. The Administration indicates that it was unable to provide this figure because it did not have data (as the change occurred in January 2014) to base its assumptions and hopes to have this information in the May Revision.

Background. Under some of the new ACA eligibility rules and the optional expansion, the state may be able to claim a 100 percent federal match for some enrollees who would have previously qualified for a 50 percent match.

LAO Comments and Recommendations. The LAO finds that preliminary fiscal estimates of factors that will likely have significant effects on the amount of General Fund spending in the Medi-Cal Program should be included in the budget even if these estimates are highly uncertain and subject to change in the coming months. The Medi-Cal budget frequently contains preliminary estimates and assumptions that are based on limited data and experience. For example, many of the other ACA–related fiscal estimates included in the Medi-Cal Estimate are subject to substantial uncertainty and are based on assumptions that are based on limited actual experience, yet these estimates are included in the budget. Such estimates serve as placeholders until more refined estimates can be completed and allow for more informed budget deliberations because the Legislature has an opportunity to assess the Administration's estimates and assumptions and discuss the budget with a more complete understanding of the factors affecting expected General Fund spending.

LAO recommends that the Administration report at budget hearings on the reasons it failed to confer with all of the relevant legislative staff and provide a fiscal estimate of enhanced federal funding available for previously eligible beneficiaries, as required by state law. In addition, the LAO recommends that the Legislature direct the Administration to describe: (1) the previously eligible populations that may now be eligible for the 100 percent federal match, (2) the total amount of General Fund that was spent on these populations in previous years, (3) the major sources of uncertainty that led to the decision to not include a fiscal estimate in the budget, and (4) the Administration's timelines for providing its fiscal estimate. LAO finds that with this additional information, the Legislature can begin to assess the potential magnitude of the fiscal effects and account for these effects as it discusses the 2014-15 budget.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. The Administration has a wealth of Medi-Cal data and often estimates

based on unknown experiences; this information, as required by law, should be provided to the Legislature no later than the May Revision.

Questions.

1. DHCS, please describe (a) the previously eligible populations that may now be eligible for the 100 percent federal match, (b) the total amount of General Fund that was spent on these populations in previous years, (c) the major sources of uncertainty that led to the decision to not include a fiscal estimate in the budget, and (d) the Administration's timeline for providing its fiscal estimate.

9. Statewide Outpatient Medi-Cal Contract Drug List

Budget Issue. DHCS requests trailer bill language to:

1. **Statewide Formulary.** Establish a core statewide outpatient Medi-Cal contract drug list (CDL) formulary for all Medi-Cal beneficiaries, including the Family Planning, Access, Care and Treatment Program (FPACT). Any of the drugs on this statewide formulary would be available without a treatment authorization request. Managed care plans would be required to use this core formulary, as a minimum, and could add additional drugs at their discretion.

2. **Additional State Supplemental Drug Rebates.** Negotiate supplemental drug rebate contracts with manufacturers for all Medi-Cal programs, including managed care plans and FPACT. The budget estimates General Fund savings of $32.5 million in 2014-15 and annual General Fund savings of at least $65 million as a result of these supplemental drug rebates.

Background. DHCS is one of the largest purchasers of drugs in the State. The fee-for-service (FFS) pharmacy program contract drug list formulary (CDL) is established and maintained by DHCS in consultation with the Medi-Cal Contract Drug Advisory Committee (MCDAC) and ongoing recommendations from the Medi-Cal Drug Use Review (DUR) Board. Currently, beneficiaries in Medi-Cal's FFS program have access to drugs listed on the Medi-Cal CDL without having to obtain prior authorization.

However, Medi-Cal managed care plans are only required to establish drug formularies that are comparable in scope to the Medi-Cal CDL. Each managed care plan develops and manages its own formulary, and as a result, Medi-Cal beneficiaries may receive different drug formulary options and be subject to different utilization controls when they move between health plans. Current regulations (California Administrative Code Title 22, § 53854) do not require a plan to include in its formulary every drug listed on the Medi-Cal formulary and do not prevent a plan from performing utilization review to determine the most suitable drug therapy for a particular medical condition.

There are currently more than twenty different Medi-Cal managed care plan formularies. Additionally, beneficiaries under FPACT may receive different drugs because FPACT administers its own outpatient drug formulary which is separate and apart from the Medi-Cal CDL.

The federal Medicaid Drug Rebate Program was created by the 1990 Omnibus Budget Reconciliation Act and requires drug manufacturers to have a national rebate agreement with the federal Department of Health and Human Services in order for states to receive federal funding for outpatient drugs dispensed to Medicaid enrollees. Prior to 2010, drugs provided to enrollees in Medicaid or Medi-Cal managed care plans were excluded from these federal rebates.

The Affordable Care Act modified this and now drug utilization from Medi-Cal managed care plans is subject to the federal drug rebate program. Pursuant to Welfare and Institutions Code Section 14105.33, DHCS is able to also negotiate with pharmaceutical manufacturers for additional rebate revenue (state supplemental rebates) over and above the mandated federal rebates for drugs provided to beneficiaries in the Medi-Cal FFS program and County Organized Health Systems. This state supplemental rebate program excludes drugs provided to beneficiaries in Medi-Cal managed care plans. The expansion of Medi-Cal managed care into all 58 counties and mandatory enrollment of families, children, seniors and persons with disabilities into managed care reduces the ability of the State to obtain the supplemental rebates for drugs provided to these beneficiaries under managed care arrangements.

Reason for Request. DHCS states that historically, its clinical and fiscal benefit design (for its pharmaceutical program) has been based on a FFS foundation for predominantly FFS-weighted pharmaceutical utilization. The shifts in population (e.g., seniors and persons with disabilities) and pharmaceutical utilization from FFS to managed care have highlighted two key issues:

1. **Inequity in the Pharmaceutical Benefit Design –** Each managed care plan develops its own drug formulary. Consequently, as people move from one managed care plan to another plan, Medi-Cal enrollees may receive different drug options and may be subject to various forms of drug utilization controls before they can receive a drug that they were previously prescribed. DHCS contends that this proposal would provide continuity of pharmaceutical benefits when a person changes plans.

2. **Lost Opportunities for General Fund Savings –** DHCS finds the state could obtain additional supplemental drug rebates resulting in General Fund savings if it had the ability to negotiate on the behalf of all Medi-Cal delivery systems, including Medi-Cal managed care plans and FPACT.

   According to DHCS, Medi-Cal drug spending includes:

Medi-Cal Fee-For- Service for Pharmacy	$2.1 billion	State supplemental rebates are collected.
Medi-Cal Managed Care Rate Pharmacy Line Item	$1.3 billion	State supplemental rebates are not collected.
Medi-Cal Managed Care Carved Out Pharmacy (e.g., HIV drugs)	$672 million	State supplemental rebates are ~~**not**~~ collected.

   ~~**DHCS finds that close to $2 billion in Medi-Cal drug spending could be subject to state supplemental rebates and that DHCS should play a more significant role in the establishment of this benefit.**~~ **The proposal would allow DHCS to collect state supplemental rebates for managed care utilization on drugs for which there is a supplemental rebate agreement.**

DHCS recognizes that as a result of the statewide drug formulary, managed care rates may need to be adjusted since managed care plans will not have the same negotiating power and may not have the same ability to managed pharmaceutical utilization. DHCS indicates that the need for this rate adjustment would be evaluated as this proposal is implemented.

DHCS also notes that this proposal makes no changes to the existing Knox-Keene continuity of care protection for drug benefits. If a drug is not on the state's core formulary and not on the health plan's formulary (if it provides supplemental drugs), then the existing treatment authorization process would still occur.

DHCS states that this proposal does not impact the list of drugs (e.g., certain HIV drugs) that are carved out of Medi-Cal managed care.

DHCS anticipates that this process will take 18 months to implement, as federal approval is necessary, but is proposing that the changes related to the state supplemental rebates be retroactive to July 1, 2014.

DHCS held four stakeholder workgroup meetings this past week with providers, health plans, the pharmaceutical industry, and beneficiary advocates.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. This is a very complex issue and discussions with stakeholders have recently commenced. It will be important for the Legislature to carefully consider the potential tradeoffs of this proposal. These tradeoffs include the additional General Fund savings and a core statewide drug benefit compared to restricting some aspects of a managed care plan's ability to control and manage pharmacy benefits which potentially could lead to pressure for increased managed care rates. It is also not clear whether or how this proposal may interfere with a plan's ability to coordinate and manage the care of enrollees, particularly those with chronic conditions.

Questions.

1. Please provide an overview of this proposal.

2. Please provide highlights of issues and concerns raised during this week's stakeholder meetings.

3. Please provide an overview of the timeline for this proposal and how DHCS intends to work with stakeholders to develop the statewide formulary.

4. Please provide an overview of the existing continuity of care protections related to prescriptions and medication. Do these only apply when an individual changes plans? Would these protections apply if this proposal is implemented and there is change due to a drug no longer being part of the formulary (but the person remains in the same health plan)?

5. Please explain how the FPACT drug formulary and the current Medi-Cal FFS drug formulary are different. Please comment on how the Administration plans to evaluate those drugs that are on the FPACT formulary and whether or not they should be included on the new formulary.

6. Please comment on the potential need to adjust Medi-Cal managed care rates as a result of this proposal.

10. Impact of Minimum Wage Increase on Medi-Cal

Budget Issue. AB 10 (Alejo), Chapter 351, Statutes of 2013, increased the minimum wage from $8 per hour to $9 per hour in July 2014 and $10 per hour on January 2016.

The Governor's budget does not account for the impact to Medi-Cal as a result of this wage increase, even though many Medi-Cal providers (e.g., skilled nursing facilities) and Medi-Cal Waiver programs (e.g., the AIDS Wavier) would likely experience an increase in wage costs as a result of AB 10.

Both the In-Home Supportive Services budget and the Department of Developmental Services (DDS) budget include rate adjustments (i.e., increased General Fund expenditures) to account for the increase in wage costs as a result of AB 10.

The Administration states that it is currently evaluating the impact of AB 10 on Medi-Cal.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic. Given that both the IHSS and DDS budgets have been adjusted to account for the wage costs increases, it would be expected to see a similar adjustment in the Medi-Cal budget.

Questions.

1. Please provide an overview of this issue and any reasoning for why Medi-Cal would not experience a similar adjustment to account for the wage costs increase.

11. Fingerprinting and Criminal Background Checks

Budget Issue. DHCS seeks statutory authority to receive the results of criminal background checks of applicants and providers from the Department of Justice (DOJ) in order to screen or enroll the Medi-Cal provider applicants and providers.

Trailer bill language is also requested to clarify that applicant/providers will be responsible for reimbursing DOJ the cost to complete the expanded background checks and fingerprinting. The added language provides DOJ with clear legal authority to charge the providers for the fingerprinting and background checks.

Background. DHCS is responsible for the enrollment and re-enrollment of fee-for-service health care service providers into the Medi-Cal program. There are approximately 150,000 enrolled Medi-Cal providers who serve the medically necessary needs of the Medi-Cal population.

In compliance with 42 Code of Federal Regulations (CFR) §455.434 and provisions of the Patient Protection and Affordable Care Act of 2010 (ACA), DHCS is required to establish a screening process for applicants or providers based on the provider types' categorical risk for fraud, waste, or abuse. The federal regulations establish three screening levels (per 42 CFR §455.450). The screening levels include "limited", "moderate" and "high", under which there are minimum requirements for screening and research to be conducted during the application review process:

- "Limited" categorical risk level providers are subject to license verification and database checks.

- "Moderate" categorical risk level providers are subject to all screening measures applicable to "limited" risk provider types in addition to onsite inspections.

- "High" categorical risk level providers are subject to all screening measures applicable to "limited" and "moderate" risk provider types in addition to the submission of fingerprints for a criminal background check (CBC).

Medi-Cal applicants or providers who CMS or DHCS designates as a "high" risk to the Medi-Cal program, and any individuals who have a five percent or greater direct or indirect ownership interest in the provider, will be required to be screened at a "high" categorical risk level and to submit fingerprints for a CBC within 30 days of a request. Furthermore, if CMS determines that "high" risk providers require federal CBCs, those providers designated as "high" risk would be required to undergo a federal CBC at the time of revalidation as DOJ does not provide federal update reports as it does for State level CBCs.

Provider types that have been designated as "high" categorical risk by Medicare are required to be screened by Medicaid programs at that same level. Currently, newly-enrolling durable medical equipment providers and newly-enrolling home health agency providers have been

designated as "high" categorical risk by Medicare. In addition to those provider types designated as "high" categorical risk, any applicant or provider will be elevated to the "high" categorical risk level if the provider has a payment suspension that is based on a credible allegation of fraud, waste, or abuse; has an existing Medicaid overpayment based on fraud, waste or abuse; has been excluded by the federal Department for Health and Human Services' Office of the Inspector General or another state's Medicaid program within the previous ten years; or, a moratorium has been lifted within the previous six months prior to applying in the Medicaid program and the applicant/provider would have been prevented from enrolling due to the moratorium.

DHCS is to designate all other provider types not recognized by Medicare to an appropriate screening level based on fraud, waste, or abuse.

SB 1529 (Alquist), Chapter 797, Statutes of 2012, sponsored by DHCS, implemented various program integrity provisions required by the ACA, including the provision requiring Medi-Cal applicants or providers, who are required to be screened at a "high" categorical risk level for fraud, waste, or abuse to provide fingerprints for a CBC. Although DHCS currently has statutory authority to require fingerprints for a CBC, the California Department of Justice (DOJ) requires specific statutory authority authorizing DOJ to accept fingerprints and furnish DHCS or its agents with CBC results. As such, this proposal seeks to establish authority for DOJ to provide criminal history information to DHCS for certain applicants or providers in the Medi-Cal program in order to become fully compliant with federal Medicaid requirements.

Reason for Request. Without the proposed trailer bill language, DHCS indicates it will not be able to implement the ACA requirement for CBCs. States are required to implement within 60 days of final guidance. This trailer bill language is in preparation to meet implementation requirements upon final guidance issuance. DHCS anticipates that guidance will be issued shortly. If California does not implement within the 60 day requirement, there would be an increased risk of losing federal financial participation (FFP) for the Medi-Cal program. State legislation is necessary in order to meet the requirements established by the federal regulations. As the single state Medicaid agency, DHCS is responsible for making sure it is in compliance with the federal regulations. DHCS intends to implement the federal minimum requirements when final guidance is issued.

Federal regulations must be followed in the administration of the Medi-Cal program, in order to guarantee the receipt of FFP dollars, on which the State's Medi-Cal budget heavily relies.

IHSS Providers. Questions have been raised about the applicability of this proposal to In-Home Supportive Services (IHSS) providers. IHSS providers are providers covered under the ACA and are not explicitly designated as a "high" risk provider category. The current procedures for obtaining and submitting fingerprints and notification by DOJ of criminal record information for IHSS workers is set forth in Welfare and Institutions Code Section 15660(a). The process currently requires a state level CBC but does not require a federal level CBC. DHCS is awaiting final guidance from CMS whether a federal level CBC will be required for "high" risk providers. In the event that final federal guidance does require a federal CBC for

"high" risk providers, DHCS will work with Department of Social Services on the steps necessary to meet these requirements.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic and further clarifications are received from the federal government.

Questions.

1. Please provide an overview of this issue.

2. Please comment on the issues raised regarding IHSS providers. Are IHSS providers considered "high risk?" Please explain.

3. What is the timeline for implementing this federal requirement?

12. Ground Emergency Medical Transportation

Budget Issue. DHCS requests five and one-half permanent positions, three three-year limited-term positions, and $1,013,000 in expenditure authority ($507,000 Federal Fund and $506,000 Reimbursement Fund) to perform audits on approximately 160 local Fire Districts and Ground Emergency Medical Transportation (GEMT) providers throughout California that will receive supplemental payments for GEMT services as authorized by AB 678 (Pan), Chapter 397, Statutes of 2011.

The change in allowable reimbursement methodology under AB 678 allows for retroactive supplemental payments through cost reports. This creates an estimated initial backlog of approximately 800 cost reports and will result in the submission of approximately 160 cost reports annually for GEMT services. The reimbursement funding will be provided by the public entities receiving the supplemental payments as required by current law.

Background. In their first response capacity, local fire departments participate in transporting Medi-Cal patients at an increasing rate. Ambulance transports of Medi-Cal patients have increased by 13 percent between 1997 and 2006 and by 19 percent between 2006 and 2009. Of the approximately 3.1 million emergency transports provided in California, it is estimated that 300,000 of those transports will be provided to Medi-Cal beneficiaries; half will be transported by fire departments or GEMT service providers that are owned and operated by public entities.

Medicaid regulations establish requirements identifying how public funds can be used to draw down Federal Financial Participation (FFP) via Medicaid. Certified Public Expenditures (CPEs) are one of several funding mechanisms that a state may employ to obtain FFP and to make supplemental payments to Medi-Cal providers without cost to the General Fund (GF). Under a CPE agreement, governmental providers must certify their Medicaid actual expenditures to the state, thus allowing the state to obtain federal reimbursement based on the CPE. States are responsible for ensuring that expenditures are eligible for federal reimbursement by reviewing cost reports filed by each governmental provider.

Under AB 678, state and local entities would have the option to claim FFP for the difference between the reimbursement rate under the Medi-Cal program and the actual allowable cost for providing this service. AB 678 allows, on a voluntary basis, eligible public entities to certify their CPEs for supplemental reimbursements for GEMT services. The intent of the legislation is to relieve the financial burden of these eligible public entities by providing a supplemental reimbursement at no cost to the State of California.

At the time of program inception, the total supplemental reimbursement was estimated to be approximately $75 million based on 160 participating Medi-Cal providers. In further discussions with the Centers for Medicare and Medicaid Services (CMS), DHCS now estimates annual supplemental reimbursements of approximately $300 million. The higher estimate results from CMS not applying an upper payment limitation and additional costs not historically reimbursed will be included in the allowable reimbursement methodology.

AB 678 authorizes retroactive supplemental payments to January 2010 via a cost report mechanism. The retroactive status will create an initial backlog of approximately 800 cost reports. The department anticipates approximately 160 cost reports annually thereafter. CMS approved the State Plan Amendment (SPA) and cost report format on September 4, 2013.

Currently, DHCS has 1.5 positions for the GEMT services. Initially, these positions were dedicated to establishing program protocol and oversight of the cost report audit function and once the protocol and cost reporting process was established DHCS would request the positions to implement the program.

Reason for Request. Approximately 160 local fire districts have expressed interest in participating in the GEMT Supplemental Reimbursement Program. As of June 30, 2014, DHCS' Audits and Investigations (A&I) unit will have a backlog of approximately 800 cost reports based on the retroactive implementation date of January 2010 for the GEMT Services Program. Cost Reports for five fiscal periods will be due at the time (160 x 5 = 800). An additional 160 cost reports will be filed each year thereafter.

The proposed positions will constitute an entire production unit designated to the GEMT audit activity. A&I will review approximately 275 cost reports annually for the first five years to significantly reduce the backlog. Thereafter, A&I will review approximately 225 cost reports annually for the next three to four years in order to reduce the inventory down to one fiscal year's worth of cost report audit production.

Subcommittee Staff Recommendation and Comment—Approve. It is recommended to approve this item. No issues have been raised.

Questions.

1. Please provide an overview of this proposal.

13. MEDS Modernization

Budget Issue. DHCS requests 16.0 two-year limited-term positions and other costs associated with a new, six-year, Information Technology (IT) project to modernize the Medi-Cal Eligibility Data System (MEDS). Funding in this proposal is requested to support the Project Planning and Requirements Elicitation activities of the project. DHCS requests $3,480,000 in expenditure authority ($528,000 General Fund and $2,952,000 Federal Funds) for the 16.0 two-year limited-term positions.

Background. Since 1983, DHCS and its partners have relied on a centralized database known as MEDS to store information on individuals receiving public benefits from the Medi-Cal and other health-related programs; as well as provide a variety of eligibility, enrollment and reporting functions. MEDS and its related subsystems provide consolidated information on beneficiary eligibility in an environment where eligibility is determined on a decentralized basis, mostly by county welfare departments through three consortia, each using a different county-based eligibility system.

Data maintained in the MEDS originates from California's 58 counties, state and federal agencies, health plans, and in the fall of 2013, from Covered California, the State's Health Benefit Exchange. Access to the MEDS' database is provided to over 35,000 distinct users involved in the administration of the state's health and human services programs. While MEDS currently supports records for about 8 million beneficiaries, program changes related to the Patient Protection and Affordable Care Act of 2010 (ACA) is expected to add up to 2 million additional beneficiaries in 2014.

Currently, MEDS serves as the 'system of record' for numerous publically subsidized health care programs including, Medi-Cal, California Work Opportunity and Responsibility to Kids (CalWORKS), the Cancer Detection Programs: Every Woman Counts (CDP:EWC) program, the Child Health and Disability Prevention Program (CHDP), Breast and Cervical Cancer Treatment Program (BCCTP), and houses eligibility for Healthy Families [the State's Children's Health Insurance Program (CHIP)], the Supplemental Nutritional Assistance Program (SNAP), and the Family Planning Access Care and Treatment (Family PACT) Program.

Maintenance and Operation (M&O) of the existing MEDS is currently supported by 85 full-time and 10 part-time, permanent staffing resources. These resources not only operate and perform routine maintenance on the MEDS, they also perform numerous tasks to assess and accommodate on-going change requests in response to ever changing program demands. Recently, these staffing resources have been burdened by increased workload demands associated with consolidation of the state's Mental Health and Alcohol & Drug programs with Medi-Cal, and impacts of the federally-required ACA implementation.

In April 2011, the Centers for Medicare and Medicaid Services (CMS) issued a new Medicaid Program Final Rule that provides enhanced federal financial participation (FFP) available at the 75 percent rate for operation of eligibility determination systems that meet the standards and conditions of the Medicaid Information Technology Architecture (MITA) initiative by

December 31, 2015. This new rule also stated FFP at the 90 percent rate for the design, development, installation, or enhancement of Medicaid eligibility determination systems that met CMS' requirements is available up to December 31, 2015. In subsequent discussions with states, CMS has indicated they will consider extending the availability of enhanced FFP beyond this date, if the state has submitted and CMS has approved the state's plan for otherwise meeting CMS' requirements.

Reason for Request. Due to the MEDS outdated technology platform and the declining workforce skilled in these technologies, it is becoming increasingly difficult for the system to meet DHCS' and other entities' data and functionality demands in a timely and cost efficient manner. The current design of MEDS also does not meet CMS' seven MITA conditions and standards for enhanced 75 percent FFP, which is jeopardizing the ability of DHCS to maintain this enhanced FFP for the system's maintenance and operations (M&O) costs. As a result, modernization of MEDS in the immediate future has become a top priority of DHCS.

DHCS will be working with CMS to ensure eligibility for enhanced 75 percent FFP to operate the existing MEDS is maintained, and the availability of 90 percent FFP is maximized for the planned MEDS Modernization Project.

DHCS plans to develop the modernized MEDS project in a way that reduces duplication of functionality in existing or planned systems. The project to modernize MEDS is expected to begin in July 2014 and continue through June 2020.

LAO Findings and Recommendation. LAO finds that (1) the modernization of MEDS is a worthwhile objective given the antiquated nature of the technology system and the increasing difficulty in maintaining the system caused in part by the decline in staff skilled in the outdated technology, (2) the current MEDS does not meet CMS' MITA standards and that failure to comply with CMS' MITA standards jeopardizes the state's ability to secure enhanced federal funding for maintenance and operation of MEDS, and (3) the focus on MEDS planning is a reasonable approach given the longer-term consequences of not allocating sufficient resources at the front-end of a project. It recommends approval of this proposal and the reporting of status of this project at 2015-16 budget hearings.

Subcommittee Staff Recommendation and Comment—Approve. It is recommended to approve this item. No issues have been raised.

Questions.

1. Please provide an overview of this proposal.

14. Breast and Cervical Cancer Treatment Program

Budget Issue. DHCS requests the extension of six limited-term positions for the Breast and Cervical Cancer Treatment Program (BCCTP) be extended to June 30, 2016. The current positions will expire on December 31, 2014. The extension of the positions will address the backlog associated with annual redeterminations, the initial eligibility determinations workload, and the processing of requests by applicants for retroactive coverage.

The total cost of these resources would be $301,000 ($151,000 General Fund and $150,000 Federal Fund) for 2014-15. For 2015-16, the total cost is $603,000 ($302,000 General Fund and $301,000 Federal Fund). Of the six positions requested, four are Associate Governmental Program Analysts, one is a Staff Services Manager, and one is an Office Technician position.

Background. BCCTP provides treatment services to eligible California residents diagnosed with breast and/or cervical cancer, who otherwise would not qualify for other Medi-Cal programs. BCCTP is comprised of both federal-state funded and state-only funded program components.

Federal BCCTP provides full-scope Medi-Cal benefits to women, who require treatment for breast or cervical cancer. Under the federal program, eligibility is restricted to women screened and diagnosed with breast and/or cervical cancer through state screening programs, funded by the Centers for Disease Control and Prevention, who are uninsured or under insured, under 65 years of age, and are United States citizens or have satisfactory immigration status. A woman remains eligible for federal BCCTP as long as she continues to meet the federal criteria and is still in need of treatment. Recognizing the need in California for breast or cervical cancer coverage beyond the limitations of federal law; which only provides coverage for women, AB 430 (Cardenas), Chapter 171, Statutes of 2001 also established a corresponding State-funded program for women and men, who do not meet the eligibility criteria for the federal program. State-funded BCCTP is limited to 18 months for breast cancer and 24 months for cervical cancer.

Since the program's inception in 2002, BCCTP has received 45,744 applications; the active BCCTP caseload has continued to increase from 5,000 cases in the first year of operation to 14,248 active cases as of July 1, 2013. Of these active cases, there are 5,337 federal cases that are overdue for an annual redetermination and another 1,324 federal cases that are currently due for an annual redetermination, which amounts to almost 7,000 cases needing a redetermination.

Reason for Request. According to DHCS, the ongoing workload associated with initial eligibility determinations, annual redeterminations, and the processing of requests by applicants for retroactive coverage makes it essential that these six positions be extended for two more years until the workload stabilizes. DHCS notes that the Affordable Care Act (ACA) will result in a reduction in the number of new applicants in the federal BCCTP by about 15 percent per year. As the number of applications diminishes, the number of completed redeterminations increases resulting in a decrease in the backlog, as show in the table below.

Table: BCCTP Projected Workload Outcomes

Workload Measure	2012-13	2013-14	2014-15	2015-16
Applications Received	4,970	4,320	3,760	3,270
Active Case Load	14,248	12,389	10,773	9,367
Completed Annual Redetermination	5,760	6,410	6,970	7,460
Backlog Annual Redetermination	7,144	4,268	3,803	1,907

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the two-year extension of these positions.

Questions.

1. Please provide an overview of this proposal.

2. Please explain why there is a backlog in annual redeterminations and how this requests proposes to address the backlog.

15. Baseline HIPPA Staffing

Budget Issue. DHCS' Office of Health Insurance Portability and Accountability Act (HIPAA) Compliance requests the conversion of seven and one-half previously approved limited-term positions to permanent status and the extension of six limited-term positions for an additional two years, effective July 2014 as these positions will expire on June 30, 2014.

The positions would cost a total of $1,907,000 ($320,000 General Fund and $1,587,000 Federal Fund, 80:20) and are necessary to maintain efforts on existing workload, current federal and state HIPAA rules, address new codified HIPAA rules and continue oversight of privacy and security requirements.

This proposal seeks to convert seven and one-half previously approved limited-term positions to permanent status and extend six limited-term positions an additional two years effective July 2014, to coordinate and carry out the workload required by HIPAA rules and updates. The permanent positions are: one Nurse Consultant III, one Senior Information Systems Analyst, two System Software Specialists II, two Staff Information Systems Analysts, and one full-time and one half-time Associate Governmental Program Analyst. These positions are to be permanent as they are supporting Affordable Care Act (ACA) requirements and new permanent HIPAA rules, such as Operating Rules, Claims Attachment Standards, National Health Plan Identifier and Health Plan Certification, Medicaid Information Technology Architecture, along with the new OMNIBUS Privacy and Security Rule.

The six limited term positions are: one Data Processing Manager II, three Senior Information Systems Analysts, one Associate Information Systems Analyst, and one Staff Information Systems Analyst (Specialist). These positions remain limited-term positions as they are all related to the existing HIPAA-2 project (the change to ICD-10 transactions) and CA-MMIS updates, which are temporary workloads that will result in future system conversion(s).

Background. The Health Insurance Portability and Accountability Act (HIPAA) was passed by Congress in 1996. HIPAA affects all individuals, providers, payers, and related entities involved in health care. HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
- Reduces health care fraud and abuse;
- Mandates industry-wide standards for health care information on electronic billing and other processes; and
- Requires the protection and confidential handling of protected health information.

DHCS' Office of HIPPA Compliance is responsible for the successful implementation by DHCS of all of the final rules of HIPAA under Title II - HIPAA Administrative Simplification.

Reason for Proposal. DHCS states that HIPAA-related workload has evolved to become a permanent undertaking. Additionally, there is new workload attributed to Health Care Reform, new federal HIPAA regulations, and integration and expansion of technological systems due to the Medicaid Information Technology Architecture (MITA) initiative. Failure to maintain or achieve HIPAA compliance by the established federal deadlines, or MITA alignment with the goals established for Medi-Cal would have the following implications for DHCS: additional administrative burden for Medi-Cal providers, increased risk of federal penalties (monetary and the withholding of federal financial participation (FFP)), loss of support to HIPAA-implemented solutions and additional breach reporting costs.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this request.

Questions.

1. Please provide an overview of this proposal.

16. Oversight on Nursing Home Referrals to Community-Based Services

Oversight Issue. AB 1489 (Committee on Budget), Chapter 631, Statutes of 2012, requires the Department of Health Care Services, in collaboration with the Department of Public Health, to provide the Legislature an analysis of the appropriate sections of the Minimum Data Set, Section Q and nursing facilities referrals made to designated local contact agencies (LCA) by April 1, 2013. This analysis should also document the LCA's response to referrals from nursing facilities and the outcomes of those referrals.

The Legislature has not yet received this report; it is almost one year overdue.

Background. On October 1, 2010, CMS required certified nursing facilities to begin using a new iteration of the Minimum Data Set (MDS 3.0). MDS is part of the federally mandated process for assessing nursing facility residents upon admission, quarterly, annually, and when there has been a significant change in status. Under Section Q of MDS 3.0, nursing facilities must now ask residents directly if they are "interested in learning about the possibility of returning to the community." If a resident indicates "yes," a facility is required to make the appropriate referrals to state designated local community organizations.

The state's California Community Transitions (CCT) project (funded with a federal Money Follows the Person grant) targets Medi-Cal enrollees with disabilities who have continuously resided in hospitals, nursing facilities, and intermediate care facilities for persons with developmental disabilities for three months or longer. The goal of this program is to offer a menu of social and medically necessary services to assist these individuals to remain in their home or community environments. By providing participants long-term services and supports in their own homes for one full-year after discharge from a health care facility, the state receives an 87 percent federal fund match.

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature has not yet received this report. Subcommittee staff has continually checked on the status of this report.

Given the state's efforts, with CCT and other initiatives, to provide services in home- and community-based settings, and the opportunity to receive enhanced federal funding for certain nursing home residents who transition to receiving services in the community, it is important to understand how and when nursing homes are making referrals to local agencies.

Questions.

1. Please provide an overview of this issue.

2. What is the status of the report? When will the Legislature receive this report?

3. How does the Administration ensure that nursing facilities make the appropriate referrals to local contact agencies?

17. Medi-Cal – Electronic Health Records Meaningful Use Federal Grant

Budget Issue. The federal government will provide a 90 percent match for activities related to health information technology (HIT), including efforts tied to electronic health record (EHR) adoption and support. Previously, these efforts were funded with federal grant funds. These grant funds have expired.

The state has the opportunity to draw down $37.5 million in federal funds (over multiple years) if it can provide a state match of $4.1 million. The Governor's budget does not include a proposal on this.

Background. The American Recovery and Reinvestment Act of 2009 established the EHR Incentive Program for Medicaid and Medicare providers. Since 2011, eligible Medi-Cal professionals and hospitals have been receiving incentive payments to assist in purchasing, installing, and using electronic health records in their practices.

The Office of Health Information Technology (OHIT) has been established in DHCS to develop goals and metrics for the program, establish policies and procedures, and to implement systems to disburse, track, and report the incentive payments. OHIT works closely with the Office of the Deputy Secretary for Health Information Technology in the California Health and Human Services Agency to coordinate the Medi-Cal EHR Incentive Program with wider health information exchange efforts throughout California and the nation.

The Medi-Cal EHR incentive payments are 100 percent funded by the federal government. California's providers have received over $1 billion in these incentive payments. The operating costs of the Medi-Cal EHR Incentive Payment Program require a 10 percent match by the state in order to draw down an additional 90 percent funding from the federal CMS. Currently, $190,000 General Fund is used as the match for the state's operations.

A federal grant was used to provide the technical assistance support to implement EHR and achieve meaningful use. This technical assistance was provided at Regional Extension Centers and other entities. This grant has expired.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on ways the state can draw down $37.5 million in additional federal funds to support the meaningful use of EHRs in the state.

Questions.

1. Please provide an overview of this issue.

2. Please discuss the role of technical assistance in the success of meaningful implementation of electronic health records.

Appendix A - Adult Dental Procedures Not Included in the May 1, 2014 Restoration

DIAGNOSTIC	
D0160	Detailed and extensive oral evaluation - problem focused, by report
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)
D0240	Intraoral - occlusal film
D0340	Cephalometric film
LABORATORY CROWNS	
D2710	Crown-Resin-Based Composite (Indirect)
D2712	Crown- ¾ Resin-Based Composite (Indirect)
D2721	Crown-Resin with Predominantly Base Metal
D2740	Crown-Porcelain/Ceramic Substrate
D2751	Crown-Porcelain Fused to Predominantly Base Metal,
D2781	Crown- ¾ Cast Predominantly Base Metal
D2783	Crown- ¾ Porcelain/Ceramic
D2791	Crown-Full Cast Predominantly Base Metal
PINS AND POST AND CORE	
D2951	Pin Retention – Per Tooth, in Addition to Restoration
D2970	Labial veneer (resin laminate) - chairside
D2980	Crown repair, by report
D2999	Unspecified restorative procedure, by report
ENDODONTICS	
D3221	Pulpal Debridement, Primary and Permanent Teeth
D3320	Endodontic Therapy, Bicuspid Tooth (Excluding Final Restoration)
D3330	Endodontic Therapy, Molar Tooth (Excluding Final Restoration)
D3347	Retreatment of Previous Root Canal Therapy-Bicuspid
D3348	Retreatment of Previous Root Canal Therapy-Molar
D3410	Apicoectomy/Periradicular Surgery-Anterior
D3421	Apicoectomy/Periradicular Surgery-Bicuspid (First Root)
D3425	Apicoectomy/Periradicular Surgery-Molar (First Root)
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)
D3999	Unspecified endodontic procedure, by report
PERIODONTICS	
D4210	Gingivectomy or Gingivoplasty-Four or More Contiguous Teeth or Tooth Bounded Spaces Per Quadrant
D4211	Gingivectomy or Gingivoplasty-One to Three Contiguous Teeth or Tooth Bounded Spaces Per Quadrant

D4260	Osseous Surgery (Including Flap Entry and Closure)-Four or More Contiguous Teeth or Tooth Bounded Spaced Per Quadrant
D4261	Osseous Surgery (Including Flap Entry and Closure)-One to Three Contiguous Teeth or Tooth Bounded Spaced Per Quadrant
D4341	Periodontal Scaling and Root Planing – Four or More Teeth Per Quadrant
D4342	Periodontal Scaling and Root Planing – One to Three Teeth Per Quadrant
D4910	Periodontal Maintenance
PROSTHODONTICS	
D5211	Maxillary Partial Denture-Resin Base (Including any Conventional Clasps, Rests and Teeth)
D5212	Mandibular Partial Denture-Resin Base (Including any Conventional Clasps, Rests and Teeth)
D5213	Maxillary Partial Denture-Cast Meal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)
D5214	Mandibular Partial Denture-Cast Metal Framework with Resin Denture Bases (Including any Conventional Clasps, Rests and Teeth)
D5421	Adjust Partial Denture-Maxillary
D5422	Adjust Partial Denture-Mandibular
D5620	Repair Cast Framework
D5630	Repair or Replace Broken Clasp
D5640	Replace Broken Teeth-Per Tooth
D5650	Add Tooth to Existing Partial Denture
D5660	Add Clasp to Existing Partial Denture
D5740	Reline Maxillary Partial Denture (Chairside)
D5741	Reline Mandibular Partial Denture (Chairside)
D5760	Reline Maxillary Partial Denture (Laboratory)
D5761	Reline Mandibular Partial Denture (Laboratory)
D5899	Unspecified removable prosthodontic procedure, by report
Maxillofacial	
D5991	Topical medicament carrier
Implants	
D6010	Surgical placement of implant body: endosteal implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6053	Implant/abutment supported removable denture for completely edentulous arch
D6054	Implant/abutment supported removable denture for partially edentulous arch
D6055	Connecting bar - implant supported or abutment supported
D6056	Prefabricated abutment, includes placement

D6057	Custom abutment, includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment for supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)
D6078	Implant/abutment supported fixed denture for completely edentulous arch
D6079	Implant/abutment supported fixed denture for partially edentulous arch
D6080	Implant maintenance procedures, including removal of prosthesis cleaning of prosthesis and abutments and reinsertion of prosthesis
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutmant supported prosthesis, per attachment
D6092	Recement implant/abutment supported crown
D6093	Recement implant/abutment supported fixed partial denture
D6094	Abutment supported crown (titanium)
D6095	Repair implant abutment, by report
Fixed Prosthodontics	
D6211	Pontic - cast predominantly base metal
D6241	Pontic - porcelain fused to predominantly base metal

D6245	Pontic - porcelain /ceramic
D6251	Pontic - resin with predominantly base metal
D6721	Crown - resin with predominantly base metal
D6740	Crown - porcelain /ceramic
D6751	Crown - porcelain fused to predominantly base metal
D6781	Crown - 3/4 cast predominantly base metal
D6783	Crown - 3/4 porcelain/ceramic
D6791	Crown - full cast predominantly base metal
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated
D6972	Prefabricated post and core in addition to fixed partial denture retainer
D6980	Fixed partial denture repair, by report
Oral and Maxillofacial Surgery	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7340	Vestibuloplasty-ridge extension (secondary epithelialization)
D7350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypoerthroped and hyperplastic tissue)
D7471	Removal of lateral exostosis (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibilaris
D7485	Surgical reduction of osseous tuberosity
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7880	Occlusal orthotic device, by report
D7899	Unspecified TMD therapy, by report
D7960	Frenulectomy also known as frenectomy or frenotomy - separate procedure not identical to another
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue - per arch
D7972	Surgical reduction of fibrous tuberosity
ADJUNCTIVE:	
D9120	Fixed Partial Denture Sectioning
D9951	Procedure Occlusal Adjustment-Limited
D9952	Occlusal Adjustment-Complete

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, March 20 (Room 4203)

4150 Department of Managed Health Care

1. Overview

- Informational item.

2. Federal Mental Health Parity Rules

- Held open.

3. New Customer Relationship Management System

- Held open.

4. AB 1 X1 – Medi-Cal Expansion Workload

- Held open.

5. SB 2 X1 – Individual Mandate Workload

- Held open.

4280 Managed Risk Medical Insurance Board & 4260 Department of Health Care Services

1. Eliminate MRMIB

- Held open.

4260 Department of Health Care Services

1. Overview

- Informational item.

2. Restoration of Adult Dental Benefits

- Informational item.

3. Pregnancy Only Proposal

- Held open.

4. AB 85 - County Realignment - Request for Positions

- Held open.

5. AB 1 X1 – Medi-Cal Eligibility Under ACA – Request for Positions

- Held open.

6. SB 1 X1 – Medi-Cal Eligibility Under ACA, Hospital Presumptive Eligibility

- Approved as budgeted (2-1, Senator Walters voting no).

7. SB 3 X1 – Health Care Coverage: Bridge Plan – Request for Positions

- Rejected budget request (3-0).

8. ACA - Estimated Savings Due to Claiming Enhanced Federal Funds

- Held open.

9. Statewide Outpatient Medi-Cal Contract Drug List

- Held open.

10. Impact of Minimum Wage Increase on Medi-Cal

- Held open.

11. Fingerprinting and Criminal Background Checks

- Held open.

12. Ground Emergency Medical Transportation

- Approved as budgeted (2-0, Senators Walters not present).

13. MEDS Modernization

- Approved as budgeted (2-0, Senators Walters not present).

14. Breast and Cervical Cancer Treatment Program

- Approved as budgeted (2-0, Senators Walters not present).

15. Baseline HIPPA Staffing

- Approved as budgeted (2-0, Senators Walters not present).

16. Oversight on Nursing Home Referrals to Community-Based Services

- Held open.

17. Medi-Cal – Electronic Health Records Meaningful Use Federal Grant

- Held open.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE No. 3 AGENDA

Chair, Senator Ellen M. Corbett

Senator Bill Monning
Senator Mimi Walters

March 27, 2014
9:30 a.m. - John L. Burton Hearing Room 4203

PART A

Staff: Peggy Collins

4300	**Department of Developmental Services (DDS)**	**2**
	Department Overview	**2**
	DDS Headquarters	**4**
Issue 1	Establish Existing Limited-Term CEA II Position as Permanent (BCP #1)	4
Issue 2	Vendor Audit Position (BCP #3)	5
	Developmental Centers	**6**
Issue 1	Closure Process for Laterman Developmental Center	8
Issue 2	Decertification of Sonoma Developmental Programs	12
Issue 3	Decertification Risk at Remaining Developmental Centers	15
Issue 4	Deferred Maintenance Projects	16
Issue 5	CA Health and Human Services Agency Report on the Future of Developmental Centers – Presentation by Secretary Diana S. Dooley	17
	Community Services	**18**
Issue 1	Regional Center Operations	20
	Adjustment for Early Start Eligibility Reductions	20
	Unallocated Reductions	20
	Core-Staffing Formula	21
	Community Placement Plans	22
Issue 2	Purchase-of-Services	23
	Minimum Wage Increase	23
	Federal Overtime Changes	24
	Impact of Multi-Year Reductions	25
	Early Start Program	26
	Insurance Co-Pays and Deductions	27

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)

Department Overview

The Department of Developmental Services (DDS) oversees the provisions of services and supports to approximately 267,042 persons with developmental disabilities and their families, pursuant to the provisions of the Lanterman Developmental Disabilities Services Act (Division 4.5 of the California Welfare and Institutions Code). 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 four state-operated institutions, known as developmental centers (DCs) and one state-leased and operated community facility. The regional center caseload is expected to increase from 265,709 in the current year to 273,643 in the budget year (a three percent increase); and the number served in state-operated facilities is expected to decrease from 1,333 in the current year to 1,110 in the budget year (a 16.7 percent decrease).

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 California 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 Early Start discussion later in the agenda).

Eligibility is established through diagnosis and assessment performed by regional centers.

Governor's Budget: The following chart from the DDS "Regional Center Local Assistance Estimate for Fiscal Year 2014-15," provides a summary of the proposed 2014-15 budget, the various fund sources, caseload, and authorized positions, as it compares to the proposed revised 2013-14 budget.

DEPARTMENT OF DEVELOPMENTAL SERVICES
2014-15 Governor's Budget

(Dollars in Thousands)

	2013-14	2014-15	Difference	
Community Services Program				
Regional Centers	$4,385,940	$4,636,758	$250,818	*
Totals, Community Services	**$4,385,940**	**$4,636,758**	**$250,818**	
General Fund	2,472,574	$2,634,203	$161,629	
Dev Disabilities PDF	5,908	5,808	-100	
Developmental Disabilities Svs Acct	150	150	0	
Federal Trust Fund	48,655	48,771	116	
Reimbursements	1,857,913	1,947,086	89,173	
Mental Health Services Fund	740	740	0	
Developmental Centers Program **				
Personal Services	$474,741	$442,163	-$32,578	
Operating Expense & Equipment	47,566	58,145	10,579	
Staff Benefits Paid Out of Operating Expense & Equipment	33,669	25,677	-7,992	
Total, Developmental Centers	**$555,976**	**$525,985**	**-$29,991**	
General Fund	$305,162	$274,546	-$30,616	
Federal Trust Fund	510	394	-116	
Lottery Education Fund	403	403	0	
Reimbursements	249,899	250,642	743	
Headquarters Support				
Personal Services	$34,648	$36,063	$1,415	
Operating Expense & Equipment	5,111	$4,661	-450	
Total, Headquarters Support	**$39,759**	**$40,724**	**$965**	
General Fund	$25,340	$25,941	$601	
Federal Trust Fund	2,525	2,518	-7	
PDF	286	321	35	
Reimbursements	11,220	11,508	288	
Mental Health Services Fund	388	436	48	
Totals, All Programs	**$4,981,675**	**$5,203,467**	**$221,792**	
Total Funding				
General Fund	$2,803,076	$2,934,690	$131,614	
Federal Trust Fund	51,690	51,683	-7	
Lottery Education Fund	403	403	0	
Dev Disabilities PDF	6,194	6,129	-65	
Developmental Disabilities Svs Acct	150	150	0	
Reimbursements	2,119,032	2,209,236	90,204	
Mental Health Services Fund	1,128	1,176	48	
Caseloads				
Developmental Centers	1,333	1,110	-223	
Regional Centers	265,709	273,643	7,934	
Authorized Positions				
Developmental Centers	4,910.5	4,464.5	-446.0	
Headquarters	374.5	381.5	7.0	

* The Governor's Budget will not reflect a $613,000 reduction of Federal Funds due the reallocation of Early Start, Part C funds. ** The Developmental Centers funding is understated by $986,282 due to an error in costing and will be corrected in May Revise 2014-15.

The **Legislative Analyst's Office (LAO)** finds both the developmental center and community services caseload estimates to be reasonable.

Question for DDS:

- *Please briefly describe the overall developmental disabilities system and the factors driving increases in consumers and utilization. How do these changes relate to trends in the past few years?*

DDS Headquarters

The Governor's budget provides $40.7 million ($25.9 million General Fund (GF)) for DDS headquarters, a $1.4 million ($0.9 million GF) increase over the enacted 2013-14 budget. The increases are attributable to increase in employee compensation costs approved through collective bargaining and changes in retirement contribution rates ($.5 million [$.3 million GF]) and the two Budget Change Proposals (BCPs) discussed below.

ISSUE 1: Establish Existing Limited-Term CEA II Position as Permanent BCP #1

DDS is requesting $160,000 ($108,000 GF) to convert 1.0 CEA II, Assistant Deputy Director, Office of Federal Programs and Fiscal Support, position from limited-term to permanent. This position was established in 2010-11, and reapproved in 2012-13, as a two-year limited-term position, pending further review of the workload associated with federal funding requirements. In May 2013, CalHR approved the permanent establishment and level of this position.

This position was initially established for the purpose of seeking and implementing new sources of federal financial participation (FFP). Currently, DDS draws down approximately $1.8 billion in federal funding under such programs as the Home and Community-Based Services (HCBS) waiver; 1915 (i) State Plan Amendment (SPA); Money Follows the Person Grant; and the Early Start Program (through the Department of Education). Additionally, pursuant to SB 468 (Emmerson), Chapter 683, Statutes of 2013, DDS is required to apply for federal Medicaid funding for the Self-Determination Program by December 31, 2014.

This position is responsible for the directing and overseeing of 46.5 staff positions that perform ongoing program development, implementation, administration, and monitoring of federal programs and ensuring compliance with complex federal regulations and requirements. The position reports to the Deputy Director over the Community Services Division.

Questions for DDS:

- *Please discuss how federal funding participation (FFP) in the community services budget has changed over the last decade.*
- *What impact does increased FFP have on DDS and regional center administrative oversight and reporting duties?*

Staff Comment and Recommendation: DDS has significantly increased its reliance on federal funding to support state programs serving persons with developmental disabilities. With this increased reliance, come increased federal requirements to monitor service delivery. No issues have been raised with this proposed. APPROVE BCP #1.

ISSUE 2: Vendor Audit Positions BCP # 3

DDS is requesting $897,000 ($605,000 GF) for 7.0 limited-term auditor positions to meet workload associated with increased demand for vendor audits and associated recovery of funds.

The DDS Vendor Audit Section was established in 2004-05, along with 16 audit positions, to audit service providers who are vendored by regional centers, receive payments in excess of $100,000, and/or provide services to consumers in multiple regional center catchment areas. In 2008-09, 7.0 audit positions and 1.0 office technician position were eliminated as part of the required 10 percent "across-the-board" budget balancing reductions.

In 2010, the CA State Auditor (CSA) released an audit[1] of DDS and regional centers that reported nearly half of regional center employee respondents did not feel safe to report suspected impropriety and that DDS did not, at that time, log, track, nor have a written process for such complaints. In response, DDS administratively established a "Whistleblower Complaint Process", including contract requirements that regional centers institute whistleblower policies and processes consistent with the DDS directive. Under this process, DDS investigates complaints alleging fraudulent fiscal activity for a vendor who received prior year annual payments above $100,000 (which may involve an audit). Additionally, any complaint alleging fraudulent activity or misuse of state funds by a regional center is referred to the DDS' Audits Branch.

In 2011, SB 74 (Committee on the Budget), Chapter 9, Statutes of 2011, further refined the monitoring and review of provider administrative costs. Among the changes adopted through AB 74 was a requirement that all regional center contracts or agreements with service providers limit administrative costs to 15 percent; strengthened regional center policies on contracting and conflict-of-interest reporting requirements, requirements for regional centers to post specified information on the website, and a requirement for independent audit/review for contractors that receive over $250,000 for services to regional centers and independent audits for contractors that receive over $500,000 for services to regional centers.

According to DDS, as of December 31, 2013, the Vendor Audit Section had an "unduplicated backlog" of whistleblower complaints of 27 vendors, primarily relating to unsupported or fraudulent billings.

Questions for DDS:

- *Please describe the audit process and the timeframe for the completion of an audit?*
- *What percentage of audits resulted in funding recoupments? How much has been recouped since the unit was established?*
- *Would additional positions result in increased recoupments in the budget year?*
- *Why are these positions proposed to be limited-term?*

Staff Comment and Recommendation: Leave open.

[1] "Department of Developmental Services: A More Uniform and Transparent Procurement and Rate-Setting Process Would Improve the Cost-Effectiveness of Regional Centers," California State Auditor, August 24, 2010.

Developmental Centers

DDS operates four 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. The Governor's budget for the DCs includes $526 million ($275 million GF) to serve an estimated average of approximately 1,110 residents in 2014-15 (excluding Lanterman Developmental Center). Compared with last year's enacted budget, this includes an anticipated decline of 223 residents, 339.5 authorized state staff positions, and $29.9 million ($30.6 million GF) in funding.

California has served persons with developmental disabilities in state-owned and operated institutions since 1888. At its peak, the developmental center system housed over 13,400 individuals in seven facilities. Of the four remaining developmental centers, the oldest is Sonoma Developmental Center (1891) and the youngest is Fairview Developmental Center (1959).

Facility	Location	Year Opened	Population as of 3/12/14
Fairview Developmental Center	Costa Mesa	1959	320
Lanterman Developmental Center	Pomona	1927	80
Porterville Developmental Center	Porterville	1953	411[2]
Sonoma Developmental Center	Eldridge	1891	454
Canyon Springs Community Facility	Cathedral City	2000	52

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 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.*

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 have used an annual community planning and placement (CPP) allocation, $67 million (total funds) in the current year, to develop community-based services and supports for individuals moving out of a developmental center, and to deflect new placements into developmental centers. On average, 175-200 individuals move out of developmental centers to the

[2] 168 residents in the Secure Treatment Program (STP); 243 residents outside the STP.

community each year.

Statutory changes adopted as part of the 2012-13 state budget, AB 89 (Committee on Budget), Chapter 25, Statutes of 2012, in part a response to a new trend of increasing developmental center placements, 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.

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.

Question for DDS:

- *Please briefly describe the budget proposal for developmental centers.*

ISSUE 1: Closure Process for Lanterman Developmental Center

Governor's Budget: The Governor's budget for the Lanterman Developmental Center (LDC), which is in the process of transitioning its residents into community-based placements as part of a closure process, currently houses 80 residents[3]. The budget assumes a net decrease of $22.7 million ($12.0 million GF) related to position reductions, staff separation costs, enhanced staffing adjustments, and post-closure activities. LDC's residential population is expected to be zero by December 31, 2014.

Background: In January 2010, DDS proposed the closure of Lanterman Developmental Center (LDC), and a closure plan was adopted along with 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. Since the approval of the closure plan, 261 LDC residents have transitioned to community living arrangements and 95 remain at LDC (as of February 1, 2014). The Governor's budget assumes all remaining residents will have transitioned to the community by January 1, 2015.

Prior to transition, a comprehensive assessment is conducted for each resident and services and supports are identified. The department and 12 regional centers involved in the closure process use Community Placement Plans as one tool to help them identify and develop necessary community-based resources. Selected community providers work closely with LDC staff to prepare for the transition.

As part of the transition, DDS visits consumers who have moved into community residences at five days, 30 days, 90 days, and six and 12 months after the move. Regional center staff also visits at regular intervals and provide enhanced case management for the first two years after the move. Special incidents, including hospitalizations and other negative outcomes, are tracked by DDS, and individuals who move from Lanterman into the community are asked to participate in a National Core Indicator (NCI) study. The NCI study uses a nationally validated survey instrument that allows DDS to collect statewide and regional center-specific data on the satisfaction and personal outcomes of consumers and family members.

The following chart describes the type of community placements that have occurred for LDC movers, as of February 1, 2014:

Community Care Facility (CCF)	231
Intermediate Care Facility (ICF)	12
Supported Living Services	5
Family Home/Other	2
Congregate Living Health Facility	2
Family Teaching Homes (FTH)	3
Long-Term Sub-Acute	6

[3] Based on 3/14/14 census report

As of December 1, 2013, 230 of the 242 individuals who have moved from LDC (not including the six individuals in long-term sub-acute facilities), have a day service activity, as illustrated by the following chart.

Service Category	Program Types	Number participating
Community-based day service	Behavior management program; community integration training program; adult development center; adult day health center; community activities support services, creative arts program, activity center	176
Home-based day service	Day services provided by residential facility; in-home/mobile day program	38
Work Activity Program (WAP)	Rehabilitation WAP	5
Other	Program support group-day service; personal assistance; adaptive skills trainer; adult day care; day program incorporated into supporting living service.	11

Staffing: As of February 2, 2014, 708 employees remain at LDC. This includes the 88 enhanced positions provided in the 2012-13 budget. DDS implemented its first phase of staff reductions in January 2013. On March 5, 2014, DDS announced the second phase of staff reductions. DDS has provided various activities and supports to mitigate the impact of closure on LDC staff. These efforts include various employee forums, the establishment of a Staff Options and Resource Center on the LDC campus to provide computer work stations to assist in searching for employment and professional development, reference materials related to self-help and career development, postings for state and local employment opportunities, on-line courses for resume writing and job-seeking enhancement tools, for mock interviews, guest speakers, and career workshops. Additionally, LDC has worked with the California Employment Development Department's Los Angeles County Rapid Response Coordinator and the Los Angeles Urban League Pomona WorkSource Center. The following chart shows the status of employee separation, as of December 1, 2013.

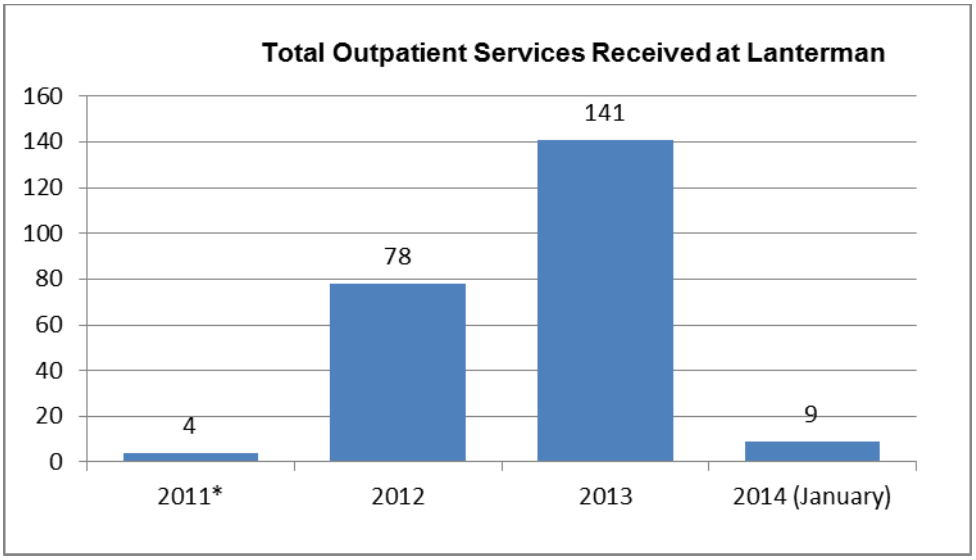
Transfer	286
Retirement	187
Resignation	85
Limited-Term Expired	8
Layoff	15
Other	32

The following chart shows employee separations by classification, as of December 1, 2013.

Level of Care Professional	69
Level of Care Nursing	276
Non-Level of Care	268

A component of the LDC closure process is the establishment of 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. An employee survey conducted in October 2012 identified 102 employees who had interest in the CSS Program. However, as of March 14, 2014 only 12 employees have accepted positions through the CSS Program (four staff are currently working in the community; six staff have projected start dates within 30 days; two staff do not yet have start dates).

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 chart[4] shows the total services received at the LDC Outpatient Clinic.



[4] DDS, March 11, 2014

Questions for DDS:

- *Please provide an update on the status of the LDC closure process.*
- *What are the characteristics of the remaining residents and what is their status relative to a selected community home?*
- *Please describe the utilization of the LDC clinic, compared to the utilization of the Agnews Developmental Center (ADC) clinic, during and following its closure.*
- *Please describe the Community State Staff Program. How has its utilization differed from the program established during the ADC closure?*
- *Please describe the layoff process, and the employment-related services provided to LDC staff.*
- *Once all residents have moved from LDC, what are the staffing requirements of LDC in warm shutdown? How long do you anticipate warm shutdown will last?*

ISSUE 2: Decertification of Sonoma Developmental Programs

Governor's Budget: Sonoma Developmental Center (SDC) houses approximately 454[5] residents with developmental disabilities. The decertification of four ICF units at SDC has cost the General Fund $1.4 million in lost federal funds each month, for a total $15.7 million in the current year. However, the Governor's budget assumes full federal financial participation will commence again in July 2014. DDS was provided an additional $7 million ($4 million GF) in the current year to implement a plan of correction. Budget year costs associated with the required plan are proposed to be $9.2 million ($5.1 million GF).

Background: State DC's are required to meet federal standards set by the federal Centers for Medicare and Medicaid Services (CMS), in order to receive federal financing participation under the Medicaid program. 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. These actions came on the heels of widely reported revelations of multiple instances of abuse, neglect, and other lapses in caregiving at the institution. The loss of federal certification for these units at SDC, and the loss of associated federal funding, has cost the state General Fund approximately $1.4 million each month. The chart below shows SDC population by facility type.

Sonoma DC Information	July 24 2013	Nov 1 2013	Feb. 1 2014
Total Population	**483**	**469**	**460**
In Nursing Facility (NF)	208	202	200
In Intermediate Care Facility (ICF)	275	267	260
In non-certified homes	103	97	95

In partial response to these quality-of-care concerns, the 2013-14 budget included a $2.4 million increase ($1.3 million GF) that would allow the facility to hire approximately 36 additional direct care staff, in order to allow staff who serve as shift leads to focus on supervision, without being counted toward required ratios of direct care staff to clients.

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 and the Department of Finance submitted a request to the Joint Legislative Budget Committee for current year supplemental funding of $3.6 million GF ($7.2 million total funds). According to the Governor's budget, the full year costs associated with the action plan at SDC will be $9.2 million ($5.1 million GF). The action plan includes the opening of a new ICF unit, 118.5 new staff positions, three new wheelchair transport vehicles, and extensive staff training. Should these efforts sufficiently correct the identified deficiencies, federal financial participation will be restored. The Governor's budget assumes this will occur in July 2014.

[5] Based on 3/14/14 census report

The charts[6] below show the progress in hiring new staff and attrition of existing staff.

New Hires
March 2013 - January 31, 2014

Total Hires	New	RA's	Total
New LOC – Nursing	106	9	**115**
New LOC – Professional	23	3	**26**
New NLOC – Clinical	36	3	**39**
New NLOC - Administrative	26	4	**30**
Total	**191**	**19**	**210**

SDC Internal Hires
30
1
51
39
121

Separations
March 2013 - January 31, 2014

Separations	Total Separations
LOC – Nursing	81
LOC – Professional	18
NLOC – Clinical	33
NLOC - Administrative	20
Total	**152**

Despite these efforts, SDC's licensed-to-unlicensed staff ratio remain well below that of other DC's. SDC's ratio was at 65 percent licensed to 35 percent unlicensed, as of January 1, 2014. LDC and PDC are at 83 percent licensed to 17 percent unlicensed and FDC is at 88 percent licensed to 12 percent unlicensed.

Legislative Analyst's Office (LAO) Recommendation: The LAO finds it reasonable for the budget to assume restoration of federal funding beginning July 1, 2014, and finds the Governor's "budget request to be reasonable and appropriate, as the funding will enable DDS to make improvements at Sonoma DC that are needed to restore federal funding and comply with federal certification requirements." The LAO further recommends that "the Legislature require the department to report at budget hearings on its progress in implementing the changes at Sonoma DC, with particular attention to the status of filling needed positions for licensed medical professionals and other staff."

[6] DDS, 3/14/14

Questions for DDS:

- *Please briefly describe the circumstances that led to the decertification of the four ICF units at SDC.*

- *Please describe the requirements of the corrective action plan and progress toward implementation.*

- *Please discuss the challenges of reducing the SDC licensed-to-unlicensed staff ratio.*

- *Please describe the process for regaining certification and federal financial participation at SDC.*

- *What is the status of the comprehensive assessments required for all residents at SDC? How have these assessments informed placement decisions for residents, both within SDC and appropriateness for community placement?*

- *The problems identified by the licensing survey at SDC are not new to this facility. Have the changes that have been implemented in response to the action plan impacted the culture at SDC in a way that could result in sustainable improvements?*

ISSUE 3: Decertification Risk at Remaining Developmental Centers

Governor's Budget. Fairview Developmental Center (FDC) has approximately 320 residents[7] with developmental disabilities. Porterville Developmental Center has approximately 411[8] residents with developmental disabilities, 168 of which reside in the Secure Treatment Program (STP). Canyon Springs is a state-leased and operated ICD/MR residential facility. It serves approximately 52 residents[9] with moderate to mild intellectual disabilities, who may have mental health treatment needs, and who are transitioning out of a developmental center.

Background: DPH recertification surveys at FDC, PDC, and LDC found ICF units at each facility to be out of compliance with federal requirements. Like the issues at SDC, areas of non-compliance include treatment plans, protection of residents, client health and safety, and client rights. In January, DDS and DPH reached an agreement to avoid decertification, and maintain federal funding of approximately $4.1 million each month. The agreement will require 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 requires DDS to contract with an independent monitor to provide oversight, among other requirements. The costs to implement these action plans are not yet known but anticipated to have both current year and budget year implications. The Governor's budget assumes DDS and DPH will resolve these issues and that no loss of federal funds will occur.

In January 2014, DPH conducted a recertification survey at Canyon Springs Residential Facility (CSRF) and found the facility to be out of compliance with federal requirements regarding resident protections and identified a number of deficiencies. On February 24, 2014, DDS was notified of DPH's intent to decertify CSRF. DDS has submitted a plan of correction to respond to the survey findings and an informal request for reconsideration to DPH.

Questions for DDS:

- *Please describe the issues that led to the DPH survey result findings at Fairview, Lanterman, and Porterville developmental centers and how they may have differed from the issues identified at Sonoma Developmental Center?*

- *Please describe the status of developing the root cause analysis and the action plan at Fairview and Porterville developmental centers. Does DDS anticipate there will be costs in the current year?*

- *Please provide the status of the required monitor at Lanterman Developmental Center. Will the monitor have a role or impact in the process of moving residents into community settings? Do you anticipate there will be current year costs?*

- *Please describe the issues identified in the recent non-compliance notice related to Canyon Springs residential facility. What types of actions are proposed in the plan of correction that has been submitted to DPH? What is the timeline for resolution of this issue?*

[7] Based on 3/14/14 census report
[8] Based on 3/14/14 census report
[9] Based on 3/14/14 census report

ISSUE 4: Deferred Maintenance Projects

Governor's Budget: The Governor's budget provides $100 million GF for deferred maintenance projects under specified departments. Of this amount, $10 million is proposed to be allocated to DDS. The Governor proposes a new process (Control Section 6.10) for allocation of these funds that would require the Department of Finance (DOF) to review and approve department projects and submit to the Joint Legislative Budget Committee for review, 30 days prior to allocating the funds.

According to DDS, these funds will be used to replace or retrofit the boilers at SDC, FDC, and PDC. These boilers do not meet local air quality management regulations for emissions, and may be subject to fees. For example, PDC was billed an emissions fee of $41,715 in 2012-13 for non-compliance, retroactive to 2009. The cost of replacing or retrofitting these boilers is estimated at $10.7 million.

On March 20, 2014, the Senate Budget and Fiscal Review Subcommittee No. 4, voted unanimously to reject the proposed Control Section 6.10 and directed the Administration to come back with a proposal that allows the Legislature to approve funding for individual department's deferred maintenance projects through the regular budget process.

Concurrent with the release of the January budget, the Governor released his five-year infrastructure plan. This plan identifies no infrastructure needs for the state's developmental centers.

Questions for DDS:

- *Please describe the need for replacing or retrofitting the boilers at SDC, FDC, and PDC. What are the ramifications of not replacing the boilers?*

- *Although the Governor's five-year infrastructure plan does not identify any infrastructure needs at the state developmental centers, these facilities range in age from 55 to 126 years old. What significant infrastructure or delayed maintenance needs will need to be addressed in the near future?*

- *Has the infrastructure at these facilities been updated to optimize new technologies? For example:*

    - *Do electrical systems fully support the needs of residents and staff?*

    - *Are security and medical emergency alert systems updated?*

    - *Does facility design reflect licensing and certification requirements for new facilities? For example, would the dorm-like design in many residential units, where bedrooms are separated by partial walls, meet existing licensing requirements?*

ISSUE 5: CA Health and Human Services Agency Report on the Future of Developmental Centers – Presentation by Secretary Diana S. Dooley

On January 13, 2014, the Secretary of the California Health and Human Services Agency released her "*Plan for the Closure of Developmental Centers in California"* (Plan). The Plan was developed pursuant to trailer bill language adopted last year that required the Secretary to submit to the Legislature a master plan for the future of DCs by November 15, 2013; and to submit to the Legislature, by January 10, 2014, the Administration's resulting plans to meet the needs of all current residents in DCs. The Plan submitted January 13th meets the requirements of the master plan; however, more specific plans to implement the recommendations of the master plan have not yet been submitted.

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 Plan provides six consensus recommendations of the task force and the Secretary, as follows:

> *"Recommendation 1: More community style homes/facilities should be developed to serve individuals with enduring and complex medical needs using existing models of care.*
>
> *Recommendation 2: For individuals with challenging behaviors and support needs, the State should operate at least two acute crisis facilities (like the program at Fairview Developmental Center), 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.*
>
> *Recommendation 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.*
>
> *Recommendation 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.*
>
> *Recommendation 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.*
>
> *Recommendation 6: Another task force should be convened to address how to make the community system stronger."*

Questions for the Secretary and/or DDS

- *The 2012-13 budget trailer bill required the submission of two documents: a master plan and a subsequent, more detailed, plan to meet the needs of current DC residents. Are you anticipating submitting the more detailed plan with the May Revision?*

- *How do you think existing resources, such as CPP funds, can be better utilized to support these recommendations?*

- *What statutory changes will be necessary to support these recommendations?*

- *Previous discussions about maintaining clinic and specialized equipment resources of the developmental centers have been thwarted by concerns of maintaining federal funding. Yet to some degree, this issue was partially resolved with the limited continuation of the clinics, post-closure, at Agnews Developmental Center. Is the agency or department exploring how this issue can be resolved to the benefit of community members who would benefit from these resources?*

- *Fairview Developmental Center is the site of an existing public/private partnership providing integrated services on existing state lands (Harbor Village). A second project at Fairview has stalled due to concerns raised by the Department of General Services. Is DDS working with the Department of General Services to resolve these concerns so this project, and potentially others like it, can move forward?*

- *The final recommendation of the report calls for another task force. What do you envision will be the role of this task force and the time frame for it to complete its work?*

Staff Comment and Recommendation: Leave OPEN the DC budget, pending May Revision.

Community Services

Services and supports for eligible persons with developmental disabilities and their families are provided through nonprofit private corporations, known as regional centers, that contract with DDS. There are 21 regional centers located throughout California, serving caseloads ranging from 3,035 to 26,996. Regional centers provide diagnosis and assessment of eligibility at no charge. Eligible individuals and their families are assigned a case manager or service coordinator to help develop a plan for services and supports, pursuant to an individual program plan, and assist in locating the necessary service providers in order to implement the plan.

Although most services and supports are free, regardless of age, parents whose adjusted gross family income is at or above 400% of the federal poverty level (FPL), and who are receiving qualifying services through a regional center for their children under the age of 18, may be assessed an Annual Family Program Fee (AFPF). Additionally, there is a requirement for parents to share the cost of 24-hour out-of-home placements for children under the age of 18. There may also be a co-payment requirement for other selected services.

Governor's Budget: The Governor's budget includes $4.6 billion ($2.6 billion GF), to serve 273,643 individuals in the community, an increase of $255.3 million ($155.2 million GF) over the enacted 2013-14 budget. The following chart illustrates proposed changes in the DDS community services budget.

	Enacted 2013-14 Budget	Adjusted 2013-14 Budget	Proposed 2014-15 Budget	Requested
Operations (OPS)	$562,059,000	$563,801,000	$579,183,000	$17,124,000
Purchase-of-Services (POS)	$3,799,754,000	$3,802,307,000	$4,037,874,000	$238,120,000
Early Start/Part C: Other Agency Costs	$17,606,000	$17,829,000	$17,698,000	$92,000
Prevention Program	$2,003,000	$2,003,000	$2,003,000	$0
Total	**$4,381,422,000**	**$4,385,940,000**	**$4,636,758,000**	**$255,336,000**

The Governor's budget projects a total regional center community caseload of 273,643 as of January 31, 2015, an increase of 8,546 (3.1 percent) over the 2013-14 enacted budget. The following chart shows changes in regional center caseloads.

	Enacted 2013-14 Budget	Revised 2013-14 Budget	Governor's Budget	Change
Active (aged 3 and older)	234,702	234,702	241,748	7,046
Early Start (Birth through 2 years)	30,395	31,007	31,895	1,500
Total	**265,097**	**265,709**	**273,643**	**8,546**

ISSUE 1: Regional Center Operations

The Governor's budget provides $579.2 million ($407.5 million GF) for regional center operations (OPS), an increase of $17.1 million ($25.2 million GF) over the enacted 2013-14 budget. This reflects an increase in core staffing funding of $13.6 million; an increase in community placement plan (CPP) staff funding of $.9 million; a decrease in the savings target related to staffing of $2.1 million; a decrease in staff funding related to the LDC closure of $.9 million; an increase in funding for case managers necessary to meet federal Home and Community-Based Services (HCBS) waiver requirements of $.5 million; and relatively small increases to contracts for Client Rights Advocacy Services, Quality Assessments, Direct Support Professional Training, and the Foster Grandparent/Senior Companion Programs. Additionally, the Governor's budget provides a small increase to address the minimum wage change. Generally, increases in the regional center OPS budget over the last several years have primarily reflected increases in caseload and requirements associated with federal funding.

Adjustment for Early Start Eligibility Reductions. The 2009-10 budget act included reductions in the Early Start Program (discussed later in this agenda). An associated reduction of $2.1 million (GF) in the regional center operations budget was made in 2010-11. It is unclear at the time of finalizing this agenda, what occurred in fiscal years 2011-12 and 2012-13. The Governor's budget includes a $2.1 million GF increase to correct this error in the budget year, and moving forward.

Questions for DDS:

- *Please clarify in what fiscal years this double-counting occurred and when DDS became aware of it.*

Unallocated Reductions. Throughout the years of budget reductions, regional center operations have been asked to absorb unallocated reductions, specifically, $10.6 million in 2001-02 and $5.4 million in 2011-12. These reductions have been cumulative and are proposed for continuation in the budget year. In addition to unallocated reductions, regional centers operations budgets have been reduced in multiple years to reflect savings associated with various "cost containment measures" implemented to reduce expenditures.

Questions for DDS:

- *How has DDS monitored the impact of these reductions on the quality and stability of regional center services funded through the operations budget?*

Core-Staffing Formula. A core staffing formula is the primary driver of regional center funding. With few exceptions, this formula has not been updated since 1991. As a result, regional centers are provided funding for positions that is far below what they are actually 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 $123,787 and a high of $279,732 (excluding benefits, retirement, bonuses, and other allowances). Other examples of core staffing formula allocations for key positions are highlighted 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 Counsel	$46,983
Human Resources Manager	$50,844

Additionally, as regional center administration requirements have changed pursuant to new laws, regulations or contractual requirements, the staffing formula has not always been adjusted to reflect these new responsibilities.

Questions for DDS:

- *Why hasn't the core staffing formula been updated?*
- *What has the impact of the outdated core staffing formula, and other regional center OPS reductions, had on the ability of regional centers to meet required caseload staffing ratios?*
- *Does the department assess how the core staffing formula relates to current hiring practices of regional centers, recruitment and retention rates, and whether existing regional center staff complements are sufficient to meet regional center contractual and legal obligations?*

Community Placement Plans (CPP). The Governor's budget provides $68.3 million ($55.3million GF) in CPP funding, an increase of $865,000 ($2.4 million GF) over the enacted 2013-14 budget. Under the CPP process, regional centers provide a plan to DDS, based on their estimates of the resources necessary for individuals moving from a developmental center to the community in a given fiscal year, and for individuals at risk of placement in a developmental center. CPP-funded regional center activities include resource development, assessments, placement, crisis service teams, and program start-up, as well as traditionally funded services and supports for the first year of placement.

In response to concerns that regional centers were lagging in providing timely comprehensive assessments of developmental center residents, the Legislature required all such assessments be completed by December 31, 2015. According to DDS, 48 percent of all initial comprehensive assessments have been completed, and are being updated during the IPP. According to DDS, based on

regional center projections, 75 percent of current DC residents will have had their initial assessment completed by June 30, 2014.

Questions for DDS:

- *Please walk through the process for determining the amount of CPP appropriated each year and how allocations are made to regional centers.*

- *How does DDS determine the number of assessments each regional center should accomplish in a given fiscal year and when those assessments should occur?*

- *How does DDS ensure that the service and support needs identified in a comprehensive assessment are identified or developed so the value of the assessment remains current and serves the purpose for which it was conducted?*

- *How were CPP funds utilized to support the closures of Agnews and Lanterman developmental centers, and did this impact residents in other DCs who were appropriate for moving to the community?*

- *How is utilization of CPP funds monitored and success measured?*

- *What happens when a regional center does not meet its goals relative to CPP funding?*

- *What happens to unspent CPP at the end of a fiscal year?*

Issue 2: Purchase-of-Services (POS)

The Governor's budget provides $4.038 billion ($2.225 billion GF) for the purchase of services (POS) in community settings by regional centers. This is an increase of $238.1 million ($130.1 million GF) over the enacted 2013-14 budget. Regional centers purchase services for consumers and their families from approved vendors, based on needs identified through a person-centered planning process. Generally, regional centers first seek to coordinate the provision of a service through private insurance or through a "generic" service provided by other state, county, or city agencies, school districts, or other agencies. There is little limitation on the types of services and supports a regional center may purchase due to the individualized need determination process, but the majority of regional center-purchased services and supports are residential care provided in a community care or health facility or support services for individuals in supported living arrangements; day and work programs; transportation; respite; health and behavioral health services.

There are multiple ways that rates are set for providers of community-based services. These include, but are not limited to:

- Rates set by DDS, based on cost statements.
- Rates established in statute or regulation.
- Rates established by negotiation between a regional center and a provider.

Minimum Wage Increase. Assembly Bill 10 (Alejo), Chapter 351, Statutes of 2013, increases the state minimum wage from $8.00 to $9.00, effective July 1, 2014; and increases it again to $10.00, effective July 1, 2016. The Governor's budget provides an increase of $110.1 million ($69.3 million GF) in POS to reflect this change.

Although the Administration has not provided detailed documentation on the assumptions behind this proposed funding increase, draft trailer bill language (TBL) would allow minimum wage adjustments to (1) work activity programs, community-based day programs, and in-home respite service agencies that demonstrated to DDS that they employ minimum wage workers; and, (2) providers who have a rate negotiated with a regional center if they demonstrate to the regional center that they employ minimum wage workers. Additionally, the Governor's budget includes minimum wage increases of $3.6 million for supported employment programs (SEP). However, after further consideration, DDS has determined that it does not have enough visibility into the composition of the SEP hourly rate to know whether a minimum wage increase is warranted. Therefore, they have withdrawn proposed TBL for SEP, and will adjust funding in the May Revision.

Provider organizations argue that the Governor's proposal falls short of making adjustments to reflect the real impact the minimum wage increase will have on their programs. For example, providers cite California Labor Code § 515 as requiring certain supervisorial staff to be paid twice the minimum wage under defined circumstances. They additionally argue that a minimum wage increase necessitates increases for staff above the minimum wage to maintain the differentials earned through seniority and promotion within their agencies.

Legislative Analyst's Office (LAO) Recommendation: The LAO recommends approval of the Governor's proposal to provide $110 million for DDS compliance with the new minimum wage requirements. They further recommend the Legislature create a separate appropriation to fund this expenditure to ensure funds are used for the intended purpose.

Questions for DDS:

- *Please describe how the minimum wage adjustment will be allocated and approved across program types?*
- *How was this level of appropriation determined?*
- *Please describe how you determine which service categories would be eligible for this increase?*
- *For programs with regional center negotiated-rates, how will you ensure the adjustments are implemented as you intend?*

Federal Overtime Changes: The United States Department of Labor recently made regulatory changes to federal Fair Labor Standards (FLSA) to require 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 will likely be impacted. The Governor's budget provides $7.5 million ($4 million GF) to address this federal change.

Pursuant to the proposed trailer bill language submitted by the Administration, the Governor's budget would provide a 2.25 percent rate increase for in-home respite service agencies; personal assistants and supported living services (SLS). According to DDS, this level of funding increase is intended to support the hiring of additional staff to ensure employees do not work overtime, except in emergency circumstances. Additionally, many regional center consumers also receive services from In-Home Supportive Services (IHSS) workers. The impact of FLSA on IHSS services was discussed at a previous subcommittee hearing.

DDS states that it based the 2.25 percent rate increase on the fact that the Department of Social Services (DSS) anticipates 1.5 percent of expenditures will be attributed to overtime in the IHSS program and because there are unique difference between IHSS and regional center services, such as the need for 24 hour care in SLS and personal assistant services, that will drive costs up for regional centers.

For regional center consumers who rely on both IHSS and a regional center-funded service that utilize the same worker, this issue may be particularly complex. There is, yet unresolved, concern that the overtime rule may apply across the IHSS and regional center systems, if the same worker is employed in both systems. Even if this is not the case, it is possible that the Administration's approach to prohibit the payment of overtime in most circumstances could result in shifting costs to regional centers. For example, if a worker who currently provides 50 hours in the IHSS services to a consumer, and another 20 hours as a regional center-funded personal assistant to the same consumer, will the prohibition of overtime in IHSS result in additional pressure to increase hours paid by the regional center? Additionally, as generic services, such as IHSS, are generally utilized first, the cost of overtime

for an individual who uses both IHSS and regional center services, when necessary in an emergency situation, may be more likely to fall on the regional center.

Legislative Analyst's Office (LAO) Recommendation: The LAO finds it reasonable to assume that vendors will incur increased administrative costs to mitigate the fiscal impact of overtime pay for home care workers. However, because of data limitations, the LAO is uncertain whether a 2.25 percent rate increase is the right amount. They therefore recommend that the department report to the Legislature on the results of the rate increase on impacted vendors in order to assess whether a 2.25 percent increase is the right amount on an ongoing basis.

Questions for DDS:

- *Please describe the fiscal assumptions behind your estimate.*
- *Does DDS believe there is an issue for individuals who are employed by both the IHSS and regional centers relative to when overtime requirements are triggered?*
- *Does DDS know how many regional center consumers will be impacted by the changes in IHSS overtime?*
- *Does DDS know how many regional consumers utilize a family member for IHSS and/or regional center-funded services that will be impacted by changes in overtime?*
- *How does DDS envision "emergencies" to be defined relative to the payment of overtime.*
- *Has DDS assessed the capacity of SLS, In-home respite, and personal assistant services to hire additional workers?*
- *Is DDS concerned about the impact on consumers who utilize family members as providers of these deeply personal services?*

Impact of Multi-Year Reductions on Community Services and Supports. 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 2009, which expired in July 2012. These providers receive 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 discussed above. Supported work providers, whose rate is set in statute, received a 24 percent rate increase in 2006, but it was subsequently reduced 10 percent in 2008.

Other changes further skewed the relationship between costs and reimbursement rates. These include:

- Exceptions to rate freezes, and reductions, justified through a "health and welfare" waiver.
- Prohibition on use of POS for program "start-up" costs.
- Implementation of a uniform holiday schedule.

- Implementation of addition administrative functions, including required audits, for providers.

Although these actions may have provided necessary fiscal relief to the state budget, the cumulative impact has been to substantially distort the relationship between rates paid for services and the actual cost of these services and, in some cases, have created a disparity in payments to programs providing similar services. Additionally, system preferences for service models have changed in the ensuing years but rates have not changed to reflect the costs of these new, preferred models. For example, ARM rates are based on six-person homes. However, regional centers increasingly prefer four person homes. Likewise, smaller day and work programs are generally viewed as more effective than the larger, congregate models.

Questions for DDS:

- *How does the wide variation in current rate-setting methodologies, and the effect of the rate freezes and rate reductions that have occurred in past years, impact the ability to measure appropriateness of rates and their impact on the quality and stability of community-based services?*
- *Do you have any concerns that the rate reduction scheduled to be imposed on Intermediate Care Facilities for Persons with Developmental Disabilities (under the DHCS budget) will have an impact the access to, or stability of, these services?*

Early Start Program. The Early Start Program was established in 1993, in response to federal legislation ensuring 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 greater to have more significant delays across a large number of domains in order to be eligible for services.

- Discontinuation of the provision of services in the Early Start Program 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 a 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.

Questions for DDS

- *Can you quantify the number of infants and children who have been denied services due to the changes adopted in 2009?*

- *How does DDS measure impact of reductions on access, quality of services, system pressures that may emerge later for infants and children who are denied services?*

Insurance Co-Pays and Deductibles. 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 consumers and their families, for the services identified as necessary in an IPP, under defined circumstances. Specially, these payments may be made when:

a. It is necessary to ensure that the consumer receives the service or support.

b. When health insurance covers the service in whole or part.

c. When the consumer or family has income that does not exceed 400 percent of the federal poverty level (FPL).

d. 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, DDS estimated that roughly 50 percent of consumers or families have incomes below 400 percent of FPL.

The adopted trailer bill also prohibited pay by regional centers of insurance deductibles (the amount the insured must spend on covered health services before insurance benefits can be utilized), as it can be difficult to link insurance deductibles to a specific service or family member.

Prior to adoption of this trailer bill, there was inconsistency across regional centers as to when and if they would pay insurance-related costs. Some regional centers paid all the costs of co-pays, co-insurance and insurance deductibles, without reference to consumer or family income, for services identified as necessary in an IPP. Others paid only certain portions of these insurance costs, while still others paid no insurance costs. The regional centers that paid these insurance costs did so under the assumption that, without such insurance coverage, the full cost of the service would fall to the regional center to pay.

The discussion around standardizing policies for the payment of insurance co-pays, co-insurance, and insurance deductibles was triggered by the shift of payment responsibility for behavioral health treatment from regional centers to private insurers following the passage of SB 946 (Steinberg), Chapter 650, Statutes of 2011. This new law requires insurers and health plans to provide coverage of behavioral health treatment for persons with autism spectrum disorders (ASD). As these services may be required with great frequency, often 3-5 times per week, the amount of insurance co-pays, co-

insurance and insurance deductibles requested to be paid for by regional centers increased significantly.

For many families, who had no share-of-cost when the service was funded by the regional center, the insurance-related costs they are required to pay can be substantial.

Regional centers were provided an appropriation of $9.9 million (GF) to cover the costs of insurance co-pays and co-insurance for the 2013-14 budget year, and the same amount is proposed for the budget year. At a recent hearing of the Senate Select Committee on Autism and Related Disorders, DDS reported that in the first six months of this fiscal year, approximately $1.9 million had been spent on co-pays and co-insurance for all health services. Of that, $240,000 appeared to be for behavioral health treatment for persons with ASD. However, DDS cautions that this data is incomplete due to the short time period since enactment of the budget trailer bill and associated implementation of new uniform reporting sub-codes for regional centers.

Questions for DDS:

- *Even if the data is incomplete at this time, do you think it is likely that regional centers will utilize the full $9.9 million appropriation in the current year on insurance co-pays and co-insurance payments for eligible consumers and families? If not, what is your best estimate?*

- *Can you estimate the cost of including insurance deductibles as an allowable regional center purchase, under the same restrictions placed on the payment of co-pays and co-insurance?*

- *Can you ascertain the savings associated with the avoidance of full service costs due to the payment of co-pays and co-insurance?*

- *Do you know the number of consumers/families who qualified under the extraordinary circumstances exception?*

Staff Comment and Recommendation: Leave OPEN the community services budget, pending May Revision.

Peggy Collins 651-1891
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, March 27 (Room 4203)
PART A

Members Present: Corbett, Monning
Members Absent: Walters

4300 Department of Developmental Services

DDS Headquarters

- ISSUE ONE. BCP #1 Establish Existing Limited-Term CEA II Position as Permanent – **APPROVED 2-0**

- ISSUE TWO. BCP #3 Vendor Audit Positions – **HELD OPEN**

DEVELOPMENTAL CENTERS

- **HELD OPEN**

COMMUNITY SERVICES

- **HELD OPEN**

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Mimi Walters
Senator Bill Monning

March 27, 2014
9:30 a.m.
Room 4203, State Capitol

PART B

Consultant: Samantha Lui

Item	Department	Page
0530	Health and Human Services Agency, Office of Systems Integration	2
	1. County Expense Claim Reporting Information System (CECRIS) Project Support	2
5160	Department of Rehabilitation	4
	1. Overview	4
	2. California PROMISE Initiative (CaPROMISE) Grant	6
	3. Traumatic Brain Injury (TBI) Supplemental Funding	10

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.

0530 Health and Human Service Agency, Office of Systems Integration (OSI)

1. County Expense Claim Reporting Information System (CECRIS) Project Support

Budget Issue. The proposal requests one two-year limited-term position and $130,000 in spending authority for the Office of Systems Integration (OSI) to provide procurement and acquisition subject matter expertise to the Department of Social Services (DSS) on the County Expense Claim Reporting Information System (CECRIS) project. The position (one senior information systems analyst) will be funded through an interagency agreement between OSI and DSS. The position's responsibilities include:

- Assisting DSS in soliciting a vendor to perform procurement activities for the project;
- Providing leadership to DSS in the Acquisition Life Cycle process and state procurement and contract processes;
- Acquiring a vendor to be the technical writer of the Request for Proposal (RFP); and,
- Developing the requirement and evaluation criteria for the system developer.

Background on OSI. In 2005, OSI was established to manage a portfolio of large, complex health and human services information technology projects. OSI provides project management, oversight, procurement, and support services for a portfolio of high criticality projects, including the following:

- Case Management Information and Payrolling System (CMIPS II) for In-Home Supportive Services (discussed during the March 13, 2014 hearing);
- Child Welfare Services - New System Project (CWS-NS);
- Child Welfare Services/Case Management System (CWS/CMS);
- Electronic Benefit Transfer (EBT);
- Statewide Welfare Automation System (SAWS); and,
- Statewide Fingerprint Imaging System (SFIS).

OSI also manages contract negotiations and contract management aspects of the acquisition of technology systems and services. After the procurement phase, OSI oversees the design, development, governance, and implementation of IT systems

Background on CECRIS. DSS oversees and administers a variety of programs, such as In-Home Supportive Services, Child Welfare Services, Community Care Licensing, Disability Determinations, and Welfare to Work. The department also manages the County Expense Claim (CEC) and County Assistance Payment Reimbursement (CA 800) processes, which distribute over $7 billion annually in state and federal funds.

On December 31, 2007, the Department of Finance approved a Feasibility Study Report (FSR) to determine the viability of replacing the existing CEC and CA 800 systems. Due to the state's financial crisis, funding for the FSR was delayed until fiscal year (FY) 2011-12. Given the long delay, in October 2012, DSS submitted a Special Project Report (SPR) that the California Department of Technology, formally known as the California Technology Agency, approved in January 2013. The SPR noted that DSS would contract with OSI for assistance with procurement and contracts processes.

The DSS Local Assistance 2013 May Revision Estimate identified project fund needs of $134,000 for 2012-13, and $356,000 for 2013-14, which included services to be provided by OSI through an interagency agreement. The funding was adopted in the 2013 Budget Act. OSI and DSS completed a multi-year interagency agreement, beginning in 2013-14, which establishes the 2013-14 funding at $98,000, and which identifies services to be provided by OSI during the term of the agreement.

Justification. The Administration states that successful implementation of the CECRIS project will benefit California's most vulnerable residents, who depend daily on social services provided by DSS; facilitate enhanced data access and analysis capability; and, improve administrative accuracy and assistance expenditure data for all 58 counties. Continued funding for these programs depends on the state's ability to ensure that payments are made timely and accurately in accordance to federal cost allocation requirements and federal reporting requirements. Further, improved capabilities will 1) help ensure that all costs are reimbursed in accordance with federal cost allocation requirements, and 2) reduce risk for federal audit issues that could result in increased cost to the General Fund.

Staff Comment & Recommendation. Approve. It is recommended to approve this proposal, as no concerns have been raised.

Questions

1. Please briefly summarize the proposal and the implementation timeline.

5160 Department of Rehabilitation

1. Overview

The Department of Rehabilitation (DOR) works in partnership with consumers and other stakeholders to provide 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 employment, and to maximize equality and ability to live independently in communities. With a proposed 2014-15 budget of $425.9 million ($57 million GF) and 1,829 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 2012-13.

Fund Source	2012-13	2013-14*	Proposed 2014-15
General Fund	**$55,266,000**	**$56,972,000**	**$57,007,000**
Traumatic Brain Injury Fund	$ 1,060,000	$ 946,000	$ 1,002,000
Vending Stand Fund	$ 982,000	$ 2,361,000	$ 2,361,000
Federal Trust Fund	$ 314,812,000	$ 347,265,000	$ 357,849,000
Reimbursements	$ 6,046,000	$ 7,680,000	$ 7,680,000
Total Expenditures	**$378,166,000**	**$415,224,000**	**$425,899,000**
Positions	1,708.3	1,823.0	1,829.0

*FY 2013-14 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 provides an individual with information and referrals to other services, as well as notification every 90 days as to which category is being served and when an individual will be served, based on application date. Currently, there are almost 200 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. 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.

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. California PROMISE Initiative (CaPROMISE) Grant

Budget Issue. The department requests $10 million in federal budget authority for the California PROMISE Initiative (CaPROMISE) federal grant, which begins October 1, 2013, to September 30, 2019. 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.

The proposal requests six permanent, full-time positions, at a cost of $620,000, for the required 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. The positions are as follows:

- One staff manager,
- Three associate governmental program analysts,
- One accounting officer specialist, and
- One office technician.

As the lead coordinating agency for CaPROMISE, DOR is responsible for statewide leadership, oversight, administration, and coordination of the grant. DOR will partner with five other state departments (identified below) 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)
2. Vallejo City USD
3. Solano COE
4. West Contra Costa USD
5. Desert Mountain Special Education Local Plan Area - San Bernardino
6. Riverside COE
7. San Bernardino City USD
8. West End Special Education Local Plan Area - San Bernardino
9. Los Angeles USD
10. Centinela Valley UHSD
11. Compton USD
12. Long Beach USD
13. Elk Grove USD
14. Whittier Union HSD
15. Irvine USD
16. San Diego USD
17. Lodi USD
18. East Side Union HSD
19. Santa Clara USD
20. Milpitas USD
21. Santa Clara County Office of Education

The participating state departments, and associated rationale for participation, are as follows:

- California Department of Education. 70 percent of the CaPROMISE budget will be contracted to LEAs to provide direct services to child SSI recipients and their families.

- Employment Development Department. Through a coordinated effort, One-Stop centers will provide vocational support to child SSI recipients and their families.

- Department of Developmental Services (DDS). Some SSI youth may receive or be eligible for regional center services at graduation or upon exit from the education system. The Administration indicates that DDS can benefit from the coordination of efforts and focus on employment for the SSI recipients who may become employed, and not enter costly day programs.

- Department of Health Care Services (DHCS). As the agency that administers the state's MediCal-related mental health services and Drug MediCal Treatment Programs, the Administration states that DHCS can benefit in a reduction of medical costs, as child SSI recipients and their families become employed and receive health care benefits from their employer. Further, vocational services are an effective component of their recovery model, which can lessen the cost of adult mental health county supports.

- Department of Social Services. The Administration notes that one in six child SSI recipients have a family member receiving assistance through the Temporary Assistance for Needy Families (TANF). The financial literacy training through CaPROMISE can assist families to obtain gainful employment, reducing reliance on TANF and SSI/SSP payments.

Each state department has committed to enter into an MOU with DOR, to participate on the CaPROMISE Interagency Council at the state level, and to refer and coordinate services at the local level. The Interagency Council will meet at least two times a year.

To fulfill the CaPROMISE research project, DOR must work with a federal evaluator, a state evaluator (San Diego State University's Interwork Institute, also known as SDSU-II), a CaPROMISE project manager, and the 21 LEAs. DOR and SDSU-II will develop an agreement for $1.75 million annually. SDSU-II, which was involved in all phases of the CaPROMISE grant proposal development, will conduct all the research, program evaluation, data gathering and analysis, training and technical assistance, and security measures for data acquisition and dissemination. In addition, SDSU-II will draft the Human Subjects review documents, maintain conformance to the Human Subjects Review requirements, and ensure that there is research integrity. The department will retain funding for direct and indirect costs to administer the program, and will contract with a public university to provide additional project support.

Service delivery and implementation timeline. According to the Administration, CaPROMISE will demonstrate student- and family-centered service delivery systems by providing the following services to SSI students and their family members: case management; transition planning; financial and benefits planning; career- and work-based learning experiences; youth development activities; health and wellness services; technology training; and, independent living services.

CaPROMISE Activities, Targets, Timelines with Benchmarks

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

Outcomes and accountability measures. Two types of data must be collected on a quarterly basis: 1) demographic and background information (e.g., Social Security Number and/or a comparable numerical code, as determined by the federal evaluator; name; gender; ethnicity; age; grades; conditions causing disability; family members' names, work, income, and disability), and 2) case management information. All data will be coordinated with the federal evaluator. Expected outcomes of the CaPROMISE interventions include:

1. Increased educational attainment, such as rate of school attendance, record of academic achievement, and program persistence;
2. Increased number of individuals earning credentials and certificates, including continuing education and AA/AS/BA/BS degree enrollment and progress;
3. Improved employment outcomes, such as volunteer work, internships, and volume and nature of paid work experiences;
4. Reduced use of public benefits for the student and family members, including SSI, Social Security Disability Insurance, welfare, and medical;
5. Increased total gross income of all members of a household; and,
6. Post-program reduction of SSI payments for the student.

The department will have a website with current information and resources, links to all CaPROMISE grantees, and other national and regional projects. Each LEA must create communication plans with relevant local agencies, such as One-Stop Centers or healthcare agencies, which are relevant for students and families.

Background. The SSI/State Supplemental Payment[1] 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 Police, 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.

On August 12, 2013, Governor Brown signed the CaPROMISE grant application through a department Governor's Office Action Request. The U.S. Department of Education notified DOR of its CaPROMISE grant award on September 27, 2013. The CaPROMISE grant will fund the design, implementation, and evaluation of a model demonstration program for California that will serve at least 1,539 SSI recipients and their families in the treatment group, and compare their progress to at least 1,539 SSI recipients and their families in the control group of the five-year research and demonstration project. The federal grant requires states to provide services to 3,078 child SSI recipients and their families to receive the maximum grant award of $10 million per year. The 21 participating LEAs will receive $7.1 million in annual funding. The department indicates that these funds are expected to remain level over the next five years.

In 2012, the Government Accounting Office reported that students with disabilities face challenges accessing needed services and programs as they transition from high school to post-secondary education and work, and as they transition from entitlement programs to eligibility-based services. As the diverse and complex needs of youth and young adults with disabilities cannot be met with any one agency, CaPROMISE consists of multiple state departments working together. Specifically, DOR, as the lead coordinating agency of the grant, will partner with state departments and 21 LEAs to coordinate services, direct outreach, recruitment, and involvement of 14- to 16-year old SSI recipients and their families.

Staff Comment & Recommendation. Approve. It is recommended to approve this proposal, as no concerns have been raised.

Questions

1. Please briefly summarize the proposal, including the coordination with other state agencies and LEAs, implementation plan, and expected outcomes and goals.

2. Please explain the enrollment and recruitment process of the 3,078 child SSI recipients and their families. How are these families selected? How is it determined which recipients will be in the treatment group and which will be in the control group?

3. Is there intent to expand the program statewide, if successful?

[1] For more information on SSI/SSP, please see pages 23-24 of the Senate Budget and Fiscal Review Subcommittee #3's March 13, 2014 agenda, which can be accessed at http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/031332014Sub3HumanResourcesDA_DSS_IHSS_OSI.pdf

3. Traumatic Brain Injury (TBI) Supplemental Funding

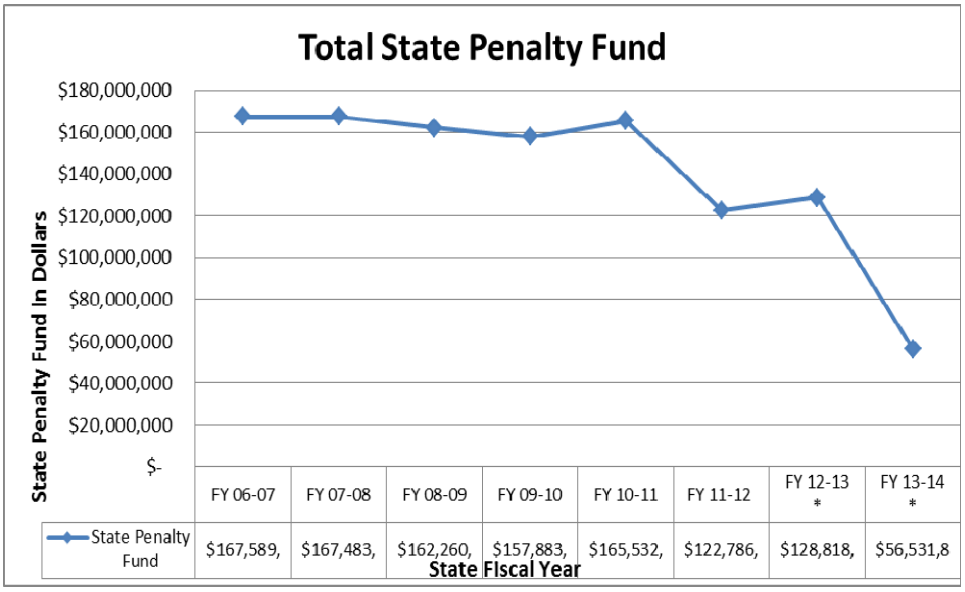
Budget Issue. The department requests an additional $500,000 to the Traumatic Brain Injury Fund from the Driver Training Penalty Assessment Fund.

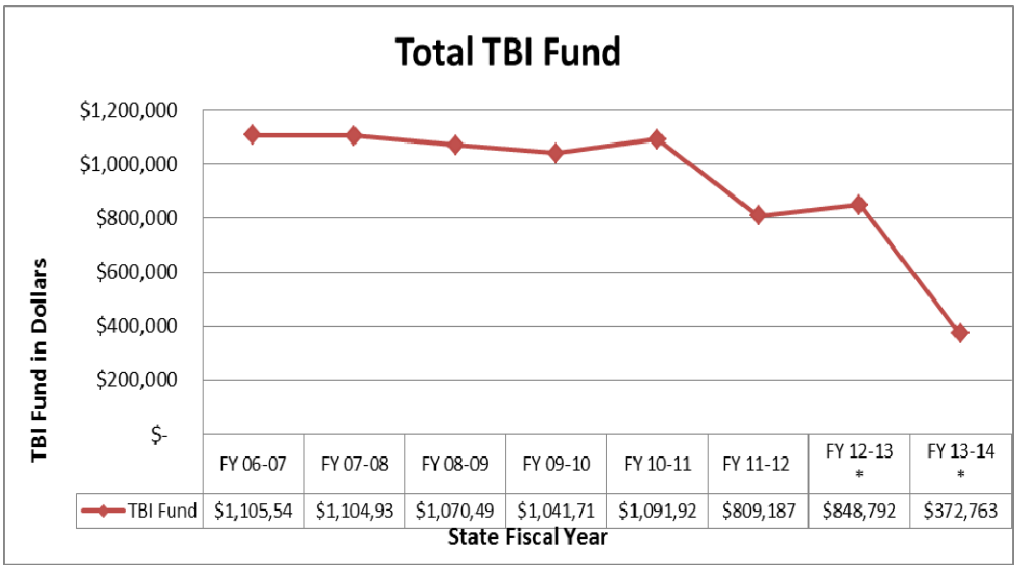
Background. With approximately $1,002,000 in proposed funding, the Department of Rehabilitation administers the Traumatic Brain Injury (TBI) program. The program's services are delivered by seven providers located throughout the state and include coordinated post-acute care, such as supported living, 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 and graphs 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	$ 122,786,073	$ 809,187
FY 12-13*	$ 128,818,031	$ 848,792
FY 13-14*	$ 56,531,855	$ 372,763

* Year-to-date revenue as of 2/28/14





The Department of Rehabilitation has been administering the TBI program since it was transferred from the Department of Mental Health, pursuant to AB 398 (Monning), Chapter 439, Statutes of 2009. The legislation 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 serves 2,400 individuals with acquired and traumatic brain injury. Generally, 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.

In February 2014, the department issued a competitive solicitation for TBI Program providers. Based on total available funding, the competitive solicitation stated the department could award up to seven grants of up to $150,000 each for the three-year grant cycle, beginning in July 2014. Applications for the funding are due April 3, 2014, for the grant period of July 1, 2014 – June 30, 2016, with a possible one-year extension. The department indicates that this is the first time the seven providers have been required to re-compete for funding, and there may be other organizations applying as well. At the time of this report, the department states that it is unclear which sites are at-risk of decreased funding or closure. The following chart includes funding for the grant period that ends in June 2014.

STATE FISCAL YEAR 2013-14					
TBI Grants	Location	Areas Served	TBI Funds	VR Match	Matched Federal Funds
Betty Clooney Foundation	Long Beach, CA	Los Angeles	$125,000	$25,000	$92,371
Central Coast IL-New Options	Salinas, CA	Monterey, San Benito and Santa Cruz	$132,000	$18,000	$66,507
Janet Pomeroy Center	San Francisco, CA	San Francisco	$125,000	$25,000	$92,371
Mercy General Hospital	Citrus Heights, CA	Sacramento, Placer and El Dorado	$110,000	$40,000	$147,793
St. Jude Medical Center	Fullerton, CA	Orange	$132,000	$18,000	$66,507
Making Headway Center	Eureka, CA	Humboldt, Mendocino and Del Norte	$150,000	$0	$0
Options Family of Services	Morro Bay, CA	Santa Barbara and San Luis Obispo	$150,000	$0	$0
		Total	**$924,000**	**$126,000**	**$465,549**

Staff Comment & Recommendation. Hold open. It is recommended to hold this item open.

Questions:

1. Please briefly provide an overview on TBI program funding and transition of the TBI program to DOR.

2. Please provide an update on the status of DOR's application for a Medicaid Home and Community-Based Services waiver.

3. How have the recent declines in TBI Fund revenues impacted services provided through the program? Are any sites anticipated to be closed, or receive reduced funding, in the near future?

4. Please briefly summarize the budget proposal, as well as alternatives to it.

Samantha Lui
Senate Budget & Fiscal Review
T: (916) 651.4103

OUTCOMES for PART B: **Senate Subcommittee #3 on Health & Human Services**
Thursday, March 27 (Room 4203)

Members present: Senator Corbett, Senator Monning
Absent: Senator Walters

0530 Health and Human Services Agency, Office of System Integration

1. County Expense Claim Reporting Information System (CECRIS) Project

- Approve as budgeted. (2-0. Senator Walters absent.)

5160 Department of Rehabilitation

1. Overview

- Informational item.

2. California PROMISE Initiative (CaPROMISE) Grant

- Approve as budgeted. (2-0. Senator Walters absent.)

3. Traumatic Brain Injury (TBI) Supplemental Funding

- Held open.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Ellen Corbett, Chair
Senator William Monning
Senator Mimi Walters

Thursday, April 3, 2014
9:30 a.m. or Upon Adjournment of Session
State Capitol Room 4203

Agenda Part A

Consultant: Julie Salley-Gray

Items Proposed for Vote-Only

Issue	Department	Page
4440	**Department of State Hospitals**	
Issue 1	Third Party Billing BCP	2
Issue 2	Cal-OSHA Standards BCP	2
Issue 3	Seismic Upgrades at Atascadero	2
Issue 4	Security Fencing at Napa	2
Issue 5	Fire Alarm Upgrade at Metropolitan	2

Items Proposed for Discussion

Issue	Department	Page
4440	**Department of State Hospitals**	
Issue 1	Medical Grade Network	7
Issue 2	Statewide Enhanced Treatment Units Capital Outlay	8
Issue 3	Patient Management Unit	10
Issue 4	Expansion to Address Incompetent to Stand Trial Waiting List	12
Issue 5	Salinas Valley and Vacaville Psychiatric Programs	15
Issue 6	Security Fencing at Patton	17

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

PROPOSED FOR VOTE ONLY

4440 Department of State Hospitals (DSH)

1. **Third Party Billing BCP.** DSH is requesting 15 two-year limited-term positions and $1,893,000 General Fund (in the form of reimbursements that result from successful third-party payer collections, and therefore not a new General Fund appropriation) to consolidate functions related to billing and collection of third party resources that are not performed by the Department of Developmental Services (DDS).

2. **Cal-OSHA Standards BCP.** DSH requests $502,000 (General Fund) and five two-year limited-term positions to establish statewide support for compliance with Department of Occupational Safety and Health (Cal-OSHA) standards.

3. **Seismic Upgrades at Atascadero.** This project requests $325,000 in General Fund for the preliminary plans necessary to perform a seismic retrofit at the main East-West corridor at Atascadero State Hospital. The retrofit will include construction of steel framed lateral frames in the upper third portion of the corridor. Construction also will include a security sally port and temporary access doors. It is anticipated that this project will reduce the risk level of the corridor from the current Level V to a Level III. Project construction costs are estimated to be $6.2 million.

4. **Security Fencing at Napa.** This project is to improve security in the courtyards in the patient housing buildings, including: replacement of gates and fabricating and installing extensions to raise the height of security fencing in specified buildings. The cost to develop working drawings is $191,000. Total costs for the fencing are estimated to be approximately $900,000.

5. **Fire Alarm Upgrade at Metropolitan.** This proposal is to completely upgrade the existing Notifier Fire Alarm Systems in patient housing and to provide a new central monitoring system located at Hospital Police Dispatch. The total project cost is estimated to be approximately $9 million. According to the proposal, the existing system is not code compliant and does not provide serviceability and/or expandability. The requested $712,000 is for the working drawings phase of the project. Development of preliminary plans was funded in the current fiscal year at $633,000.

Recommendation: APPROVE Items 1-5

ITEMS TO BE HEARD

4440 Department of State Hospitals

The Department of State Hospitals (DSH) is the lead agency overseeing and managing the state's system of mental hospitals. The DSH seeks to ensure the availability and accessibility of effective, efficient, and culturally competent services. DSH activities and functions include advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.

The Governor's 2011 May Revision first proposed the elimination of the former Department of Mental Health (DMH), the creation of the new DSH, and the transfer of Medi-Cal and other community mental health programs to the Department of Health Care Services (DHCS). The 2011 Budget Act approved of just the transfer of Medi-Cal mental health programs from the DMH to the DHCS. In 2012, the Governor proposed, and the Legislature adopted, the full elimination of the DMH and the creation of the DSH. All of the community mental health programs remaining at the DMH were transferred to other state departments as part of the 2012 budget package. The budget package also created the new DSH which has the singular focus of providing improved oversight, safety, and accountability to the state's mental hospitals and other psychiatric facilities.

California has five state hospitals and three prison-based psychiatric programs that treat people with mental illness. Approximately 92 percent of the state hospitals' population is considered "forensic," in that they have been committed to a hospital through the criminal justice system. The state hospitals are as follows:

- Atascadero (ASH). ASH is located on the central coast. It is an all-male, maximum security, forensic facility (i.e., persons referred by the court due to criminal violations).
- Coalinga (CSH). Located in the City of Coalinga, CSH is the newest state hospital, opened in 2005, and treats forensically committed and sexually violent predators.
- Metropolitan (MSH). Located in Norwalk, MSH serves individuals placed for treatment pursuant to the Lanterman-Petris-Short Act (civil commitments), as well as court-ordered penal code commitments.
- Napa (NSH). Located in the City of Napa, NSH is a low-to-moderate security state hospital.
- Patton (PSH). PSH is located in San Bernardino and cares for judicially committed, mentally disordered individuals.
- Vacaville & Salinas Valley Psychiatric Programs. These programs are located within state prisons.
- Stockton Psychiatric Program. This is the newest facility that began operation in July of 2013, serving 432 High Custody/Level IV inmates/patients at the intermediate level of care, within the California Department of Corrections and Rehabilitation’s (CDCR) California Health Care Facility in Stockton.

Cost Over-Runs. Over the past several years, state hospital costs had been rising at an alarming rate, and substantial current year deficiencies had become the norm and even expected from year to year. For example, in the 2010-11 fiscal year, the deficiency rose from $50 million to $120 million and the then-DMH staff could not explain why. In general, the

department lacked any clear understanding of what the major cost drivers were and how to curb or stabilize costs in the system. In 2011, DMH leadership facilitated and oversaw an in-depth exploration and analysis of state hospital costs, resulting in a lengthy report that is available on the department's website. The research team identified the following system-wide problems/cost drivers: increased patient aggression and violence; increased operational treatment models; and redundant staff work.

Based on the report described above, in 2012, the Administration proposed a comprehensive list of reforms, to reverse the rising cost trend, which addressed three stated goals: 1) improve mental health outcomes; 2) increase worker and patient safety; and, 3) increase fiscal transparency and accountability. Perhaps the most significant of these proposed reforms was the reduction of 600 positions throughout the state hospital system. Of these 600 positions, 230 were vacant. In addition to the reduction in positions, the 2012 budget package included key changes in the following areas:

1. Reduced layers of management and streamlined documentation.

2. Flexible staffing ratios, focusing on front-line staff, and redirecting staff to direct patient care.

3. New models for contracting, purchasing, and reducing operational expenses.

4. Elimination of adult education.

State Hospitals Caseload

The five state hospitals provide treatment to approximately 6,000 patients, who fall into one of two categories:

1. Civil commitments (referrals from counties).

2. Forensic commitments (committed by the courts).

The psychiatric facilities are located within state prisons, and currently treat approximately 1,000 inmates. They include:

1. Vacaville Psychiatric Program.

2. Salinas Valley Psychiatric Program.

3. Stockton Psychiatric Program.

Approximately 92 percent of the state hospitals' population is considered forensic, in that they have been committed to a hospital by the criminal justice system. The following are the primary Penal Code categories of patients who are either committed or referred to DSH for care and treatment:

Committed Directly From Superior Courts:

- *Not Guilty by Reason of Insanity* – Determination by court that the defendant committed a crime and was insane at the time the crime was committed.

- *Incompetent to Stand Trial (IST*) – Determination by court that the defendant cannot participate in trial because the defendant is not able to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. This includes individuals whose incompetence is due to developmental disabilities.

Referred From The California Department of Corrections and Rehabilitation (CDCR):

- *Sexually Violent Predators (SVP)* – Hold established on inmate by court when it is believed probable cause exists that the inmate may be a SVP. Includes 45-day hold on inmates by the Board of Prison Terms.

- *Mentally Disordered Offenders (MDO)* – Certain CDCR inmates for required treatment as a condition of parole, and beyond parole under specified circumstances.

- *Prisoner Regular/Urgent Inmate-Patients (Coleman Referrals)* – Inmates who are found to be mentally ill while in prison, including some in need of urgent treatment.

State Hospitals & Psychiatric Programs
Caseload Projections

	2013-14	2014-15
Population by Hospital		
Atascadero	1,052	1,091
Coalinga	1,151	1,206
Metropolitan	814	930
Napa	1,287	1,407
Patton	1,513	1,503
Subtotal	**5,817**	**6,137**
Population by Psych Program		
Vacaville	386	386
Salinas	177	177
Stockton	514	514
Subtotal	**1,077**	**1,077**
Population Total	**6,894**	**7,214**

Population by Commitment Type		
Incompetent to Stand Trial (IST)	1,583	1,912
Not Guilty By Reason of Insanity (NGI)	1,375	1,398
Mentally Disordered Offender (MDO)	1,126	1,067
Sexually Violent Predator (SVP)	909	936
Lanterman-Petris-Short Act/PC 2974	556	556
Coleman Referral – Hospitals	258	258
Coleman Referral – Psych Programs	1,077	1,077
Department of Juvenile Justice	10	10

State Hospitals Budget.

The Governor's proposed budget includes $1.6 billion for DSH in 2014-15 ($1.5 billion General Fund). This represents a 1.4 percent increase over 2013-14 funding. The proposed budget year position authority for DSH is 11,234 positions, an increase of 363 positions (3.3 percent) from the current year. The department's budget includes increased funding for several proposals, including plans to operate 242 more beds than were budgeted in 2013-14, initiate a program to manage bed space on a statewide level, and develop a cost estimate for enhanced security units.

(dollars in thousands)

Funding	2012-13 Actual	2013-14 Projected	2014-15 Proposed
General Fund (GF)	$1,274,968	$1,475,926	$1,497,970
Reimbursements	117,910	127,560	127,560
CA Lottery Education Fund	74	91	91
Total	$1,392,952	$1,603,577	$1,625,621
Positions	9,715.2	10,871.7	11,234

Issue 1: Medical Grade Network (MGN)

Background. DSH network infrastructure is required for clinical programs to communicate in support of critical patient care and clinical operations at each hospital. Infrastructure Services in medical settings are required to secure and protect medical data and support 24/7 network connectivity throughout the state hospital system. DSH states that the current network lacks the complete infrastructure necessary to sustain hospital operations.

Currently, the DSH network is a single Wide Area Network (WAN). The DSH states that a single WAN does not have redundant network connections between points, introducing many single points of failure, and is therefore substantially less reliable than a redundant WAN, which has a network with multiple connections between locations. The DSH states that a single WAN cannot adequately support the connection of critical clinical applications needed to provide more cost efficient and effective patient care.

Existing infrastructure has experienced significant network disruptions that have had a negative impact on medical care operations. For example, Metropolitan State Hospital experienced a technology failure in March 2012, resulting in two days when staff was unable to communicate with other facilities and had no access to clinical applications needed for patient treatment. In another example, all DSH facilities experienced a technology failure in June 2013, resulting in an interruption in access for all users to any applications deployed in an enterprise manner.

The DSH states that the health and safety of state hospital patients is at risk when medication records and treatment plans are not fully accessible. Currently, there are times when clinicians are unable to make well-informed or appropriate treatment decisions critical to the patient's well-being as a result of network-caused data errors, incorrect or missing patient information, or unavailable systems. The inadequate capacity of the current network also prohibits the DSH from maintaining offsite data backups.

According to the DSH, this project will add redundant network connectivity paths across the enterprise network, thereby eliminating single points of network connectivity failure. The Medical Grade Network (MGN) helps form an essential foundation for implementation of shared enterprise clinical systems such as electronic health records. The DSH states that without the MGN upgrade, the DSH will not be able to deploy any enterprise applications that are critical to life and safety because they cannot guarantee reliable 24/7 access to these systems.

Governor's Budget. DSH is requesting two permanent positions and $7.4 million General Fund in 2014-15, and $2.3 million General Fund ($726,000 one-time and $1.5 million on-going) for 2015-16 to implement the MGN project to add foundational infrastructure to the DSH inter-hospital network.

Staff Comments. No concerns have been brought to the subcommittee's attention regarding this proposal.

Staff Recommendation: Approve as budgeted.

Issue 2: Statewide Enhanced Treatment Units Capital Outlay

Background. The state hospitals were designed and constructed for a patient population that was quite different than the population currently in the state hospitals. Now, 92 percent of the population is forensic, having been referred to the state hospitals by either courts or prisons. Substantial evidence demonstrates an increasing rate of aggression and violent incidents at state hospitals.

The Administration argues that, in spite of this significant change in the state hospitals' patient population, there is currently no legal, regulatory, or physical infrastructure in place for DSH to effectively and safely treat patients who have demonstrated severe psychiatric instability or extremely aggressive behavior. As a result, often the only option available to a state hospital dealing with an extremely violent patient is the use of emergency seclusion and restraints, which is short term only and a more extreme response. Subsequent to the use of seclusion and restraint, a violent patient must be placed in one-on-one or two-on-one observation, which DSH states is labor intensive and does not necessarily improve safety.

DSH requests funding to develop and plan enhanced treatment units (ETUs) to provide a secure environment to more effectively treat patients that become psychiatrically unstable resulting in highly aggressive and violent behavior towards themselves, other patients, or staff. Candidates for an ETU would exhibit a level of physical violence that is not containable using other interventions or protocols currently available in the state hospitals. DSH argues that the existing physical facilities are old and designed for a different population, therefore it is not possible to provide more security within existing facilities.

Licensing & Statutory Changes. The proposal states that the establishment of the proposed statewide ETU may require statutory and regulatory changes, licensing changes, development of a specialized treatment program with appropriate staffing, patient parameters, an admissions/discharge system, and an analysis of physical plant space. It states further that the proposed ETU can be accomplished through statutory language added under the licensing for acute psychiatric hospitals. DSH assumes that such statutory changes would include allowing for individual rooms with bathroom facilities and doors that lock externally. None of the necessary policy is currently in place to develop the type of ETUs outlined in the budget proposal.

AB 1340 (Achadjian). This proposed legislation would require, beginning on July 1, 2015, and subject to available funding, each of the five state mental hospitals to establish and maintain an enhanced treatment unit for the placement of aggressive patients and requires any case of assault by a patient be immediately referred to the local district attorney. This legislation is currently awaiting hearing in the Senate Health Committee and, if approved and signed into law, could provide the necessary policy guidance for the development and running of potentially locked ETUs in the state hospitals. Absent this legislation, DSH currently has the authority to establish ETUs that do not involve individual, externally locked rooms, as they have done at Atascadero State Hospital.

Governor's Budget. The Governor's budget requests $1.5 million in General Fund for DHS and the Department of General Services (DGS) to prepare an analysis, estimate, and infrastructure design for the development of 44 locked ETUs in the five state hospitals.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. Please describe how the current ETUs in the state operate and whether or not they are an effective treatment model.

2. How does the Administration intend to ensure that the locked rooms are used only for treatment and not as punishment for patients?

Legislative Analyst's Office (LAO). The Administration has not provided language that would give DSH the authority it seeks. As such, the details of the project remain uncertain. For example, there is no information about the approved lengths of stay or types of locked facilities that would be permitted under statute. Without that clarity, DGS may not be able to create an accurate budget package or determine the most appropriate infrastructure design for these units. The LAO is also concerned that the lack of specificity about the ETUs creates uncertainty about DSH's ability to build the units. Under the Administration's proposal, it is unclear whether each hospital will be permitted to maintain ETUs or whether units will be required at each location. Additionally, it is unclear what design specifications may be required, such as room size, bathroom facilities, or type of door lock. Without such information, it is unclear how DGS will be able to conduct the proposed analysis. Because each hospital has a different physical plant design, some hospitals may not meet those specifications, or it may be prohibitively expensive to build the units.

LAO Recommendation. In light of these concerns, the LAO recommends that the Legislature reject the Governor's proposed $1.5 million to obtain a DGS study of ETUs. While the LAO does not have major concerns with the proposal to consider the development of ETUs in DSH hospitals, they are concerned that planning the units without having specific guidelines could result in unnecessary costs.

Staff Comments. Given the complexity of the policy required for the ETUs and the fact that none of those policy decisions have been made, this proposal appears to be premature. The Legislature should ensure that the appropriate statutory language is in place to adequately protect both patients and staff and to restrict the use of ETUs for treatment, rather than for the inappropriate incarceration of patients, prior to approving $1.5 million in funding for the planning and infrastructure design of 44 ETUs.

Staff Recommendation: Hold open.

Issue 3: Patient Management Unit

Background. DSH is in the process of implementing various policy reforms aimed at transforming the state hospitals into a coordinated, singular system of hospitals. Historically, state hospitals have operated as independent entities. One of the consequences of this lack of coordination has been an inefficient system of patient placement that leads to delays and often inappropriate placements. Current law states that judges may refer individuals to "a state hospital." Judges often interpret this statute as giving them the authority to refer an individual to one specific hospital, rather than to DSH generally (i.e., to the state hospitals system). The result can be excess patients at one hospital, with substantial excess bed space at another hospital. It also results in certain patients being placed at hospitals that are not best suited to treat them or otherwise meet their needs.

Therefore, DSH proposes creating a patient management unit to help improve:

1. Timely access to in-patient care.

2. Placement in the most appropriate clinical settings based on treatment and security needs.

3. Timely resolution to placement issues.

4. More cost-effective utilization of hospital beds and staffing resources.

Governor's Budget. The budget includes $1.1 million General Fund and 10 two-year limited-term positions to establish a patient management unit to centralize admissions and transfers of patients throughout the state hospital system.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. How many vacant beds does DHS have throughout the state hospital system, and where are they located?

2. How will DSH ensure that the new system will allow for judicial discretion when appropriate?

3. How does DSH plan to ensure that the needs of the patients and proximity to their families and communities are protected, rather than simply placing patients where it is easiest and most convenient for the hospital system?

Legislative Analyst's Office (LAO).

Proposal Has Merit. The current disconnected system of patient placement has numerous drawbacks. The Governor's proposal has the potential to address many of the issues. For example, the proposal might allow DSH to find placements for patients more quickly, which could reduce court orders requiring DSH to accept specific patients from waitlists. It could

also improve the department's ability to budget for each institution, because it would allow DSH to place patients in available bed space rather than having some facilities have empty space while others have patients waiting for entry. It could also reduce lengths of stay by placing patients in the most clinically appropriate setting.

The LAO notes, however, that there could be some additional costs associated with the patient management unit. For example, patients assigned to locations far from their county of commitment might incur additional travel costs for court visits. In addition, evaluating patients before placement could also slow the placement and transfer processes, resulting in longer lengths of stay. Despite this, the potential operational benefits of the proposal would likely outweigh such drawbacks.

But Department Lacks Authority to Fully Realize Benefits of Management Unit. The DSH currently does not have the statutory authority to implement patient placement programs, and the Governor's proposal does not include trailer bill language to provide the department with that authority. Although some courts and counties permit DSH to manage patient placement, the discretion to allow this remains with those entities, not the department. Even if DSH were to establish a patient management and bed utilization unit, it would be unable to fully realize the benefits of such a program because, without statutory changes, referring entities would remain the arbiters of patient placement.

LAO Recommendation. Although the Administration's proposal could result in increased efficiency and potential cost savings, until statutory language exists permitting DSH to fully control the placement of the patients committed to its care, the benefits of the patient management unit cannot be fully realized. Therefore, the LAO recommends the Legislature support the Administration's proposal to create a patient management and bed utilization unit and adopt trailer bill language clarifying that DSH has the authority to fully control patient placements.

Staff Comments. Current law gives the courts the discretion to place an individual in a state hospital, rather than placing them into the state hospital system and allowing DSH to determine the appropriate placement of the individuals. At a minimum, DSH would need trailer bill language to clarify what discretion, if any, the courts will have in determining where an individual would be hospitalized. In addition, trailer bill language may be needed to protect the best interests of the patients in order to ensure that patients are placed in hospitals close to their communities and families whenever possible.

The Administration has not proposed any trailer bill language to accompany this budget item.

Staff Recommendation. Hold open pending the receipt of necessary trailer bill language.

Issue 4: Incompetent to Stand Trial Waiting List

Background. When a judge deems a defendant to be incompetent to stand trial, the defendant is referred to the state hospital system to undergo treatment for the purpose of restoring competency. Once the individual's competency has been restored, the county is required to take the individual back into the criminal justice system to stand trial, and counties are required to do this within ten days of competency being restored.

For a portion of this population, the state hospital system finds that restoring competency is not possible. There is no statutory deadline for the county to retrieve these individuals, and therefore they often linger in the state hospitals for years. The state pays the costs of their care while in the state hospitals; whereas their costs become the counties' responsibility once they take them out of the state hospitals. This funding model creates a disincentive for counties to retrieve patients once it is determined that competency restoration is not possible.

Over the past several years, state hospitals have maintained a waiting list of forensic patients. The largest waiting lists are for incompetent to stand trial (IST) and *Coleman* referrals (inmates in state prison who have been deemed too mentally ill to remain in a prison setting). As of January 2014, there were 393 IST and 63 *Coleman* patients awaiting placement in DSH facilities. When queried about the potential causes of the growing number of referrals from judges and CDCR, the Administration describes a complex puzzle of criminal, social, cultural, and health variables that together are leading to increasing criminal and violent behavior by individuals with mental illness.

DSH is required to admit patients within certain timeframes and can be (and has been) required to appear in court, or be held in contempt of court, when it fails to meet these timeframes.

The budget proposes to activate 105 new beds at DSH-Coalinga. Those beds would be occupied by current MDO patients transferred from the other four state hospitals. The beds made available from this transfer would then be utilized to treat IST patients currently on the waiting list.

Governor's Budget. The budget proposes $7.87 million General Fund for the current year (2013-14) and $27.8 million General Fund for 2014-15, to increase bed capacity by 105 beds to address the waiting list specific to IST patients.

Specifically, the DSH is proposing three new units with 35 beds each, anticipating activation of the first unit in March 2014, the second in May 2014, and the third in July 2014. The DSH proposes to use savings realized from delays in the activation of the Stockton facility for the current year costs.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. Does the length of the waiting list vary from month-to-month? If so, please provide the subcommittee with data on the last 12 to 24 months.

2. How many ISTs are left by counties at state hospitals after their competency is restored and what is the average length of stay for this population that is left lingering in the hospitals?

3. Is this only a problem with certain counties? If so, which ones?

4. Has the Administration considered charging a per-day rate for those patients who should have been retrieved by the county responsible for their commitment?

5. Has the Administration done an inventory and analysis to determine whether the state has the appropriate mix of types of treatment beds throughout the system to meet the needs of its current population?

6. How flexible are the bed types within the system? For example, can vacant SVP beds be used to serve MDOs or IST patients?

Legislative Analyst's Office (LAO). DSH has seen an increase in waiting lists for forensic patients. The largest waitlists are for IST and *Coleman* commitments. As noted above, as of January 2014, there were 393 IST and 63 *Coleman* patients awaiting placement in DSH facilities. Such long waitlists are problematic because they could result in increased court costs and higher risk of DSH being found in contempt of court orders to admit patients. This is because DSH is required to admit patients within certain time frames and can be required to appear in court, or be held in contempt, when it fails to do so. In light of these concerns, the 2013-14 budget provided $22.1 million to increase treatment capacity for IST and MDOs by 155 beds.

DSH Over-Budgeted. In recent years, there has been a significant mismatch between the size of the population DSH is funded to serve and the number of patients actually in the hospitals. This is because while DSH has received funding increases in recent years to support additional beds, the department has not been able to activate the planned beds at the rate expected—resulting in much lower-than-expected growth in the patient population. DSH has consistently maintained a smaller population than beds for which it is budgeted to support. In total, DSH is currently budgeted for 616 more beds than it has patients. Specifically, the department is over-budgeted by 365 beds in state hospitals and 251 beds in the psychiatric programs. Despite this, the department has not reverted unused funds to the General Fund at the end of the year.

There are several reasons that may explain why there is a gap between the population DSH is budgeted to serve and the population it actually serves. First, DSH is not always able to utilize beds for which it has received funding. For example, DSH often has difficulty hiring clinical staff to support available bed space, and, therefore, cannot utilize available beds. Also, patients are committed to specific locations by referring agencies (such as courts), so some available beds may not be filled because patients are not being referred to those locations.

Second, according to DSH, it must receive funding to staff beds that will remain vacant for a portion of the year. For example, the department indicates that some beds are budgeted for certain commitment types—such as for IST patients—and those beds must be open for only

those commitment types. Also, a certain percentage of beds must remain vacant for patients who are attending court hearings or transferring locations. While the LAO acknowledges that it is necessary to maintain some number of vacant beds for this purpose, it is unclear from the information provided by DSH that the current number of vacant beds is appropriate. The LAO notes, for example, that the number of vacant beds—both at various DSH facilities and by commitment type—changes frequently with little evidence of corresponding changes in care. This suggests that DSH has been able to operate with fewer vacant beds than they currently have.

The gap between the budgeted and actual population is problematic for two reasons. First, it suggests that the department is over-budgeted to serve its current population. Second, it suggests that approving additional funds for the department will not necessarily result in an increase in population or a reduction in waitlists. Instead, additional funding may only result in funding for positions that DSH is unable to fill, not an increase in hospital capacity. For example, despite the Legislature approving funding to support 155 additional beds in the 2013-14 budget for IST and MDO populations, these populations have actually declined by 30 patients statewide.

LAO Recommendation. The LAO recommends rejecting the increased funding for additional IST beds. In addition, they recommend that the Legislature direct DSH to report at budget subcommittee hearings this spring on:

1. Why the patient population remains stable despite growing waitlists.

2. Why there is a mismatch between their budgeted capacity and their patient population.

3. What steps the department is taking to address its high vacancy rate.

4. The department's progress on expanding restoration of competency (ROC) services in county jails and the findings of the IST working group.

Such information could assist the Legislature in making a determination about the appropriate level of budget and staffing increases necessary to treat the DSH patient population. The LAO further recommends that the Legislature direct DSH to develop a proposal to contract for an independent staffing analysis to determine appropriate staffing levels for each facility. These staffing ratios should be based on licensing requirements, clinical need, necessary bed vacancies, and other factors; as deemed appropriate by the independent assessor.

Staff Comment. DSH's proposal to develop a patient management unit may address many of the problems associated with the current waiting lists as the department is able to better manage its existing beds and fill some of the 600 vacant beds in its current budget. In addition, the Legislature may wish to consider adopting the LAO proposal to require an independent staffing analysis prior to approving any additional funding for DSH.

Staff Recommendation. Hold open pending updated population data in the May Revision.

Issue 5: Salinas Valley and Vacaville Psychiatric Programs

Background. In April 2012, CDCR released a report entitled *The Future of California Corrections* detailing the Administration's long-range plan to reorganize various aspects of CDCR operations, facilities, and budgets in response to the effects of the 2011 realignment of adult offenders, as well as to meet federal court requirements. The plan was intended to build upon realignment, create a comprehensive plan for CDCR to significantly reduce the state's investment in prisons, satisfy the Supreme Court's ruling to reduce overcrowding in the prisons, and get the department out from under federal court oversight.

The plan included a proposal to transfer 450 beds from the Salinas Valley and Vacaville Psychiatric programs to the new Stockton program at the new California Health Care Facility (CHCF). DSH is in the process of transferring these beds and was scheduled to complete the transfer by December 2013; however, completion of the transfer has been delayed, primarily due to staff recruitment challenges.

This proposal reflects the following:

1. DSH originally expected to complete the migration of patients to Stockton by the end of 2013, however this has not been completed as a result of difficulty filling the psychiatry staff classifications.

2. An increase in the rate of *Coleman* referrals through 2013.

3. DSH indicated in 2013 that a higher level of staffing should be provided at Salinas and Vacaville than what has been there in the past.

Governor's Budget. DSH is requesting authority to permanently continue operating an additional 137 beds at Salinas Valley and Vacaville (beyond the bed migration plan), at a cost of $13.3 million in the current year (to be funded with savings from the delayed activation of beds at the Stockton program) and $26.3 million General Fund in 2014-15 (and on-going). DSH requests these resources to permanently maintain 204.3 existing positions at Salinas Valley and Vacaville.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. Please provide an update on the staffing and activation of DSH – Stockton.

2. What caused the *Coleman* referrals to increase steadily in recent years and why does the Administration believe those referrals are leveling off?

3. Why is the Administration backing off from the commitment made in the CDCR plan to significantly reduce the programs at Vacaville and Salinas Valley by requesting this permanent expansion of program beds?

Legislative Analyst's Office (LAO). As noted in the previous section, in recent years, there has been a significant mismatch between the size of the population DSH is funded to serve and the number of patients actually in the hospitals. This is because, while DSH has received funding increases in recent years to support additional beds, the department has not been able to activate the planned beds at the rate expected—resulting in much lower-than-expected growth in the patient population. DSH has consistently maintained a smaller population than beds for which it is budgeted to support. *In total, DSH is currently budgeted for 616 more beds than it has patients. Specifically, the department is over-budgeted by 365 beds in state hospitals and 251 beds in the psychiatric programs.* Despite this, the department has not reverted unused funds to the General Fund at the end of the year.

The gap between the budgeted and actual population is problematic for two reasons. First, it suggests that the department is over-budgeted to serve its current population. Second, it suggests that approving additional funds for the department will not necessarily result in an increase in population or a reduction in waitlists. Instead, additional funding may only result in funding for positions that DSH is unable to fill, not an increase in hospital capacity. For example, despite the Legislature approving funding to support 155 additional beds in the 2013-14 budget for IST and MDO populations, these populations have actually declined by 30 patients statewide.

LAO Recommendation. In view of their current over-budgeting, the LAO recommends that the Legislature reject the Governor's proposal to provide additional funding for increased bed capacity at DSH–Vacaville and DSH–Salinas Valley.

Staff Comment. Similar to the previous issue, prior to providing any additional funding, the Legislature may wish to require the department to better manage its existing beds and fill some of the 600 vacant beds in its current budget, including 251 beds in the prison psychiatric programs. In addition, the Legislature may wish to consider adopting the LAO proposal to require an independent staffing analysis prior to approving any additional funding for DSH.

Staff Recommendation: Hold open pending updated population data in the May Revision.

Issue 6: Security Fencing at Patton

Governor's Budget. This project proposes to demolish ground guard posts, existing fencing, lighting, paving, and selected trees and shrubs. Construction will be a Level II design, double perimeter fence with barbed tape, fence detection system, 13 ground guard posts, two vehicle and pedestrian sally ports, perimeter patrol roadway improvements, modification to portions of the internal roads, new security lighting, and closed circuit television cameras. This project will support the re-evaluation of existing working drawings, and fund the construction phase. The total project cost is estimated to be $16.4 million, and CDCR expects savings of $4.8 million in annual savings due to a reduction in security staff.

Staff Comments. No concerns have been brought to the subcommittee's attention concerning this proposal.

Staff Recommendation. Approve as budgeted.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Ellen Corbett, Chair
Senator William Monning
Senator Mimi Walters

Thursday, April 3, 2014
9:30 a.m. or Upon Adjournment of Session
State Capitol Room 4203
Outcomes

Agenda Part A

Consultant: Julie Salley-Gray

Items Proposed for Vote-Only

Issue	Department	Page
4440	**Department of State Hospitals**	
Issue 1	Third Party Billing BCP	2
Issue 2	Cal-OSHA Standards BCP	2
Issue 3	Seismic Upgrades at Atascadero	2
Issue 4	Security Fencing at Napa	2
Issue 5	Fire Alarm Upgrade at Metropolitan	2

Items Proposed for Discussion

Issue	Department	Page
4440	**Department of State Hospitals**	
Issue 1	Medical Grade Network	7
Issue 2	Statewide Enhanced Treatment Units Capital Outlay	8
Issue 3	Patient Management Unit	10
Issue 4	Expansion to Address Incompetent to Stand Trial Waiting List	12
Issue 5	Salinas Valley and Vacaville Psychiatric Programs	15
Issue 6	Security Fencing at Patton	17

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N

Street, Suite 255 or by calling 916-651-1505. Requests should be made one week in advance whenever possible.

PROPOSED FOR VOTE ONLY

4440 Department of State Hospitals (DSH)

1. **Third Party Billing BCP.** DSH is requesting 15 two-year limited-term positions and $1,893,000 General Fund (in the form of reimbursements that result from successful third-party payer collections, and therefore not a new General Fund appropriation) to consolidate functions related to billing and collection of third party resources that are not performed by the Department of Developmental Services (DDS).

   Action: Approved Vote: 3 – 0

2. **Cal-OSHA Standards BCP.** DSH requests $502,000 (General Fund) and five two-year limited-term positions to establish statewide support for compliance with Department of Occupational Safety and Health (Cal-OSHA) standards.

   Action: Approved Vote: 2 – 1 (Walters "No.")

3. **Seismic Upgrades at Atascadero.** This project requests $325,000 in General Fund for the preliminary plans necessary to perform a seismic retrofit at the main East-West corridor at Atascadero State Hospital. The retrofit will include construction of steel framed lateral frames in the upper third portion of the corridor. Construction also will include a security sally port and temporary access doors. It is anticipated that this project will reduce the risk level of the corridor from the current Level V to a Level III. Project construction costs are estimated to be $6.2 million.

   Action: Approved Vote: 3 – 0

4. **Security Fencing at Napa.** This project is to improve security in the courtyards in the patient housing buildings, including: replacement of gates and fabricating and installing extensions to raise the height of security fencing in specified buildings. The cost to develop working drawings is $191,000. Total costs for the fencing are estimated to be approximately $900,000.

   Action: Approved Vote: 3 – 0

5. **Fire Alarm Upgrade at Metropolitan.** This proposal is to completely upgrade the existing Notifier Fire Alarm Systems in patient housing and to provide a new central monitoring system located at Hospital Police Dispatch. The total project cost is estimated to be approximately $9 million. According to the proposal, the existing system is not code compliant and does not provide serviceability and/or expandability. The requested $712,000 is for the working drawings phase of the project. Development of preliminary plans was funded in the current fiscal year at $633,000.

   Action: Approved Vote: 3 – 0

Recommendation: APPROVE Items 1-5

ITEMS TO BE HEARD

4440 Department of State Hospitals

The Department of State Hospitals (DSH) is the lead agency overseeing and managing the state's system of mental hospitals. The DSH seeks to ensure the availability and accessibility of effective, efficient, and culturally competent services. DSH activities and functions include advocacy, education, innovation, outreach, understanding, oversight, monitoring, quality improvement, and the provision of direct services.

The Governor's 2011 May Revision first proposed the elimination of the former Department of Mental Health (DMH), the creation of the new DSH, and the transfer of Medi-Cal and other community mental health programs to the Department of Health Care Services (DHCS). The 2011 Budget Act approved of just the transfer of Medi-Cal mental health programs from the DMH to the DHCS. In 2012, the Governor proposed, and the Legislature adopted, the full elimination of the DMH and the creation of the DSH. All of the community mental health programs remaining at the DMH were transferred to other state departments as part of the 2012 budget package. The budget package also created the new DSH which has the singular focus of providing improved oversight, safety, and accountability to the state's mental hospitals and other psychiatric facilities.

California has five state hospitals and three prison-based psychiatric programs that treat people with mental illness. Approximately 92 percent of the state hospitals' population is considered "forensic," in that they have been committed to a hospital through the criminal justice system. The state hospitals are as follows:

- Atascadero (ASH). ASH is located on the central coast. It is an all-male, maximum security, forensic facility (i.e., persons referred by the court due to criminal violations).
- Coalinga (CSH). Located in the City of Coalinga, CSH is the newest state hospital, opened in 2005, and treats forensically committed and sexually violent predators.
- Metropolitan (MSH). Located in Norwalk, MSH serves individuals placed for treatment pursuant to the Lanterman-Petris-Short Act (civil commitments), as well as court-ordered penal code commitments.
- Napa (NSH). Located in the City of Napa, NSH is a low-to-moderate security state hospital.
- Patton (PSH). PSH is located in San Bernardino and cares for judicially committed, mentally disordered individuals.
- Vacaville & Salinas Valley Psychiatric Programs. These programs are located within state prisons.
- Stockton Psychiatric Program. This is the newest facility that began operation in July of 2013, serving 432 High Custody/Level IV inmates/patients at the intermediate level of care, within the California Department of Corrections and Rehabilitation’s (CDCR) California Health Care Facility in Stockton.

Cost Over-Runs. Over the past several years, state hospital costs had been rising at an alarming rate, and substantial current year deficiencies had become the norm and even expected from year to year. For example, in the 2010-11 fiscal year, the deficiency rose from $50 million to $120 million and the then-DMH staff could not explain why. In general, the

department lacked any clear understanding of what the major cost drivers were and how to curb or stabilize costs in the system. In 2011, DMH leadership facilitated and oversaw an in-depth exploration and analysis of state hospital costs, resulting in a lengthy report that is available on the department's website. The research team identified the following system-wide problems/cost drivers: increased patient aggression and violence; increased operational treatment models; and redundant staff work.

Based on the report described above, in 2012, the Administration proposed a comprehensive list of reforms, to reverse the rising cost trend, which addressed three stated goals: 1) improve mental health outcomes; 2) increase worker and patient safety; and, 3) increase fiscal transparency and accountability. Perhaps the most significant of these proposed reforms was the reduction of 600 positions throughout the state hospital system. Of these 600 positions, 230 were vacant. In addition to the reduction in positions, the 2012 budget package included key changes in the following areas:

1. Reduced layers of management and streamlined documentation.

2. Flexible staffing ratios, focusing on front-line staff, and redirecting staff to direct patient care.

3. New models for contracting, purchasing, and reducing operational expenses.

4. Elimination of adult education.

State Hospitals Caseload

The five state hospitals provide treatment to approximately 6,000 patients, who fall into one of two categories:

1. Civil commitments (referrals from counties).

2. Forensic commitments (committed by the courts).

The psychiatric facilities are located within state prisons, and currently treat approximately 1,000 inmates. They include:

1. Vacaville Psychiatric Program.

2. Salinas Valley Psychiatric Program.

3. Stockton Psychiatric Program.

Approximately 92 percent of the state hospitals' population is considered forensic, in that they have been committed to a hospital by the criminal justice system. The following are the primary Penal Code categories of patients who are either committed or referred to DSH for care and treatment:

Committed Directly From Superior Courts:

- *Not Guilty by Reason of Insanity* – Determination by court that the defendant committed a crime and was insane at the time the crime was committed.

- *Incompetent to Stand Trial (IST*) – Determination by court that the defendant cannot participate in trial because the defendant is not able to understand the nature of the criminal proceedings or assist counsel in the conduct of a defense. This includes individuals whose incompetence is due to developmental disabilities.

Referred From The California Department of Corrections and Rehabilitation (CDCR):

- *Sexually Violent Predators (SVP)* – Hold established on inmate by court when it is believed probable cause exists that the inmate may be a SVP. Includes 45-day hold on inmates by the Board of Prison Terms.

- *Mentally Disordered Offenders (MDO)* – Certain CDCR inmates for required treatment as a condition of parole, and beyond parole under specified circumstances.

- *Prisoner Regular/Urgent Inmate-Patients (Coleman Referrals)* – Inmates who are found to be mentally ill while in prison, including some in need of urgent treatment.

State Hospitals & Psychiatric Programs
Caseload Projections

	2013-14	2014-15
Population by Hospital		
Atascadero	1,052	1,091
Coalinga	1,151	1,206
Metropolitan	814	930
Napa	1,287	1,407
Patton	1,513	1,503
Subtotal	**5,817**	**6,137**
Population by Psych Program		
Vacaville	386	386
Salinas	177	177
Stockton	514	514
Subtotal	**1,077**	**1,077**
Population Total	**6,894**	**7,214**

Population by Commitment Type		
Incompetent to Stand Trial (IST)	1,583	1,912
Not Guilty By Reason of Insanity (NGI)	1,375	1,398
Mentally Disordered Offender (MDO)	1,126	1,067
Sexually Violent Predator (SVP)	909	936
Lanterman-Petris-Short Act/PC 2974	556	556
Coleman Referral – Hospitals	258	258
Coleman Referral – Psych Programs	1,077	1,077
Department of Juvenile Justice	10	10

State Hospitals Budget.

The Governor's proposed budget includes $1.6 billion for DSH in 2014-15 ($1.5 billion General Fund). This represents a 1.4 percent increase over 2013-14 funding. The proposed budget year position authority for DSH is 11,234 positions, an increase of 363 positions (3.3 percent) from the current year. The department's budget includes increased funding for several proposals, including plans to operate 242 more beds than were budgeted in 2013-14, initiate a program to manage bed space on a statewide level, and develop a cost estimate for enhanced security units.

(dollars in thousands)

Funding	2012-13 Actual	2013-14 Projected	2014-15 Proposed
General Fund (GF)	$1,274,968	$1,475,926	$1,497,970
Reimbursements	117,910	127,560	127,560
CA Lottery Education Fund	74	91	91
Total	$1,392,952	$1,603,577	$1,625,621
Positions	9,715.2	10,871.7	11,234

Issue 1: Medical Grade Network (MGN)

Background. DSH network infrastructure is required for clinical programs to communicate in support of critical patient care and clinical operations at each hospital. Infrastructure Services in medical settings are required to secure and protect medical data and support 24/7 network connectivity throughout the state hospital system. DSH states that the current network lacks the complete infrastructure necessary to sustain hospital operations.

Currently, the DSH network is a single Wide Area Network (WAN). The DSH states that a single WAN does not have redundant network connections between points, introducing many single points of failure, and is therefore substantially less reliable than a redundant WAN, which has a network with multiple connections between locations. The DSH states that a single WAN cannot adequately support the connection of critical clinical applications needed to provide more cost efficient and effective patient care.

Existing infrastructure has experienced significant network disruptions that have had a negative impact on medical care operations. For example, Metropolitan State Hospital experienced a technology failure in March 2012, resulting in two days when staff was unable to communicate with other facilities and had no access to clinical applications needed for patient treatment. In another example, all DSH facilities experienced a technology failure in June 2013, resulting in an interruption in access for all users to any applications deployed in an enterprise manner.

The DSH states that the health and safety of state hospital patients is at risk when medication records and treatment plans are not fully accessible. Currently, there are times when clinicians are unable to make well-informed or appropriate treatment decisions critical to the patient's well-being as a result of network-caused data errors, incorrect or missing patient information, or unavailable systems. The inadequate capacity of the current network also prohibits the DSH from maintaining offsite data backups.

According to the DSH, this project will add redundant network connectivity paths across the enterprise network, thereby eliminating single points of network connectivity failure. The Medical Grade Network (MGN) helps form an essential foundation for implementation of shared enterprise clinical systems such as electronic health records. The DSH states that without the MGN upgrade, the DSH will not be able to deploy any enterprise applications that are critical to life and safety because they cannot guarantee reliable 24/7 access to these systems.

Governor's Budget. DSH is requesting two permanent positions and $7.4 million General Fund in 2014-15, and $2.3 million General Fund ($726,000 one-time and $1.5 million on-going) for 2015-16 to implement the MGN project to add foundational infrastructure to the DSH inter-hospital network.

Staff Comments. No concerns have been brought to the subcommittee's attention regarding this proposal.

Staff Recommendation: Approve as budgeted.

Action: Approved Vote: 3 – 0

Issue 2: Statewide Enhanced Treatment Units Capital Outlay

Background. The state hospitals were designed and constructed for a patient population that was quite different than the population currently in the state hospitals. Now, 92 percent of the population is forensic, having been referred to the state hospitals by either courts or prisons. Substantial evidence demonstrates an increasing rate of aggression and violent incidents at state hospitals.

The Administration argues that, in spite of this significant change in the state hospitals' patient population, there is currently no legal, regulatory, or physical infrastructure in place for DSH to effectively and safely treat patients who have demonstrated severe psychiatric instability or extremely aggressive behavior. As a result, often the only option available to a state hospital dealing with an extremely violent patient is the use of emergency seclusion and restraints, which is short term only and a more extreme response. Subsequent to the use of seclusion and restraint, a violent patient must be placed in one-on-one or two-on-one observation, which DSH states is labor intensive and does not necessarily improve safety.

DSH requests funding to develop and plan enhanced treatment units (ETUs) to provide a secure environment to more effectively treat patients that become psychiatrically unstable resulting in highly aggressive and violent behavior towards themselves, other patients, or staff. Candidates for an ETU would exhibit a level of physical violence that is not containable using other interventions or protocols currently available in the state hospitals. DSH argues that the existing physical facilities are old and designed for a different population, therefore it is not possible to provide more security within existing facilities.

Licensing & Statutory Changes. The proposal states that the establishment of the proposed statewide ETU may require statutory and regulatory changes, licensing changes, development of a specialized treatment program with appropriate staffing, patient parameters, an admissions/discharge system, and an analysis of physical plant space. It states further that the proposed ETU can be accomplished through statutory language added under the licensing for acute psychiatric hospitals. DSH assumes that such statutory changes would include allowing for individual rooms with bathroom facilities and doors that lock externally. None of the necessary policy is currently in place to develop the type of ETUs outlined in the budget proposal.

AB 1340 (Achadjian). This proposed legislation would require, beginning on July 1, 2015, and subject to available funding, each of the five state mental hospitals to establish and maintain an enhanced treatment unit for the placement of aggressive patients and requires any case of assault by a patient be immediately referred to the local district attorney. This legislation is currently awaiting hearing in the Senate Health Committee and, if approved and signed into law, could provide the necessary policy guidance for the development and running of potentially locked ETUs in the state hospitals. Absent this legislation, DSH currently has the authority to establish ETUs that do not involve individual, externally locked rooms, as they have done at Atascadero State Hospital.

Governor's Budget. The Governor's budget requests $1.5 million in General Fund for DHS and the Department of General Services (DGS) to prepare an analysis, estimate, and infrastructure design for the development of 44 locked ETUs in the five state hospitals.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. Please describe how the current ETUs in the state operate and whether or not they are an effective treatment model.

2. How does the Administration intend to ensure that the locked rooms are used only for treatment and not as punishment for patients?

Legislative Analyst's Office (LAO). The Administration has not provided language that would give DSH the authority it seeks. As such, the details of the project remain uncertain. For example, there is no information about the approved lengths of stay or types of locked facilities that would be permitted under statute. Without that clarity, DGS may not be able to create an accurate budget package or determine the most appropriate infrastructure design for these units. The LAO is also concerned that the lack of specificity about the ETUs creates uncertainty about DSH's ability to build the units. Under the Administration's proposal, it is unclear whether each hospital will be permitted to maintain ETUs or whether units will be required at each location. Additionally, it is unclear what design specifications may be required, such as room size, bathroom facilities, or type of door lock. Without such information, it is unclear how DGS will be able to conduct the proposed analysis. Because each hospital has a different physical plant design, some hospitals may not meet those specifications, or it may be prohibitively expensive to build the units.

LAO Recommendation. In light of these concerns, the LAO recommends that the Legislature reject the Governor's proposed $1.5 million to obtain a DGS study of ETUs. While the LAO does not have major concerns with the proposal to consider the development of ETUs in DSH hospitals, they are concerned that planning the units without having specific guidelines could result in unnecessary costs.

Staff Comments. Given the complexity of the policy required for the ETUs and the fact that none of those policy decisions have been made, this proposal appears to be premature. The Legislature should ensure that the appropriate statutory language is in place to adequately protect both patients and staff and to restrict the use of ETUs for treatment, rather than for the inappropriate incarceration of patients, prior to approving $1.5 million in funding for the planning and infrastructure design of 44 ETUs.

Staff Recommendation: Hold open.

Issue 3: Patient Management Unit

Background. DSH is in the process of implementing various policy reforms aimed at transforming the state hospitals into a coordinated, singular system of hospitals. Historically, state hospitals have operated as independent entities. One of the consequences of this lack of coordination has been an inefficient system of patient placement that leads to delays and often inappropriate placements. Current law states that judges may refer individuals to "a state hospital." Judges often interpret this statute as giving them the authority to refer an individual to one specific hospital, rather than to DSH generally (i.e., to the state hospitals system). The result can be excess patients at one hospital, with substantial excess bed space at another hospital. It also results in certain patients being placed at hospitals that are not best suited to treat them or otherwise meet their needs.

Therefore, DSH proposes creating a patient management unit to help improve:

1. Timely access to in-patient care.

2. Placement in the most appropriate clinical settings based on treatment and security needs.

3. Timely resolution to placement issues.

4. More cost-effective utilization of hospital beds and staffing resources.

Governor's Budget. The budget includes $1.1 million General Fund and 10 two-year limited-term positions to establish a patient management unit to centralize admissions and transfers of patients throughout the state hospital system.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. How many vacant beds does DHS have throughout the state hospital system, and where are they located?

2. How will DSH ensure that the new system will allow for judicial discretion when appropriate?

3. How does DSH plan to ensure that the needs of the patients and proximity to their families and communities are protected, rather than simply placing patients where it is easiest and most convenient for the hospital system?

Legislative Analyst's Office (LAO).

Proposal Has Merit. The current disconnected system of patient placement has numerous drawbacks. The Governor's proposal has the potential to address many of the issues. For example, the proposal might allow DSH to find placements for patients more quickly, which could reduce court orders requiring DSH to accept specific patients from waitlists. It could

also improve the department's ability to budget for each institution, because it would allow DSH to place patients in available bed space rather than having some facilities have empty space while others have patients waiting for entry. It could also reduce lengths of stay by placing patients in the most clinically appropriate setting.

The LAO notes, however, that there could be some additional costs associated with the patient management unit. For example, patients assigned to locations far from their county of commitment might incur additional travel costs for court visits. In addition, evaluating patients before placement could also slow the placement and transfer processes, resulting in longer lengths of stay. Despite this, the potential operational benefits of the proposal would likely outweigh such drawbacks.

But Department Lacks Authority to Fully Realize Benefits of Management Unit. The DSH currently does not have the statutory authority to implement patient placement programs, and the Governor's proposal does not include trailer bill language to provide the department with that authority. Although some courts and counties permit DSH to manage patient placement, the discretion to allow this remains with those entities, not the department. Even if DSH were to establish a patient management and bed utilization unit, it would be unable to fully realize the benefits of such a program because, without statutory changes, referring entities would remain the arbiters of patient placement.

LAO Recommendation. Although the Administration's proposal could result in increased efficiency and potential cost savings, until statutory language exists permitting DSH to fully control the placement of the patients committed to its care, the benefits of the patient management unit cannot be fully realized. Therefore, the LAO recommends the Legislature support the Administration's proposal to create a patient management and bed utilization unit and adopt trailer bill language clarifying that DSH has the authority to fully control patient placements.

Staff Comments. Current law gives the courts the discretion to place an individual in a state hospital, rather than placing them into the state hospital system and allowing DSH to determine the appropriate placement of the individuals. At a minimum, DSH would need trailer bill language to clarify what discretion, if any, the courts will have in determining where an individual would be hospitalized. In addition, trailer bill language may be needed to protect the best interests of the patients in order to ensure that patients are placed in hospitals close to their communities and families whenever possible.

The Administration has not proposed any trailer bill language to accompany this budget item.

Staff Recommendation. Hold open pending the receipt of necessary trailer bill language.

Issue 4: Incompetent to Stand Trial Waiting List

Background. When a judge deems a defendant to be incompetent to stand trial, the defendant is referred to the state hospital system to undergo treatment for the purpose of restoring competency. Once the individual's competency has been restored, the county is required to take the individual back into the criminal justice system to stand trial, and counties are required to do this within ten days of competency being restored.

For a portion of this population, the state hospital system finds that restoring competency is not possible. There is no statutory deadline for the county to retrieve these individuals, and therefore they often linger in the state hospitals for years. The state pays the costs of their care while in the state hospitals; whereas their costs become the counties' responsibility once they take them out of the state hospitals. This funding model creates a disincentive for counties to retrieve patients once it is determined that competency restoration is not possible.

Over the past several years, state hospitals have maintained a waiting list of forensic patients. The largest waiting lists are for incompetent to stand trial (IST) and *Coleman* referrals (inmates in state prison who have been deemed too mentally ill to remain in a prison setting). As of January 2014, there were 393 IST and 63 *Coleman* patients awaiting placement in DSH facilities. When queried about the potential causes of the growing number of referrals from judges and CDCR, the Administration describes a complex puzzle of criminal, social, cultural, and health variables that together are leading to increasing criminal and violent behavior by individuals with mental illness.

DSH is required to admit patients within certain timeframes and can be (and has been) required to appear in court, or be held in contempt of court, when it fails to meet these timeframes.

The budget proposes to activate 105 new beds at DSH-Coalinga. Those beds would be occupied by current MDO patients transferred from the other four state hospitals. The beds made available from this transfer would then be utilized to treat IST patients currently on the waiting list.

Governor's Budget. The budget proposes $7.87 million General Fund for the current year (2013-14) and $27.8 million General Fund for 2014-15, to increase bed capacity by 105 beds to address the waiting list specific to IST patients.

Specifically, the DSH is proposing three new units with 35 beds each, anticipating activation of the first unit in March 2014, the second in May 2014, and the third in July 2014. The DSH proposes to use savings realized from delays in the activation of the Stockton facility for the current year costs.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. Does the length of the waiting list vary from month-to-month? If so, please provide the subcommittee with data on the last 12 to 24 months.

2. How many ISTs are left by counties at state hospitals after their competency is restored and what is the average length of stay for this population that is left lingering in the hospitals?

3. Is this only a problem with certain counties? If so, which ones?

4. Has the Administration considered charging a per-day rate for those patients who should have been retrieved by the county responsible for their commitment?

5. Has the Administration done an inventory and analysis to determine whether the state has the appropriate mix of types of treatment beds throughout the system to meet the needs of its current population?

6. How flexible are the bed types within the system? For example, can vacant SVP beds be used to serve MDOs or IST patients?

Legislative Analyst's Office (LAO). DSH has seen an increase in waiting lists for forensic patients. The largest waitlists are for IST and *Coleman* commitments. As noted above, as of January 2014, there were 393 IST and 63 *Coleman* patients awaiting placement in DSH facilities. Such long waitlists are problematic because they could result in increased court costs and higher risk of DSH being found in contempt of court orders to admit patients. This is because DSH is required to admit patients within certain time frames and can be required to appear in court, or be held in contempt, when it fails to do so. In light of these concerns, the 2013-14 budget provided $22.1 million to increase treatment capacity for IST and MDOs by 155 beds.

DSH Over-Budgeted. In recent years, there has been a significant mismatch between the size of the population DSH is funded to serve and the number of patients actually in the hospitals. This is because while DSH has received funding increases in recent years to support additional beds, the department has not been able to activate the planned beds at the rate expected—resulting in much lower-than-expected growth in the patient population. DSH has consistently maintained a smaller population than beds for which it is budgeted to support. In total, DSH is currently budgeted for 616 more beds than it has patients. Specifically, the department is over-budgeted by 365 beds in state hospitals and 251 beds in the psychiatric programs. Despite this, the department has not reverted unused funds to the General Fund at the end of the year.

There are several reasons that may explain why there is a gap between the population DSH is budgeted to serve and the population it actually serves. First, DSH is not always able to utilize beds for which it has received funding. For example, DSH often has difficulty hiring clinical staff to support available bed space, and, therefore, cannot utilize available beds. Also, patients are committed to specific locations by referring agencies (such as courts), so some available beds may not be filled because patients are not being referred to those locations.

Second, according to DSH, it must receive funding to staff beds that will remain vacant for a portion of the year. For example, the department indicates that some beds are budgeted for certain commitment types—such as for IST patients—and those beds must be open for only

those commitment types. Also, a certain percentage of beds must remain vacant for patients who are attending court hearings or transferring locations. While the LAO acknowledges that it is necessary to maintain some number of vacant beds for this purpose, it is unclear from the information provided by DSH that the current number of vacant beds is appropriate. The LAO notes, for example, that the number of vacant beds—both at various DSH facilities and by commitment type—changes frequently with little evidence of corresponding changes in care. This suggests that DSH has been able to operate with fewer vacant beds than they currently have.

The gap between the budgeted and actual population is problematic for two reasons. First, it suggests that the department is over-budgeted to serve its current population. Second, it suggests that approving additional funds for the department will not necessarily result in an increase in population or a reduction in waitlists. Instead, additional funding may only result in funding for positions that DSH is unable to fill, not an increase in hospital capacity. For example, despite the Legislature approving funding to support 155 additional beds in the 2013-14 budget for IST and MDO populations, these populations have actually declined by 30 patients statewide.

LAO Recommendation. The LAO recommends rejecting the increased funding for additional IST beds. In addition, they recommend that the Legislature direct DSH to report at budget subcommittee hearings this spring on:

1. Why the patient population remains stable despite growing waitlists.

2. Why there is a mismatch between their budgeted capacity and their patient population.

3. What steps the department is taking to address its high vacancy rate.

4. The department's progress on expanding restoration of competency (ROC) services in county jails and the findings of the IST working group.

Such information could assist the Legislature in making a determination about the appropriate level of budget and staffing increases necessary to treat the DSH patient population. The LAO further recommends that the Legislature direct DSH to develop a proposal to contract for an independent staffing analysis to determine appropriate staffing levels for each facility. These staffing ratios should be based on licensing requirements, clinical need, necessary bed vacancies, and other factors; as deemed appropriate by the independent assessor.

Staff Comment. DSH's proposal to develop a patient management unit may address many of the problems associated with the current waiting lists as the department is able to better manage its existing beds and fill some of the 600 vacant beds in its current budget. In addition, the Legislature may wish to consider adopting the LAO proposal to require an independent staffing analysis prior to approving any additional funding for DSH.

Staff Recommendation. Hold open pending updated population data in the May Revision.

Issue 5: Salinas Valley and Vacaville Psychiatric Programs

Background. In April 2012, CDCR released a report entitled *The Future of California Corrections* detailing the Administration's long-range plan to reorganize various aspects of CDCR operations, facilities, and budgets in response to the effects of the 2011 realignment of adult offenders, as well as to meet federal court requirements. The plan was intended to build upon realignment, create a comprehensive plan for CDCR to significantly reduce the state's investment in prisons, satisfy the Supreme Court's ruling to reduce overcrowding in the prisons, and get the department out from under federal court oversight.

The plan included a proposal to transfer 450 beds from the Salinas Valley and Vacaville Psychiatric programs to the new Stockton program at the new California Health Care Facility (CHCF). DSH is in the process of transferring these beds and was scheduled to complete the transfer by December 2013; however, completion of the transfer has been delayed, primarily due to staff recruitment challenges.

This proposal reflects the following:

1. DSH originally expected to complete the migration of patients to Stockton by the end of 2013, however this has not been completed as a result of difficulty filling the psychiatry staff classifications.

2. An increase in the rate of *Coleman* referrals through 2013.

3. DSH indicated in 2013 that a higher level of staffing should be provided at Salinas and Vacaville than what has been there in the past.

Governor's Budget. DSH is requesting authority to permanently continue operating an additional 137 beds at Salinas Valley and Vacaville (beyond the bed migration plan), at a cost of $13.3 million in the current year (to be funded with savings from the delayed activation of beds at the Stockton program) and $26.3 million General Fund in 2014-15 (and on-going). DSH requests these resources to permanently maintain 204.3 existing positions at Salinas Valley and Vacaville.

Questions for the Administration. The department should be prepared to present the proposal and to address the following questions:

1. Please provide an update on the staffing and activation of DSH – Stockton.

2. What caused the *Coleman* referrals to increase steadily in recent years and why does the Administration believe those referrals are leveling off?

3. Why is the Administration backing off from the commitment made in the CDCR plan to significantly reduce the programs at Vacaville and Salinas Valley by requesting this permanent expansion of program beds?

Legislative Analyst's Office (LAO). As noted in the previous section, in recent years, there has been a significant mismatch between the size of the population DSH is funded to serve and the number of patients actually in the hospitals. This is because, while DSH has received funding increases in recent years to support additional beds, the department has not been able to activate the planned beds at the rate expected—resulting in much lower-than-expected growth in the patient population. DSH has consistently maintained a smaller population than beds for which it is budgeted to support. *In total, DSH is currently budgeted for 616 more beds than it has patients. Specifically, the department is over-budgeted by 365 beds in state hospitals and 251 beds in the psychiatric programs.* Despite this, the department has not reverted unused funds to the General Fund at the end of the year.

The gap between the budgeted and actual population is problematic for two reasons. First, it suggests that the department is over-budgeted to serve its current population. Second, it suggests that approving additional funds for the department will not necessarily result in an increase in population or a reduction in waitlists. Instead, additional funding may only result in funding for positions that DSH is unable to fill, not an increase in hospital capacity. For example, despite the Legislature approving funding to support 155 additional beds in the 2013-14 budget for IST and MDO populations, these populations have actually declined by 30 patients statewide.

LAO Recommendation. In view of their current over-budgeting, the LAO recommends that the Legislature reject the Governor's proposal to provide additional funding for increased bed capacity at DSH–Vacaville and DSH–Salinas Valley.

Staff Comment. Similar to the previous issue, prior to providing any additional funding, the Legislature may wish to require the department to better manage its existing beds and fill some of the 600 vacant beds in its current budget, including 251 beds in the prison psychiatric programs. In addition, the Legislature may wish to consider adopting the LAO proposal to require an independent staffing analysis prior to approving any additional funding for DSH.

Staff Recommendation: Hold open pending updated population data in the May Revision.

Issue 6: Security Fencing at Patton

Governor's Budget. This project proposes to demolish ground guard posts, existing fencing, lighting, paving, and selected trees and shrubs. Construction will be a Level II design, double perimeter fence with barbed tape, fence detection system, 13 ground guard posts, two vehicle and pedestrian sally ports, perimeter patrol roadway improvements, modification to portions of the internal roads, new security lighting, and closed circuit television cameras. This project will support the re-evaluation of existing working drawings, and fund the construction phase. The total project cost is estimated to be $16.4 million, and CDCR expects savings of $4.8 million in annual savings due to a reduction in security staff.

Staff Comments. No concerns have been brought to the subcommittee's attention concerning this proposal.

Staff Recommendation. Approve as budgeted.

Action: Approved Vote: 3 – 0

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Ellen Corbett

Senator Bill Monning
Senator Mimi Walters

April 3, 2014

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

Room 4203, State Capitol

Agenda – Part B
(Michelle Baass)

Community Mental Health Overview 3

0977 California Health Facilities Financing Authority 5
1. Investment in Mental Health Wellness Act of 2013 5

4560 Mental Health Services Oversight and Accountability Commission 7
1. Overview 7
2. Investment in Mental Health Wellness Act of 2013 – Triage Personnel 10

4260 Department of Health Care Services 13
1. Community Mental Health Overview 13
2. 2011 Realignment – Behavioral Health Subaccount Growth Allocation 14
3. SB 1 X1 - Mental Health and Substance Use Disorder Benefit Expansion 17
4. Monitoring of County Mental Health Plans 21
5. Performance Outcomes System Plan for EPSDT Mental Health Services 23
6. Implementation of SB 82 and SB 364 – Staff Request 28
7. Drug Medi-Cal Overview and Major Issues 30
8. Re-Certification of Drug Medi-Cal Providers 37
9. Substance Use Disorder Program Integrity – Counselor & Facility Complaints 41
10. Continuance of Driving Under the Influence Program Evaluation 43

Appendix A: Medi-Cal Mental Health and Substance Use Disorder Services 45

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.

Community Mental Health Overview

Background: County Mental Health Plans. 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.

Specifically, counties are responsible for: (1) all mental health treatment services provided to low-income, uninsured individuals with severe mental illness (2) Medi-Cal Specialty Mental Health Services for adults and children, (3) mental health treatment services for individuals enrolled in other programs, including special education and CalWORKs, and (4) programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Medi-Cal Specialty Mental Health Services Program. 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. Medi-Cal enrollees may also receive certain limited mental health services, such as pharmacy benefits, through the Fee-For-Service system.

California's Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2015. See below for budget summary.

Table: Medi-Cal Specialty Mental Health Services Funding Summary

2013-14		2014-15	
General Fund	**Federal Funds**	**General Fund**	**Federal Funds**
$28,981,000	$1,891,641	-$6,000,000	$1,835,949

In 2014-15, it is projected that 242.843 adults and 261,507 children will receive Medi-Cal Specialty Mental Health Services (using the accrual methodology). It should be noted that these projected caseload estimates do not include the anticipated caseload growth as a result of the optional Medi-Cal expansion as provided by AB 1 X1 (Pérez), Chapter 3, Statutes of 2013-14 of the First Extraordinary Session.

Mental Health Services Act (Proposition 63 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). See Overview item under the Mental Health Services Oversight and Accountability Commission for more information on the MHSA.

The budget projects $1.587 billion in MHSA revenues in 2014-15, of this $1.36 billion is for local assistance and about $80 million is for state administration. For 2013-14, the budget projects $1.375 billion in MHSA revenues, of this about $69 million is for state administration. Counties receive MHSA funds from the State Controller's Office on a monthly basis.

Behavioral Health Realignment Funding. As discussed above, the 2012 budget implemented the realignment of Medi-Cal Specialty Mental Health Services and in 2011, the Drug Medi-Cal program was realigned to the counties. The table below provides a summary of realignment revenue for these two programs.

Table: Behavioral Health Realignment Funding (dollars in millions)

Account	**2013-14**			**2014-15**		
	Base	**Growth**	**Total**	**Base**	**Growth**	**Total**
1991 Realignment						
Mental Health Subaccount*	-	$0.237	$0.2	-	$76.3	$76.3
2011 Realignment						
Mental Subaccount Health Account*	$1,120.6	$8.0	$1,128.6	$1,120.6	$19.8	$1,140.4
Behavioral Health Subaccount**	$992.3	$52.8	$1,045.1	$1,045.3	$184.3	$1,229.6
Total			**$2,173.9**			**$2,446.3**

*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.

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 which 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, 2014 and on or before May 1, 2015, a report on the progress of the implementation of these grant programs.

Implementation Status. As required by SB 82, CHFFA conducted public forums throughout the state in the fall of 2013 to gather stakeholder input into the design of this competitive grant program. It also adopted emergency regulations to implement the grant program.

Per SB 82 and the implementing emergency regulations, the scoring for these applications was weighted more towards applications that proposed to develop this crisis treatment infrastructure in a community-based residential setting instead of a institutional or hospital-like setting.

CHFFA has completed its review of the first round of applications and anticipates announcing the recommended grant awards by the first week of April. These recommendations must be adopted by the CHFFA board and are tentatively scheduled to be heard at the April CHFFA board meeting. Counties would have an opportunity to appeal the CHFFA recommendations. Depending on if counties appeal and the nature of the appeals, grant awards could be distributed as early as the end of April and likely no later than the end of May.

The following counties applied for these grants: Alameda, Butte, Contra Costa, El Dorado, Fresno, Humboldt, Kern, Los Angeles, Lake Marin, Mendocino, Merced (with Calaveras, Tuolumne, Mariposa, Madera), Monterey, Napa, Nevada, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta (to serve Siskiyou, Trinity, Modoc, Lassen, Tehama), Solano, Sonoma, Stanislaus, Ventura, and Yolo.

The total first round of capital funding recommended by CHFFA for approval by the board is $76.5 million (out of the $142.5 million available). This funding would support 835 new crisis beds and 52 new mobile crisis vehicles.

The total personnel funding recommended by CHFFA for approval by the board is about $6.5 million (of the $6.8 million for personnel).

According to CHFFA, a second funding round for crisis residential treatment programs appears very likely. The second funding round will begin immediately following awards made by the CHFFA board for the first funding round. Whether a second funding round will also include crisis stabilization or mobile crisis programs is not yet clear. An update on funding for these programs will be provided as soon as CHFFA knows for certain whether additional funds remain.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide an overview and update on this item.

2. Please discuss how SB 82 and the emergency regulations to implement this competitive grant program are focused on developing a crisis treatment infrastructure that is community-based.

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. 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.

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 who meet criteria as contained in the MHSA.

The Commission consists of 16 voting members as follows:

- The Attorney General or his or her designee.
- The Superintendent of Public Instruction or his or her designee.
- The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.
- The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.
- The following are appointed by the Governor:
    - Two persons with a severe mental illness.
    - A family member of an adult or senior with a severe mental illness.
    - A family member of a child who has or has had a severe mental illness.
    - A physician specializing in alcohol and drug treatment.
    - A mental health professional.
    - A county sheriff.
    - A superintendent of a school district.
    - A representative of a labor organization.
    - A representative of an employer with less than 500 employees.
    - A representative of an employer with more than 500 employees.
    - A representative of a health care services plan or insurer.

  In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

The MHSOAC provides vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure Californians understand mental health is essential to overall health. The MHSOAC holds public systems accountable and provides oversight for eliminating disparities, promoting mental wellness, recovery and resiliency and ensuring positive outcomes for individuals living with serious mental illness and their families.

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.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide a brief overview of the MHSOAC and an update on recent activities and explain how they are in furtherance of its mandate.

2. What efforts does the MHSOAC have underway to utilize its evaluations regarding the successes and challenges of MHSA programs?

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-two counties received the highest score within their region and were awarded grant funding.

A total of 478.6 triage personnel (184 are for peer positions) will be added through the awarding of these MHSA grant funds. These positions will be mobile and able to travel to respond to mental health crises, including crisis involving law enforcement. 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. See table below for award details.

Table: Investment in Mental Health Wellness – Triage Personnel Grant Awards

	2013-14	2014-15	2015-16	2016-17		FTEs
Amount Allocated	**$32,000,000**	**$32,000,000**	**$32,000,000**	**$32,000,000**		
Southern Region	**$10,848,000**	**$10,848,000**	**$10,848,000**	**$10,848,000**	**County Total**	
Ventura	$840,259	$2,126,827	$2,242,542	$2,364,043	$7,573,671	23.0
Riverside	$488,257	$2,134,233	$2,307,808	$2,510,844	$7,441,142	32.3
Santa Barbara	$933,135	$2,352,536	$2,468,608	$2,594,250	$8,348,529	23.5
Orange	$1,250,000	$3,000,000	$3,000,000	$3,000,000	$10,250,000	28.0
Region Total	**$3,511,651**	**$9,613,596**	**$10,018,958**	**$10,469,137**		**106.8**
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	$31,177,000	183.0
Region Total	**$3,802,000**	**$9,125,000**	**$9,125,000**	**$9,125,000**		**183.0**
Central	**$4,576,000**	**$4,576,000**	**$4,576,000**	**$4,576,000**	**County Total**	
Yolo	$221,736	$505,786	$496,247	$504,465	$1,728,234	8.3
Calaveras	$41,982	$73,568	$73,568	$73,568	$262,686	1.0
Tuolumne	$74,886	$132,705	$135,394	$135,518	$478,503	3.0
Sacramento	$545,721	$1,309,729	$1,309,729	$1,309,729	$4,474,908	20.8
Mariposa	$88,972	$196,336	$203,327	$210,793	$699,428	4.3
Placer	$402,798	$750,304	$667,827	$688,417	$2,509,346	13.6
Madera	$163,951	$389,823	$410,792	$396,030	$1,360,596	4.2
Merced	$359,066	$868,427	$882,550	$893,026	$3,003,070	8.0
Region Total	**$1,899,112**	**$4,226,678**	**$4,179,434**	**$4,211,546**		**63.2**
Bay Area	**$6,208,000**	**$6,208,000**	**$6,208,000**	**$6,208,000**	**County Total**	
Sonoma	$351,672	$871,522	$897,281	$923,888	$3,044,363	8.0
Napa	$126,102	$411,555	$403,665	$382,313	$1,323,635	6.0
San Francisco	$1,751,827	$4,204,394	$4,204,394	$4,204,394	$14,365,009	63.7
Marin	$137,065	$315,738	$320,373	$326,746	$1,099,922	3.0
Alameda	$311,220	$765,811	$785,074	$804,692	$2,666,797	11.6
Region Total	**$2,677,886**	**$6,569,020**	**$6,610,787**	**$6,642,033**		**92.3**
Superior	**$1,216,000**	**$1,216,000**	**$1,216,000**	**$1,216,000**	**County Total**	
Butte	$358,519	$514,079	$199,195	$3,277	$1,075,070	18.0
Lake	$26,394	$52,800	$52,800	$52,800	$184,794	1.0
Trinity	$60,697	$145,672	$145,672	$145,672	$497,713	2.5
Nevada	$289,260	$694,169	$728,878	$765,321	$2,477,628	11.8
Region Total	**$734,870**	**$1,406,720**	**$1,126,545**	**$967,070**		**33.3**
Total	**$12,625,519**	**$30,941,014**	**$31,060,724**	**$31,414,786**		**478.6**
Surplus	**$19,374,481**	**$1,058,986**	**$939,276**	**$585,214**		

Contracts between the MHSOAC and county mental health departments receiving grant awards are expected to be executed in March. with funding available to counties shortly thereafter.

In the current year, $19 million in these MHSA grant funds were not awarded due to the time it took to develop this competitive program. The Administration is considering options for the use of this funding.

Subcommittee Staff Comment. This is an informational item.

Questions.

1. Please provide an overview of this item.

4260 Department of Health Care Services

1. Community Mental Health Overview

As discussed in detail in the "Community Mental Health Overview" section of the agenda, 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. Specifically, counties are responsible for: (1) all mental health treatment services provided to low-income, uninsured individuals with severe mental illness (2) Medi-Cal Specialty Mental Health Services for adults and children, (3) mental health treatment services for individuals enrolled in other programs, including special education and CalWORKs, and (4) programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Subcommittee Staff Comments. This is an informational item. However, it should be noted that the January Medi-Cal Specialty Mental Health estimate did not include a forecast of the utilization of these services by individuals eligible for Medi-Cal through the optional expansion implemented by AB 1 X1. Even though these services would be fully funded by the federal government, it is important to have an understanding of the projected changes in utilization of these services as a result of the Medi-Cal expansion.

The Administration indicates that the projected impact of the optional Medi-Cal expansion on Medi-Cal Specialty Mental Health will be included in the May Revise.

Questions.

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

2. 2011 Realignment – Behavioral Health Subaccount Growth Allocation

Budget Issue. The formula to allocate 2011 Realignment Behavioral Health Subaccount Growth funds has not yet been determined. These growth funds are estimated at $27.9 million in 2012-13, $52.8 million in 2013-14, and $184.3 million in 2014-15.

The Department of Finance, in consultation with the appropriate state agencies and the California State Association of Counties, is required to develop a schedule for the allocation of these funds to the counties.

The Administration indicates that it is still in discussions with counties to finalize the Behavioral Health Subaccount Growth schedule. As part of these discussions, the Administration is looking at the most recent expenditure data available to determine which counties are over and under Behavioral Health Subaccount allocations and where growth funding could fund entitlements.

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, per 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, per 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, per 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 Mental Health Directors Association to ensure all counties are aware that entitlement programs and clients cannot be denied services.

Additionally, the Administration cites that Section 1810.226 of the California Code of Regulations defines a mental health plan to be an entity that contracts with the Department of Health Care Services to provide directly or arrange and pay for specialty mental health services to beneficiaries in a county as provided in Chapter 11 of Title 9 of the California Code of Regulations. The Department has executed contracts with the county mental health departments to be the mental health plans for Medi-Cal where the county agrees to provide directly or arrange and pay for the provision of Medi-Cal specialty mental health services to beneficiaries in a county. Statute also provides DHCS the ability to investigate complaints and the authority to impose sanctions on counties that do not fulfill its obligations as a mental health plan. Those sanctions may include fines or penalties.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as the Administration has not yet released its proposed formula. Key considerations when evaluating the proposed formula include:

- Does the proposed formula reflect actual expenditures for Medi-Cal Specialty Mental Health and Drug Medi-Cal?

- Does the proposed formula make it clear to counties that funding for entitlement programs is not capped and that counties need to provide the entitled services?

- Does the proposed allocation of growth funds incentivize improvement in the delivery of services?

- Will the allocation of growth funds be done on a timely basis so counties can budget and rely on the prompt allocation of these funds?

Questions.

1. Please provide an overview of this item and an update on when the Administration will release the proposed allocation formula.

2. Please confirm that Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs that the counties must fully fund. How does the state monitor to

ensure that counties are not capping services and are not providing less comprehensive services for these entitlement programs.

3. SB 1 X1 - Mental Health and Substance Use Disorder Benefit Expansion

Budget Issue. In order to implement SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, which expanded Medi-Cal mental health and substance use disorder (SUD) benefits, the Governor's budget proposes the following:

1. **Mental Health Benefit Expansion -** $300 million ($119 million General Fund, $181 federal funds).

2. **Substance Use Disorder (SUD) Services Benefit Expansion -** $206 million ($79 million General Fund, $127 million federal funds).

3. **Additional Positions to Implement SUD Expansion -** DHCS requests 10 permanent positions and 12 two-year limited-term positions to implement new requirements set forth in the Affordable Care Act (ACA), and enacted in SB 1 X1 and as a part of the 2013-14 budget, for enhanced Medi-Cal substance use disorders services.

   According to DHCS, these positions would provide program oversight and monitoring, policy development, program integrity and compliance with applicable state and federal policies, statutes and regulations. The total proposed funding for the 22 positions is $2,748,000 ($1,303,000 General Fund and $1,445,000 federal funds).

Background. The ACA requires states electing to participate within 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 that comports with federal requirements. The ACA regulations have delineated mental health and substance use disorder services as part of the EHB standard and require all alternative benefit plans under Section 1937 of Title XIX of the Social Security Act to cover such services.

California is required to meet these federal standards for the Medi-Cal expansion population. The EHB standard must also be met by non-grandfathered private health plans in a state's individual and small group markets. SB 1 X1 addressed the EHB standard by specifying that Medi-Cal would provide the same services for its members that they could receive if they bought a non-grandfathered health plan in the state's individual and small group markets for mental health and substance use disorder services. Consequently, those individuals previously and newly-eligible for Medi-Cal will have access to the same set of services.

Starting in 2014, the array of mental health and substance use disorder services will expand to better meet the needs of individuals eligible for Medi-Cal. See Appendix A for more information.

The following mental health benefits will be available through Medi-Cal managed care plans or the fee-for-service delivery system:

- Individual and group mental health evaluation and treatment (psychotherapy)

- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies, and supplements
- Psychiatric consultation

Specialty mental health services currently provided by County Mental Health Plans will continue to be available.

The following substance use disorder services benefits will also be made available to eligible Medi-Cal beneficiaries:

- Voluntary Inpatient Detoxification
- Intensive Outpatient Treatment Services
- Residential Treatment Services
- Outpatient Drug Free Services
- Narcotic Treatment Services

Status of the Mental Health Benefit Expansion. According to DHCS, the mental health benefit expansion is operational. DHCS completed readiness assessments for all new mental health benefits for all Medi-Cal Managed Care Plans (MCPs). A few plans are refining their policies and procedures based on ongoing communication with DHCS. DHCS expects to complete review during spring 2014.

For the period of January 1 - June 30, 2014, DHCS finalized mental health rates for the optional expansion population and the plans are currently receiving those payments as part of the optional expansion rates. For the non-expansion population, DHCS is in the process of submitting capitation rates. Once those rates are approved, payments to plans will be retroactive to January 1, 2014. The rates for 2014-15 have not been finalized.

DHCS finalized the Medi-Cal Managed Care contract amendments. The amended contracts are in the process of being executed. DHCS worked with stakeholders and created Memorandum of Understanding (MOU) templates to be used by Medi-Cal Managed Care Plans and Mental Health Plans. Plans are required to submit signed MOUs to DHCS, by June 30, 2014.

These MOUs are critical in that they outline the agreed upon process between Medi-Cal Managed Care Plans and Mental Health Plans for referrals, common screening tools, and dispute resolution, for example.

Status of SUD Benefit Expansion. Effective January 1, 2014, providers are able to offer the new substance use disorder benefits. However, for these specific providers, they cannot receive reimbursement through the Drug Medi-Cal program until the Centers for Medicare and Medicaid Services (CMS) approves California's pending State Plan Amendment for reimbursement of these services. As of February 25, 2014, no claims have been submitted for the expanded services available through SB 1 X1.

SB 1 X1 authorizes all Medi-Cal beneficiaries with a medical need for the service to receive Day Care Rehabilitation (to be renamed Intensive Outpatient Treatment) and Residential Treatment services. These services will no longer be restricted to specific subpopulations. DHCS anticipates these services will be available as soon as CMS approves the relevant State Plan Amendment (SPA) 13-038.

IMD Exclusion. Additionally, in implementing the new expanded residential Drug Medi-Cal benefit for all adults, DHCS has encountered an issue. Based on CMS current interpretation of the Institutions for Mental Disease (IMD) Exclusion, DHCS is prohibited from using federal funds to reimburse for any Medi-Cal service when a Medi-Cal beneficiary is receiving substance use disorder services in residential facilities larger than 16 beds. Ninety percent of the residential treatment beds in California exceed the current IMD limit.

DHCS is currently working with CMS to address and resolve outstanding issues associated with approval of SPAs 13-038 and 13-035, as well as with the interpretation of the IMD definition as it relates to residential SUD residential treatment facilities.

DHCS is in the process of re-certifying Drug Medi-Cal providers; however, existing providers are still certified while they are going through the re-certification process. DHCS is working to ensure there will be enough providers. DHCS recently mapped the locations of DMC treatment providers. As expected, most providers are located in major population areas, with far fewer DMC providers in rural areas. DHCS will continue to work with county partners and stakeholders to track issues related to provider capacity.

Proposed rates for expanded Drug Medi-Cal services are part of SPA 09-022, which has not yet been approved by CMS.

Definition of "Moderate" Mental Illness. The definition of "moderate" mental illness has not been agreed upon by the state, Medi-Cal managed health care plans, and county mental health plans. This definition is important to ensure that a person can easily access needed services and does not have to navigate back and forth between the managed care plan and the county health plan to receive the service.

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

Questions.

1. Please provide an overview of this issue.

2. How did DHCS notify existing Medi-Cal enrollees about these new Medi-Cal mental health and substance use disorder services benefits?

3. Are there any examples of best practices or innovative models from how the plans have implemented this?

4. Are there any recent updates regarding discussions with the federal government and the IMD exclusion?

5. What steps is DHCS taking to work with managed care plans and county mental health plans to define “moderate” mental illness? Have there been any issues with consumers not receiving services because this definition is not clear?

6. Do all Medi-Cal managed care plans have existing MOUs with county mental health plans? What is the status of MOU amendments or new MOUS? Please provide an overview of the new components of the MOU regarding the expanded mental health benefits.

7. Does DHCS track issues or consumer difficulties related to the interaction between managed care plans and county mental health plans? Please explain.

8. Is DHCS tracking utilization of these new benefits?

4. Monitoring of County Mental Health Plans

Budget Issue. DHCS requests 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 request is in direct response to concerns which the Centers for Medicare and Medicaid Services (CMS) has communicated to DHCS regarding the following areas: (1) timely access to services in the Medi-Cal Specialty Mental Health Services (SMHS) Program; (2) the availability of interpreter services, especially for Spanish speaking beneficiaries; and (3) significantly elevated rates of non-compliance observed during DHCS compliance system reviews of MHP operations, California External Quality Review Organization (EQRO) reviews, as well as the continuing high rates of claim disallowance resulting from both outpatient and inpatient medical record reviews.

CMS has made clear its expectation that DHCS will take effective remedial action immediately to bring the levels of non-compliance and claims disallowance down to acceptable levels.

Background. CMS sent DHCS a letter dated June 27, 2013, stating that it had approved DHCS's SMHS Waiver Renewal Application for a two-year period, rather than the five-year period which DHCS had requested. The letter states that:

> *".....CMS harbors concerns about access challenges faced by some County Mental Health Plans… CMS will be carefully analyzing the State's monitoring activities and corrective action plans to ensure all necessary actions are implemented and improvement occurs."*

The letter also requests that DHCS begin submitting *"all triennial monitoring reports to CMS within 30 days of completion,"* for its review, and expresses concerns regarding the frequency of reviews and what appears to be a lack of follow-up on areas identified as being out of compliance.

In a follow-up telephone call to the June 27, 2013 letter, CMS reiterated concerns about the continuing elevated rates of disallowance resulting from inpatient and outpatient medical record reviews, stating that a non-compliance or disallowance rate above three percent is considered high.

California's current disallowance rates are as follows:

- The average MHP non-compliance rate for system reviews of MHPs for fiscal years 2011-2012 and 2012-2013 was 23 percent.

- The average MHP disallowance rate for outpatient medical record reviews for fiscal years 2011-2012 and 2012-2013 was 32 percent.

- The average MHP disallowance rate for the 18 Short-Doyle/Medi-Cal acute psychiatric inpatient hospitals resulting from inpatient medical record reviews from 2002 to the present was approximately 50 percent.

Without the additional resources being requested in this proposal, DHCS indicates it will not be able to address the concerns stated by CMS and will not be able to increase the scope, frequency and intensity of monitoring which is needed.

Position Details. DHCS requests the following seven additional positions in the Mental Health Services Division:

1. Program Oversight and Compliance Branch—Compliance (4.0 Positions): Increase scope, intensity, and frequency of oversight and monitoring of the county MHPs and identified providers.

2. Program Policy and Quality Assurance Branch—County Support (2.0 Positions): Increase the level of monitoring and technical assistance provided to the MHPs by the county support unit, including clinical technical assistance in order to ensure they are in compliance with state and federal requirements, and increasing the level of follow-up when out-of-compliance areas are identified.

3. Program Policy and Quality Assurance Branch—Appeals (1.0 Positions): Establish staffing for appeals within the branch which includes licensed clinical staff who will be responsible for reviewing appeals and making appeal decisions.

Subcommittee Staff Comment and Recommendation—Approve. No concerns have been raised regarding this proposal. It is critical that DHCS take immediate action to address CMS's concerns and ensure that county mental health plans comply with Medi-Cal rules.

Questions.

1. Please provide an overview of this request.

2. Please explain how this proposal will ameliorate CMS concerns?

3. What are some examples of sanctions or corrective actions that have been undertaken by plans?

5. Performance Outcomes System Plan for EPSDT Medi-Cal Mental Health Services

Budget Issue. DHCS requests ongoing funding of $563,000 ($242,000 General Fund and $321,000 federal funds) for four permanent positions to implement a Performance Outcome System for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services 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 these 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.

Background. SB 1009 required DHCS to: (1) convene a stakeholder advisory committee no later than September 1, 2012, (2) submit to the Legislature by October 1, 2013, a Performance Outcomes System Plan, and (3) submit to the Legislature by January 10, 2014, a Performance Outcomes System Implementation Plan.

DHCS convened the Stakeholder Advisory Committee in September 2012, and held the first meeting in October 2012 to discuss how best to approach the development of a Performance Outcome System to evaluate California's Medi-Cal specialty mental health services for children and youth. This committee included participation by representatives of youth family members and/or caregivers; county staff; child/youth advocates; other California state-level entities, including the Legislature, and the Mental Health Services Oversight and Accountability Commission (MHSOAC); as well as other members of the interested public.

Informed by input from the Stakeholder Advisory Committee and Subject Matter Expert Workgroup, DHCS produced a System Plan that sets forth a framework from which specialty mental health services outcomes may be measured. It described next steps that must be taken to identify an evaluation methodology (e.g., specifying the evaluation questions, identifying the target population, selecting valid and reliable measurement tools) and to develop a continuous reporting and quality improvement process between the state, counties, and their providers.

In January 2014, DHCS submitted its Performance Outcomes System Implementation Plan to the Legislature. This implementation plan discusses the steps necessary to implement a fully operational performance outcomes system and includes a timeline to achieve this. See below for timeline.

Table: Timeline to Build the EPSDT Performance Outcome System

Milestones	Date
System Implementation Plan	
Draft System Implementation Plan	November 2013
Obtain input on the final draft Implementation Plan from the Stakeholder Advisory Committee	December 2013
Deliverable: System Implementation Plan	**January 2014**
Establish Performance Outcome System Methodology	
Facilitate stakeholder input on the Performance Outcome System evaluation methodology (including standardized data sources and data collection tools used for the system, frequency of administration, etc.)	October 2014
Obtain Input on the Performance Outcome System methodology protocol from the Stakeholder Advisory Committee	December 2014
Deliverable: Performance Outcome System Protocol	**February 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	September 2014
Counties remedy data quality issues	Ongoing Beginning in October 2014
Develop performance outcomes report template(s)	November 2014
Obtain input on the report template(s) from the Stakeholder Advisory Committee	December 2014
Deliverable: Statewide and County Reports on Initial Performance Outcomes Using Data from Existing DHCS Databases	**Ongoing Beginning in December 2014**
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 outcome system from the Performance Outcomes System Stakeholder Advisory Committee	April 2014

Milestones	Date
Deliverable: Performance Outcome System Plan Update	**October 2014**
Deliverable: Performance Outcome System Implementation Plan Update	**January 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 Outcome System methodology.	FY 2014-15
Obtain input on the report template(s) from the Stakeholder Advisory Committee	Summer 2015
Deliverable: Statewide and County Reports on Comprehensive Performance Outcomes Using Existing and Expanded Data	**Summer 2016**
Continuous Quality Improvement Using Performance Outcomes Reports	
Develop trainings to support interpretation of the performance outcomes reports (initial and comprehensive)	Ongoing Beginning in January 2015
Develop quality improvement plan template(s)	Ongoing Beginning in March 2015
Obtain input on the quality improvement plan template(s) from the Stakeholder Advisory Committee	Spring 2015
Deliverable: Quality Improvement Plans	**Summer 2015**
Support and monitoring of quality improvement plans	Ongoing

According to DHCS, the success of this Performance Outcome System requires adequate and appropriate staff resources. Research and information technology staff are needed to support the development of the Performance Outcome System evaluation methodology, as well as to extract, compile, and analyze the data to produce reports. Furthermore, technical assistance and quality improvement staff are required to provide counties with the support that is necessary to interpret reports and develop strategies to monitor and improve local performance and outcomes.

The major steps for the positions requested are:

- Collaborate with mental health stakeholders to define the information needed in the Performance Outcome System
- Assess what information is currently available at DHCS, the counties, and providers

- Design, develop and implement the Performance Outcome System, including production of preliminary counties reports and establishment of a quality improvement process
- Prepare and train DHCS staff and collaborate with counties on the necessary training for county staff who will analyze and make decisions based on the outcomes information
- Identify system improvements and methods to include additional data

To support these development, implementation, and ongoing efforts, DHCS requests the following four positions:

- One Research Program Specialist (RPS) III
    - Leads the research activities associated with the most complex efforts (such as POS)
    - Independently analyzes complex matters and makes recommendations
    - Acts as the research/evaluation subject matter expert
    - Coordinates with high-level staff and officials
    - Completes deliverables and products
- One Staff Programmer Analyst/Specialist (SPA/S)
    - Maintains the research analytics data requirements, including system connectivity and database design.
    - Works as a liaison with information technology staff
    - Leads the technology activities associated with data systems, Electronic Health Record Systems, and Health Information Exchange systems, to provide data reporting solutions that work with county systems
    - Assists with complex data analysis
    - Writes complex programming logic to extract and compile data for analysis
    - Provides recommendations for report development
    - Performs system testing
- One Health Program Specialist (HPS) II
    - Works with Stakeholders to identify and utilize tools to measure the administrative data elements
    - Monitors implementation of the Performance Outcome System plan
    - Analyzes data reported by the counties using the indicators from the Performance Outcome System
    - Provides technical assistance and guidance to DHCS, counties, and providers in interpreting and utilizing the administrative Performance Outcome System report information at the program and system levels
    - Provides consultation and technical assistance as needed to local Quality Improvement (QI) Committees to ensure consistency in utilization of the administrative Performance Outcome System data
    - Assists mental health plans (MHPs) to identify ways to integrate review and analysis of administrative Performance Outcome System information within existing QM work plans and QI Committee processes

  - Provides technical assistance to counties on data collection, timely submission, and refinement of administrative performance and outcomes measures

- One Consulting Psychologist (CP)
  - Works with Stakeholders to identify and utilize tools to measure the clinical data elements
  - Monitors implementation of the Performance Outcome System plan
  - Analyzes data reported by the counties using the indicators from the Performance Outcome System
  - Provides technical assistance and guidance to DHCS, counties, and providers in interpreting and utilizing the clinical Performance Outcome System report information on their clinical and practice improvements at the individual and provider levels
  - Provides consultation and technical assistance as needed to local QI Committees to ensure consistency in utilization of the clinical Performance Outcome System data
  - Assists MHPs to identify ways to integrate review and analysis of clinical Performance Outcome System information within existing quality improvement work plans and QI Committee processes.
  - Provides technical assistance to counties on data collection and refinement of clinical performance and outcomes measures.

Subcommittee Staff Comment and Recommendations—Approve. No issues have been raised regarding this proposal. The findings from this Performance Outcome System will help ensure that consistent, high quality, and fiscally effective services are delivered to children and youth and that these services improve the lives of children and youth.

Questions.

1. Please provide an overview of this proposal and the timeline to develop this Performance Outcome System.

2. Is DHCS confident that it can fill these positions in a timely manner to ensure that there are no delays in implementing this system?

6. Implementation of SB 82 and SB 364 – Staff Request

Budget Issue. DHCS requests the authority to establish three permanent, full-time positions due to the enactment of SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, the Investment in Mental Health Wellness Act of 2013, and the enactment of SB 364 (Steinberg), Chapter 567, Statues of 2013, which broadens the types of facilities that can be used for the purposes of 72-hour treatment and evaluation under Welfare and Institutions Code (WIC) Section 5150.

The cost for these positions is $353,000 ($177,000 General Fund and $176,000 Federal Fund). Two positions would support the workload related to SB 82 and one position would support the workload related to SB 364.

SB 82 – Investment in Mental Health Wellness Act of 2013. SB 82, the Investment in Mental Health Wellness Act of 2013, set goals of adding at least 25 mobile crisis support teams, and 2,000 crisis stabilization and/or treatment beds for use in California communities over the next two years. As discussed in an earlier agenda item, 835 beds will be added in the first round of grant awards and priority was given to proposals that were community-based versus institution-based.

DHCS finds that SB 82 would increase its workload related to (1) conducting initial and annual site certifications for residential facilities; (2) conducting initial and triennial certifications of mobile crisis teams and crisis stabilization units; and (3) carrying out tasks related to DHCS approval of 5150 designated facilities related to the new facilities that are added through SB 82.

SB 364 – 72-Hour Treatment Facilities. SB 364 broadens the types of facilities that can be used for 72-hour treatment and evaluation under WIC 5150. WIC 5150 provides that, "when a person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, he or she may, upon probable cause, be taken into custody by a peace officer, member of the attending staff of an evaluation facility, designated members of a mobile crisis team, or other designated professional person, and placed in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services."

DHCS contends that implementation of SB 364 would increase workload related to (1) maintaining a statewide list of all 5150-designated facilities, (2) updating 5150 regulations, (3) conducting statewide site-reviews of these facilities, and (4) investigate complaints related to these facilities.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. Part of the estimated workload for these proposed positions is based on the assumption that 2,000 crisis beds would be up in 2014-15; however, awards to develop only 835 have been recommended by the California Health Facilities Financing Authority (CHFFA). Additionally, it is estimated that SB 82 and SB 364 would increase the workload

related to the 5150 designation, however, it is not clear if this workload would materialize (1) given that the CHFFA grants focused on community-based residential treatment and (2) because it is not clear if DHCS has received any requests related to the broadening of facility types that can be used per WIC 5150 as allowed by SB 364.

Questions.

1. Please provide an overview of this proposal.

2. Has DHCS received requests related to designating new facilities as 5150 per SB 364?

7. Drug Medi-Cal Overview and Major Issues

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 $392.2 million for DMC in 2014-15, a $134.4 million increase over the current year. This increase reflects the increased costs of the enhanced substance use disorder (SUD) benefits that were adopted in SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session, as discussed in an earlier agenda item. See the following table for DMC funding summary.

Background. Since 1980, the DMC program has provided medically necessary drug and alcohol-related treatment services to Medi-Cal beneficiaries who meet income eligibility requirements. Services include:

- **Narcotic Treatment Services** – These services are provided to beneficiaries that are opiate addicted and have a substance abuse diagnosis, and/or are Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible.

- **Residential Substance Use 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.)

- **Outpatient Drug Free Treatment Services** – These services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance abuse diagnosis in an outpatient setting.

- **Intensive Outpatient Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week.

- **Naltrexone Treatment Services** – These are outpatient services provided to individuals with confirmed opioid dependence who are at least 18 years of age, opioid-free, and are not pregnant. It is projected that there will be no claims for this service in the current year and budget year.

The DMC program was transitioned from the Department of Alcohol and Drug Programs (DADP) to DHCS, effective July 1, 2012. As part of this transition, a stakeholder process was convened in the fall of 2011. During this process stakeholders raised various recommendations on how to improve the DMC Program.

Table: Drug Medi-Cal Program Funding Summary (dollars in thousands)

	2013-14				2014-15			
Service Description	**GF**	**County Funds**	**FF**	**TF**	**GF**	**County Funds**	**FF**	**TF**
Narcotic Treatment Program		$54,437	$55,944	$110,381		$54,363	$57,938	$112,301
Residential Substance Use Services*	$21,016	$1,768	$32,255	$55,039	$50,345	$3,082	$77,684	$131,111
Outpatient Drug Free Treatment Services		$45,942	$27,083	$73,036		$50,013	$31,226	$81,250
Intensive Outpatient Services**	$7,823	$12,820	$24,336	$44,979	$18,642	$14,769	$42,654	$76,065
Provider Fraud Impact		-$14,650	-$14,650	-$29,300		-$14,650	-$14,650	-$29,300
Drug Medi-Cal Program Cost Settlement		$393	$3,036	$3,429		$396	$3,033	$3,429
Annual Rate Adjustment					-$248	-$2,426	-$2,359	-$5,033
County Administration					$4,197	$7,403	$10,529	$22,129
3rd Party Validation of Providers	$125		$125	$250	$125		$125	$250
Total	**$28,964**	**$100,710**	**$128,129**	**$257,814**	**$73,061**	**$112,950**	**$206,180**	**$392,202**

*Previously named “Perinatal Residential Substance Abuse Services
**Previously name “Day Care Rehabilitative Services”

Drug Medi-Cal Fraud. 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. The investigative report alleged that, over the past two fiscal years, the DMC program paid $94 million to 56 drug and alcohol rehabilitation clinics in Southern California that have shown signs of deceptive or questionable billing. 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.

In July and August 2013, the DHCS ordered temporary suspensions against 48 alcohol and drug treatment programs at 132 sites where DHCS established credible allegations of fraud. According to the DHCS, these actions were the first phase of an ongoing review of the DMC program by the department's Audits and Investigations (A&I) Division.

Since then, the DHCS has implemented a process requiring all DMC providers to become recertified in order to continue to participate in the program. As of December 17, 2013, the review had resulted in the suspension of 61 DMC providers at 177 locations and 68 of referrals to the California Department of Justice for criminal investigation and prosecution. The DHCS will also be conducting field reviews of all facilities in March and April.

Internal Department Audit. In response to the fraud allegations, DHCS conducted an internal audit of its DMC program. The review concluded that the DMC program's weak internal control structure has exposed DHCS to financial and legal risks as well as increased risks to fraud, waste, and abuse within DMC program. Processes that are intended to serve as vital checks and balances within the program were not effective. DHCS also observed an organization that has historically focused more heavily on programmatic deliverables and services for DMC beneficiaries than measures associated with program integrity.

According to the internal audit, under the former DADP, management's attitude towards program integrity could have been strengthened, as evidenced by the following broad observations made during its limited scope review:

- Weak performance / certification standards for participating providers.
- No re-certification of DMC providers.
- Inconsistent monitoring of both DMC providers and counties for compliance with certification standards and State/county contract requirements, respectively.
- Lack of adequate financial oversight of Narcotic Treatment Programs.
- Minimal sanctions or penalties imposed on DMC providers in the past.
- Staff integrity issues.

As a result of this internal audit, DHCS prepared an implementation plan to act on the findings and recommendations from the audit. This implementation plan identifies action steps to address the problems identified in the audit.

Additionally, a Bureau of State Audit's audit of the Drug Medi-Cal program is in progress and is expected to be released in June 2014.

Proposed Drug Medi-Cal Waiver. In January, DHCS announced its intent to request a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to operate the Drug Medi-Cal Program (DMC) as an organized delivery system.

DHCS hopes to address the following issues with a waiver:

- ***Integration through Coordination.*** The need to maximize services for the beneficiary, with integration through improved coordination of substance use disorder treatment with county mental health and public safety systems and primary care.
- ***Building Upon the Mental Health System.*** The opportunity to build upon the experience and positive results California has achieved in the state administered and county operated Medi-Cal Specialty Mental Health program. In 54 of the 58 counties, mental health and substance use disorder programs are consolidated in the same department.
- ***Medi-Cal Eligibility and Benefit Expansion.*** The expansion of eligibility and substance use benefits in the Medi-Cal program under the Affordable Care Act and enacted in the 2013-14 Budget Act. This will result in tens of thousands of additional potential Medi-Cal beneficiaries seeking enhanced substance use disorder treatment.
- ***Improving Drug Medi-Cal.*** Need to improve the DMC program, in light of recent significant program integrity issues.

Additionally, DHCS contends that the waiver would give state and county officials more authority to select quality providers to meet drug treatment needs. This would strike an appropriate balance between ensuring access to these vital services while also ensuring that drug treatment services are being provided consistent with program goals.

Federal law allows states seeking to improve the performance of Medicaid programs to seek permission from the federal government to deliver those programs in innovative ways in their state. The process for making the change involves seeking a *waiver* of federal Medicaid law.

The waiver would only be operational in counties that elect to opt into this organized delivery system for DMC. DHCS will work with counties to move forward with implementation, particularly in light of 2011 Realignment, which provided counties with the financial and administrative responsibilities for DMC services. Given the spectrum of county infrastructure and resources, DHCS does expect some counties to implement sooner than others. However, DHCS encourages all counties to implement this new model.

DHCS describes a variety of goals of the waiver, such as improving care, increasing access to services, strengthening county oversight of network adequacy, and standardizing provider selection practices. They also cite the following two primary goals:

- ***Elimination of Unscrupulous Providers.*** Currently, the state is required to contract with any provider who fails to acquire a contract with their county, which DHCS believes results in a greater number of fraudulent providers participating in the program; and

- ***Creation of a Single Point of Entry.*** Currently, a Medi-Cal beneficiary seeking substance use disorder treatment services can seek and receive those services from any provider anywhere in the state. There is no organized system to determine if that person is receiving duplicate services or the most appropriate services. DHCS hopes to create a no-wrong-door approach wherein beneficiaries seek many different types of services through counties, and counties would be responsible for conducting medical necessity assessments and providing appropriate, effective referrals.

Proposed Waiver Comparable to Medi-Cal Specialty Mental Health Waiver. DHCS expects that this waiver will improve quality of care, access to services, and program integrity similar to the experience with the Medi-Cal Specialty Mental Health waiver. DHCS finds that this waiver:

- Helps promote a higher quality of provider and increases beneficiary protections. It does this through selective provider contracting based on uniform and federally-approved performance standards (such as HEDIS Measures) and oversight requirements.
- Provides increased administrative authority for counties to select and maintain the highest-quality service providers in all regions of counties.
- Provides for a single-point of beneficiary assessment to determine medical necessity and provide appropriate service referrals.
- Allows for better monitoring oversight by the county and the state through annual external and triennial audits which ensures that providers are meeting expected standards and regulations.

Stakeholder Engagement. DHCS has convened stakeholder calls to discuss, at a very high-level, this proposal. It plans to hold all-day stakeholder meetings on April 2, April 15, and April 30, to further discuss this proposal and solicit stakeholder feedback. No other timeline has been provided by DHCS.

Stakeholder Comments on Proposed Waiver. Although the details of the waiver have not been worked out, stakeholders have provided general comments on the concept of the waiver. For example, the County Mental Health Directors Association and the County Alcohol and Drug Program Administrators Association of California generally support the concept of the proposed waiver as they find that an organized delivery system for SUD services would improve care, increase efficiency, and reduce costs in the Drug Medi-Cal program. Additionally, they find that the proposed waiver would allow counties and the state to better select quality providers to provide these services.

In contrast, some providers, such as the California Opioid Maintenance Providers (COMP), have significant concerns with DHCS' intent to pursue a waiver. COMP finds that a waiver of federal law could limit access to services and could remove entitlement protections.

Additionally, COMP finds that a single-point of entry at counties for Drug Medi-Cal services could impose a barrier for individuals who show-up at a narcotic treatment provider seeking immediate services.

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

- **Drug Medi-Cal Program Integrity.** As discussed in the next agenda item, DHCS plans to recertify all Drug Medi-Cal providers by the end of the budget year. This is an important step in ensuring that these providers meet standards to participate in Medi-Cal and is a critical component to ensure program integrity. However, there are other issues that must be acted upon by DHCS, such as strengthening and clarifying the regulations regarding the requirements and responsibilities of providers and medical directors and developing data mining protocols that could identify "high risk" providers. It will be important for the Legislature to hold DHCS accountable for taking all steps necessary to ensure the integrity of this program.

- **Proposed Drug Medi-Cal Waiver.** At the time of this agenda, DHCS had not yet presented a clear detailed proposal on the waiver. Questions on what an "organized delivery system" means still remain. For example, would this organized delivery system meet Knox Keene requirements or would these requirements be waived; if this organized delivery system is still under a fee-for-service model, how would coordination be ensured and who would pay for the coordination services?

  DHCS points to the Medi-Cal Specialty Mental Health waiver as an example of an organized delivery system that has improved access, quality of care, and program integrity. However, as discussed earlier in the agenda, the federal government has significant concerns with this program, including concerns about timely access to services and language access for non-English speakers.

Questions.

<u>Drug Medi-Cal Overview</u>

1. Please provide an overview of the Drug Medi-Cal program and budget.

<u>Drug Medi-Cal Program Integrity</u>

2. Please provide an overview of the Drug Medi-Cal program integrity issues uncovered this past summer and fall.

3. What steps has DHCS taken to address these program integrity issues?

4. Please describe the different types of programs and providers within Drug Medi-Cal, the various types of licenses and certifications different types of providers are required to have,

and what patterns of fraud have been uncovered related to these different categories of providers. Is there evidence that most of the provider fraud is occurring within one (or more than one) category of providers (or type of treatment)?

5. Does DHCS find that statutory or regulatory changes are necessary to ensure Drug Medi-Cal program integrity? Does DHCS find that a federal waiver is necessary to ensure Drug Medi-Cal program integrity?

6. Is DHCS monitoring to ensure that access to services has not been impacted as a result of suspended/decertified providers? Please explains.

Proposed Drug Medi-Cal Waiver

7. Please provide an overview of the proposed Drug Medi-Cal waiver. What existing problems is the proposed waiver attempting to address?

8. Please explain how DHCS finds that this proposed waiver would improve access to Drug Medi-Cal services.

9. In view of significant CMS concerns with specialty mental health waiver, what is DHCS proposing that will ensure program integrity, quality control, and consumer protections?

10. Does this proposed waiver relate to the expansion of SUD benefits per SB 1 X1? If so, please explain.

11. Please explain how DHCS would work with stakeholders on the development of the proposed waiver. What is the timeline for this process? Who is on the Waiver Advisory Group?

8. Re-Certification of Drug Medi-Cal Providers

Budget Issue. DHCS requests 21 one-year limited-term positions at a cost of $2.2 million ($1.1 million General Fund) to recertify all providers in the Drug Medi-Cal program (DMC). These positions would continue efforts commenced in the current year to improve DMC program integrity and recertify only providers meeting standards of participation in Medi-Cal. DHCS redirected 21 positions in 2013-14 to begin this work.

Background. The administration of the DMC program was previously delegated to the California Department of Alcohol and Drug Programs (DADP) through an Interagency Agreement with DHCS. DADP received Medi-Cal funding from DHCS for eligible services provided to eligible Medi-Cal beneficiaries. At the local level, county welfare departments determined the eligibility of beneficiaries for Medi-Cal and were reimbursed by DADP for the cost of those activities.

The 2012-13 budget transferred administration of the DMC program and applicable Medicaid functions from DADP to DHCS, effective July 1, 2012. Upon the transfer of the program, DHCS began a review of the DMC program. Based on issues it identified, DHCS has initiated a complete review of the DMC program in an effort to address fraud, waste and abuse allegations. As of December 17, 2013, the review had resulted in the suspension of 61 DMC providers at 177 locations and 68 of referrals to the California Department of Justice for criminal investigation and prosecution.

In July 2013, DHCS sent a Notice of Intent to all 1,059 DMC providers that are active billers, notifying them of this recertification process. DMC providers will be mailed recertification packets in three phases beginning with Southern California in July 2013 and ending in Northern California in December 2014. Providers will have 30 days to respond with a submission of an application package and supporting documentation to confirm that the provider continues to meet certification requirements; those who fail to respond will be decertified. All DMC providers that respond will receive an unannounced on-site visit by the DHCS's Audits and Investigations Division (A&I) to confirm they meet standards of participation in the DMC program. DHCS anticipates concluding its recertification efforts by the end of 2014.

The DMC program certification and recertification is a new process for the Provider Enrollment Division (PED) staff which will entail developing the necessary job skills and institutional knowledge to maintain, enhance, and enforce DMC policies and safeguards. In addition, the DMC program certification and program standards have not been updated in years; PED staff will need to become familiar with federal and state laws and regulations governing the DMC program, perform policy review, analysis and interpretation, recommend policies, rules and regulations on program matters, strengthen standards of the certification requirements, and provide recommendations for any necessary State Plan Amendments.

Table: Drug Medi-Cal Program (DMC) –Recertification Timeline

Activity	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Locations	Los Angeles, Orange, San Diego, Riverside, San Bernardino	Remaining Southern Locations, Central Valley & Coastal Counties	Northern California	Narcotic Treatment Providers Statewide	Reconciliation
	Projected Completion Dates				
Notice of Intent to Recertify all DMC providers*	07/15/2013	07/15/2013	07/15/2013	07/15/2013	TBD
Notices returned undeliverable - immediate A&I onsite.					
Redetermination packet mail date	07/31/2013	11/15/2013	12/31/2013		
Provider to submit packet	08/31/2013	12/15/2013	01/31/2014		
Non-responders will be decertified.					
DHCS - Program requirements review Request additional information or forward for onsite	04/17/2014	09/25/2014	12/25/2014		
Provider response to deficiencies	6/27/2014	12/03/2014	3/05/2014		
DHCS Review: Complete deficiency response review and forward to onsite	08/27/2014	01/10/2014	4/15/2015		
A&I onsite reviews and findings report	0827/2014 through 02/27/2014	01/10/2014 through 07/10/2015	4/15/2015 through 10/15/2015		
DHCS – Final Review Recertify or decertify	03/27/2015	08/10/2015	11/15/2015		

*** DMC providers billing in 2012-13**

Tables: Drug Medi-Cal Recertification Applications and Decertifications

PHASE I County	# of Apps Accepted	Sites Decertified
L.A. County	115	106
Orange	1	0
Riverside	24	32
San Diego	30	0
San Bernardino	16	3
Totals	**186**	**141**

PHASE II County	# of Apps Accepted	Sites Decertified
Fresno	54	11
Imperial	9	8
Kern	17	3
Kings	3	0
Madera	2	3
Mariposa	1	0
Merced	4	0
Monterey	0	1
San Benito	0	5
San Joaquin	4	0
San Luis Obispo	4	0
Santa Barbara	14	1
Santa Cruz	13	10
Stanislaus	1	0
Tulare	18	6
Ventura	7	3
Totals	**151**	**51**

PHASE III County	# of Apps Received	Sites Decertified
Alameda	11	1
Butte	4	0
Contra Costa	7	1
El Dorado	5	5
Glenn	2	0
Humboldt	2	0
Lake	2	3
Lassen	1	3
Marin	0	0
Mendocino	3	0
Napa	4	0
Nevada	5	1
Placer	4	1
Sacramento	44	21
San Francisco	4	1
San Mateo	1	0
Santa Clara	30	11
Shasta	3	1
Solano	6	1
Sonoma	8	0
Yolo	2	1
Yuba	1	0
Totals	**149**	**51**

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. The recertification of Drug Medi-Cal providers is a critical component in ensuring the program integrity of the Drug Medi-Cal program. Prior to this process, Drug Medi-Cal providers have not been recertified or evaluated on a regular basis.

Questions.

1. Please provide an overview of this request. How many Drug Medi-Cal providers have been recertified?

2. Please describe the efforts DHCS has undertaken to assist providers in recertification.

3. How is DHCS monitoring changes to access to Drug Medi-Cal services as a result of the recertification efforts (since it is anticipated that some Drug Medi-Cal providers would be decertified through this process)?

4. Please explain how this process will improve program integrity and prevent recurrences of prior problems?

9. Substance Use Disorder Program Integrity – Counselor and Facility Complaints

Budget Issue. DHCS requests $739,000 and six three-year limited-term positions to investigate complaints related to counselors and facilities that provide 24-hour, non-medical residential and outpatient alcohol and other drug (AOD) detoxification, treatment, or recovery services to adults. DHCS states that it is currently backlogged with investigating provider and counselor complaints and is not complying with the state mandate of investigating complaints regarding counselor misconduct within the ninety days of receipt.

The requested position authority and resources would be funded from the Residential and Outpatient Program Licensing Fund (ROLF) and contingent on approval of proposed fee increases for licensed and certified facilities. See table below for current and proposed fees.

Fee Type	Current Fee	Proposed Fee
Initial Residential Licensure Application Fee	$2,773	$3,050
Biennial Residential Licensure Fee	$147 (per bed)	$324 (per bed)
Adolescent Waiver Application Fee	$1,370	$1,507
Facility Relocation Fee	$916	$1,008
Additional Services Fee	$940	$1,034
Initial Combined Residential Licensure and Certification Fee	$3,698	$4,068
Biennial Combined Residential Licensure and Certification Initial/Extension Fee	$147 (per bed)	$324 (per bed)
Initial Outpatient Certification Application Fee	$2,664	$2,931
Biennial Outpatient Certification Initial/Extension Fee	$3,452	$3,798

Background. DHCS licenses and certifies facilities that provide 24-hour, non-medical residential and outpatient AOD detoxification, treatment, or recovery services to adults. There are 796 of these facilities in the state. DHCS also determines the appropriate skills and qualifications of an individual providing AOD counseling to clients in licensed residential and/or certified facilities, narcotic treatment facilities, programs certified to receive Medi-Cal reimbursement; and driving under the influence facilities. Approximately 36,000 alcohol and drug counselors are certified in the state.

DHCS investigates facility and counselor complaints, unlicensed facilities, and death reports. Facility complaints include all complaints involving licensed, unlicensed and/or certified residential and outpatient AOD programs to determine whether the allegations are substantiated. Counselor certification complaints include all complaints of inappropriate conduct by certified counselors and those who are registered with a certifying organization, or working in a state-licensed or certified facility. If allegations are substantiated, it may result in a suspension or revocation of the counselor's certification. Complaints are received from current and former clients, current and former facility staff, other state agencies, and the general public. Complaints are processed for investigation based on the seriousness of the offense.

Over the last five years, the state has experienced an increase in non-medical AOD facilities providing medical services and/or operating outside the scope of their licensure, and has therefore increased revocation of these licenses when corrective action is non-responsive or not an appropriate option based on the violation.

Currently, DHCS is experiencing a backlog of 500 open complaints from 2010-2011. The current staffing levels were initially determined based on the workload necessary to conduct facility complaint investigations received; however, the workload associated with unlicensed facility complaints and the revocation of a license or certification was not factored into currently approved staffing levels. On average, about 300 complaints are received each year.

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

Questions.

1. Please provide an overview of this budget request.

2. Please provide an overview of the state laws regarding investigating provider and counselor complaints.

10. Continuance of Driving Under the Influence (DUI) Program Evaluation

Budget Issue. DHCS requests $96,000 (DUI Program Licensing Trust Fund) to renew a contract to continue its evaluation of the Driving-Under-the Influence (DUI) Programs licensed and monitored by the state.

The evaluation would run from 2014-15 through 2015-16, at an annual cost of $96,000. According to DHCS, the continuation of this program evaluation will ensure that specific recommendations provided in the previous and existing evaluation will be acted upon. If approved, the next two years' scope of work will focus on establishing critically needed program benchmarks and performance measures, outcomes, and suggested recommendations for related regulations.

Background. Since 1978, individuals convicted of a DUI have been mandated by the court to attend DUI programs, which are regulated and licensed by the state. Licensing and monitoring of DUI programs had been done by the former-Department of Alcohol and Drug Programs (DADP), until that department was eliminated in 2013, and the program was transferred to DHCS.

The DHCS Substance Use Disorder Compliance Division licenses and monitors all DUI programs statewide, which seek to reduce the number of repeat DUI offenders and address drivers' substance use disorders. DHCS licenses 492 DUI programs throughout California that offer programs for first-offenders, multiple-offenders, and 30-month services.

The DUI Program Licensing Trust Fund receives licensing fees, enrollment fees, fines, and penalties collected from DUI programs, and these revenues are used to offset costs incurred by DHCS in administering the program. DUI programs pay a one-time $400 licensing fee, and each enrollee pays $10 which is then paid to DHCS.

The 2008 Budget Act appropriated $96,000 (DUI Trust Fund) to DADP for two years to review the DUI program structure at both the state and provider levels, and develop recommendations in order to improve service delivery. DADP contracted with San Diego State University (SDSU) to conduct the review. According to DHCS, this study was exploratory in nature and has laid the groundwork for future evaluations to identify and promote the effective components of DUI programs. The purpose of this proposal would be to pursue further recommendations from this study.

Accordingly, DHCS expects this request to do all of the following:

1. Continue an in-depth analysis of the system improvements recommended in the first DUI descriptive study.

2. Provide continued systematic assessment of DUI program providers.

3. Reveal best practices in program processes, data collection and monitoring.

4. Establish program benchmarks, performance measures, and outcomes.

5. Revisit recommendations provided in the descriptive study to determine which have and have not been addressed by the state.

6. Provide DHCS with future direction on how to best collect participant data, determine and develop program performance benchmarks, and develop outcome measures needed to measure DUI program success.

7. Identify what is working in the first and multiple offender programs in order to develop a statewide, standardized curriculum for DUI participants which takes in account variables such as culture, gender, and age.

8. Establish critically needed program benchmarks and performance measures, outcomes, and suggested recommendations for related regulations.

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

Questions.

1. Please provide an overview of this proposal.

Appendix A

Medi-Cal Mental Health (MH) and Substance Use Disorder (SUD) Benefits

Source: Department of Health Care Services

County Mental Health Plan (MHP)

Target Population: Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental health Services

Outpatient Services

- ✓ Mental Health Services (assessments plan development, therapy, rehabilitation and collateral)
- ✓ Medication Support
- ✓ Day Treatment Services and Day Rehabilitation
- ✓ Crises Intervention and Crises Stabilization
- ✓ Targeted Case Management
- ✓ Therapeutic Behavior Services

Residential Services

- ✓ Adult Residential Treatment Services
- ✓ Crises Residential Treatment Services

Inpatient Services

- ✓ Acute Psychiatric Inpatient Hospital Services
- ✓ Psychiatric Inpatient Hospital Professional Services

County Alcohol & Other Drug Programs (AOD)

Target Population: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services

Outpatient Services

- ✓ Outpatient Drug Free
- ✓ Intensive Outpatient **(newly expanded to additional populations)**
- ✓ Residential Services **(newly expanded to additional populations**)
- ✓ Narcotic Treatment Program
- ✓ Naltrexone

New Services

- ✓ Inpatient Detoxification Services
- ✓ (Administrative linkage to County AOD still being discussed)

Medi-Cal Managed Care Plans (MCP)

Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services

MCP services to be carved-in effective 1/1/14

- ✓ Individual/group mental health evaluation and treatment (psychotherapy)
- ✓ Psychological testing when clinically indicated to evaluate a mental health condition
- ✓ Outpatient services for the purposes of monitoring medication treatment
- ✓ Psychiatric consultation
- ✓ Outpatient laboratory, medications, supplies and supplements
- ✓ Screening and brief intervention

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, April 3 (Room 4203)
Agenda – Part B

0977 California Health Facilities Financing Authority (CHFFA)

1. Investment in Mental Health Wellness Act of 2013

- Information item.

4560 Mental Health Services Oversight and Accountability Commission (MHSOAC)

1. Overview

- Information item.

2. Investment in Mental Health Wellness Act of 2013 – Triage Personnel

- Information item.

4260 Department of Health Care Services

1. Community Mental Health Overview

- Information item.

2. 2011 Realignment – Behavioral Health Subaccount Growth Allocation

- Held open.

3. SB 1 X1 - Mental Health and Substance Use Disorder Benefit Expansion

- Held open.

4. Monitoring of County Mental Health Plans

- Approved as budgeted (2-0, Senator Walters absent)

5. Performance Outcomes System Plan for EPSDT Medi-Cal Mental Health Services

- Approved as budgeted (2-0, Senator Walters absent)

6. Implementation of SB 82 and SB 364 – Staff Request

- Held open.

7. Drug Medi-Cal Overview and Major Issues

- Held open.

8. Re-Certification of Drug Medi-Cal Providers

- Held open.

9. Substance Use Disorder Program Integrity – Counselor and Facility Complaints

- Held open.

10. Continuance of Driving Under the Influence (DUI) Program Evaluation

- Held open.

SUBCOMMITTEES No. 1 and 3
Education and Health & Human Services

Chair, Senator Marty Block | **Chair, Senator Ellen Corbett**

Senator Mark Wyland | **Senator Mimi Walters**
Senator Carol Liu | **Senator Bill Monning**

Joint Hearing

April 10, 2014
9:30 a.m. or Upon Adjournment of Session
Room 4203, State Capitol

AGENDA

Consultant: Samantha Lui

Informational		**Page**
I.	Early Childhood Education and Poverty Dr. Jill Cannon, Policy Researcher, RAND Corporation	2
II.	Overview of California's Child Care and Development System Ryan Woolsey, Legislative Analyst's Office Carolyn Chu, Legislative Analyst's Office	4
Item	**Department**	
5180	Department of Social Services	14
	1. Parent-Child Engagement Pilot Project	14
Public Comment		
6110	Department of Education, Child Care	19
	1. Overview of the Governor's Budget	19
	2. Transitional Kindergarten	22
	3. California State Preschool Program (CSPP)	25
	4. CSPP Family Fees	29
	5. LAO Restructure Proposal	31
Public Comment		

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.

California's Child Care and Development System

Context Setting

BACKGROUND

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 proposal on child care and early childhood education and of the Department of Social Services' Parent-Child Engagement Pilot Project, the following sections will: (1) present the impact of poverty on child development; (2) discuss the importance of early childhood education and development programs; and, (3) provide an overview of California's child care and early education programs.

Impact of Poverty on Child Development. Both cognition and character can determine future social and economic status. On average, children from poor families score below peers from higher-income families in early vocabulary and literacy development, in early math, and in the social skills needed to get along in classrooms.[4,5] For example, children from low-income families hear around 13 million words by age 4, compared to middle-class families, where children hear about 26 million words by age 4. In upper-income families, children hear 46 million words. Vocabulary development and exposure is a critical tool in the formation, gathering, and analysis of information. Also, character traits, like perseverance, motivation, self-esteem, self-control, and conscientiousness, are proven to be as powerful a predictor of the same health and behavioral outcomes.[6] However, children from low-income families, or in chronically stressed environments, may be exposed to factors that challenge social skill development. Specifically, chronic distress affects brain development, reduces attention control, boosts impulsivity, and impairs working memory. [7] Further, poverty can effect classroom engagement. Children

[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.

[4] V. Lee, and D. Burkham (2002). *Inequality at the starting gate: Social background differences in achievement as children begin school.* Washington, DC: Economic Policy Institute.

[5] C. Lamy. (2013, May). How Preschool Fights Poverty. *Faces of Poverty*, pp. 32-36.

[6] J. Heckman (2011). "The Economic of Inequality: The value of early childhood education." *American Educator*, pp.31-47.

[7] E. Jensen (2013, May). How Poverty Affects Classroom Engagement. *Faces of Poverty,* 70(8).

who grow up in poor families are likely to be exposed to food with lower nutritional value, which can affect gray matter mass in children's brains.[8]

In 2013, Stanford University researcher, Sean Reardon, found that the "income achievement gap" or "school readiness gap" -- defined as the gap between how students from low- and high-income families fare in standardized test scores, grades, high school completion rates, and college enrollment and completion dates -- is already large when children enter kindergarten. This finding suggests that the primary cause of the gap is not unequal school quality but other factors that occur from birth to kindergarten-age. Further, his research finds that the gap does not grow significantly as children progress through school, but could actually narrow based on a child's involvement with school.

Value of Early Childhood Education and Development. High-quality child care experiences can mitigate the negative effects of poverty on children's academic achievement. For example, low-income children, including linguistically isolated children, participating in center-based care may experience greater gains in school readiness skills than those in home-based settings or parent-only care.[9]Also, children who had greater numbers of experiences in high-quality childcare from six- to 54- months tended to show higher levels of reading and math achievement (averaged) across the elementary-school years. However, some quality experiences remain limited to socio-economic factors. High-income families now spend nearly seven times as much on children's development as low-income families.[10]

Family engagement in a child's early education also contributes to the child's school readiness and later academic success.[11] Unlike past models that focused on parent involvement (i.e., fundraising activities, attending school events or activities, volunteering in the classroom), a strong family-program partnership is culturally sensitive, recognizing that all family members -- grandparents, aunts, uncles, siblings -- contribute in significant ways to a child's education and development. Other positive family-program connections have been linked to greater academic motivation, grade promotion, and socio-emotional skills.[12,13]

The National Association for the Education of Young Children conducted an academic literature review, which identified the value and impact of home visits:

> Home visits provide opportunities for teachers and families to connect in an informal setting, [and] to expand the teacher's knowledge of students' home life and cultural backgrounds. [14,15] Home visits have

[8] *Id.*

[9] J. Cannon, A. Jacknowitz, and L. Karoly (2012, May). Preschool and School Readiness: Experiences of children with non-English speaking parents. Public Policy Institute of California.

[10] S. Kornrich, and F. Furstenberg (2013). Investing in children: Changes in parental spending on children, 1972 to 2007. *Demography*, 50(1), 1-23.

[11] L. Halgunseth, A. Peterson, D. Stark, and S. Moodie (2009). Family Engagement, Diverse Families, and Early Childhood Education Programs: An Integrated Review of the Literature. National Association for the Education of Young Children and Pre-K Now.

[12] S.L. Christenson (2000). Families and schools: Rights, responsibilities, resources, and relationships. In R.C. Pianta & M.J. Cox (Eds.), The Transition to kindergarten (pp. 143-77). Baltimore, MD: Paul H. Brookes Publishing Co.

[13] P. Mantzicopoulos (2003). Flunking kindergarten after Head Start: An inquiry into the contribution of contextual and individual variables. *Journal of Educational Psychology*, 95(2), 268-278.

[14] G.B. Ginsberg (2007). Lessons at the kitchen table. *Educational Leadership*, 64(6) 56-61.

been associated with higher scores for children in math, reading, and classroom adaptation.[16] Children who receive home-visits are also found to have greater engagement in literacy activities and are more likely to choose and participate in group activities.[17] Furthermore, kindergarten through second grade teachers who participated in home visits reported that home visits led to improved communication with parents, enhanced understanding of the child, and a greater insight on how the home environment influences school performance.[18]

OVERVIEW OF CALIFORNIA'S CHILD CARE AND DEVELOPMENT SYSTEM

Programs in the early care and education system have two objectives: to support parental work participation and to support child development. This section will provide an overview of California's child care and early childhood education programs.

Eligibility and access. Subsidized child care is generally designed for low-income, working families. 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 that are 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" or are transitioning off of cash assistance; and Stage 3, for families who have been off cash assistance for at least two years. Families that formerly participated in CalWORKs are typically guaranteed subsidized child care services, as long as they continue to meet specified income requirements. However, only a portion of non-CalWORKs families receive subsidized child care, and waiting lists are common.

---

[15] C.D. Delgado-Gaitan (2004). *Involving Latino families in schools: Raising Student Achievement through home-school partnerships*. Thousand Oaks, CA: Corwin Press.

[16] C. Kagitcibas, D. Sunar, and S. Beckman (2001). Long-term effects of early intervention: Turkish low-income mothers and children. *Applied Developmental Psychology*, 22, 333-361.

[17] E. Logan and A. Feiler (2006). Forging links between parents and schools: a new role for Teaching Assistants? *Support for Learning*, 21(3), 115-120.

[18] J.A. Meyer and M.B. Mann (2006). Teachers' perceptions of the benefits of home visits for early elementary children. *Early Childhood Education Journal*, 34(1), 93-97.

Table 1: Summary of California's Child Care and Development Program

Program	Description	Proposed Slots 2014-15
CalWORKs		
Stage 1	Provides cash aid and services to eligible families. Begins when a participant enters the CalWORKs program.	42,719
Stage 2[19]	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.	55,943
Stage 3	When a family expends time limit in Stage 2, and as long as family remains otherwise eligible.	30,830
Non-CalWORKs		
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.	48,431
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.	29,803
Migrant Child Care	Serves children of agricultural workers while parents work.	2,595
Severely Handicapped Program	Provides supervision, therapy, and parental counseling for eligible children and young adults until 21 years old.[20]	145
State Preschool	Part-day and full-day care for 3 and 4-year old children from low-income families.	136,755

According to data from CDE, the aggregate number of children served by program type has fluctuated by year. From 2008-2009 to 2012-13, the total unduplicated number of children served across programs has decreased from 503,670 to 396,711. The General Child Care Program saw the largest decrease -- from 2008-08 to 2012-13, 89,790 less children were served. For more specifics of number of children by program type, please see Table 2 below.

[19] Average cost per case for CalWORKs Stage 2 is $542; average cost per case for Stage 3 is $502.
[20] Recipients must have an individualized education plan (IEP) or individualized family service plan (IFSP) issued through special education programs.

Table 2: Aggregate Number of Children Served by Program Type (2008-09 to 2012-13)

	2008-09	2009-10	2010-11	2011-12	2012-13
General Child Care	145,353	71,004	68,386	60,3175	55,563
CalWORKs Stage 2	115,242	107,505	109,495	110,033	104,890
CalWORKs Stage 3	81,035	76,247	67,128	40,391	42,332
Alternative Payment	54,678	58,226	56,937	51,000	39,768
California State Preschool Program*	N/A	201,630	213,931	200,426	181,052
General Migrant Care	4,906	4,393	4,845	4,474	4,069
Severely Handicapped	178	229	235	245	235

* 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.

Administration and funding. The Department of Social Services (DSS) administers CalWORKs Stage 1, while the California Department of Education (CDE) administers all other programs. The programs are also funded by a combination of both state and federal funds.

In 2013-14, around $947 million was allocated for CalWORKs Child Care, $678 million for non-CalWORKs Child Care, and $507 million for State Preschool. These programs were funded with non-Proposition 98 General Fund ($776 million), Proposition 98 ($507 million), and federal funds ($924 million).

According to the LAO, since 2008, the state's overall child care and development funding has decreased by $985 million, or 31 percent. Until the 2011-12 fiscal year, the majority of these programs were funded from within the Proposition 98 guarantee for K-14 education. Additionally, 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, which is used to help families with incomes below 85 percent of the state median income level. Four percent of the federal block grant must be spent on improving the quality of child care.

Payments to providers. The state pays for child care services based on how services are delivered -- by voucher or by direct contract.

- Vouchers. First, care provided through CalWORKs Stage 1, Stage 2, and Stage 3 child care, and the Alternative Payment Program, is reimbursed through vouchers. Reimbursement rates vary by county, and are based on a Regional Market Rate (RMR). Currently, the RMR is set to the 85th percentile of the 2005 RMR survey. The RMR represents the maximum the state will pay for care. 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. 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. The maximum monthly RMR for full-day care of a four-year-old ranges from $643 (Sutter County) to $1,100 (Marin County).

Typically, a "Title 22" program serves families who receive vouchers. Title 22 regulations require that a licensed provider meet basic health and safety standards, as monitored by the Department of Social Services' (DSS) Community Care Licensing Division. 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.

- Contracts. Second, care provided through General Child Care, Migrant and Handicapped child care, and State Preschool is reimbursed through contracts with CDE. These programs, known as "Title 5" centers 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. Providers are reimbursed based upon the number of children they serve, and reimbursements are based on a Standard Reimbursement Rate (SRR). All Title 5 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) has been $34.38 per child, per day of enrollment. The monthly SRR for full-day care for a four-year-old is $716. Over the past few years, small and medium-sized providers have increasingly gone out of business and have been absorbed by larger providers that have greater economies of scale. This is one indication that the SRR may not be sufficient for small and medium-sized providers to operate.

Settings and standards. State subsidized child care is provided in centers, family child care homes (FCCHs), or through license-exempt providers. Each child care program must meet specified requirements pertaining to staffing ratio, staff qualifications, and monitoring, according to Title 5 or Title 22 regulations.

Table 3: Child Care Settings and Standards, by Program

Standards for Child Care Providers

Preschool-Age Children[a]

	License-Exempt Providers	Title 22 FCCHs	Title 22 Centers	Title 5 Centers[b]
Staff Qualifications	None.	15 hours of health and safety training.	Child Development Associate Credential or 12 units in ECE/CD.[c]	Child Development Teacher Permit (24 units of ECE/CD plus 16 general education units).[d]
Staffing Ratios	None.	1:6 adult-child ratio.	1:12 teacher-child ratio or 1 teacher and 1 aide per 15 children.	1:24 teacher-child and 1:8 adult-child ratio.
Health and Safety Standards	Criminal background check. Self-certification of certain health and safety standards.	Staff and volunteers are finger printed. Subject to health and safety standards.	Same as Title 22 FCCHs.	Same as Title 22 FCCHs.
Content Standards	None.	None.	None.	Requires developmentally appropriate activities.
Monitoring	None.	Unannounced visits by CCL every five years or more frequently under special circumstances.	Same as Title 22 FCCHs.	Same as Title 22 FCCHs, but also onsite reviews by CDE every three years (or as resources allow) and annual outcome reports.
Applicable Programs	CalWORKs, AP Program	CalWORKs, AP Program	CalWORKs, AP Program	General Child Care, Migrant Child Care, State Preschool

[a] Standards for children of other ages similar to those displayed here.
[b] Same standards apply to Title 5 family child care network homes.
[c] The Child Development Associate Credential is issued by the National Credentialing Program of the Council for Professional Recognition.
[d] The Child Development Teacher Permit is issued by California's Commission on Teacher Credentialing.
FCCHs = family child care homes; ECE/CD = Early Childhood Education/Child Development; CCL = Community Care Licensing; CDE = California Department of Education; and AP = Alternative Payment.

Table 3: Legislative Analyst's Office (2014, April). "Restructuring California's Child Care and Development System." http://www.lao.ca.gov/reports/2014/education/child-care/restructuring-child-care system-040414.pdf

Impact of the Recession. Between 2008-09 and 2012-13, child care and preschool programs experienced significant reductions. Specifically, overall funding for programs decreased by around $984 million (31 percent), and about one-quarter of all slots were eliminated (110,000 across all programs). In addition, the following policies impacted child care and preschool programs:

- Maintaining the RMR and SRR at 2005 and 2007 levels, respectively.
- Lowering income eligibility thresholds from 75 percent to 70 percent of the state median income.
- Reducing payments to administrative agencies from 19 percent to 17.5 percent of total contract amounts.
- Reducing or eliminating several of the state's quality improvement projects.
- Implementing parent fees for part-day State Preschool.
- Reducing nutrition funding for some private child care centers and homes.

Other 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, which aims to serve preschool-age children and their families in Head Start programs around the state. Head Start programs offer a variety of service models, depending on the needs of the local community. 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.

According to the 2011 First 5 California Annual Report[21], the State Commission has invested in the following:

- Power of Preschool - $15.2 million to fund Power of Preschool demonstration projects in certain counties. Power of Preschool provides free, voluntary, high-quality, part-day preschool to assist three- and four-year old children in becoming effective learners with a focus on developing preschool in underserved and high-priority communities.
- School Readiness - $51.7 million to counties for the School Readiness Program that strives to improve the ability of families, schools, and communities to prepare children to enter school ready to learn. Services are provided to focus on family functioning, child development, child

[21] http://www.ccfc.ca.gov/pdf/annual_report_pdfs/Annual_Report_11-12.pdf

health, and systems of care with a specific target to children and their families in schools with an Academic Performance Index score in the lowest three deciles.

- Low-Income Investment Fund Constructing Connections - $600,000 to support Constructing Connections that coordinates and delivers technical assistance, training, knowledge, and facility financing information to support child care facilities development through local lead agencies. The State Commission indicates that it leveraged more than $86 million in resources to create and renovate child care facilities and spaces.

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).[22] 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)[23] 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 counties[24] 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 have also made 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 tax and parent fees. School

[22] For more information on California' 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

[23] 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.

[24] 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.

districts have flexibility to use their funding streams on early childhood education. There are various funding mechanisms that can also be used to support early childhood education, such as:

- 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.[25]
- 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.

ISSUES TO CONSIDER

The Legislature may wish to consider the following issues when considering the child care and early childhood education proposals.

Statewide "stability" standard for CalWORKs Stages. 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 choose to define "stable" for purposes of determining eligibility to be transferred from Stage 1 to Stage 2 of CalWORKs Child Care.

Regional Market Rate and Standard Reimbursement Rate. For child care, CDE conducts its RMR survey every two years, but state law does not require that California adopt the rate. The RMR is currently at the 85th percentile of the 2005 survey. 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

[25] 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

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. Similarly, the state has held the Standard Reimbursement Rate at the 2007 level. The Legislature may wish to discuss whether updating the RMR, based on a more recent survey, and the SRR, is appropriate and helpful for families determining where to access care.

Updating quality measures.[26] 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 for 27 distinct projects, including professional development, stipends for providers, and activities related to health and safety. The Legislature may wish to examine more closely how those quality measure funds are being used and identify if there are better ways to allocate the quality funding measures.

Child Care and Development Block Grant. On March 13, 2014, the U.S. Senate voted to approve (96-2) a reauthorization for the federal child care program, the Child Care and Development Block Grant (CCDBG).[27] The original law was designed to primarily provide low-income parents a way to re-enter the work force, and was last authorized in 1996. The bill's provisions, among others, would:

- Require that states phase in higher levels of quality set-aside dollars until they reach 10 percent of funds in 2018 and every year thereafter.
- Increase, from two to three years, the period that a state child care and development plan must cover.
    - Revise plan requirements to include compliance with child abuse reporting requirements and protection for working parents; and, prescribes early learning and developmental guidelines.
- Require that states conduct background checks for all providers, and annual unannounced health, safety, and fire inspections.
- Make ineligible a licensed, regulated, or registered child care provider if he or she (1) refuses to consent to a criminal background check, (2) knowingly falsifies information on a background check, (3) is registered on a state sex offender or National Sex Offender registry, or (4) has been convicted of one or more specified felonies.
- Limit child to provider ratio in programs, as identified by the age group of children served;
- Require that state early learning guidelines be aligned with state K-3 standards; and,
- Prioritize access to early childhood education in high-poverty and high-unemployment areas.

The bill is currently in the House of Representatives.

---

[26] Every two 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

[27] S. 1086 -- 113th Congress (Mikulski, 2013). For full text of the bill, please see: http://www.gpo.gov/fdsys/pkg/BILLS-113s1086is/pdf/BILLS-113s1086is.pdf

Demographics of young, low-income children. According to 2011 data from the National Center for Children in Poverty at the Columbia University, Mailman School of Public Health, nearly 1.4 million young children in California live in low-income families, defined as income below 200 percent of the federal poverty level (FPL).[28] In 2011, the FPL for a family of four with two children was $22,350. Nearly 44 percent of young children in low-income families in California have at least one parent employed full-time, year-round. Around 47 percent of those young children in low-income families live with a single parent, and 86 percent of young children have parents who do not have a high-school degree.

Reviewing current Transitional Kindergarten (TK) system. The current TK framework may deserve additional review and discussion. First, the current TK program provides an additional year of public school, regardless of need, to children born between September and December. However, it is unclear why this subset of children, simply based on birth date, should receive the benefit. Second, current law allows parents of children, who are born after the cutoff, to request a waiver to have their children begin kindergarten early. In addition, districts have much flexibility in providing waivers, creating classrooms, and modifying kindergarten curriculum for TK. The Legislature may be interested in issuing a statewide standard or learning foundation to ensure that quality education is provided to all children, regardless of geographic location. Lastly, there are a number of legislative proposals that affect early childhood education and development awaiting consideration.

Coordination in patchwork system. Some families, despite similar characteristics, are provided different funding and educational opportunities. The Legislature may want to examine how current child care services and early education programs are administered and delivered, so that these efforts and programs can best maximize the use of available funding, deliver quality services, and meet the needs of California's families.

[28] National Center for Children in Poverty (2013, May) ."California: Demographics of Young, Low-Income Children." http://www.nccp.org/profiles/state_profile.php?state=CA&id=8

5180 Department of Social Services

1. Parent-Child Engagement Pilot Project

Budget Issue. The budget proposes a three-year, six-county pilot project to serve 2,000 low-income families, and to connect 3,200 preschool-age children between the ages of two and five with licensed child care. Pilot counties would be selected through an application process. A selected pilot county will identify participant cohorts of CalWORKs children and families through an initial assessment and screening. Under the pilot, child care will be provided in a stable environment, and parents must work with their child for an average of ten hours per week for at least six months. Child care providers will work directly with parents through mentoring. The proposal assumes the first cohort of families to enroll in March 2015 and the second cohort in 2016.

The budget projects a $9.9 million General Fund (GF) cost in 2014-15, and a total of $115.4 million GF over three years.

Full-time child care will be provided throughout the entire project, if the parent completes the parental involvement component. However, the Administration assumes that ten percent of participants will not meet the parental component requirements within three months. If the parent does not complete the component, but does continue to participate in welfare-to-work (WTW) activities, the child will receive part-time care for the duration of the project. Based on the weighted statewide average of monthly preschool age in a child care center at the 85th percentile of the 2005 RMR survey, full-time and part-time care cost per case is $873.40 and $732.31, respectively. Monthly cost per case for parental involvement is $335.

The budget includes an accompanying trailer bill, which contains the following provisions:

1. Expresses the Legislature's intent in authorizing a three-year pilot project, in up to six counties, to demonstrate improved outcomes for CalWORKs hardest-to-serve families, including sanctioned families and their preschool aged children;
2. Sets forth information that a county must include in its proposal, prior to being selected as a project site, such as:
    a. How the county plans to attain the project goals.
    b. The basis of its project plan (e.g., Child-Parent evidence-based model, or an alternate model).
3. Requires participating counties to prepare and submit progress reports, annual reports, and a final report, on a schedule determined by DSS;
4. Requires counties to measure the program's success based on the following outcomes:
    a. Regular child care attendance;
    b. Continuity of parental involvement for at least the first six months of a family's participation;
    c. Reduce barriers to achieving self-sufficiency, including improved parental employment history, as determined by caseworker review; and,
    d. Improved school readiness of participating children, as assessed using a standardized tool to measure cognitive, emotional, and social skill development.

5. Authorizes the Department of Social Services (DSS) to terminate any, or all, of the pilot projects after six months of operation, if DSS receives information that the project is not cost-effective or adversely impacts recipients.
6. Authorizes DSS to waive specific statutory requirements, regulations, and standards, by formal order of the director, for the purpose and duration of the project.
7. Authorizes a participating county to dis-enroll children from the project who have unsatisfactory child care attendance, after project representatives have actively attempted on multiple occasions to engage the family, to allow the child care slot to be utilized by a new participant.
8. Authorizes the department to implement and administer the pilot project through all-county letters or a similar mechanism.

Panelists: Will Lightbourne, Director, Department of Social Services
Todd Bland, Deputy Director of WTW Division, Department of Social Services
Ryan Woolsey, Legislative Analyst's Office
Department of Finance

Background on CalWORKs. The CalWORKs program provides temporary cash assistance and welfare-to-work services to low-income families with children. Over the last several years, the program has sustained very significant reductions, including a decrease from 60 to 48 months in the amount of time adults can receive assistance in a lifetime, and additional restrictions that will result in some adults losing all assistance after 24 months. The Governor proposes an overall 2014-15 budget of $5.5 billion in federal, state, and local funds for the program and estimates a caseload of 529,000 families (a decrease of four percent).

As a condition of reviving aid, families receiving CalWORKs must be employed or participate in welfare-to-work (WTW) activities. Adults that fail to comply with the work requirement without good cause are "sanctioned," meaning the adult portion is removed from the calculation of the family's grant (resulting in decreased assistance, usually around $125). Many CalWORKs recipients face barriers to employment, such as low-educational attainment, low English proficiency, responsible of caring for children or parents with disabilities, lack of child care, substance abuse, prior criminal convictions, and others. The CalWORKs program seeks to provide services to address those barriers, including English as a Second Language services, subsidized child care, and mental health and substance abuse treatment.

In 2013, the Legislature enacted AB 74 (Budget Committee), Chapter 21, Statutes of 2013, which created three "early engagement" strategies to assist CalWORKs recipients in addressing barriers to employment. The strategies include:

- Subsidized employment for CalWORKs recipients.

- Family stabilization services, such as intensive case management and specialized services, to adults and children in CalWORKs families that face certain immediate, destabilizing needs.

- Statewide WTW appraisal tool for new WTW participants. The Online CalWORKs Appraisal Tool (OCAT) is expected to be available to all counties by July 2014.

Background on the Parent-Child Model.[29] The Chicago Child-Parent Center (CPC) program provides school-based educational enrichment and comprehensive family services from preschool to third grade, or ages three to nine years old. The intervention served around 1,500 children born in 1979 or 1980. Beginning in preschool, the program emphasizes acquisition of basic skills in language arts and math. Major elements of the intervention include low child-to-staff ratios in preschool (17:2), kindergarten (25:2), and primary grades (25:2). Parents are expected to participate up to half a day per week through a variety of activities. Preschool is three hours a day, five days a week, and also usually includes a six-week summer program.

Researchers conducted a follow-up analysis on 1,539 low-income participants who enrolled in a CPC program in 20 sites or kindergarten intervention of a group at aged 24 – around 19 years after the initial intervention. The academic literature analyzing the effects of the Chicago Longitudinal Study for the CPC program finds that CPC preschool participants, compared to the comparison group, had higher rates of school completion and attendance in four-year colleges; are more likely to have health insurance coverage; lower rates of felony arrests, convictions, incarceration, depressive symptoms, and out of home placements; and, higher rates of full-time employment.

Justification. According to the Administration, studies have shown that parental involvement at school has a significant impact on long-term school achievement, yet there remains a lack of access to high-quality child care for CalWORKs families, primarily, sanctioned families, and their preschool aged children.

The Administration states that the goals of the Parent-Child Engagement Pilot Project's goals are to:

1. Connect vulnerable children with stable, high-quality child care;
2. Engage parents with their children in the child care setting;
3. Enhance parenting and life skills; and,
4. Provide an educational preparatory platform for achieving eventual self-sufficiency.

Parents must work in their child's classroom, an average of ten hour per week, for at least six months. In doing so, parents will learn parenting techniques, how to nurture positive relationships with their children, understand their role in their child's learning, and learn about available community resources.

LAO Comments. The LAO makes the following comments and recommendations:

- Reject Governor's proposal. On balance, the LAO recommends rejecting the proposal, due to several issues:
    - Duplicative services. Certain aspects of the proposal pilot would duplicate services already available in the CalWORKs program, particularly given recent significant statutory changes that are still partially under implementation. As part of the CalWORKs program, families that are employed or participating in WTW activities are already guaranteed access to subsidized child care. This pilot would not provide anything

[29] 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.

substantially different in addressing adult work-readiness and employment outcomes than what is currently available.

- A pilot for proven outcomes? The state currently funds child care programs with an educational focus for similar low-income children, so a new pilot may not be necessary to demonstrate the impact of these programs on child outcomes. However, CalWORKs families historically have had a difficult time accessing these programs because of the way the state structures services.

- Unknown impact of parental involvement on employment outcomes. Lastly, there is little evidence to suggest that parental involvement activities would directly improve employment outcomes. The pilot's cost ($115 million over three years) may not justify the value of testing the impact of parental involvement activities.

- Explore ways to address inconsistencies in child care standards**.** The LAO recommends the Legislature explore alternative ways to provide CalWORKs families access to educationally-focused childcare programs.

Staff Comments and Recommendation. Hold open. It is recommended to keep this item open for further discussion and review.

Questions for DSS

1. Please briefly summarize the proposal, including the implementation process, parental engagement component, and expected outcomes.

2. What are some of the barriers current CalWORKs families face when selecting a child care program? How does this pilot project address those barriers?

3. According to the Administration, the projected cost per case for parental case management is $361.43, compared to family stabilization/barrier removal ($143.93). What components of the pilot project's parental case management are different from the intensive case management, otherwise offered under family stabilization?

4. Has the department identified potential counties and project sites to participate in the pilot?

5. According to the Administration, an additional $335/per month, per case will pay for "additional, qualified staff in centers" that will provide services for parents. What additional training will center staff receive prior to enrolling parents and their children? Will the newly-hired staff positions focus specifically on engaging the parents, or also provide services to their children?

6. In addition to TrustLine and tuberculosis testing, what other screenings must a parent fulfill before entering a child care center? Will a parent be denied from participating in the pilot if he or she has an arrest or conviction record?

7. Proposed trailer bill language states that a county must use a standardized tool to measure a participating child's cognitive, emotional, and social skill development. Is this a standardized tool that is currently in use? If not, please describe the development of this tool.

8. Proposed trailer bill language authorizes a county participating in a pilot to dis-enroll a child. Please explain the due process afforded to a family to prevent a child from dis-enrollment.

9. If the department terminates any of the projects, will another county be able to apply for the pilot and take its place? What happens to the participating families and children in the pilot county?

10. When does the department intend to release the pilot's comprehensive final report?

11. What is the current stakeholder process? Has the department received any feedback?

6110 Department of Education

1. Overview of Governor's Proposal

Budget Issue. The budget proposes few substantive changes for child care and preschool funding. Overall funding across all programs decreases by $3 million (less than one percent change since last year). The budget includes the following proposals:

- **Increases CalWORKs Stage 2 and Stage 3 funding to reflect increased cost-of-care.** The budget proposes an increase in $6.3 million and $2.8 million non-Proposition 98 General Fund for CalWORKs Stage 2 and Stage 3 recipients, respectively.

- **Reflects decreases in federal funds.** The budget reflects a net decrease of $9.1 million federal funds to reflect a reduction of $3.2 million carryover funds, and a decrease of $5.9 million to the base grant.

Tables 4 and 5 (below) provide information on proposed funding and slots for CCD programs, including State Preschool.

Table 4: Legislative Analyst's Office, Budget Summary

(Dollars in Millions)

	2012-13 Actual	2013-14 Revised	2014-15 Proposed	Change From 2013-14 Amount	Change From 2013-14 Percent
Expenditures					
CalWORKs Child Care					
Stage 1	$289	$406	$385	-$22	-5%
Stage 2	419	358	364	6	2
Stage 3	162	183	186	3	2
Subtotals	**($870)**	**($947)**	**($935)**	**(-$12)**	**(-1%)**
Non-CalWORKs Child Care					
General Child Care	$465	$473[a]	$479[b]	$6	1%
Alternative Payment	174	177[a]	179[b]	2	1
Other child care[c]	28	28[a]	28[b]	—	1
Subtotals	**($666)**	**($678)**	**($687)**	**($9)**	**(1%)**
Support Programs	$76	$74	$73	-$2	-2%
Totals	**$1,612**	**$1,699**	**$1,694**	**-$5**	—
Funding					
State Non-Proposition 98 General Fund	$779	$776	$783	$8	1%
Other state funds	14	—	—	—	—
Federal CCDF	549	541[a]	556[b]	15	3
Federal TANF	372	383	355	-28	-7
State Preschool (Proposition 98)	**$481**	**$507**	**$509**	**$2**	—

[a] Differs from administration's estimate due to reflecting the federal sequestration cut and the associated General Fund backfill.
[b] Does not include potential federal sequestration reduction, as estimates are still pending.
[c] Includes Migrant Child Care program and Handicapped Child Care program.
CCDF = Child Care and Development Fund and TANF = Temporary Assistance for Needy Families.
Posted January 2014.

Table 4: Child Care Budget Summary. Legislative Analyst's Office: EdBudget Tables, 2014 <http://www.lao.ca.gov/sections/education/ed-budget/Child-Care-Budget-Summary.pdf >

Table 5: Child Care and Preschool Subsidized Slots

Summary of Child Care and Preschool Subsidized Slots[a]

	2012-13 Actual	2013-14 Revised	2014-15 Proposed	Change From 2013-14 Amount	Change From 2013-14 Percent
CalWORKs Stage 1	34,849	45,532	42,719	-2,813	-6%
CalWORKs Stage 2	63,379	56,593	55,943	-650	-1
CalWORKs Stage 3	25,448	32,784	30,830	-1,954	-6
General Child Care	46,036	48,968	48,431	-537	-1
Alternative Payment	24,854	30,132	29,803	-329	-1
Migrant	2,491	2,534	2,595	61	2
Handicapped	143	144	145	1	1
Total Child Care	**197,200**	**216,687**	**210,466**	**-6,221**	**-3%**
State Preschool	**129,511**	**136,182**	**136,755**	**573**	—[b]

[a] Reflects average monthly slots. For 2012-13, reflects actual caseloads. For 2013-14 and 2014-15, reflects administration's caseload estimates for all programs other than Migrant and Handicapped. Caseloads for these two programs reflect LAO estimates, as administration's estimates historically have been higher than actuals.

[b] Less than 1 percent.

Posted January 2014.

Table 5: Child Care and Preschool Subsidized Slots. Legislative Analyst's Office: EdBudget Tables, 2014
http://www.lao.ca.gov/sections/education/ed-budget/Summary-of-Child-Care-and-Preschool-Subsidized-Slots.pdf

Panelists: Jessica Holmes, Department of Finance
Carolyn Chu, Legislative Analyst's Office

Background. The child care and early childhood education programs funded by the State are generally capped programs. This means that funding is not provided for every qualifying family or child, but instead funding is provided for a fixed amount of slots or vouchers. The exception is the CalWORKs child care program (Stages 1 and 2), which are entitlement programs in statute. Stage 2 child care is approximately $542 per case, while Stage 3 child care is around $502 per case.

In general, Stage 1 child care is provided to families on cash assistance until they are "stabilized". After families are stabilized, they are transferred to Stage 2, where they are entitled to child care while on aid and for two additional years after they leave aid. Stage 3 has been for those families that have exhausted their Stage 2 entitlement.

Historically, caseload projections have generally been funded for Stages 1, 2, and 3 in their entirety – even though, technically speaking, Stage 3 is not an entitlement or caseload-driven program. There has been considerable turmoil in the Stage 3 program since Governor Schwarzenegger first vetoed all of the funding for Stage 3 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. In 2012-13, the State Assembly has provided $13.5 million from their administrative budget to ensure all eligible families are covered in the Stage 3 program.

In 2012, funding for the State Preschool program and the General Child Care Programs were consolidated so that all funding for the part-day/part-year state preschool program 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.

Also in 2012, the Governor proposed a significant consolidation and realignment of the vast majority of the child care programs to the counties. This reorganization was not approved.

LAO Comment and Recommendation. The LAO makes the following comments and recommendations:

- Governor Likely Overestimates CalWORKs Stage 2 Caseload. The LAO estimates that the Stage 2 caseload will be around 3,000 cases lower than the Governor's estimates for two reasons:
  - First, existing Stage 2 caseload are almost 2,000 cases below the administration's caseload estimate for the budget year.
  - Second, data suggests that a large number of families will reach the end of Stage 2 eligibility, and will transition to Stage 3 in the budget year.

- Governor Likely Underestimates Per-Child Costs for CalWORKs Stages 2 and 3. The LAO notes that the budget's per-child cost estimates for Stages 2 and 3 programs are too low. Specifically, 2013-14 per-child costs are averaging about four percent higher in Stage 2, and about two percent higher in Stage 3, compared to the Governor's estimates for 2014-15. The LAO expects these current-year increases in per-child costs will likely continue into 2014-15.

- Budget Currently Looks Short but Better Estimates Available in late April. Data from the first three-quarters of 2013-14 are released and will be available in late April. More data will enable the Legislature to develop more accurate caseload and cost estimates for child care programs.

Staff Comment and Recommendation. Hold open. It is recommended to keep the item open for further discussion.

Questions

1. To DOF: Please briefly summarize the Governor's proposal.

2. To LAO: Why might the per-child cost for CalWORKs Stages 2 and 3 be higher than expected? Has there been a trend in individuals selecting licensed care or license-exempt care?

2. Transitional Kindergarten (TK) - Overview

Panelists: Department of Education
Carolyn Chu, Legislative Analyst's Office
Department of Finance

Background. SB 1381 (Simitian), Chapter 705, Statutes of 2010, enacted the "Kindergarten Readiness Act," which changed the required birthday for admission to kindergarten and first grade, and established a TK program, beginning in 2012-13, for children who turn five between September 1 and December 1. The program calls for a modified kindergarten curriculum that is age and developmentally appropriate. While state law requires school for six-year-olds, TK, like kindergarten, is not compulsory for a child.

WHO IS ELIGIBLE FOR TK?

A child is eligible if he or she has her fifth birthday between:

- For the 2013-14 school year, October 2 and December 2.
- For the 2014-15 school year and each school year thereafter, September 2 and December 2.

Each elementary or unified school district must offer TK and kindergarten for all eligible children. TK programs must also have 36,000 minutes per year, or 180 minutes per school day, of instructional teaching. According to CDE, there is no state-mandated curriculum for TK, so Local Educational Agencies (LEAs) must modify current kindergarten curriculum to make it appropriate. Also, LEAs may determine the standards, or learning foundations, for TK.[30] Similar to kindergarten, the maximum teacher-to-student ratio will be 1:24 upon full implementation of the Local Control Funding Formula, and teachers must be credentialed.

Funding. TK is entirely funded through Average Daily Attendance (ADA), so a local district receives the same ADA funding rate as kindergarten students. During the Local Control Funding Formula[31] phase-in, it is not yet possible to determine the statewide rate for TK; however, based on the current level of funding, CDE estimates average cost per child in TK to range from $5,118 per pupil to $7,676, depending on whether a pupil receives a supplemental grant amount.

Enrollment and Program Information. All districts report TK information via the California Longitudinal Pupil Achievement Data System (CALPADS), which is a data system that includes information on student demographics, staff assignments, and course data for state and federal reporting. CALPADS was created to meet federal requirements in the No Child Left Behind Act of 2001, and provides LEAs with data and reports on student achievement over time. The 2013-14 school year is the first year in which CALPADS will collect TK program data that will provide solid enrollment information. That data will

[30] CDE suggests that in implementing TK locally, districts may consult California's Preschool Learning Foundations, California Preschool Curriculum Frameworks, California Academic Content Standards, and the Common Core State Standards for English Language Art and Mathematics.

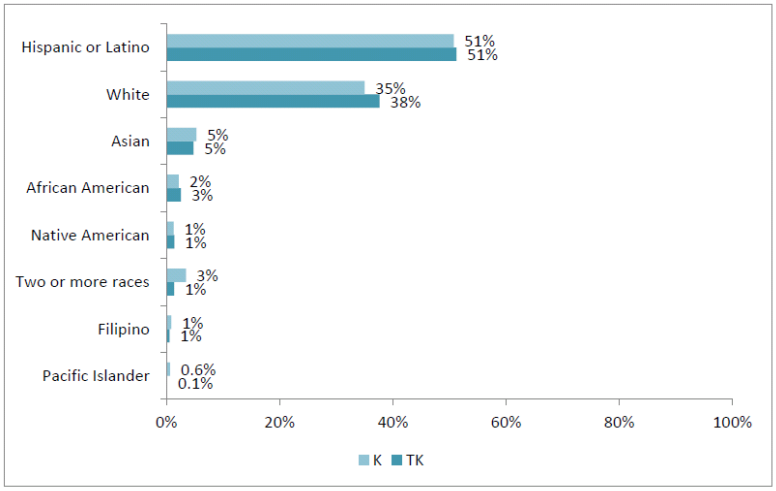
[31] For more information on LCFF, please see the Senate Budget and Fiscal Review Committee's Overview on Education: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/overview/Overview2014_15BudgetBillSB851.pdf Nothing about LCFF requires specified funding for specified programs. Districts can identify money as supplemental/concentration funds, or for another use.

be submitted by school districts in late May and reported by the department in mid-summer, following data quality review.

American Institute for Research (AIR) Survey. AIR is conducting the Study of California's Transitional Kindergarten Program, which will investigate the planning for and implementation of TK in the 2012-13 school year. The study includes a survey of California school districts and an analysis of the survey responses.[32]The full study will be released in late April, but preliminary findings include the following:

- 89 percent of districts reported providing TK in 2012–13, and an additional seven percent reported they had no students enroll. The remaining four percent of districts cited a variety of reasons for not implementing TK, including having too few students to warrant establishing a program and a lack of resources or uncertainty about funding for the program.
- 58 percent of districts reported offering full-day TK, and 41 percent reported offering half-day TK.
- The vast majority of TK teachers had early education teaching experience, with 87 percent reporting they had taught kindergarten, and 29 percent reporting prior experience as preschool teachers.
- The demographic characteristics of students enrolled in TK largely mirrored the characteristics of kindergarten students enrolled in the same district. Characteristics examined included gender, ethnicity, eligibility for free or reduced price lunch, and English learner status.

Figure 1: Comparisons of TK and Kindergarten Enrollment by Race/Ethnicity, 2012-13 School Year



Note: Differences are not statistically significant unless noted.
Sources: In-depth district survey (n = 75), California Department of Education

Figure 1: American Institutes of Research (2014, April). "Comparisons of TK and Kindergarten Enrollment by Race/Ethnicity, 2012-13 School Year."

[32] Funding for the study was provided by the Heising-Simons Foundation and The David and Lucile Packard Foundation. AIR surveyed administrators in all California districts with kindergarten enrollment (n=868). Surveys were administered electronically. The research team conducted intensive follow-up to obtain responses from a random subsample of non-respondents. These responses were used to create survey weights that correct for non-response bias, providing a weighted analysis that is intended to be representative of the state. The survey had a final response rate of 72 percent (n=629).

Related Legislation: During this legislative session, there are policy bills, introduced in both houses, which address issues, such as enhanced funding for infant and toddler education and care; removal of State Preschool Program family fees; TK revision and expansion; dual eligibility for four-year olds in TK and the State Preschool Program; mandatory kindergarten; and, full-day kindergarten.

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

Questions

1. To CDE: What are some of the biggest challenges faced by school districts as they implement the existing TK program?

2. To CDE or LAO: Should TK have its own learning standards, distinct from kindergarten? Is 1:24 an appropriate teacher-to-child ratio for four-year olds?

3. To CDE or LAO: What does research tell us about the most effective Pre-K programs?

3. California State Preschool Program - Overview

Panelists. Department of Education
Legislative Analyst's Office
Department of Finance

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 LEAs serve approximately two-thirds of all children enrolled in State Preschool.

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. Family fees, or the cost a family must pay for child care if their income is above a certain level, are based on a sliding scale. In general, a family pays a family fee if their income is above 50 percent of the state median income (more information about the family fee to follow). Additionally, 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.

Evaluation. Contractors must develop and implement an annual evaluation process, which includes a parent survey assessment, an agency self-evaluation, and an analysis of categorical program monitoring/contract monitoring review (CPM/CMR) findings.

Characteristics of CSPP families. For part-day CSPP, there were 66,532 families that were 40 percent or less than the state median income (SMI); 24,894 families were between the 40 percent to 70 percent of SMI; and, 1,538 families were 70 percent or above the SMI. For full-day CSPP, 26,005 families were 40 percent or less than the SMI; 13,145 were between 40 percent to 70 percent of SMI; and 76 families were 70 percent or above the SMI. The table below compares the SMI ranges of families served in CSPP, full-day and part-day care, in October 2010 and October 2013.

California State Preschool (CSPP)						
	Oct. 2010			Oct. 2013		
SMI % Range	Full Day	Part Day	Total	Full Day	Part Day	Total
0-5%	1,399	4,011	5,410	1,194	3,852	5,046
6-10%	1,733	5,856	7,589	1,378	7,105	8,483
11-15%	3,611	10,670	14,281	2,626	9,662	12,288
16-20%	3,617	8,129	11,746	2,563	7,688	10,251
21-25%	5,161	9,952	15,113	3,773	9,695	13,468
26-30%	6,351	10,199	16,550	4,828	10,060	14,888
31-35%	6,012	9,408	15,420	4,982	9,749	14,731
36-40%	5,544	7,640	13,184	4,673	8,730	13,403
41-45%	3,973	6,707	10,680	3,368	6,431	9,799
46-50%	3,347	5,792	9,139	3,012	5,284	8,296
51-55%	2,615	5,256	7,871	2,368	4,371	6,739
56-60%	1,858	4,656	6,514	1,914	3,658	5,572
61-65%	1,359	4,015	5,374	1,399	2,897	4,296
66-70%	1,058	3,438	4,496	1,075	2,249	3,324
Over 70%	669	5,407	6,076	73	1,533	1,606
Total	48,307	101,136	149,443	39,226	92,964	132,190

Source: CD-801 Monthly Child Care Report, October 2010 and October 2013 (archived data).
Note: Data represent a "point-in-time" and do not reflect annual aggregate figures.
Missing/Unknown family monthly income and family size are excluded.

According to 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.

Lastly, of the 132,190 families in CSPP, 39,403 families (29.8 percent) are a family of four. 11,644 of 39,226 families (29.7 percent) in full-day care were a family of three.

CSPP Family Size			
Family Size	Care		
	Full Day	Part Day	Total
1	461	747	1,208
2	9,930	10,801	20,731
3	11,644	20,616	32,260
4	9,756	29,647	39,403
5	5,121	19,832	24,953
6	1,725	8,031	9,756
7	438	2,286	2,724
8	120	722	842
9	21	200	221
10	8	56	64
11	1	10	11
12	1	16	17
Total	39,226	92,964	132,190

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.

3. California State Preschool Program - Family Fees

Panelists. Department of Education
Legislative Analyst's Office
Department of Finance

Background. Effective July 1, 2012, SB 1016 (Budget and Fiscal Review Committee), Chapter 38, Statutes of 2012, required agencies to assess family fees for families receiving part-day CSPP services, who were previously exempt from family fees, according to the most current family fee schedule (see Table 6 on next page).

For families certified for part-day CSPP services, the family fee will be assessed at the time of certification and remain effective for the remainder of the program year, as long as the child remains enrolled and receives part-day CSPP services. A family may request a reduction to their family fee when there are changes to family income, size, or other specified factors listed in state law that would support a reduction to the family fee.[33] Families whose eligibility is based on a child(ren) receiving child protective services, or are at risk of being abused, neglected, or exploited, will not be assessed a family fee when the referral from a legal, medical, or social service agency indicates that the fee should be waived. Additionally, families receiving CalWORKs cash aid are exempt from paying family fees.

Family fees are based on a sliding scale for income and family size. For example, a family of three with an adjusted monthly income of $2,100 is assessed a part-time daily fee of $1.25; a family of four with adjusted monthly income of $2,400 is assessed a part-time daily fee of $1.50. Only 11 percent of the families with children in preschool had high enough incomes to be impacted when the program was initiated. However, in the first six months of the program's implementation, about five percent of the total enrollment withdrew from preschool and an addition 2,757 children did not enroll in the program after their parents were informed of the fee.

According to CDE, in fiscal year 2013-14, through the second quarter, the state received around $5.4 million in family fees for part-day CSPP and $6.5 million for full-day CSPP.

[33] California Code of Regulation, Title 5 (5 *CCR*), Section 18109

Table 6: Current Family Fee Schedule

Family Fee Schedule												
Part-time Daily Fee	Full-time Daily Fee	Family Size 1 or 2	Family Size 3	Family Size 4	Family Size 5	Family Size 6	Family Size 7	Family Size 8	Family Size 9	Family Size 10	Family Size 11	Family Size 12
$ 1.00	$ 2.00	1,820	1,950	2,167	2,513	2,860	2,925	2,990	3,055	3,120	3,185	3,250
$ 1.25	$ 2.50	1,893	2,028	2,253	2,614	2,974	3,042	3,109	3,177	3,245	3,312	3,380
$ 1.50	$ 3.00	1,965	2,106	2,340	2,714	3,089	3,159	3,229	3,299	3,369	3,440	3,510
$ 1.75	$ 3.50	2,038	2,184	2,426	2,815	3,203	3,276	3,349	3,421	3,494	3,567	3,640
$ 2.00	$ 4.00	2,111	2,262	2,513	2,915	3,317	3,393	3,468	3,544	3,619	3,694	3,770
$ 2.25	$ 4.50	2,184	2,340	2,600	3,016	3,432	3,510	3,588	3,666	3,744	3,822	3,900
$ 2.65	$ 5.30	2,257	2,418	2,686	3,116	3,546	3,627	3,707	3,788	3,869	3,949	4,030
$ 3.05	$ 6.10	2,329	2,496	2,773	3,217	3,661	3,744	3,827	3,910	3,993	4,076	4,160
$ 3.45	$ 6.90	2,402	2,574	2,860	3,317	3,775	3,861	3,946	4,032	4,118	4,204	4,290
$ 3.85	$ 7.70	2,475	2,652	2,946	3,418	3,889	3,978	4,066	4,154	4,243	4,331	4,420
$ 4.25	$ 8.50	2,548	2,730	3,033	3,518	4,004	4,095	4,186	4,277	4,368	4,459	4,550
$ 4.65	$ 9.30	2,621	2,808	3,120	3,619	4,118	4,212	4,305	4,399	4,492	4,586	4,680
$ 5.05	$ 10.10	2,693	2,886	3,206	3,719	4,232	4,329	4,425	4,521	4,617	4,713	4,810
$ 5.45	$ 10.90	2,766	2,964	3,293	3,820	4,347	4,446	4,544	4,643	4,742	4,841	4,940
$ 5.85	$ 11.70	2,839	3,042	3,380	3,920	4,461	4,563	4,664	4,765	4,867	4,968	5,070
$ 6.25	$ 12.50	2,912	3,120	3,466	4,021	4,576	4,680	4,784	4,888	4,992	5,096	5,200
$ 6.65	$ 13.30	2,985	3,198	3,553	4,122	4,690	4,797	4,903	5,010	5,116	5,223	5,330
$ 7.05	$ 14.10	3,057	3,276	3,640	4,222	4,804	4,914	5,023	5,132	5,241	5,350	5,460
$ 7.45	$ 14.90	3,130	3,354	3,726	4,323	4,919	5,031	5,142	5,254	5,366	5,478	5,590
$ 7.60	$ 15.20	3,203	3,374	3,749	4,348	4,948	5,061	5,173	5,286	5,398	5,510	5,623
$ 7.75	$ 15.50	3,283	3,393	3,770	4,373	4,976	5,089	5,202	5,315	5,428	5,541	5,655
$ 7.90	$ 15.80		3,413	3,792	4,399	5,006	5,120	5,233	5,347	5,461	5,575	5,688
$ 8.05	$ 16.10		3,432	3,813	4,423	5,033	5,148	5,262	5,376	5,491	5,605	5,720
$ 8.23	$ 16.45		3,518	3,835	4,448	5,062	5,177	5,292	5,407	5,522	5,637	5,752
$ 8.43	$ 16.85			3,856	4,473	5,090	5,206	5,322	5,437	5,553	5,669	5,785
$ 8.63	$ 17.25			3,880	4,500	5,121	5,237	5,354	5,470	5,586	5,703	5,819
$ 8.88	$ 17.75			3,908	4,534	5,159	5,276	5,394	5,511	5,628	5,745	5,863
Monthly Income Ceilings		**3,283**	**3,518**	**3,908**	**4,534**	**5,159**	**5,276**	**5,394**	**5,511**	**5,628**	**5,745**	**5,863**

Table 6: California Department of Education. "Management Bulletin 11-26: Early Education and Support Division." http://www.cde.ca.gov/sp/cd/ci/documents/famfeeschedule1112v002.pdf

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

Questions

1. To LAO: Please provide a brief history of the CSPP family fee. Have enrollment figures in CSPP declined due to the family fee? After the family fee was put in place, has there been a change in the income-distribution of families who participate in CSPP?

2. To CDE: Please provide a summary of the feedback received from centers regarding the collection and notice practices.

3. To CDE: Please provide an update on the proposed family fee structure.

5. LAO - Restructuring Proposal[34]

Budget Issue. The LAO recommends the Legislature consider restructuring California's child care and development system, according to a specified five-year roadmap. The timeline, as summarized below, assumes no additional resources are provided for the restructured system.

- Year 1. The Legislature updates the reimbursement rates based on current data, and determines time limit for services. Direct CDE to modify standards for programs serving children birth through age four and to develop regulations for regional monitoring of developmental standards.

- Year 2. The Legislature adopts new standards for programs serving children, birth through age four. Wait until year four to require all providers meet the new standards. Consolidate CalWORKs Stage 1 and Stage 2, and shift all CalWORKs childcare to DSS. Determine how to align reimbursement rates with new standards.

- Year 3. Begin converting reimbursements for former Title 5 private providers from direct contracts to vouchers.

- Year 4: The Legislature requires all providers serving children birth through age four to meet standards. Adjust reimbursement rates to reflect new standards.

- Year 5: Finalize conversion of former Title 5 providers from contracts to vouchers. Families can now access subsidized child care through vouchers, with the exception of LEA preschool programs.

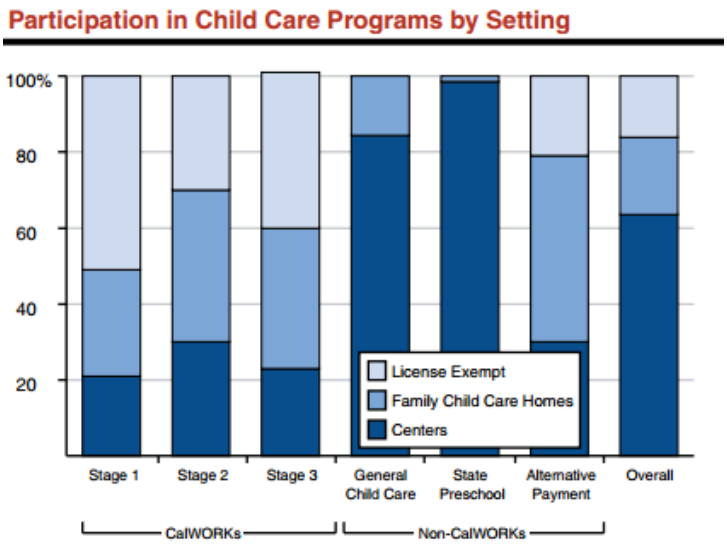
Panelists. Carolyn Chu, Legislative Analyst's Office

Background. California's child care and development system is a complex patchwork of providers and policies. To qualify for subsidized child care, families, generally, meet three criteria: (1) parents must demonstrate "need" for care (parents either working or participating in an education or training program); (2) family income must be below 70 percent of the state median income (SMI), as calculated in 2007-08 (for a family of three, the SMI cap is $42,216); and (3) children must be under the age of 13.

CalWORKs families are statutorily guaranteed subsidized care during Stage 1 (when a family first enters CalWORKs) and Stage 2 (when a county deems the family "stable"). Stage 3 is not treated as an entitlement, but historically, the Legislature has funded all eligible families. Non-CalWORKs families with the lowest income are prioritized over families with relatively higher incomes. Once a CalWORKs or non-CalWORKs family accesses a subsidy, the family may continue receiving the subsidy as long as it continues to meet the program's eligibility criteria.

Slots and participation, by program and setting. In 2012-13 data, non-CalWORKs programs comprised 62 percent of all slots, whereas CalWORKs child care comprised 38 percent of all slots.[35] State

[34] For the entire LAO report, "Restructuring California's Child Care and Development System," please see http://www.lao.ca.gov/reports/2014/education/child-care/restructuring-child-care-system-040414.aspx



Preschool makes up the largest program, with 40 percent of all slots. In 2012-13, 25 percent of children served in the state's subsidized child care system were infants and toddlers (birth to age three); 34 percent were preschool-aged children, and 41 percent were school-aged children. Also, reliance on particular child care settings differs across programs. For example, 64 percent of children are served in centers, and 20 percent of children are served in family child care homes (FCCHs) (see figure above).

Reimbursement rate structures vary. Title 5 providers are paid a Standard Reimbursement Rate (SRR) that is set in the Education Code and the annual budget act. The SRR is higher for Title 5 centers than for Title 5 FCCHs. The SRR is adjusted for characteristics of the child served, such as age, having a disability, or being limited English proficient. In contrast, providers that meet Title 22 standards are reimbursed according to the Regional Market Rates (RMR), which varies based on the county in which the child is served. Like the SRR, the RMR is adjusted based on the age of the child and if the child has a disability. The SRR and the statewide average RMR for full-day care of a preschool-aged child is $716 per month and $714 per month, respectively. The state held the RMR and SRR at 2005 and 2007 levels, respectively.

The state reimburses license-exempt providers at a percentage of the county's maximum RMR or their actual costs, whichever is lower. Currently, the reimbursement rate for license-exempt providers is set at 60 percent of each county's maximum RMR.

Further, actual reimbursements vary based on what the provider charges. If a family selects a provider that charges above the RMR of a county, the family must pay the difference, known as a co-pay. The state requires that providers charge subsidized families and non-subsidized families the same price.

Family fees. Families not receiving CalWORKs cash assistance must also pay fees for child care. Fees are based on family size, income, and whether the family receives part-day or full-day care (six hours or more of care). All fees are collected to offset the state GF cost of the programs. In 2012-13, the state collected around $54 million in fees across all child care programs.

Administration and oversight. The Department of Social Services (DSS) administers the CalWORKs program and Stage 1 child care. CDE administers the funding for families in CalWORKs Stages 2 and 3. CDE also administers all other non-CalWORKs child care programs.

DSS' Community Care Licensing Division processes applications for child care licensees, inspects applicants, and must visit a licensed facility at least once every five years. CCL monitors Title 5

[35] In 2012-13, CalWorks Stage 2 comprises 20 percent of all slots.

providers for health and safety standards, while CDE monitors Title 5 for developmental standards. License-exempt providers are not actively monitored by a state agency.

State-by-state context. All 50 states have subsidized child care for low-income families. 22 states, including California, guarantee child care subsidies for welfare-to-work families. 19 states, including California, guarantee subsidized child care to families transitioning off cash assistance. 21 states, including California, have stricter health and safety licensing standards for child care providers. California also exceeds federal regulations by requiring providers to have training in child development.

California differs from other states in how it provides child care and the duration of benefit. First, in contrast with the majority of states that use vouchers as a primary means of providing subsidized child care, California uses both vouchers and direct contracts. Second, unlike other states that limit eligibility to subsidized child care to those participating in Temporary Assistance to Needy Families (time limits associated with TANF programs also act as time limits for child care), California guarantees child care for former recipients as long as they meet work requirements, income requirements, and have a child(ren) younger than 13 years old.

LAO Comments and Recommendations. California's child care system exhibits two main strengths: (1) families have a choice in selecting among an array of providers, and (2) there are some programs with developmentally appropriate care. However, according to the LAO, no subsidized program exhibits both of these strengths concurrently. This section will detail some of the child care and development system's design flaws and the consequences of those flaws, as well as identify recommendations to restructure the system.

Assessment. Critical design flaws treat similar families differently. Specifically, the LAO finds:

- Similar families have different levels of access. The prioritization of families, in or formerly in, CalWORKs over otherwise similar non-CalWORKs families results in different access to services. As a result, if a family formerly on CalWORKs remains eligible for child care, the family can receive up to 13 years of child care, whereas a similar low-income family may not receive the same level of benefits.

- Similar families have differing amounts of choice in selecting care. Families receiving a contract slot can result in match issues, because the slot may not meet the parent's needs due to location of the center, or the slot does not fit the hours of care a family requires. This issue is prevalent for State Preschool Programs, since a majority of the programs only offer part-day care.

- Similar families are provided different standards of care. Families receiving vouchers are guaranteed providers that meet Title 22 health and safety standards, while families that have contract slots can receive care that meets health, safety, and developmental standards under Title 5.

- State has higher reimbursement rate for lower standard of care. The RMR is used to pay Title 22 providers, which are subject to health and safety standards, whereas the SRR is used to pay Title 5 providers, which are subject to health, safety, and developmental standards. In 19 counties, the RMR is higher than the SRR for preschool-age children, based only monthly reimbursements.

- Resources not always used the most strategically. The existing system does not target resources to low-income children to promote school readiness. Also, the state pays a higher rate – nearly 50 percent more – for non-need based TK than need-based preschool.

- Service levels vary across the state. The number of working parents with low-income children eligible for subsidized child care is unknown. However, data is available on low-income children by county, compared with total number of subsidized slots by county. The highest share of children served through subsidized child care is in Modoc County (with 30 percent of low-income children served). Kern County serves the lowest proportion of low-income children. Almost all counties, however, serve a relatively small proportion of children, with 54 counties serving less than 20 percent of low-income children.

Recommendation. The LAO finds that families have different levels of access to programs that offer different choices among providers that meet different standards of care, and are reimbursed at different rate levels. In response, the LAO recommends the following:

- Continue to prioritize families new to CalWORKs, which would help families overcome a barrier to employment.

- Set a six to eight year time limit for child care subsidies. The time limit would apply to both CalWORKs and non-CalWORKs families. Providing child care for six to eight years still represents at least a $40,000 investment per child. Capping the number of years a family could receive care would allow the state to serve more low-income families. Further, after six to eight years of child care, many families' children would be school age, and could then access before- and after-school care.

- Continue to contract with LEAs for State Preschool. Without direct contracts, LEAs could be less likely to provide preschool programs. Collocating CSPP with LEAs could help children transition into kindergarten and could utilize LEAs' resources, like counselors and nurses.

- Provide similar levels of service of access across the state. The Legislature could serve the same share of families in each county (e.g., serve 10 percent of all eligible families in each county). Alternatively, the Legislature could serve families based on statewide median income (e.g., all families under 50 percent of SMI).

- Require programs serving four-year-olds to focus on school readiness. Not all four-year-olds in subsidized child care have access to programs required to provide educational components. The Legislature may wish to direct CDE to develop standards that are similar to existing Title 5, but modified to reduce some programmatic restrictions, like flexibility in teacher ratios or classroom configuration.

- Apply development standards to part of the day. The Legislature may wish to consider requiring programs that serve children birth through age four to meet new developmental standards for three hours per day, consistent with the state's current approach for CSPP, TK, and kindergarten. For the other portion, providers could meet only Title 22 health and safety standards.

- Do not require educational component for child care programs serving school-age children. School age children already receive several hours of instruction from certified teachers. The Legislature may wish to consider repealing the Title 5 requirement to free up additional resources to support developmentally appropriate activities for children birth through aged four.

- Reimburse vouchers based on high-, medium-, and low-cost areas. The LAO recommends the Legislature provide all eligible families similar levels of choice by providing subsidies primarily through vouchers, which would eliminate the "match" issue some families currently experience. Further, the LAO recommends reimbursing vouchers based on a three-tiered system – high cost area, medium cost area, and low-cost area. Urban and coastal counties tend to be high-cost; lowest-cost counties tend to be located in the rural northern part of the state and in the Central Valley. San Bernardino and Sacramento are examples of medium cost counties. The figure (right) shows what rate would be under the proposed, simplified rate structure, assuming current funding levels.

A New, Greatly Simplified Rate Structure

	2014-15 Rate[a]
High-Cost Counties	
Infants	$1,342
Preschool	902
School-age	601
Medium-Cost Counties	
Infants	$1,077
Preschool	719
School-age	479
Low-Cost Counties	
Infants	$836
Preschool	594
School-age	396

[a] Reflects reimbursement per month for full-time child care.

- Provide higher subsidy for programs with higher cognitive and development standards. For LEAs, the LAO recommends that the Legislature continue to use a standard reimbursement rate, as LEAs receive a standard rate for nearly all other K-12 services.

- As a starting point, set reimbursements at 70th percentile of most recent survey. Setting the initial reimbursement rates at the 70th percentile of the 2012 RMR survey would serve the same number of children without additional cost. The state would still need to ensure that the reimbursement rate is adequate enough that low-income families can access child care providers that meet required standards without undue burden.

- Merge CalWORKs Stage 1 and Stage 2 into one program. Shift all CalWORKs administration to DSS, as DSS already administers other aspects of the CalWORKs program.

- Merge CalWORKs Stage 3 and non-CalWORKs child care programs. CDE would administer the merged programs. Stage 3 families, which have been off CalWORKs cash aid for more than two years, and non-CalWORKs families would be treated in the same manner, if the Legislature were to make changes to the non-CalWORKs child care program.

- Direct CDE to conduct inspections based on risk reviews from regional monitoring agencies. Resources currently used to oversee Title 5 providers could be redirected for risk reviews and inspections.

- Re-establish Centralized Eligibility Lists. Restarting the CELs would cost between $5 million and $10 million annually.

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

Questions

1. What are some of the strengths and weaknesses of the state's current child care and development system? Please present the LAO's report and recommendations for restructuring.

2. The report states that levels of service to low-income children vary across counties. What are possible explanations for this experience?

3. Please explain briefly the tiered reimbursement rate structure.

SUBCOMMITTEES No. 1 and 3
Education and Health & Human Services

Chair, Senator Marty Block | **Chair, Senator Ellen Corbett**

Senator Mark Wyland | **Senator Mimi Walters**
Senator Carol Liu | **Senator Bill Monning**

Joint Hearing

April 10, 2014
9:30 a.m. or Upon Adjournment of Session
Room 4203, State Capitol

Consultant: Samantha Lui

OUTCOMES

Informational

I.	Early Childhood Education and Poverty Dr. Jill Cannon, Policy Researcher, RAND Corporation	Informational item.
II.	Overview of California's Child Care and Development System Ryan Woolsey, Legislative Analyst's Office Carolyn Chu, Legislative Analyst's Office	Informational item.

Item	Department	
5180	Department of Social Services	
	1. Parent-Child Engagement Pilot Project	Held open.
Public Comment		
6110	Department of Education, Child Care	
	1. Overview of the Governor's Budget	Held open.
	2. Transitional Kindergarten	Informational item.
	3. California State Preschool Program (CSPP)	Informational item.
	4. CSPP Family Fees	Informational item.
	5. LAO Restructure Proposal	Informational item.
Public Comment		