Senate Budget and Fiscal Review

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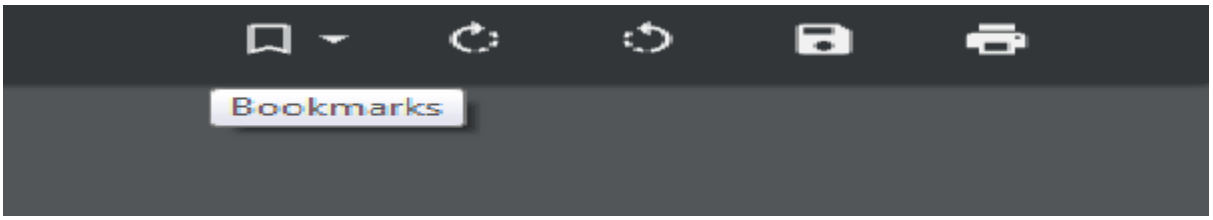

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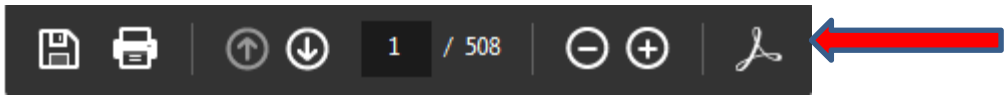

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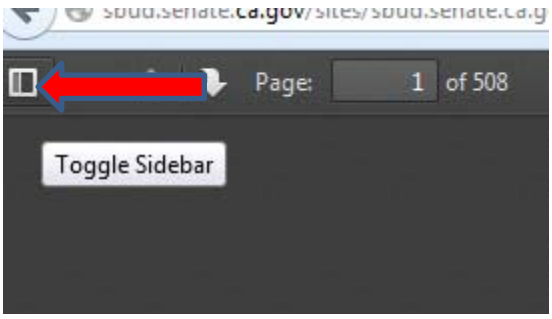

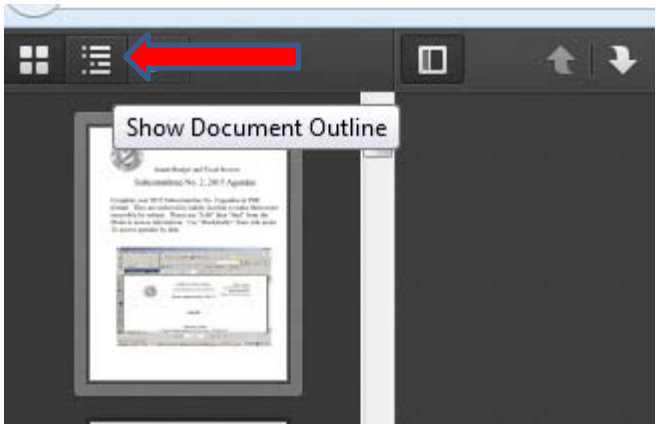

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California Legislature

SENATE COMMITTEE ON HUMAN SERVICES

MIKE McGUIRE
CHAIR

Joint Oversight Hearing
Senate Human Services Committee
Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services

Tuesday, February 23, 2016
1:30 p.m.
State Capitol, Room 4203

AGENDA

A Defining Moment: Considering the Closure of Developmental Centers and Its Impact on Residents, Families and the Regional Center System

1. **Opening Comments**
   - Senator McGuire, Chair, Senate Human Services Committee
   - Senator Mitchell, Chair, Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services

2. **Overview of the Administration's Proposed Closure of Remaining Developmental Centers**
   - Michael Wilkening, Undersecretary, California Health and Human Services Agency and Acting Director, Department of Developmental Services
   - John Doyle, Chief Deputy Director, Department of Developmental Services

3. **Current Status of Developmental Centers**
   - John Doyle, Chief Deputy Director, Department of Developmental Services

4. **Challenges Faced and Lessons Learned from Previous Developmental Center Closures**

   Regional Center Perspectives
   - R. Keith Penman, Director, San Gabriel/Pomona Regional Center
   - Jim Burton, Director, Regional Center of the East Bay

State Perspectives

- John Doyle, Chief Deputy Director, Department of Developmental Services
- Coby Pizzotti, Consultant, California Association of Psychiatric Technicians
- Dr. Anne French, Staff Physician, Sonoma Developmental Center

Vendor Perspective

- Michael Kottke, Executive Director, Elwyn of California

Advocate Perspectives

- William Leiner, Associate Managing Attorney, Disability Rights California
- Dr. April Lopez, Chair, State Council on Developmental Disabilities

Consumer and Family Perspectives

- Debbie Batterson, Consumer – Former Sonoma Developmental Center Resident
- Diana Pastora Carson, Family Member – Former Fairview Developmental Center Resident
- Dorothy Diamond, Family Member – Former Lanterman Developmental Center Resident
- Jerra Letrich Hardy, Family Member – Former Lanterman Developmental Center Resident

5. **Maintaining a Safety Net: What Should Be the State's Ongoing Role in Providing Unique Services, Addressing Unmet Needs, and Ensuring the Well-Being of Those with Challenging Medical and Behavioral Needs**

- Eileen Richey, Director, Association of Regional Center Agencies
- Kathleen Miller, President, Parent Hospital Association of Sonoma Developmental Center
- Ray Ceragioli, Fairview Families and Friends, Inc.
- Willie West, Client
- Rebecca Donabed, Member, Self-Advocates Advisory Committee of the State Council on Developmental Disabilities
- Catherine Blakemore, Executive Director, Disability Rights California
- Marty Omoto, California Person-Centered Advocacy Partnership
- Tony Anderson, Executive Director, The Arc California
- Rod Stroud, Special Projects Director, County of Sonoma

6. **Public Comment**

- Public comment is limited to 3 minutes per person.

7. **Adjournment**

BACKGROUND PAPER

Purpose of Hearing. The California Department of Developmental Services (DDS) owns and operates three state developmental centers (DCs), which include residential programs licensed and certified as Skilled Nursing Facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and General Acute Care hospitals. These are Sonoma Developmental Center (located in Sonoma County), Fairview Developmental Center (located in Orange County), and Porterville Developmental Center (located in Tulare County). Additionally, DDS leases and operates one smaller 56-bed community-based ICF/IID, known as Canyon Springs, serving residents with developmental disabilities and challenging behaviors, in Riverside County. As of February 10, 2016, these four facilities collectively serve approximately 1,031 individuals with significant physical or behavioral developmental disabilities. Of these, 202 individuals reside in the secure treatment program at Porterville Developmental Center. In April of 2015, the Administration submitted a proposed plan of closure for the Sonoma Developmental Center. This plan is currently under review of legislative budget committees and must be approved prior to implementation. On November 30, 2015, the Administration announced its intention to submit proposed closure plans for Fairview Developmental Center and the general treatment programs at Porterville Developmental Center. These plans, once submitted, must also be approved by the Legislature.

The purpose of this joint hearing is to discuss the lessons learned from previous closures of developmental centers in California; examine the proposal for the closure of Sonoma Developmental Center, currently before the Legislature; and identify issues associated with the proposed closures of Fairview Developmental Center and the general treatment program at Porterville Developmental Center. Specifically, the hearing will review: the process for moving persons from a developmental center to the community; how the department will maintain quality services and supports for persons residing at developmental centers throughout the closure process, how the resources at the developmental centers will be utilized following closure, how the department will ensure the quality, stability and appropriateness of services and supports provided to persons once they have moved to the community; and the role of the state in providing safety net services for all Californians with developmental disabilities in crisis or in need of a placement of last resort once the developmental center option is no longer available.

Developmental Services System in California

Developmental Centers.

Prior to the passage of the Lanterman Act in 1969, the developmental centers were the primary provider of state-funded services to persons with developmental disabilities. California has served persons with developmental disabilities in state-owned and operated institutions since 1888. At its peak in 1968, the developmental center system housed over 13,400 individuals in seven facilities. Of the three remaining facilities, the oldest is Sonoma Developmental Center (1891) and the newest is Fairview Developmental Center (1959).

Developmental Center	Years of Operation	Notes
Agnews	1888-2009	Initially served persons with mental illness. Expanded to serve persons with developmental disabilities in 1965. Discontinued services to persons with mental illness in 1972. West campus closed in 1995. East campus closed in 2009.
Camarillo	1936-1997	Served both persons with mental illness and developmental disabilities.
DeWitt	1947-1972	Served both persons with mental illness and developmental disabilities.
Fairview	1959-present	DDS is currently developing a closure plan for this facility.
Lanterman	1927-2014	Closed in 2014.
Mendocino	1893-1972	Over the years, various programs were established and disbanded, including programs for the criminally insane, alcoholic and drug abuse rehabilitation, psychiatric residency program, industrial (work) therapy, and others.
Napa	1995-2000	Served a forensic population.
Patton	1893-1981	Served both persons with mental illness and developmental disabilities.
Porterville	1953-present	DDS is currently developing a closure plan for the general treatment program. The secure treatment program is proposed to remain operational.
Sonoma	1891-present	DDS has submitted a proposed closure plan to the Legislature.
Stockton	1851-1996	Opened as a state hospital for persons with mental illness; began admitting persons with developmental disabilities in the early 1970's and officially became a developmental center in 1986.

With the passage of the Lanterman Act, and subsequent legislation that has expanded eligibility for, and availability of, services and supports in the community, the developmental center population began to decline. Since 1972, eight developmental centers or developmental disability programs within state hospitals have closed. However, the population decline in developmental centers slowed considerably from the mid-1980's through the early 1990's. During this period the number of person moving out of a developmental center was balanced by nearly an equal number of persons being admitted.

In 1993, the population decline accelerated again, reducing by 1,005 between April 1993 and March 1995. Several factors contributed, and continue to contribute, to this change.

- Nationally, and in California, persons with disabilities began a movement calling for equal access to all aspects of community life, the removal of barriers that excluded and segregated them, and the provision of reasonable accommodations that would make such access possible. In 1973, federal law banned discrimination based on disability by recipients of federal funds[1]. The federal Individuals with Disabilities Education Act of 1975, and the Americans with Disabilities Act (ADA) of 1990, further established and defined the rights of persons with disabilities.

- In California's developmental disabilities system, the movement for inclusive communities manifested itself in substantive changes to the Lanterman Act that expanded eligibility, introduced person-centered planning, and broadened the array of services and supports available to support persons in the community. Additionally, regional centers have used an annual community planning and placement (CPP) allocation, to develop community-based services and supports for individuals moving out of a developmental center, and to deflect new placements into developmental centers. This enriched service system, along with changing attitudes, resulted in fewer persons being placed into developmental centers.

- Several class action lawsuits also impacted the use of developmental centers. In *Coffelt v. Department of Developmental Services*, plaintiffs alleged that the department and specified regional centers had not taken sufficient action to develop community-based services and supports, thus denying developmental center residents the opportunity to live in the community. The case was settled in 1994, with the department agreeing to a net reduction of 2000 persons by 1998, and to find alternative living arrangements for 300 persons living in inappropriate community-settings; establish a new assessment and individual service planning procedure; create a quality assurance system; and develop alternative models of service.

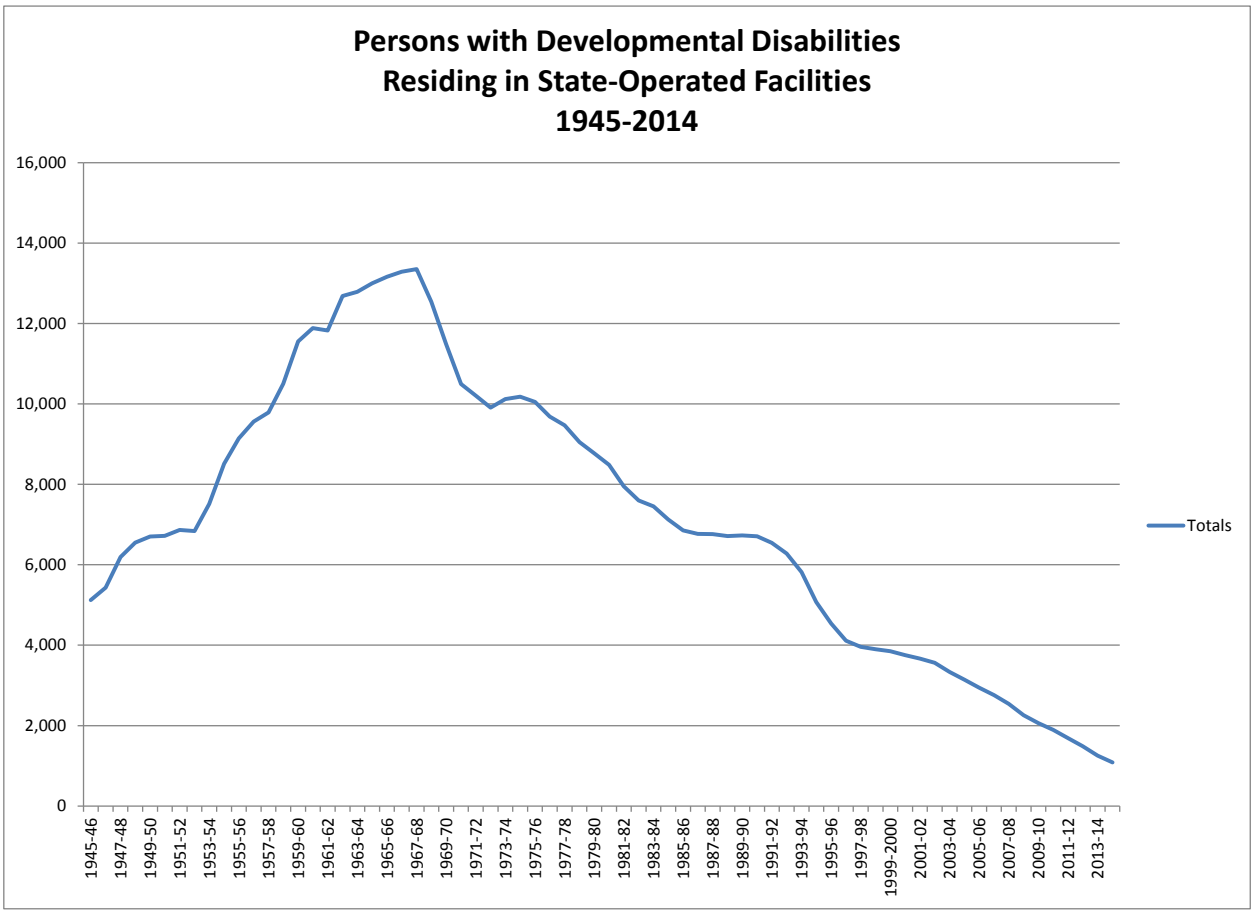
- In the United States Supreme Court's 1999 decision in *Olmstead v. L.C., et al.*, the court found that unjustified segregation of persons with disabilities constitutes discrimination in violation of the Americans with Disabilities Act.

- In the early 1990's, the federal Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS), approved a Medicaid Home and Community-Based Waiver program for California allowing for federal financing participation in funding community-based services and supports. Prior to this waiver, most federal funding for persons with developmental disabilities was available only for persons living in institutional care. Medicaid waiver funding increased from approximately $48 million in fiscal year 1990-91 to $276 million in fiscal year 1995-96, and to an estimated $2.3 billion the fiscal year 2016-17. The availability of federal funding to support the community-based service system removed a significant fiscal barrier to moving persons from developmental centers.

[1] Section 504 of the 1973 Rehabilitation Act.

- Additional changes in state law, particularly limitations on placements into developmental centers, and the development of community-based resources for persons with significant medical or behavioral needs, further served to accelerate reductions in the developmental center population and increase the per capita costs for remaining residents.

The following charts illustrate the drop in developmental center population since 1945 and the population, by program type, over the past four years at each developmental center.



DC CLOSURE POPULATION (Includes those on leave*) WEDNESDAY MIDNIGHT POPULATION				
	1/1/13	1/1/14	1/1/15	1/1/16
FAIRVIEW	**362**	**322**	**296**	**248**
General Acute Care (GAC)	1	0	0	1
Nursing Facility (NF)	146	134	118	100
Intermediate Care Facility (ICF)	215	188	178	147
PORTERVILLE **General Treatment Program**	**276**	**246**	**217**	**171**
GAC	5	7	0	3
NF	71	63	64	48
ICF	200	176	153	120
SONOMA	**516**	**463**	**417**	**370**
GAC	5	3	5	5
NF	221	200	181	158
ICF	290	260	231	207
TOTAL	**1154**	**1031**	**930**	**789**

Secure Treatment Program (STP) & TRANSITIONAL POPULATION (Includes those on leave*) WEDNESDAY MIDNIGHT POPULATION				
	1/1/13	1/1/14	1/1/15	1/1/16
CANYON SPRINGS ICF	**54**	**52**	**49**	**49**
FAIRVIEW CRISIS (STAR)	**0**	**0**	**0**	**4**
PORTERVILLE STP (incl GAC)	**176**	**166**	**167**	**192**
SONOMA CRISIS (STAR)	**0**	**0**	**0**	**5**
TOTAL	**230**	**218**	**216**	**250**

*Leave is Therapeutic Leave, Court Leave, Acute Hospital, or Unauthorized Absence

**STP = Secure Treatment Program

Issues in Developmental Center Licensing and Certification Compliance

1973 to 1982 Background. Senate Bill 413 (Beilenson), Chapter 1201, Statutes of 1973, took effect July 1, 1974, mandating licensure of state and county health facilities that had been previously exempt. For various reasons related to the Department of Health Services (DHS) inability to implement the law by the deadline, licensing surveys did not begin until late summer of 1975. Licenses were issued to the

state facilities in the fall of 1975, despite the identification of a number of deficiencies and issues that would not be resolved until years later.

Developmental Centers were first certified as general acute care hospitals beginning in 1965. The federal skilled nursing facility program became effective in California state facilities on May 1, 1973, and each facility was certified on that date without undergoing a survey. The federal intermediate care facility/mental retardation program came into existence on January 1, 1972, and was a radical departure from other programs. Regulations for its implementation were not available until 1974, with compliance not expected until March 1977. DHS, because of its lateness in beginning licensing surveys in state facilities, did not start reviewing for federal requirements until November 1976. ICF/MR certifications could not be granted until surveys confirmed compliance.

1977 to 1978 – Decertification Actions: Napa, Lanterman, Fairview, Agnews. A May 1977 DHS summary report found all of the state facilities were out of compliance, with serious and pervasive systemwide deficiencies in almost every area, but especially in staffing ratios, professional staff, organizational structure, active treatment, and environment. Deficiencies were found in all levels of care, including general Acute Care, Skilled Nursing Facility (SNF) and Acute Psychiatric programs; and DDS facilities were not compliant with or eligible for initial certification under the new ICF/MR requirements. On June 30, 1977, DHS terminated the SNF programs at Napa, Lanterman, Fairview and Agnews. DDS then switched from the SNF category to the new ICF/MR, but initial certification could not be approved because of major uncorrected deficiencies. Only Porterville, Sonoma and Stockton were spared.

Legislative hearings ensued and massive state efforts were initiated, reportedly with Governor Brown himself chairing a 13-hour meeting for all facilities and state and federal officials, held at Metropolitan State Hospital, to develop state-wide plans of correction. A federal extension provided for a revised deadline of July 17, 1978 for staffing compliance. Legislation was adopted, and eventual corrections included new organizational structures, new staffing classifications, an infusion of 2,890 new positions, and new staffing standards that incorporated licensing and certification requirements.

Another major impediment to regaining certification was the lack of environmental and fire life safety compliance. DDS and the Department of Mental Health negotiated an extension of the 1978 compliance deadline to July 18, 1982, submitted a plan to reduce the state facility population to 7,000 by that date, and to complete extensive renovations of all facilities to bring them to code compliance, utilizing waivers to the maximum extent.

With assurances of acceptable plans of correction and compliance for staffing and environmental deficiencies, SNF certifications were restored at Agnews in September 1977; at Fairview in February 1978; and at Lanterman in June 1978. Initial ICF/MR certifications were granted to Porterville, Sonoma, and Stockton in January 1978, to Agnews and Napa in February 1978, to Camarillo in March 1978, Fairview and Patton (DD) in May 1978, and Lanterman partially in June 1978, with remaining residences in October 1978.

1992 – Agnews Decertification. The January 14, 1992 stabbing death of a resident by an employee led to DHS' facility-wide investigation and about 33 licensing citations at Agnews within six months. Surveys in the SNF level of care found that certification requirements for administration, quality of care, and physician services were not met and constituted a serious and immediate threat. Actions were taken to terminate the SNF certification and cease all federal reimbursements. Consequently, the federal Health Care Financing Administration (HCFA) imposed a denial of payment sanction for new admissions to the SNF program and a termination of federal financial participation for ICF/MR services, which the Department appealed. Funds continued pending appeal. The denial of payment action was lifted for SNF in September 18, 1992, and the ICF/MR termination was rescinded after a new provider agreement went into effect.

This period began one of the most intensive periods of facility improvements in the DC history. Major statewide initiatives were approved to improve employee fingerprinting, screening, hiring, and training; investigations procedures, services and organization; physician peer review, quality assurance, risk management, incident and abuse reporting, and management oversight. Much of Agnews management and senior staff were removed and replaced within a year's time. Expert consultants were hired.

1997 to 2001 – Partnership Survey Certification Actions. The initiation of joint HCFA/DHS partnership ICF/MR surveys in July 1998 led to systemwide issues with compliance and an inability to satisfy new federal guidelines and survey protocols being imposed on California facilities for the first time. The state DCs went from averaging .4 conditions out of compliance under state surveys, to 5.2 conditions unmet in the partnership surveys. All facilities faced difficult surveys, with each having 5 to 7 conditions unmet in initial partnership surveys. Sanctions for denial of payment for new ICF/MR admissions were imposed on Fairview and Porterville in 1997 and early 1998, on Agnews and Lanterman in 1998. Agnews lost its full ICF/MR certification from April 1999 to October 2000; Sonoma lost its ICF/MR certification from August 2000 to April 2001; and Porterville lost its Secure Treatment Program certification in September 2001. Porterville STP certification has never been restored.

Federal losses for denial of payment and federal financial participation during this time period were approximately $59.3 million, not counting Porterville, whose losses have continued to this day. Corrective actions were systemwide, extensive, and costly with reports from that date indicating more than $17 million was spent in staffing, staff training, client services, recruitment and retention bonuses, consultant contracts and physical plant for Agnews alone. With all of these actions still being insufficient to restore certifications, DDS resorted to a major systemwide staffing augmentation in 1998-99 that proposed 1,700 new positions totaling more than $105 million over a four year period. (Actual amount budgeted and positions allocated may have varied over the course of the implementation.)

DDS also was required to develop a "Corporate Compliance Plan," which it submitted to DHS in 1999, which committed to statewide actions and monitoring in all facilities. In combination with the staffing augmentation, recruitment and retention bonuses, new psychiatric technician training programs, above-minimum hiring authority, a contract for extensive developmental center training and consultation, and

a Certification Unit in headquarters to provide intensive monitoring, training, and technical assistance, DHS agreed to restore all certifications except Porterville's. Porterville's decertification rested more on the nature of the clientele and the restrictions placed on them than staffing and program deficiencies.

2003 – Lanterman. Additional revisions to federal survey protocols resulted in "Look Behind" surveys initiated by CMS. As with the partnership surveys, these new surveys upped the ante for developmental centers, causing a new round of compliance problems. Lanterman's look behind survey found 5 of 8 conditions out of compliance. After threats of decertification actions, DDS asked CMS for a consultative survey, followed by numerous additional consultations over the next year in order to negotiate an acceptable plan of correction. While Lanterman never lost its certification, it was required to undergo extensive monitoring, site visits, and revisions to its numerous plans of correction. DDS hired a national consultant team to work with Lanterman, providing extensive staff training, mock surveys, and facility-wide improvement efforts. Additional staff were also added to improve client-staff ratios. Costs of consultants and staffing augmentation are not readily available, but totaled several million over the course of two years.

2013 to Present – Sonoma, Fairview, Porterville, and Lanterman. In January 2013, four out of 10 intermediate care facility (ICF) units at Sonoma (SDC) were withdrawn from federal certification by DDS, in response to notice that the federal government was moving to decertify the larger group of ICF units at the facility. These actions came on the heels of widely reported revelations of multiple instances of abuse, neglect, and other lapses in caregiving at the institution.

In March 2013, DDS entered into a Program Improvement Plan (PIP) agreement with the state Department of Public Health (DPH), which was accepted by the federal Centers for Medicare and Medicaid Services. As a condition of the PIP, DDS contracted with an outside consultant to conduct a root cause analysis of the problems at SDC, and to develop an action plan to ensure SDC is in compliance with federal and state licensing and certification requirements.

On October 31, 2013, the DPH accepted the SDC action plan which included the opening of a new ICF unit, 118.5 new staff positions, three new wheelchair transport vehicles, and extensive staff training. The Administration assumed these corrective actions would result in the restoration of certification and federal funding by July 1, 2014. However, this did not occur. Rather, a survey of the seven certified ICF units at SDC occurred May of 2014, and these units were found to be out-of-compliance in four out of eight conditions, resulting in their decertification. However, CMS extended, several times, the date on which federal funding for these units would be withdrawn while they engaged in active conversation with the Administration. On June 30, 2015, DDS entered into a settlement agreement with CMS to extend the final termination date for the remaining ICF residences to July 1, 2016 (with the potential for one or more extensions), and DDS must continue program improvement activities. Federal funding participation will continue during this period unless a subsequent survey finds additional or continuing deficiencies.

Following the Sonoma loss of federal certification, DPH conducted surveys at Fairview (FDC), Porterville (PDC), and Lanterman (LDC) developmental centers and found ICF units at each facility to be out of compliance with federal requirements. Like SDC, areas of non-compliance include treatment plans, protection of residents, client health and safety, and client rights. In January 2014, DDS and DPH reached an agreement to avoid decertification at these three facilities. The agreement requires the development of a

root-cause analysis and action plan for PDC and FDC, similar to what was required at SDC. For LDC, the agreement required DDS to contract with an independent monitor to provide oversight, among other requirements. FDC and PDC were resurveyed in early 2015; and in August 2015, both facilities were notified that they failed the surveys. The department has appealed and, like with Sonoma, CMS has extended the date on which federal funding for these units will be withdrawn several times, while they engaged in active conversation with the Administration.

Community-Based Service System

California has a uniquely designed community-based system of services and supports for persons with developmental disabilities. 21 private, non-profit organizations, known as regional centers, conduct outreach, assessment and intake activities; determine, through an individualized planning process, services and supports necessary to meet the needs of each person and, when appropriate, their family; and secure those identified services and supports for the consumer. Regional centers assist consumers in accessing community-based generic services, as well as vendor and purchase services from providers, including residential, training, work, recreation, transportation, personal assistance, and family respite services, among others. Persons with a developmental disability, as defined in law, are entitled to access services and supports through the regional center system.

Initially started as a pilot program in 1965-66, the first two regional centers were established in Los Angeles and San Francisco to serve persons with mental retardation. Today, there are 21 regional centers throughout the state. Over the years, since its enactment, the Lanterman Act has been amended to expand eligibility to include persons with an "intellectual disability, cerebral palsy, epilepsy, and autism." Eligibility is also extended to persons with "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability".[2]

The Lanterman Act has also been amended to give consumers and families a stronger voice in determining the services and supports they receive through a person-centered planning process, and has introduced new models of service delivery, including supported living services, supported employment services, and self-determination (in which consumers and families receive a set budget and directly control expenditures on services and supports of their choosing. This model is currently pending federal approval). Additionally, new residential models have been developed, intended to provide more intensive medical and behavioral supports in a home-setting.

Developmental Closures and Consolidations

Mendocino State Hospital.[3] Established in 1889 as the Mendocino State Asylum for the Insane, this facility was opened in 1893 and was renamed as Mendocino State Hospital in 1897. The hospital's population peaked in 1955 at over 3,000 patients, but dropped to less than 1,800 by 1966. Over the years, various programs were established and disbanded, including programs for the criminally insane, alcoholic and drug abuse rehabilitation, psychiatric residency program, industrial (work) therapy, and

[2] Welfare and Institutions Code 4512 (a).
[3] Source: Online Archive of California

others. The hospital closed in 1972, and at that time, was solely serving persons with mental illness.

DeWitt State Hospital.[4] DeWitt State Hospital was constructed as an Army facility and purchased from the federal government in 1946. The facility began to receive patients in 1947, initially only accepting patients on transfer from another state facility in order to relieve overcrowding. In 1950, it began receiving patients from its direct catchment area, the counties of Modoc, Lassen, Sierra, Yuba, Sutter, Placer, and El Dorado. By 1960, the population at DeWitt peaked at 2,800. After 1960, the population steadily declined until it was closed in 1972.

Patton State Hospital. A distinct program serving persons with developmental disabilities at Patton State Hospital closed in 1980-81. Of the 282 residents with developmental disabilities residing at Patton at that time, it was projected that 82 would be transferred to Camarillo Developmental Center and State Hospital, 41 would be transferred to other developmental centers (primarily Lanterman and Fairview), and 159 be placed into community settings. Community placements were developed through contracts between the department and regional centers, primarily San Diego and Inland regional centers.

Stockton Developmental Center. At the time of its proposed closure, Stockton Developmental Center was the smallest of the remaining seven centers and the one experiencing the most rapid population decline. Stockton was originally designed to serve persons with mental illness and, at its peak population, served 4,978 persons (1956). In the early 1970s, Stockton stopped serving persons with mental illness.

In March of 1995, the department released its proposal to close Stockton Developmental Center during the 1995-96 fiscal year. According to the plan:

> "*…the consolidation of developmental services has become unavoidable: developmental center populations have dropped dramatically, resulting in an escalation in the average cost of providing services and staff overages at several facilities. In February, 2005, the department took the first steps in a layoff process to reduce approximately 250 excess staff positions. Continuing to operate seven developmental centers under these conditions, especially when the population is expected to continue to decline, is inefficient and fiscally irresponsible. Stockton is proposed as the facility to close because it has the smallest population, its residents come from throughout the state, the facility is old and requires expensive repair to meet earthquake and other standard, and its location provides many potential alternative job opportunities for staff."*[5]

Other factors that led to the decision to close Stockton were the associated costs operating it. At the time, Stockton was the oldest of the state's developmental centers, (opened in 1852), with significant anticipated costs to bring the facility up to current standards. Stockton had the highest per capita costs of all the centers.

[4] Ibid.
[5] Plan to Close Stockton Developmental Center During Fiscal Year 1995/96, Department of Developmental Services, March 1995.

At the time the plan was released, 390 individuals resided at Stockton Developmental Center and 844 staff were employed there. Two thirds of Stockton residents were committed by the courts due to inappropriate behaviors, including criminal activities. In order to serve judicially-committed adults following the closure of Stockton, a program was established at Napa State Hospital in fiscal year 1995-96, and much of the staff for the Napa program transferred from Stockton. The judicially-committed children, 64 percent of whom came from southern California, were proposed to be moved to Camarillo Developmental Center and State Hospital. The remaining population was proposed to move to a community-placement or one of the remaining six developmental centers.

Transition Process. The plan described the following process and factors for determining where persons would reside following closure:

- Residents were to be individually assessed to determine the appropriate and preferred residential setting and to identify the necessary services and supports.

- Residents, along with their family members and advocates, would have the opportunity to choose the type of new living arrangement they would prefer and to help design their own services and supports.

- Residents not preferring to live in community settings would be transferred to Porterville Developmental Center or another developmental center, if appropriate for their needs.

- Adult residents who had been judicially committed because of a criminal offense or other severe behavior in the community, and who continued to require specialized treatment services in a developmental center would be transferred as a program unit, along with assigned staff, to Napa State Hospital.

- A small group of adolescents who had been committed by a court were to be transferred, along with their assigned staff, to Camarillo State Hospital and Developmental Center.

Stockton Developmental Center Staff. Relative to employee accommodation, the plan stated that although it would make every reasonable effort to minimize the impact of the closure on its employees, the *"closure must be understood with the context of the staff layoffs that will occur because of the number of excess staff within the developmental center system."* The plan committed the department to the following activities on behalf of the staff:

- Provide certain employees with the opportunity to transfer to Napa or Camarillo with residents and their programs. Staff who were mandatorily transferred were to receive full relocation assistance.

- Help some employees transfer to vacant positions in other developmental centers. Stockton employees were to be given first priority for positions in other centers currently occupied by persons in limited-term positions.

- Help other employees transition to employment in the community system.
- Conduct job fairs and training workshops.
- Hold monthly meetings and publish a newsletter to inform staff about the closure process.
- Maintain a career center at Stockton Developmental Center.

Use of Land Following Closure. As for the options for the future use of the Stockton Developmental Center site, once closed, the department agree to participate in a broad-based planning group convened by local legislators and invite the Department of General Services (DGS) to participate in, and consider recommendations made by, the planning group. At the time the plan was published, the department had leases with nine non-state agencies on the grounds of the developmental center providing a multitude of services. These included a sheltered work programs and day programs for persons with developmental disabilities living in the community, county alcohol detoxification services, a residential program for persons with mental illness, various mental health programs, a youth crisis residential facility, child care center, and residential and training sites for the California Conservation Corps. Ultimately, the Stockton site was deeded to the California State University and is now the site of a collaborative regional center serving multiple CSU campuses.

Study of Stockton Movers. For the first time associated with measuring the impact of a developmental center closure, the department contracted for a three-year longitudinal study to track the quality of life of 317 persons moving from Stockton Developmental Center. The study measured residents' quality of life, satisfaction with services, and other factors before the individual left the developmental center and one and two years after they had moved. Additionally, developmental center residents and their family members were asked to assess how well the closure was handled and to make recommendations for how the process could be improved.

The third, and final, report of the study described participants as living in the following settings:[6]

- 47.2 percent remained living in a developmental center.
- 15.2 percent resided in a nursing facility.
- 26.0 percent resided in a community care facility.
- 14.5 percent were living in supported living setting.
- 7.1 percent were characterized as other.[7]

[6] Longitudinal Quality of Life Study, Phase III, Business Services Group, CA State University, Sacramento, March 16, 1999.
[7] The "other" category includes persons who had died, were in jail, or refused to participate in the interview process.

The final report made the following findings:

- 76 percent of the population was living in a stable living situation.
- The nursing population appeared to be easier to place in the community than judicial or other commitments.
- Eight percent of individuals experienced multiple moves, defined as five of more moves in the two years following the developmental center closure.
- Consumer attendance in day or work programs declined from about 90 percent in Phase II (one year following move) to 85.5 percent in Phase III (two years following move).
- Consumer health rated as good to excellent increased from 72.9 percent in Phase I to over 83 percent in Phase III.
- A larger proportion of individuals received medications but doses in milligrams decreased.

Generally, quality of life improved following movement from the developmental center, as rated by consumers or the person who knew them best, but decreased between Phase II and Phase III. The following chart[8] shows how, on a scale of 1-5 (five being highest), quality of life was rated between each phase of the study and across the measured characteristics.

Characteristics	Phase I		Phase II		Phase III	
	1995 (remembered)	1996 (actual)	1996 (remembered)	1997 (actual)	1997 (remembered)	1998 (actual)
Health	3.6	3.6	3.5	3.9	3.7	4.0
Running Own Life	2.8	2.9	2.7	3.2	2.9	3.2
Family Relationships	2.6	2.8	2.8	3.2	2.9	3.1
Seeing Friends	2.8	2.8	2.9	3.3	3.2	3.5
Getting Out	2.9	2.8	2.9	3.3	3.2	3.6
What I Do All Day	3.1	3.0	3.0	3.5	3.3	3.5
Food	3.0	3.0	3.0	3.7	3.2	3.8
Happiness	3.1	3.2	3.0	3.8	3.3	3.7
Comfort	3.3	3.5	2.9	3.8	3.5	3.9
Safety	3.4	3.5	3.6	4.1	3.9	4.2

[8] Longitudinal Quality of Life Study, Phase III, page 56.

The report cites its significant findings as:

- *The most significant change is the increased number of consumers who are living in supported living which appear to be the goal of many relatives.*

- *The most disturbing finding is that the system does not appear to be able to support the small proportion of judicial commitments who live independently in the community because they have fulfilled their obligation to the court or simply refuse to live in a community facility.*

- *Cause of death shifted from the seriously ill in Phase II to a combination of seriously ill and violent accidents in Phase III.*

- *In at least two circumstances, relatives of a consumer were notified that the consumer would be returning to the relative's home with only a few days' notice.*

Camarillo State Hospital and Developmental Center.[9] One year after submitting a proposal to close Stockton Developmental Center, the Administration submitted a proposal for the closure of Camarillo State Hospital and Developmental Center.[10]

According to the plan, *"the consolidation of developmental center services has become unavoidable: developmental center populations have dropped dramatically, resulting in an escalation in the average cost of providing services and staff overages at several facilities."* At the same time, persons with mental illness civilly committed under the Lanterman-Petris-Short (LPS) Act to a state hospital had declined rapidly, dropping from 2,557 LPS beds in 1991 to about 1,250 in 1996, largely due to the 1991 realignment of mental health services and funding to counties.

The plan stated Camarillo was chosen because it served the smallest number of both persons with developmental disabilities and persons with mental illness compared to other state facilities; its population was expected to continue to decline; and its per capita costs were the second highest in the DDS system. Additionally, the department pointed to the fact that most of the residents did not come from the immediate area but from Los Angeles and other southern California communities; Lanterman and Fairview developmental centers and Metropolitan State Hospital served the same catchment area. Camarillo had good success in finding community residential settings for persons with developmental disabilities who choose to leave the facility.

At the time the closure plan was released approximately 872 individuals resided at Camarillo and approximately 1,604 staff were employed there. Approximately one half of the residents with developmental disabilities were persons who had been judicially-committed due to criminal or behavioral issues. Generally, Camarillo served an ambulatory, relatively healthy population. The institution was licensed to serve up to 596 individuals with developmental disabilities on 16 ICF/DD

[9] At the time of its planned closure, DDS served persons with mental illness through an Interagency Agreement with the Department of Mental Health.
[10] Plan to Close Camarillo State Hospital and Developmental Center During Fiscal Year 1996/97, Department of Developmental Services and Department of Mental Health, March 1996.

residences ranging in size from seven to 43. Of these, almost 15 percent were under the age of 21, with eight percent under the age of 18, and less than one percent under the age of 13. 57 percent were adults between the age of 22 and 40; 29 percent was over the age of 40. Men made up 74 percent of residents with developmental disabilities; 66 percent were Caucasian, 13 percent were African-American, and 14 percent Hispanic. 32 percent of this population was classified as having profound or severe mental retardation, compared to 91 percent in other developmental centers. 44 percent were classified as having mild or no mental retardation, as compared to three percent in other developmental centers. Camarillo residents with developmental disabilities were significantly less likely to have cerebral palsy (nine versus 51 percent) or epilepsy (34 versus 57 percent), but more likely to have autism (14 versus eight percent) than those in other developmental centers. Persons were more likely to have a psychiatric diagnosis, in addition to a developmental disabilities (61 versus 18 percent) that at other developmental centers. Nearly 71 percent received medication for psychiatric or behavioral conditions, compared to 27 percent at other developmental centers. Camarillo did not serve persons in nursing facilities.

The plan called for the facility to close by the end of the 1996-97 fiscal year.

Transition Planning. According to the plan, residents with developmental disabilities:

- Would be individually assessed to determine the appropriate and preferred alternative living arrangements and to identify the services and supports necessary.

- With their families or advocates, would have the opportunity to choose the types of new living arrangement they would prefer.

- Who have been judicially-committed because of criminal offenses or other severe behavior in the community, and who require specialized treatment services in a developmental center, will be transferred as a program unit, to Porterville Developmental Center.

- Who have autism, will be transferred to Fairview Developmental Center, unless they prefer to move to the community or another facility.

- Who do not prefer to live in the community, will be transferred to Fairview, Lanterman or Porterville developmental centers, or to another facility.

Camarillo State Staff. As to employee accommodation, the department committed to make every *"reasonable effort to minimize the impact of closing Camarillo on the employees"* but noted that its declining population had already resulted in excess staff and subsequent staff layoffs. Specifically, the closure plan committed the department to:

- Help employees transfer to vacant positions in other developmental centers and state hospitals.

- Work with state departments and other government agencies to facilitate hiring of Camarillo employees.

- Help interested employees to transition to employment in the community system.
- Conduct job fairs and training workshops.
- Through frequent meetings and other efforts, keep staff informed about the closure process.
- Maintain a career center at Camarillo.

Use of Land Following Camarillo Closure. The plan described numerous meetings with local government officials and other individuals and listed the "options that are being considered by the local community" as:

- A "forensic" facility for persons with mental illness serving both Department of Mental Health and Department of Corrections and operated by DMH.
- A California State University campus.
- A southern California Veterans Home.
- Multiple, joint uses by Ventura County.

Ultimately the land was deeded to California State University and is now the site of CSU-Channel Islands.

Napa State Hospital Developmental Disabilities Program. In the 1995-96 fiscal year, the Department of Developmental Services contracted with the Department of Mental Health to establish the Developmental Disabilities Program at Napa State Hospital. The Napa program was established to serve persons designated as having "forensic" or behavior issues, initially many of which transferred from Stockton Developmental Center when it was closed. In February 2000, the department identified approximately 371 persons designated as having "forensic" or "behavior" issues. Of these, 115 individuals were served in the Napa program and approximately 256 were served at a Porterville Developmental Center.[11]

Two reports, in 1997 and 1999, attempted to establish a plan to address a growing "forensic" or "behavioral" population within the developmental disabilities and mental health systems. Due to population growth in the mental health "forensics" population, DMH notified DDS that it would no longer be able to provide the space for the Developmental Disabilities Program at Napa.

Unlike the closure of Stockton and Camarillo developmental centers, the closure of the Developmental Disabilities Program at Napa necessitated the transfer of nearly all residents to another secured environment, due to their forensic or behavioral issues. Initially, the department planned to open a

[11] The Porterville program was established in June 1007 when Camarillo State Hospital and Developmental Center was closed.

program at Lanterman Developmental Center, in Costa Mesa, for both high-security forensic individuals and low to moderate-security individuals with severe behavioral challenges. However, there was significant community opposition to this plan and it was withdrawn. Provisional language was adopted in the 2000-01 Budget Act to prohibit the placement of consumers with "forensic issues", and limit the type and number of consumers with behavioral issues, at Lanterman. As an alternative, the department proposed, and the Legislature approved, a plan for DDS to lease and operate a community-based facility in Northern California for individuals with behavioral issues and to add three new residences at Porterville Developmental Center for persons with forensic issues. In March 2000, the department opened Sierra Vista in Yuba City, a 56 bed, state-leased and operated ICF designed to serve persons with significant behavioral issues. Sierra Vista was closed in February of 2010, due largely to a state fiscal crisis. In December of 2000, Canyon Springs in Cathedral City, a second 56 bed, state-leased and operated facility designed to serve persons with forensic issues was opened. The plan for the closure of Developmental Disabilities Program at Napa was released in February of 2000.[12] The plan described how the Department of Developmental Services and the Department of Mental Health would collaborate throughout the closure process, how consumers and families would be notified and prepared for the closure, transfer planning procedures and transfer protocols, and training for consumers and staff.

The Napa program was formally closed in 2000.

Agnews Developmental Center Closure

Agnews Developmental Center occupied two campuses – the West Campus in the City of Santa Clara and the East Campus in San Jose.

West Campus consolidation. In early 1995, the department proposed to close the West Campus by June 1995 and consolidate all programs on its East Campus. At the time, only 200 residents were served in a behavioral program on the West Campus.

Use of Land Following Closure of West Campus. Soon after the announcement of the West campus closure, Sun Micro Systems expressed interest in purchasing a portion of the campus. The state began site assessment evaluation and planning in 1995, and began negotiating with Sun Micro Systems.

Local opponents who favored preservation of the site formed the Agnews Preservation Coalition and moved to have the 90-acre core campus registered on the National Register of Historic Places, and four buildings designated as historically significant. They blocked and delayed the purchase until Sun Micro Systems provided assurances that the historic buildings and the historic graveyard would be preserved. The Agnews site was added to the National Register of Historic Places (under the name "Agnews Insane Asylum") on August 13, 1997.

[12] Plan for the Closure of the Developmental Disabilities Program at Napa State Hospital, Department of Developmental Services and Department of Mental Health, February 2000.

The state declared the West campus as surplus in April 1996, and Sun Micro Systems proceeded with negotiations, committing $10 million to historic preservation. The sale was completed in October 1998, for 82.5 acres at a cost of $51 million. The proceeds went to the state General Fund.

During the negotiation process, Sun Micro Systems advanced $10 million for construction and construction management of needed facilities on the East campus, so DDS could vacate the West campus more quickly to allow for the demolition of the 41 non-historic buildings. Sun Micro Systems oversaw completion of modular training and education buildings, a multi-purpose building and parking on the East campus, and off-campus leased space for maintenance and support. Sun Micro Systems opened its new World Headquarters on the West campus in August 23, 2000. It provided an 11-acre easement to the City of Santa Clara for access to the historic site and visitor's center.

The City of Santa Clara wanted to preserve the remaining acreage for community use. The state turned over decision-making to the City, but maintained ultimate control over disposition. Beginning in August 2001, escrow closed in three phases on 152 acres of the remaining campus. At the time, it was the largest-ever sale of surplus property in state history, netting $149 million for the state General Fund. The property became the Rivermark Planned Development Master Community of six distinct neighborhoods, a mix of 3,020 housing units, a commercial retail center, fire station, police and electric substations, a hotel, school, park, and branch library. Separate from the Rivermark property, the state entered into the long-term Hope Lease, which provided for acreage for development of several hundred units of affordable housing for homeless families, seniors, low-income families, and others. Twenty-three units, now overseen by a housing coalition, were set aside exclusively for individuals with developmental disabilities.

East Campus. In 2003, the Administration proposed to develop a closure plan for the East Campus of Agnews Developmental Center (ADC). The plan was envisioned to transition persons living in Agnews into community placements or another developmental center in order to close Agnews by July 2005.

As part of its early planning process, the department established the Bay Area Project, a planning team consisting of departmental staff and bay area regional centers, an advisory committee consisting of consumers and families, and various planning teams. A centerpiece of this proposed effort was to expand and enrich the availability of community-based services and supports to enable persons moving from Agnews to remain in their home communities. At the time of the proposed closure, Agnews had approximately 400 residents. Over 85 percent had significantly involved families and over two-thirds of those families lived in the bay area.

In April 2004, the department announced it would delay this closure date to July 2006, in order to ensure sufficient community capacity. This announcement included an estimate that one fourth of the Agnews residents would be moved to Lanterman Developmental Center in southern California. By the May Revision, this plan had changed to moving 200 individuals from Agnews to Sonoma Developmental Center. The department requested $11 million General Fund to make renovations at Sonoma for this purpose, primarily to purchase portable day treatment buildings.

The Legislature expressed concern about approving funding for this purpose in absence of a closure plan; whether the decision to double the number of persons expected who would move to another developmental center was rooted in the Administration's desire to expedite the closure of Agnews; and whether increasing the (then) population at Sonoma from approximately 800 to 1,000 residents was prudent, in light of continuing federal certification challenges. Further, the department signaled that the move of 200 persons to Sonoma was intended to be temporary, while additional community resources were developed, triggering concerns about the potential negative effect of multiple moves on the medical and behavioral health of residents. In the end, the Legislature placed the $11 million in a special budget item that limited its use to the development of community-based options for persons moving from Agnews.

In January 2005, the Administration finally submitted its closure plan for Agnews Developmental Center to the Legislature. At the time of plan submission, 376 persons lived at Agnews, two-fifths of who lived in nursing facility residences. According to the plan, over 90 percent of Agnews residents were served by one of the three bay area regional centers – San Andreas Regional Center, Regional Center of the East Bay, and Golden Gate Regional Center. 65 percent of the residents were over 40 years of age; eight percent were over 65 years of age; only five residents were under the age of 18. Thirty percent of the residents had lived at Agnews for over 30 years; eleven percent had lived there for ten years or less. Over 63 percent of residents were male. Seventy-five percent of residents were Caucasian; 13 percent Hispanic; six percent African-American; and two percent Asian and Pacific Islander. Seventy-nine percent of residents had severe and profound mental retardation; 57 percent had epilepsy; 53 percent had cerebral palsy; and 13 percent had autism. Over one-third of residents also had a diagnosed mental disorder. Fourteen percent of residents had significant health needs; 42 percent had significant behavioral issues; 19 percent required a highly structured setting due to protection and safety needs; and two percent required a low structured setting.

Transition Planning. Unlike previous closures, where a large number of residents were moved to another developmental center, the Agnews closure was based on an extensive closure plan, developed with input from an advisory committee made up of system stakeholders. The plan included some unique components not included in previous closure efforts. These included:

- **Housing Development.** Authorized by Assembly Bill 2100 (Steinberg), Chapter 831, Statutes of 2004, the Bay Area regional centers contracted with a local non-profit housing coalition to develop housing using a lease-purchase-donate model. The goal was to separate home ownership from service delivery and create a housing stock that would remain permanently available to persons with developmental services, even as provider agencies changed. The department and regional centers worked with the California Housing Finance Agency (CalHFA) to develop the Bay Area Housing Plan and secure bond funding for the development of sixty homes.

- **Family Teaching Home Model.** Also authorized by Assembly Bill 2100, this model provided a new residential option where up to three persons with developmental disabilities live next door (usually a duplex) to a family support team who manage the home and provide direct supports.

- **Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHNs).** Authorized by Senate Bill 962 (Chesbro), Chapter 558, Statutes of 2005, the department established a new pilot residential project designed for individuals with special health care needs and intensive support needs. The pilot was limited to 120 beds and could only initially serve persons moving from Agnews. Subsequent legislation removed the pilot status and expanded eligibility to persons moving from Lanterman Developmental Center or another developmental center.

- **Specialized Residential Homes.** Provided augmented staffing and professional services to persons with challenging behaviors or other unique needs.

- **Community State Staff Program.** Assembly Bill 1378 (Lieber), Chapter 538, Statutes of 2005, authorized Agnews employees to work in community facilities, under specified conditions, and to maintain their state employee status and rights. This program was later expanded to include employees at Lanterman Developmental Center and then to employees at all developmental centers. Agnews staff was also used to train community staff and help transition persons into community homes.

- **Health Care Services.** Each regional center was provided dedicated staff to coordinate community health care for Agnews movers. DDS coordinated collaborative efforts between the regional centers, the Department of Health Care Services, and designated health care plans to ensure community access.

- **Agnews Community Clinic.** The department continued to operate a health, dental and behavioral services clinic throughout the closure process and until the Agnews property was no longer under DDS control.

- **Quality Management System (QMS).** The department received a three-year federal grant to design a new quality management system, designed and piloted to support Agnews movers. The system utilized the National Core Indicator survey to measure performance, outcomes and satisfaction of Agnews' movers and their families. The QMS included a provider performance and quality improvement tool, known as the Quality Services Review (QSR); third party interviews conducted by regional offices of the State Council on Developmental Disabilities; and a Visitor Snapshot survey designed to obtain information from visitors to community homes.

The Agnews closure was achieved through intensive individualized planning for its residents, the development of sufficient community capacity, new service and support options in the community, innovative housing and staffing models, and partnerships between the Department of Health Care Services (DHCS), DDS, regional centers, and designated health plans to ensure the health care needs of residents could be met in the community, among other innovations.

Agnews Developmental Center was closed in March 2009. A total of 327 Agnews residents transitioned to the community and 20 transferred to other developmental centers.

Use of Land Following Closure. Eighty-one acres of the east campus was sold to the Santa Clara Unified School District and the City of San Jose for the future development of a K-12 campus and regional park. 155 acres were sold to Cisco Systems and is now home to their corporate headquarters.

Lanterman Developmental Center Closure. In January 2010, DDS proposed the closure of Lanterman Developmental Center, and a closure plan[13] was adopted along with the Budget Act of 2010.

Lanterman was home to 393 residents when the closure plan was submitted. 92 individuals were living in nursing facility residences; 301 were living in ICF residences. Ninety-nine percent of the Lanterman residents were served by a southern California regional center. San Gabriel/Pomona Regional Center served 20 percent of residents; North Los Angeles Regional Center served 18 percent; and, 17 percent was served by Frank D. Lanterman Regional Center. Nine additional southern California regional centers served between 2 percent and 11 percent each. Fifty-nine percent of individuals had resided at Lanterman for more than 30 years. More than 80 percent of the residents were over 40 years of age, with 8.6 percent over 65 years of age. Only seven residents were under 21 years of age and no children resided at the facility. Fifty-nine percent of the population was male; 70 percent was Caucasian; 18 percent Hispanic; eight percent African-American; and four percent Asian and Pacific Islander. Seventy-seven percent of residents had profound mental retardation; 13 percent have severe mental retardation, and ten percent had mild or moderate mental retardation. Fifty-four percent had epilepsy, 13 percent had autism; and ten percent had cerebral palsy. Seventy-four percent of residents had challenges with ambulation; 46 percent had vision difficulties; and 18 percent had hearing impairment. Twenty-five percent were identified as having significant health care needs; 19 percent requiring extensive personal care services; 23 percent requiring significant behavioral support; 32 percent requiring highly structured environments due to protection and safety concerns, and one percent requiring low structured settings.

The Lanterman closure plan borrowed heavily from the process employed to close Agnews, 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.

At the time the plan was released, Lanterman employed 1,280 employees. Ninety-one percent were full-time, four percent were part-time; and five percent were intermittent, temporary or limited-term. Almost half the workforce worked at Lanterman for ten years or less; 30 percent worked there between 11 and 20 years; and 22 percent worked there over twenty years. Direct care nursing staff made up 50 percent of the workforce; ten percent were level-of-care professionals; and 40 percent were non-level-

[13] Plan for the Closure of Lanterman Developmental Center, Department of Developmental Services, April 1, 2010.

of-care and administrative support. Forty-six percent of employees resided in San Bernardino County, 40 percent lived in Los Angeles County (where Lanterman is located), eight percent in Riverside County, and five percent in Orange County. As in other closures, the plan described various options for Lanterman staff post-closure, including opportunities at other developmental centers, private sector service provider or support staff positions, and voluntary transfer to other state positions. Additionally, the State Staff in the Community program, used in the Agnews closure, was statutorily extended to benefit interested Lanterman staff.

Transition Process. In December 2014, the last resident moved from the developmental Center. The final report of this closure process, due to the Legislature in May 2015, has not been submitted to the Legislature. The following chart shows the type of community placement to which residents moved, according to the last update report submitted by the department to the Legislature, reflecting the closure status in November - December 1, 2014[14].

Community Living Arrangement[15]	Number of Lanterman Movers
Adult Residential Facility	256
ARFPSHN	59
ICF	16
Long-Term Subacute Facility	7
Supported Living Program	6
Family Home Agency	3
Congregate Living Health Facility	2
Individual's Family Home	2
Other	1 (Germany)

According to the report, DDS and DHCS finalized its MOU to define responsibilities for ensuring access to and the provision of health care services to Lanterman movers and had secure technical statutory changes necessary to clarify the participating health plans and the method to be used by DHCS to reimburse health plans. Additionally, according to the plan, processes were put in place to expedite health plan eligibility and enrollment prior to discharge to ensure timely access to health services once moved and DHCS was working with the health plans to ensure adequate provider networks were in place to meet the unique medical needs of movers.

The Lanterman Outpatient Clinic remained open for the delivery of health and dental services to remaining residents and those who had moved to the community until responsibility for the property was transferred to DGS.

Lanterman Developmental Staff. The following chart shows the types of separations for 1,188 Lanterman staff who had separated as of December 2, 2014.

[14] Update on the Plan for the Closure of Lanterman Developmental Center, Department of Developmental Services, January, 2015.
[15] As of December 1, 2014, six residents remained at Lanterman Developmental Center, three in an ICF residence and three in a NF residence.

Transfer	Retirement	Resignation	Limited Term Expired	Layoff	Other
536	310	93	20	189	40

The Governor requested and the Legislature provided an extension of 13 positions to continue to monitor persons who have moved from Lanterman, continue to perform work related to staff layoffs, and perform similar planning and oversight activities related to persons moving from other developmental centers.

Use of Lanterman Developmental Center Land Following Closure. The developmental center land was transferred to the California State University, specifically to Polytechnic University, Pomona on July 1, 2015. CalPoly Pomona is working with local and state stakeholders to determine to ultimate use of the land, which is expected to include educational and research uses, other state departments, and housing. CalPoly committed to working with the department to secure some portion of accessible housing for persons with developmental disabilities.

The Administration Plans for the Future Needs of Developmental Center Residents

Options to Meet the Future Needs of Consumers in Developmental Centers Report. The 2000-2001 Budget Act included trailer bill language[16] that required the department to "identify a range of options to meet the future needs of individuals currently served, or who will need services similar to those provided, in state developmental centers." Specifically, the department was required to establish a workgroup of system stakeholders to identify options evaluated for "their appropriateness in meeting consumers' needs, compliance with the requirements of federal and state law, and efficient use of state and federal funds" and report on these options and recommendations to the Legislature by March 1, 2001. In addition to establishing and consulting with an advisory group, as required, the department obtained information from other states an contracted with two consulting firms to guide the work and provide expert advice regarding housing issues. The report was submitted to the Legislature in June 2002. The following excerpt[17] presents the conclusions reached at the end of this process:

> *There was a multitude of issues discussed by the stakeholders (consumers, parents of DC clients, parents of individuals living in the community, advocacy organizations, legislative staff, regional centers, and community service provider organizations) as they examined the various options. While there was not a consensus on all the issues, there was a preponderance view among the stakeholders' group on a number of the issues. These stakeholder views are summarized below:*
>
> *A. The DCs should not be renovated. The long-range future of State-provided services should not be tied to the existing buildings or the geographic location of current campuses. The funds required to make modifications to existing structures may be better utilized to create a new service structure. The exception to this is Porterville,*

[16] Assembly Bill 2877 (Thomson), Chapter 93, Statutes of 2000.
[17] Options to Meet the Future Needs of Consumers in Developmental Centers, California Health and Human Services Agency, Department of Developmental Services, June 2002

which everyone expects will continue indefinitely as the home for persons with forensic/severe behavior issues.

B. *Because the development of new options will be a slow process, funding for physical improvements to some buildings will be needed to keep them safe and habitable until they are no longer needed.*

C. *There is an ongoing need for the State to provide direct services, but only as the "provider of last resort." There is little interest in having the State set up a system of services that would compete with the private sector. Rather, the State's role needs to be carefully defined as providing residential services to those whom the private sector cannot serve at any point in time.*

D. *State staff employed by the developmental centers are an essential component to assuring stability, quality, and continuity of services. Planning should incorporate how to best use these valuable resources.*

E. *Options for increasing federal financial participation and other funding streams in funding the cost of developmental services without a corresponding increase in the cost to the State should be explored. Leveraging of DC property for the sole benefit of the DD service system is a public policy issue that will continue to be debated. As programs compete for limited funding resources a determination on the level of resources to be provided should be decided through the budget process.*

F. *There is a serious need to strengthen and expand the capacity of the private service delivery system so that it is better able to meet the needs of persons such as those who reside in the DCs or who will need DC-type services in the future.*

G. *Developing high-quality community services should be a priority activity, along with designing effective methods for monitoring and assuring that quality.*

H. *Planning must begin with the individual. A comprehensive person-by-person assessment should be the foundation for determining the array of services and supports that will be required to meet individuals' physical, service, support, and environmental needs.*

I. *Determining the resources that will be needed in various parts of the State can best be accomplished on an area or regional basis with the participation of the regional center(s), the DC, vendors, families, and other stakeholders. Each area should be evaluated for the services it most needs, including those that potentially could be provided by State staff.*

J. *Rather than recommending a single option, the stakeholders agreed that a range of different options should be developed to meet the varying needs of persons in the DCs or who have similar needs. They concluded that the State's basic policy strategy*

should be to balance the consumer-related and system-related criteria that have been identified.

Future of Developmental Centers in California Plan. On January 13, 2014, the Secretary of the California Health and Human Services Agency released her "*Plan for the Future of Developmental Centers in California."* The plan was developed pursuant to trailer bill language that required the Secretary to submit to the Legislature a master plan for the future of DCs by November 15, 2013. 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 provided six consensus recommendations[18] for 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."

[18] Plan for the Future of Developmental Centers in California, California Health and Human Services Agency, Task Force on the Future of Developmental Centers, January 13, 2014.

The 2014 Budget Act funded several new initiatives to support the vision laid out in the Secretary's Plan. These include:

- **Crisis Services.** A five-bed crisis program was established at both Sonoma and Fairview Developmental Centers. Funding and authority to develop two community crisis homes.

- **State Staff in the Community Program.** Expanded statewide to support both persons moving from developmental centers and prevent the unnecessary institutionalization or hospitalization of persons in the community.

- **Enhanced Behavioral Support Homes.** Authorized up to six homes to serve persons with significant behavioral challenges.

- **Transitional Homes and an Adult Residential Facilities for Persons with Special Health Care Needs facility for Persons with Behavioral Issues.** Funded these models to support persons who may need transitional or ongoing significant behavioral support.

- **Regional Center Staffing.** Provided additional funding to support resources development, quality assurance, enhanced case management and other support for these specialized facilities.

Governor Proposes Closure of Remaining Developmental Centers.

In the 2015 May Revision, the Governor proposed to initiate the closure of the remaining three developmental centers (the proposal would leave open the Secure Treatment Program at Porterville Developmental Center). Under the Governor's proposal, it was estimated that Sonoma Developmental Center would close by the end of 2018; and Fairview Developmental Center and the General Treatment Program at Porterville Developmental Center would close by 2021. The budget requested $49.3 million ($46.9 million General Fund) to begin the development of resources necessary to support Sonoma residents in the community and for other closure-related activities. Specifically, the Administration requested:

- An additional $1.3 million General Fund and seven positions to be transferred from developmental centers to headquarters to support transition planning and activities.

- $118,000 for an interagency agreement with the Department of Social Services to provide dedicated staff to expedite the licensing on new facilities and for an external services contract for legal consultation on matters of housing acquisition.

- $48 million General Fund for additional community placement plan funding for start-up and placement costs and enhanced regional center operational activities.

Finally, the Governor requested budget trailer bill language to require the department to submit to the Legislature by October 1, 2015, a plan to close one or more developmental centers. The Legislature amended the proposed language to: (1) require the consideration of utilizing developmental staff for mobile health and crisis teams; (2) require the department to confer with stakeholders on alternative uses of the developmental center property post-closure; (3) expand the specific information that must be provided in the report including a description of stakeholder input including at least one local public hearing, a description of the unique and specialized services provided by the developmental center and viability of transferring these services to support persons in the community, a description of resident characteristics that will determine service needs, estimates on the location and nature of services and supports that will be needed in the community, a description of how the client rights advocacy services will be transitioned to the community, a description of how the department will monitor the movement of residents to the community, and a description of local issues, concerns and recommendations regarding closure and alternative uses of developmental center property. The Legislature also required quarterly updates throughout the closure process.

The Governor's budget also requested authority to modify two of the new models of community residential services approved in 2014, related to the Secretary's Report on the Future of Developmental Centers and reflecting needs associated with proposed closures of the developmental centers:

- **Enhanced Behavioral Supports Homes.** Removed cap on number of facilities that can be developed.

- **Delayed Egress/Secured Perimeter Homes.** Removed requirement that these home be eligible for federal funding participation.

The 2015 Budget Act included two other components related to the future use of developmental center properties.

- **Community Housing Development at Fairview Developmental Center.** After a delay of eight years, and at the request of the Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services, the Administration proposed and the Legislature adopted language that will allow a housing development that will serve the community at-large and persons with developmental disabilities on the grounds of the developmental center. This is the second such development at Fairview.

- **Secured Treatment Program at Porterville Developmental Center.** The Administration requested, and the Legislature approved, an expansion of secured treatment beds at Porterville. This program is not included in the proposed closure plans.

Proposed Sonoma Developmental Center Closure

In the 2015 May Revision, the Governor proposed to initiate the closure of the remaining three developmental centers. The department estimated that 132 homes would need to be acquired or

renovated to support Sonoma residents in the community. At that time, the department stated that 55 of these were currently under development. Additionally, non-residential services and supports would need to be developed. The nature of these residential and non-residential services would be driven by needs identified in individual comprehensive assessments of developmental center residents, individual program plans, and the choices of consumers and families.

Current law[19] requires that, whenever the department proposes a closure of a developmental center, they submit to the Legislature a detailed closure plan no later than April 1 the year immediately prior to the fiscal year in which the plan is to be implemented. The 2015-16 Budget Act included trailer bill language[20] requiring the department to submit a closure plan for one or more developmental centers by October 1, 2015, rather than April 1, and expanded the issues to be discussed in the plan. This requirement also provided six additional months for public and legislative review.

On October 1, 2015, the department submitted a closure plan for Sonoma Developmental Center.[21]

At the time of the plan's release, approximately 405 persons resided at Sonoma. Forty-five percent lived in a nursing facility residence, and 55 percent lived in an ICF residence. The plan identifies 98 percent of residents as being served by a northern California regional center, with 32 percent being served by the Regional Center of the East Bay; 25 percent being served by Golden Gate Regional Center; 21 percent being served by North Bay Regional Center; and, 14 percent being served by Alta California Regional Center. The remaining eight percent are served by eight additional regional centers. Sixty-two percent of individuals have resided at the developmental center for more than 30 years; 23 percent for 21 to 30 years; eight percent for 11 to 20 years; and seven percent for less than ten years. Ninety percent of residents are over the age of 40, with 23 percent aged 65 or older. There are no children under 18 residing at the facility. About 75 percent of residents have identified family connections and involvement. Thirty-eight percent are conserved by a family member, and 37 percent have family representatives. Twelve percent have non-family conservators; nine percent access advocacy services; and four percent have no identified representatives. Fifty-nine percent of residents are male. Eighty-six percent are identified as White; six percent identified as Black/African-American; three percent identified as Hispanic/Latino. Seventy-one percent of residents have profound intellectual disabilities, and 21 percent have severe intellectual disabilities. Eight percent have been identified with mild, moderate or other levels of intellectual disabilities. Twenty-nine percent are identified and have significant mental health issues; 55 percent have epilepsy; 23 percent have autism; 51 percent have cerebral palsy. Sixty-four percent have challenges with ambulation; 81 percent have vision difficulties; 26 percent have hearing impairment. Twenty-seven percent have significant health care needs; 22 percent require extensive personal care assistance; 20 percent need significant behavioral support, and 31 percent require a highly structured environment due to protection and safety issues.

The plan sets forth several "parameters and principals" to guide its implementation. These are:

[19] Welfare and Institutions Code 4474.1
[20] Senate Bill 82 (Committee on Budget and Fiscal Review), Chapter 23, Statutes of 2015.
[21] Plan for the Closure of Sonoma Developmental Center, Department of Developmental Services, October 1, 2015.

- *Meeting the needs of the SDC residents, now, during transition and ongoing through quality services, and ensuring their health and safety;*

- *Enabling the active and meaningful participation of the consumers, families, consumer representatives, advocates, RCs, the Sonoma community and other interested parties throughout the closure process;*

- *Being in compliance with federal and State laws, and applicable court decisions;*

- *Being in compliance with the settlement agreement entered into by various State entities and CMS that requires the California Parties to address compliance issues at SDC and achieve appropriate community or other placements for residents of the affected SDC units, so that federal funding will continue, as specified in the agreement;*

- *Implementing and being in compliance with the new federal regulations for the Home and Community-Based Services waiver (HCBW).*

- *Effectively using State funds and maximizing federal funds for the short-and long-term costs associated with the delivery of services and the closure of SDC; and*

- *Implementing this Plan as approved by the Legislature through the legislative budget process, including any future modifications.*

The plan discusses "Lessons Learned" and notes the following observations relative to the Agnews closure:

- *The use of the Community State Staff Program (CSSP) was essential to building support for, and the effective carrying out of transitions for Agnews residents. However, wage differentials between state staff and non-state staff working in the community was an issue. Carefully negotiated rates or reimbursements were suggested as possible ways to enhance the CSSP in future closures.*

- *Overnight visits proved to be very helpful for residents with behavioral challenges in order to feel comfortable with the move.*

- *The use of Non-Profit Organizations (NPO) in acquisition and development of homes worked well; families and residents had the opportunity to visit the housing models which helped with the decision-making of residential options and ease concerns about transition.*

- *Early planning and a strategy for working with health plans and a payment system are as important as developing housing arrangements.*

- *Starting day programs immediately upon the individual arriving at the behavioral/medical home is important.*

- *It would be helpful to have an occupational therapist involved during the planning stages of remodel or construction projects, as knowledge of the residents' needs would be beneficial during the design phase.*

- *Families were not interviewed as a part of this assessment; however, information shared by families since the closure indicates that many families are very pleased with their loved ones' transitions.*

According to the plan, relatives to the Lanterman closure made the following observations:

- *Many Lanterman families expressed that they are very pleased with their loved ones' new homes and described their loved ones as "very happy."*

- *Families conveyed that their loved ones' physical, medical, emotional, spiritual and social needs are taken care of in the community and they have built strong, trusting relationships with staff in the homes.*

- *Staff in the homes is described as "caring," "competent," "consistent," "compassionate," "tops," and "quality."*

- *Families like the physical attributes of homes (clean and truly homelike, good adaptations for people with disabilities, necessary specialized medical equipment is right in the home) and appreciated that home were built in "nice areas" or near their homes, enabling more frequent visits.*

- *Many families shared instances of personal growth experienced by their loved ones since moving to the community (speaking for the first time, enhancing their vocabulary, learning new skills, participating in new activities, reductions of behaviors or outbursts, etc.).*

- *Also shared was that access to medical care has not been a significant barrier, and in instances where there were delays, the RC's were able to effectively address the issue.*

- *More recently, a letter was received from the Parent Coordinating Council & Friends for Lanterman urging the Department to suspend placements out of SDC (implement a "moratorium") until there is conclusive evidence that "equal or better" services and supports are available in the community.*

- *Other issues raised by Lanterman families that the Department has taken note of are:*

    - *There may be a need for National Core Indicator (NCI) process improvements to ensure movers and their families are able to participate;*

    - *Funds should be made available now to address community issues experienced by Lanterman movers and for future movers.*

- *High staff turnover and low pay continue to be issues in community-based homes;*
- *Concerns exist about the availability of dental care, especially sedation/general anesthesia dentistry;*
- *Cross-training of community staff should start sooner in closure, so the DC staff who know residents the best are the ones training their counterparts in the community, not just the staff left at the end of closure;*
- *Day program services need to be developed specifically for DC movers, as they present unique challenges standard day programs may not be able to address;*
- *Families overwhelmingly felt there should be consistent coordination and approval of services among all 21 RCs so that the same types of services can be available anywhere they are needed and easily accessed by families. Different usage of some service types and varying vendorization and approval processes by RCs have troubled some families and consumers that moved from Lanterman.*

The plan was informed by two formal public hearings held in Sonoma, individual and group meetings with residents, families, employees, unions, advocates, regional centers, providers, local government officials, state legislative representatives, and other organizations. A combined 134 witnesses testified at the two public hearings, and 355 stakeholders provided written testimony. Additionally, the department has worked with a group of community partners known as the Sonoma Developmental Center Coalition.

The plan acknowledges:

> *Overall, input received has noted significant concerns and/or opposition to closure. However, many have indicated that, as it appears that the closure is going to proceed, a number of issues must be addressed to ensure the continuity of specialize services and development of new models of service on the grounds of SDC.* The plan further states that "*general sentiment communicated to the department during public hearing and in written comments, predominantly by families, employees and community partners, is the SCD should not close entirely, but instead services should be rebuilt and reimagined on SDC's property to continue to provide services that will benefit the residents of SDC, all people with developmental disabilities and the general Sonoma community. Advocates and regional centers support closure and emphasize the need for individualized program planning, expansion of community resources, appropriate funding and the inclusion of individuals in everyday community-based settings.*

Transition Planning. The plan describes in some detail the process that will occur, or are occurring, relative to transitioning individuals from the development center to the community. Each resident has an ID team consisting of the resident; the legally authorized representative, family and/or advocate; identified staff from the developmental center and Regional Resource Development Project (RRDP); one or more regional center representatives, including the regional center case manager; and others

invited by the resident or his or her authorized representative. This team develops the persons individual program plan, which builds on the comprehensive assessment completed by the regional center and which identifies the person's choices, preferences and types of community-based services and supports that will be necessary to ensure a successful transition into the community. The ID team also develops the individualized health transition plan and the specialized behavior and safety plan.

The report describes the process as fluid, flexible, and ongoing. For example, residents, family members and potential providers engage in "meet and greet" introductions to explore different residential placement models. Once a residential model is chosen, staff arranges visits to potential community homes, meetings with proposed vendors, meetings other residents in a home and staff who work in a home. Cross-training of community providers is provided through in-person visits of community staff to the developmental center and developmental center staff to the community location. Once all the transition plan components have been implemented, community-services and supports have been identified and secured, and the person is ready to move, the ID team holds a transition review meeting and sets a movement date. This meeting occurs no less than 15 days prior to the planned move.

Monitoring and Quality Management. The plan calls for the establishment of a Resident Transition Advisory Group made up of residents and family members, involved regional centers and the department. The group will review the existing transition planning process and make recommendations to the department. Additionally, the department has contracted with H&W Independent Solutions, an independent external organization to serve as an independent monitor, as required by the CMS agreement.

The department will develop and maintain a detailed quality management plan for SDC that will be utilized throughout the closure process. Building on the existing statewide Quality Management System (QMS) and regional center quality management processes, the department is developing a specific Sonoma QMS to monitor consumers' quality outcomes and satisfaction and identify areas that need improvement. Additionally, the report commits the department to an annual family and consumer satisfaction survey through the National Core Indicators project.

The report recognizes that, due to the early departure of knowledgeable staff during previous closures, significant effort was required on the part of the department to stabilize the care and services during the final months of closure. The plan commits the department to providing diligent monitoring and management of staffing levels to ensure the needs of the residents at Somona are met.

Following movement to the community, enhanced face-to-face visits from RRDP staff, in coordination with the regional center, will occur at intervals of five days, 30 days, 90 days, six months, and 12 months. Additional visits, assistance with follow-up activities, or guidance occur as necessary. Additionally, individuals will receive enhanced regional center case management for at least two years following their move.

ID teams will identify any known or anticipated issues, or challenges, the consumer could experience in their new setting; and, where indicated, will develop a contingency plan of actions that may be

necessary. As needed, additional resources, services and supports may be provided by the regional center or developmental center.

Finally, while Sonoma remains open, and under defined circumstances, persons may return to the developmental center for up to one year following provisional placement in the community.

State-Funded Advocacy Services. Existing law[22] requires the department to contract for client rights advocacy services for persons living in the community and in developmental centers. DDS contracts with the State Council on Developmental Services to provide advocacy services for persons living in developmental centers through the Volunteer Advocacy Services (VAS) program. The VAS program is implemented through an interagency contract with the State Council on Developmental Disabilities, and is designed to provide advocacy services to persons living in a developmental center and who have no legally appointed representative to assist them, or may assist legally appointed representatives. The department contracts with the Disability Rights California Office of Clients' Rights Advocacy (OCRA) to provide advocacy services to persons in the community. When a person moves from the developmental center to the community, the OCRA assumes the provision of advocacy services. State law[23] also requires that OCRA be provided with copies of each developmental center resident's comprehensive assessment or update and allows OCRA to participate in IPP meetings unless the consumer objects. This is intended to allow OCRA to become familiar with the individual prior to their move to the community. Once Sonoma has closed, the plan states that the department will work to transition the services to the community.

Community Resource Development. According to the plan, the department works with regional centers to determine the type and location of services and supports that must be developed for persons moving from Sonoma, based on the comprehensive assessments and individual program plans. In addition to the use of existing community living options, such as adult family homes and family teaching homes, intermediate care facilities, and adult residential facilities, the plan describes a focus on the development of additional models to meet the unique and specialized needs of individuals. These include:

- Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHCN)
- Enhanced Behavioral Supports Homes
- Community Crisis Homes
- Delayed Egress and Delayed Egress/Secured Perimeter Homes
- Supported Living Services
- Self-Determination Program

[22] Welfare and Institutions Code 4433 (b)(1)
[23] Welfare and Institutions Code 4418.25

Access to Health and Medical Services. According to the plan, all Sonoma residents are Medi-Cal eligible; 91 percent are dually covered by Medicare; and a small percent have additional private insurance. Medi-Cal and Medicare coverage will provide residents with access to existing health services in the community. The plan commits to working collaboratively with regional centers, DHCS, and health plans to assess and ensure the availability of needed health, dental and behavioral services in the community. Where gaps are identified, DDS will work with regional centers and the health care communities to ensure resources are available. Consumers will receive comprehensive case management which will include coordination and oversight of their individualized health services.

The plan proposes, as was the case at Agnews and Lanterman, to operate the existing health resource center/clinic to provide medical, dental, and behavioral services at the developmental center to current and former residents, until such time as the property is no longer under DDS control.

Additionally, the plan states that the department is assessing needs and availability of staff and resources; options for operation as a federally-qualified health center (FQHC) in partnership with Sonoma County or other partner organization, and reviewing the potential for educational partners and, if there are opportunities, to create a "teaching" center/clinic.

Sonoma Developmental Center Employees. As of August 2015, there were 1,365 employees at Sonoma: 88 percent of which were full-time, five percent part-time, and seven percent intermittent, temporary or limited-term. Forty-one percent have worked at the developmental center for ten or less years; 40 percent for 11 to 20 years; and 19 percent for over 20 years. 63 percent of the workforce are women, 40 percent are Caucasian; 36 percent Filipino; seven percent African-American; five percent Asian. Forty-five percent of the workforce lives in Sonoma County; 31 percent in Solano County; seven percent in Napa County; 5 percent in Contra Costa County; and between two and three percent each in Alameda, Marin and Sacramento counties. Forty-eight percent of the employees are direct care nursing staff; eight percent are level-of-care professional staff; and 44 percent are non-level-of-care and administrative support staff.

The developmental center provides a number of staff who perform specialized services including:

- Customized positioning equipment and shoes by the adaptive technology staff.
- Specialized dentistry utilizing sedation by dentists experienced in working with persons with developmental disabilities.
- Specialized health clinics that address the medical complexities and the complications that may be associated with some persons with developmental disabilities.
- Acute behavior stabilization.
- Water treatment professionals.

As noted earlier, retention of necessary and experienced staff during the closure process has been challenging in previous closures. The plan notes that the department is exploring various strategies

including retention bonuses, state service credit opportunities, and the ability to guarantee positions or specialized training for employees that stay through the end of closure. The report notes that these types of employee benefits may require legislative authority and may be subject to collective bargaining.

The department has conducted several employee forums and has met with union representatives. The report itemizes various strategies the unions have asked the department to explore and additional suggestions made by employees through the stakeholder process.

As in previous closures, the plan commits the department to establishing an employee career center, working with other state departments and county agencies to identify potential job opportunities. The plan notes that job opportunities will be available at other developmental centers in Costa Mesa, Porterville, or at Canyon Springs Community Facility in the Palm Desert. However, proposed additional closures limit these options. The plan commits the department to partnering with regional centers in providing information to employees about private sector jobs in the developmental disabilities community system. The plan notes that it is expected a number of developmental center staff, especially those in non-nursing positions, will find opportunities in other state departments through the use of surplus status and state restriction of appointments processes, which provide hiring priority status for eligible staff.

State Staff in the Community Program (CSSP). Senate Bill 856 (Committee on Budget and Fiscal Review), Chapter 30, Statutes of 2014, expanded the CSSP statewide to support any consumer moving from a developmental center or to deflect such a placement. State employees work through contracts established between DDS and a regional center or community provider. Employees maintain their salary and benefits and the department is reimbursed by the regional center or provider. The department has entered into agreements with the California Association of Psychiatric Technicians (CAPT) and the Service Employees International Union (SEIU) to address the employee selection process, the provision of ongoing supervision, and employee rights and representation issues. Despite the current availability of training resources and information for this program, the plan development stakeholder process identified additional need for more. The plan commits the department to developing, refining and increasing training and information resources, assessing the possibility of rate exemptions, and processing enhancements that could assist in providing vendor participation in the program.

The following chart shows the progression of the program for previous Agnews and Lanterman developmental center employees, measured in March of each year and in December 2015. To date, no other employees have entered the program.

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	March 2015	December 2015
Agnews	1	3	9	35	109	89	78	62	28	20	19	15
Lanterman								0	0	10	12	7

Developmental Center Land and Buildings

Sonoma Developmental Center is located on approximately 900 acres near Glen Ellen in Sonoma County. The campus has substantial open space, including: a lake, a residential campground, a store/cafeteria, a post office, a petting farm, sports fields, swimming pools, an equestrian program, and picnic areas. There are approximately 140 structures with approximately 1.3 million square feet of facility space. In 1997, Senate Bill 1418 (Thompson), Chapter 1144, Statutes of 1996, required that an approximate 300-acre conservation easement be conveyed to the Sonoma County Agriculture and Open Space District covering lands above the 1,100 foot elevation level of the upper watershed property on the western boundary of the center. In 2002, this parcel was transferred to the California Department of Parks and Recreation and is now a part of Jack London State Park. In 2007, 41 additional acres located on the property's eastern boundary adjacent to Highway 12 were transferred to Sonoma County Regional Parks.

The state currently has five active leases utilizing space on the developmental center grounds. These are: Challenge Sonoma Ropes Course, Sonoma Ecology Center, Horizon Tower, Eldridge Store/Department of Rehabilitation, and the United States Postal Service. All the leases extend between 2015 and 2036 with short-term cancellation notices that can be exercised by either party.

Infrastructure and Environmental Issues. The report offers various descriptions of the condition of the center's infrastructure. These include:

- Vanir Construction Management, Inc. Study, 1998. Vanir conducted a system-wide planning and condition assessment, including: land, infrastructure, seismic, and facilities assessments. The report concluded that Sonoma's physical and functional condition, like the other developmental centers, was significantly inadequate to address the then-current codes required to be structurally viable in the long term. The most significant findings in the Vanir study related to kitchen and food service deficiencies, which remain largely unaddressed today.

- Fire and Life Safety and Residential Deficiencies. Sonoma operates under a large number of waivers, granted in the late 1970s and early 1980s, for variances to the 1967 building-and-life-safety codes. Most of these waivers relate to the lack of required windows, exits and corridors; problems with corridor and door widths for evacuation; and problems with heating, ventilation and air conditioning systems.

- Seismic Safety Deficits. DGS evaluated the developmental center for seismic risk in 1994. On a scale of Level I (least risk) to Level VII (highest risk), no buildings were rated Level I or II; 23 buildings were rated Level III; one building was rated Level IV; 13 buildings were rated Level V; eight buildings were rated Level VI, and one building was rated Level VII. Seventy-two buildings have not had a risk level assignment.

- Americans with Disabilities Act (ADA) Compliance. In 2001, the department contracted with an independent entity to conduct an ADA compliance review and make recommendations to address identified access issues. The plan states that although some repairs have been completed, major work remains.

- Residential and Programmatic Space. The plan identifies the following deficiencies in these living and program areas:

    - Congested bedrooms limit space for care, storage and do not meet requirements for size and privacy.

    - Insufficient electrical outlets, lighting, and inadequate voice/data outlets in nurse stations; medical units lack call systems and adequate space for mobility and medical equipment and supplies.

    - Bathing areas are too small for staff to easily maneuver and transfer consumers and allow for storage of individual grooming and hygiene supplies.

    - Space for separate and simultaneous consumer activities in unavailable in living units.

- Property Assessment Study, 2012. DGS conducted an infrastructure study to review sewer, water, gas, electrical and storm drainage systems. This study found deficiencies in all of these systems.

- Special Repairs. The plan notes that approximately $4.5 million has been expended on special repairs over the past five years, including repairs to plumbing systems, roof replacements, fire alarm system replacement, and renovation to living areas. The plan notes, that even with a pending closure, there are immediate issues related to the electrical system that could affect the health and safety of residents and staff during the closure process, if not addressed.

- Environmental Conditions. An environmental site assessment, which identifies potential environmental concerns, such as the presence of hazardous materials and potential contamination sources, has not been completed, but is planned as part of the closure process.

Additional and update assessments will be necessary to inform future use decisions. DGS has indicated that once funded, it will take approximately six months to contract with outside consultant(s) for the assessments and up to 24 to 30 months to complete the assessments.

Usual Process for Disposing of Surplus State Land. Typically, departments notify the DGS when they have deemed a property to be excess. If DGS determines that there is another state use for the property, it may transfer jurisdiction of that property to another department, with the concurrence of the Department of Finance. If there is no other state use, the property is included in the annual omnibus surplus land bill which must be approved by the Legislature before listed properties may be disposed. Once a surplus property is approved for disposal, local government agencies and affordable housing sponsors have ninety days to notify DGS of their interest in the property. Local agencies may acquire surplus property at fair market prices for local government-owned facilities or affordable housing or may pay less than fair market value for open space or parks. If there is no local government interest in the property, affordable housing sponsors may acquire the property for housing developments for low

or moderate income families at less than fair market, under specified conditions. Property not acquired by a local government or affordable housing sponsor is sold on the open market pursuant to a public bidding process.

DGS uses an enhanced process for disposing of surplus property of particular value. This process provides more enriched assessments of the property, marketing strategies, negotiation strategies, and other components. The Asset Enhancement program was used for the sale of the east and west campuses of Agnews Developmental Center and the portion of Fairview Developmental center utilized for the Harbor Village housing project.

Sonoma Developmental Center Land Options. In its closure plan, the department states that *"it is not the intention of the state to declare SDC property as surplus, but instead to work with the community to identity how the property can best be utilized."* Local stakeholders have formed the Sonoma Developmental Center Coalition, which includes: the County of Sonoma, the Sonoma County Agricultural Preservation and Open Space, the Sonoma County Water Agency, the Parent Hospital Association, the Sonoma County Land Trust, and the Sonoma Ecology Center. These stakeholders seek to be partners in the discussion about the future of the developmental center property, should the facility close, and have been exploring options for alternative uses that would support persons with developmental disabilities and the broader Sonoma County community.

Status of Closure Activities. The 2015 Budget Act includes $49.3 million ($46.9 million General Fund) to begin development of community resources to support the transition of Sonoma residents. The following chart shows the current status of start-up activities, for the period of July 1, 2015 through December 31, 2015.

SONOMA DEVELOPMENTAL CENTER (SDC)
CURRENT START-UP SUMMARY : REGULAR CPP AND SDC CLOSURE
First Quarter Through Second Quarter : July 1, 2015 - December 31, 2015

REGULAR COMMUNITY PLACEMENT PLAN

	RESIDENTIAL DEVELOPMENT					NON RESIDENTIAL DEVELOPMENT								TOTAL				
	SPECIALIZED RESIDENTIAL FACILITY (SRF)	ENHANCED BEHAVIORAL SUPPORT HOME (EBSH)	ADULT RESIDENTIAL FACILITY FOR PERSONS WITH SPECIAL HEALTH CARE NEEDS (ARFPSHN/962/853)	COMMUNITY CRISIS / TRANSITION HOME	TOTAL RESIDENTIAL DEVELOPMENTS	SUPPORTED LIVING SERVICES (SLS)	CLINICAL AND HEALTH RELATED SUPPORT SERVICES	CRISIS SERVICES AND SPPORTS	TRANSPORTATION	DAY AND EMPLOYMENT SERVICES	TRAINING	OTHER [A]	TOTAL NON-RESIDENTIAL DEVELOPMENTS	TOTAL DEVELOPMENTS	TOTAL ACQUISITION	TOTAL REHABILITATION	TOTAL PROVIDER START-UP	TOTAL POS START-UP
ACRC	4	0	1	0	5	2	0	1	0	1	0	1	5	10	$ 250,000	$ 300,000	$ 941,857	$ 1,491,857
FNRC	2	0	1	0	3	1	1	0	0	1	1	1	5	8	$ 250,000	$ 400,000	$ 913,670	$ 1,563,670
GGRC	5	0	0	0	5	0	0	0	0	0	0	0	0	5	$ 1,400,000	$ 1,200,000	$ 288,000	$ 2,888,000
NBRC	4	1	1	0	6	0	0	0	0	1	1	1	3	9	$ 1,275,000	$ 1,150,000	$ 915,000	$ 3,340,000
RCEB	3	0	0	0	3	0	0	0	0	0	0	0	0	3	$ -	$ -	$ 600,000	$ 600,000
SARC	2	0	1	0	3	0	0	0	0	0	0	0	0	3	$ 525,000	$ 1,215,000	$ 618,670	$ 2,358,670
TOTAL	20	1	4	0	25	3	1	1	0	3	2	3	13	38	$ 3,700,000	$ 4,265,000	$ 4,277,197	$ 12,242,197

SONOMA DEVELOPMENTAL CENTER CLOSURE

	RESIDENTIAL DEVELOPMENT					NON RESIDENTIAL DEVELOPMENT								TOTAL				
	SPECIALIZED RESIDENTIAL FACILITY (SRF)	ENHANCED BEHAVIORAL SUPPORT HOME (EBSH)	ADULT RESIDENTIAL FACILITY FOR PERSONS WITH SPECIAL HEALTH CARE NEEDS (ARFPSHN/962/853)	COMMUNITY CRISIS / TRANSITION HOME	TOTAL RESIDENTIAL DEVELOPMENTS	SUPPORTED LIVING SERVICES (SLS)	CLINICAL AND HEALTH RELATED SUPPORT SERVICES	CRISIS SERVICES AND SPPORTS	TRANSPORTATION	DAY AND EMPLOYMENT SERVICES	TRAINING	OTHER [A]	TOTAL NON-RESIDENTIAL DEVELOPMENTS	TOTAL DEVELOPMENTS	TOTAL ACQUISITION	TOTAL REHABILITATION	TOTAL PROVIDER START-UP	TOTAL POS START-UP [B]
ACRC	1	2	3	0	6	0	2	0	0	0	0	1	3	9	$ 1,300,000	$ 1,600,000	$ 2,500,000	$ 5,400,000
FNRC	1	0	0	0	1	0	1	0	1	1	0	0	3	4	$ 150,000	$ 100,000	$ 775,000	$ 1,025,000
GGRC	10	0	3	0	13	0	1	0	0	2	0	0	3	16	$ 4,475,000	$ 4,850,000	$ 1,996,519	$ 11,321,519
NBRC	6	2	4	0	12	1	3	0	0	4	1	0	9	21	$ 2,700,000	$ 3,650,000	$ 2,979,747	$ 9,329,747
[illegible]	2	4	8	0	14	2	1	0	0	3	0	0	6	20	$ 5,600,000	$ 4,100,000	$ 4,234,177	$ 13,934,177
[illegible]	0	2	0	0	2	0	0	0	0	0	0	0	0	2	$ 511,392	$ 350,000	$ 200,000	$ 1,061,392
TOTAL	20	10	18	0	48	3	8	0	1	10	1	1	24	72	$ 14,736,392	$ 14,650,000	$ 12,685,443	$ 42,071,835

COMBINED REGULAR COMMUNITY PLACEMENT PLAN & SONOMA DEVELOPMENTAL CENTER CLOSURE

	RESIDENTIAL DEVELOPMENT					NON RESIDENTIAL DEVELOPMENT								TOTAL				
	SPECIALIZED RESIDENTIAL FACILITY (SRF)	ENHANCED BEHAVIORAL SUPPORT HOME (EBSH)	ADULT RESIDENTIAL FACILITY FOR PERSONS WITH SPECIAL HEALTH CARE NEEDS (ARFPSHN/962/853)	COMMUNITY CRISIS / TRANSITION HOME	TOTAL RESIDENTIAL DEVELOPMENTS	SUPPORTED LIVING SERVICES (SLS)	CLINICAL AND HEALTH RELATED SUPPORT SERVICES	CRISIS SERVICES AND SPPORTS	TRANSPORTATION	DAY AND EMPLOYMENT SERVICES	TRAINING	OTHER [A]	TOTAL NON-RESIDENTIAL DEVELOPMENTS	TOTAL DEVELOPMENTS	TOTAL ACQUISITION	TOTAL REHABILITATION	TOTAL PROVIDER START-UP	TOTAL POS START-UP
ACRC	5	2	4	0	11	2	2	1	0	1	0	2	8	19	$ 1,550,000	$ 1,900,000	$ 3,441,857	$ 6,891,857
FNRC	3	0	1	0	4	1	2	0	1	2	1	1	8	12	$ 400,000	$ 500,000	$ 1,688,670	$ 2,588,670
GGRC	15	0	3	0	18	0	1	0	0	2	0	0	3	21	$ 5,875,000	$ 6,050,000	$ 2,284,519	$ 14,209,519
NBRC	10	3	5	0	18	1	3	0	0	5	2	1	12	30	$ 3,975,000	$ 4,800,000	$ 3,894,747	$ 12,669,747
RCEB	5	4	8	0	17	2	1	0	0	3	0	0	6	23	$ 5,600,000	$ 4,100,000	$ 4,834,177	$ 14,534,177
SARC	2	2	1	0	5	0	0	0	0	0	0	0	0	5	$ 1,036,392	$ 1,565,000	$ 818,670	$ 3,420,062
TOTAL	40	11	22	0	73	6	9	1	1	13	3	4	37	110	$ 18,436,392	$ 18,915,000	$ 16,962,640	$ 54,314,032

[A] Other developments consists of resources not identified above such as custom facility to maintain medical equipment and consultation.
[B] SDC Start-Up POS does not include $2,228,165 reserve funds for mid-year request.

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Proposed Fairview and Porterville Developmental Center Closures. On November 30, 2015, the department announced its intent to submit a closure plan for Fairview Developmental Center and the general treatment program at Porterville Developmental Center by April 1, 2016. The department has begun the closure plan development process for each center, holding a public hearing at Porterville Developmental Center on January 30, 2016, with approximately 88 people in attendance; and at Fairview Developmental Center on February 6, 2016, with approximates 178 people in attendance.

The following chart shows the status of transition planning for all developmental center residents, as of December 31, 2015.

	Current Pop (does not include crisis homes)	Of the current population, number who have had initial activity (e.g., Meet & Greet) only	Those who have had initial activity and a Transition Planning Meeting (TPM)	Those who have had a TPM, and who have an identified placement/scheduled move date	Percent (%) with transition activity
CS-ICF	49	5	7	1	27%
CS-Grand Total	49	5	7	1	27%
FDC-NF	101	13	7	0	20%
FDC-ICF	143	34	6	2	29%
FDC-Grand Total	244	47	13	2	25%
PDC-NF	51	0	2	0	4%
PDC-ICF	121	5	7	4	13%
PDC-STP	191	3	8	0	6%
PDC-Grand Total	363	8	17	4	8%
SDC-NF	159	0	1	3	3%
SDC-ICF	206	4	0	1	2%
SDC-Grand Total	365	4	1	4	2%
ALL-NF	311	13	10	3	8%
ALL-ICF	519	48	20	8	15%
STP	191	3	8	0	6%
ALL-Grand Total	1021	64	38	11	11%

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 3, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Michelle Baass

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

0530 CALIFORNIA OFFICE OF HEALTH INFORMATION INTEGRITY (CALOHII)

Issue 1: Restructure the California Office of Health Information Integrity

Budget Issue. CalOHII requests a reduction of five positions and operating expenses for a net reduction of $1.4 million ($1.3 million General Fund). Based on a zero base budget analysis, CalOHII requests to reduce its staffing and amend its statutory obligations. CalOHII will continue to serve as the state's authority on the Health Insurance Portability and Accountability Act (HIPAA) matters, but will reduce the scope of its activities to updating statewide HIPAA policy and monitoring progress of HIPAA impacted and covered departments.

The Administration also proposes trailer bill language to implement these changes.

Background. The Health Insurance Portability and Accountability Act (HIPAA) of 2001, established CalOHII and specified the office's responsibilities and authority, including:

- Statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA implementation by impacted state departments;
- Authority relative to state entities to establish policy, provide direction to state entities, monitor progress, and report on HIPAA implementation efforts; and,
- Responsibility for determining which provisions of state law concerning personal health information are preempted by HIPAA for state agencies.

The federal government continues to update existing HIPAA regulations periodically. The federal government utilizes HIPAA to govern the privacy and security requirements associated with its efforts to promote nationwide adoption of health information technology (HIT) and promote health information exchange (HIE). Because HIT and HIE are in the early stages of implementation, it is expected the federal government will be issuing and modifying HIPAA rules for years to come.

CalOHII is responsible for planning, policy articulation, education, monitoring, tracking, and evaluation of HIPAA implementation as a whole. Successful implementation requires close coordination and communication between CalOHII and HIPAA-impacted departments. CalOHII interprets HIPAA for all HIPAA-impacted entities and works with individual departments to ensure that HIPAA is implemented uniformly across the departments.

According to the Administration, now that CalOHII and the other HIPAA-impacted departments have established HIPAA programs, the purpose of CalOHII's activities has shifted to a "maintenance and operation" mode. Consequently, a review of the positions, funding, and workload revealed that CalOHII activities can focus on monitoring of departments and periodic updates to statewide HIPAA policy, thereby, allowing for a reduction in positions and operating expenses.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.
2. Please describe why the Administration feels confident that the state will remain HIPAA compliant given the proposed reduction in staff and operating expenses.

0530 OFFICE OF THE PATIENT ADVOCATE

Issue 1: Complaint Data Reporting Project

Oversight Issue. The Office of Patient Advocate (OPA) is responsible for collecting, analyzing, and reporting complaint data from the Department of Managed Health Care (DMHC), Department of Insurance (CDI), Department of Health Care Services (DHCS), and Covered California. The first complaint data report was due to the Legislature on July 1, 2015. This report has not yet been finalized or made public.

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

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

Subcommittee Staff Comment and Recommendation—Hold Open. At the request of the Brown Administration, the requirement that OPA be a single point of entry for consumer assistance and inquiries with its own 1-800 number for all health care consumer entries was repealed. This was based on the assertion that existing consumer assistance help lines such as the Department of Managed Health Care and the Department of Health Care Services' Managed Care Ombudsman Program were more than adequate and another line would be redundant. In exchange, the OPA responsibilities as an oversight agency were expanded. As part of this agreement, OPA was required to conduct this complaint data report as a baseline in order to make recommendations for improvements and uniformity among systems; and for the legislature, the public, and advocates to have a more robust picture of the adequacy of existing help lines. The fact that the report is more than six months overdue is a major breach of this agreement. It is also makes it impossible to accomplish the intended purpose of the legislation (i.e., assess adequacy of the help lines and make improvements).

It is recommended to hold this item open to explore potential remedies or sanctions if the report is not immediately forthcoming.

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

1. Please provide an update on the status of the complaint data report due July 1, 2015. When do you expect finalizing and releasing the report?

2. What lessons did OPA learn in developing the report that will improve the process for future years?

0530 OFFICE OF SYSTEMS INTEGRATION (OSI)

Issue 1: MEDS Modernization Multi-Departmental Planning Team

Budget Issue. OSI requests 18.0 positions and $3.7 million to provide dedicated staffing and resources required for the agency-wide planning effort for Medi-Cal Eligibility Data System (MEDS) Modernization. See table below for details on the funding components of this request.

MEDS FY 2016-17 BCP Request			Department		
Line Items	PYs	Total Project	DHCS	OSI	CDSS
Total Staffing (includes Staff OE&E)	**18.0**	**$2,567,021**	**$2,542,021**	**$1,961,021**	**$249,000**
Core Planning Staff (10.0 PY, 1.0 Redirected, 1.0 DHCS Transfer)	10.0	$1,587,346	$1,587,346	$1,587,346	$0
Program/Stakeholder Staff (6.0 PY)	6.0	$745,448	$720,448	$139,448	$249,000
DHCS (3.0 PY)		$357,000	$357,000	$0	$0
CDSS (2.0 PY)		$249,000	$224,000	$0	$249,000
OSI (1.0 PY)		$139,448	$139,448	$139,448	$0
Direct Administrative Services (2.0 PY)	2.0	$234,227	$234,227	$234,227	$0
Total Other OE&E		**$1,172,787**	**$1,172,787**	**$597,000**	**$0**
Indirect Administrative Services		$575,787	$575,787	$0	$0
Facilities		$597,000	$597,000	$597,000	$0
Subtotal (BCP Requests)			**$3,714,808** [2]	**$2,558,021**	**$249,000**
Consultant Contracts		$2,914,665	$2,914,665	$2,914,665	$0
Subtotal (DHCS Local Assistance)		**$2,914,665**	**$2,914,665**	**$2,914,665**	$0
Total Project Costs	**18.0**	**$6,654,473** [1]	**$6,629,473**	**$5,472,686** [3]	**$249,000** [4]

[1] Total Project Funding of $6,654,473 for FY2016-17 consists of $6,629,473 (DHCS Total = BCP & L.A.) and $25,000 (CDSS 10% GF)

[2] BCP amount requested for DHCS.

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

[4] BCP amount requested for CDSS. (10% GF and 90% Reimbursement from DHCS.)

According to OSI, the requested positions include a variety of project management (PM), technical and program resources necessary to ensure that the modernized system is designed not only to be technically sound, but to best facilitate a health and human services system that can most effectively meet the needs of the client. These positions would be used to support the the planning phase, which consists of:

- Establishing formal Project Steering and Executive Steering Committees (governance)
- Initiating and managing stakeholder engagement
- Developing all required PM plans and associated artifacts
- Completing documentation of the current business and technical environment

- Conducting organizational readiness assessments
- Assessing readiness gaps and developing a mitigation plan
- Developing high-level business and technical requirements
- Assessing alternatives for future state business processes
- Conducting market research
- Assessment of viable alternatives for system modernization

Background. DHCS is the single state agency responsible for the administration of California's Medicaid Program known as Medi-Cal, which provides health care services to more than 12 million beneficiaries. Since 1983 DHCS has maintained the current MEDS system to support key programmatic functions both internally and externally for its critical partners. Today the system is used for a variety of eligibility, enrollment and reporting functions specific to Californians receiving Medi-Cal benefits. MEDS and its related subsystems have been designed over many years to capture client information from a variety of different sources. Key stakeholders that manage the beneficiary eligibility data include the three consortia (LEADER, C-IV, and CalWIN) representing all 58 counties, state and federal partners, and Covered California.

MEDS also serves as the "system of record" and houses eligibility information for numerous publicly subsidized health care and human services programs. Programs managed within the DHCS leveraging the system include Every Woman Counts, Child Health and Disability Prevention, Breast and Cervical Cancer Treatment, Family Planning Access Care and Treatment, and Cancer Detection. Programs managed within the California Department of Social Services leveraging the system include California Work Opportunity and Responsibility to Kids (CalWORKS), CalFresh (Supplemental Nutritional Assistance Program), Cash Aid Program for Immigrants, In-Home Supportive Services (IHSS) and Refugee Cash Assistance. In addition to the state managed programs, multiple programs at the local level also leverage the system such as the County Medical Services Program (CMSP), County Welfare and Tribal Temporary Assistance for Needy Families. MEDS data is also used in a wide variety of administrative functions and purposes such as accounting, reporting, and legislation and budget development and research. Access to the MEDS database is currently provided to over 35,000 distinct end-users in the administration of the state's health and human services programs.

According to OSI, supporting this mission-critical system on outdated technology, with a declining workforce of those skilled in the technology, has created significant risk to the DHCS and its critical partners. In addition, federal rules have been released that require states to modernize their eligibility determination systems to meet the standards of the Medicaid Information Technology Architecture (MITA) in order to maintain enhanced federal financial participation (FFP).

On July 1, 2015, the California Department of Technology (CDT) implemented a Stage/Gate Model for IT project approval process that consists of four stages and gates. Each stage requires specific deliverables and approvals prior to moving into the next stage. The four stages take a project from concept through contract award which ultimately results in formal project approval. According to OSI, this approach to planning for MEDS Modernization addresses the following issues surrounding this large and complex IT project:

- Enterprise Approach and Stakeholder Involvement: Ensures that common business needs are addressed in a consistent and collaborative manner. Supports full inclusion and collaborative decision making on informed investment decisions through a formal governance body. Prevents a siloed approach that results from stakeholders operating independently and duplicating efforts in a parallel manner. Lack of critical partners early in project planning is regularly identified as a key reason for large IT project delays, cost overruns, and even failure. Identifying the program and business needs up-front, and designing the IT system to meet those needs is widely considered best practice, but requires an up-front dedication of resources from all partners to ensure that planning is done properly. This request is specifically intended to meet that critical need.

- Project Approval Life Cycle: Ensures experienced PM and leadership is provided to all participating departments throughout the stage/gates of the new project approval life cycle. Given the newness of the stage/gate process, having experienced, dedicated PM to guide the project through will be critical to maintaining the schedule and subsequently best positioning the project best for control agency support and approval.

- Federal Funding Availability: Through leveraging enhanced FFP, departments will benefit from federal funds available which minimizes the impact on the General Fund.

- Sustaining enhanced FFP: Proper planning and implementation of MEDS Modernization will ensure that future MEDS maintenance and operations costs will continue to be reimbursed at the enhanced FFP of 75% federal and 25% state, as the state will comply with MITA standards.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

Issue 2: eWIC Management Information System Project

Budget Issue. OSI requests $4.1 million in expenditure authority and 19.5 permanent positions for the new Women, Infants and Children (WIC) Management Information Systems (eWIC MIS) project. The California Department of Public Health (DPH), as the single State entity responsible for the federally-funded WIC Program, is proposing to contract with the OSI to assume management of the eWIC MIS Project including completing the system acquisition and managing the project through successful completion of statewide implementation. DPH will fund the project with 100 percent federal funding and has submitting a separate BCP to request the necessary appropriation authority.

In addition, because completion of the eWIC MIS project is a critical component of meeting the federal mandate for California to issue WIC food benefits via Electronic Benefit Transfer (EBT) by October 1, 2020, DPH intends to redirect some existing positions and funding to OSI in the current year to begin its work.

Background. The United States Department of Agriculture's Special Supplemental Nutrition Program for WIC is a federally-funded nutrition education and supplemental food program established in 1972 under Public Law 92-433. DPH administers the WIC Program in California, contracting with 84 local agencies throughout California (in all 58 counties) to provide WIC services at over 650 sites, with approximately 1.4 million participants served on a monthly basis.

The federal Healthy, Hunger-Free Kids Act of 2010 requires all states to migrate from a WIC paper-based food benefits delivery system to an EBT system by 2020. Without an EBT system automating WIC benefits by October 1, 2020, California will not be in compliance with federal law, which may jeopardize millions of dollars in federal funding for the California WIC Program. DPH performed a detailed analysis that revealed the current WIC MIS was outdated and not EBT-compliant; therefore, DPH received both federal and state approvals to begin the procurement to solicit bids and contract for the services of a design, development, and implementation systems integrator. DPH also contracted with the OSI (via an interagency agreement) to leverage the new California EBT Services Contract to automate the issuance of WIC food benefits via the California EBT system.

The new eWIC MIS must be fully operational in California before WIC food benefits can be issued via EBT. In its June 2015 eWIC MIS Project Status Report, the California Department of Technology (CDT) gave the project an overall rating of "Yellow" (which indicates a project is slipping). This report also identified other possible delays that will likely cause the project to slip even further behind schedule. With the approaching federal deadline of October 1, 2020, DPH decided to leverage OSI's experience and have OSI manage the project. This would include the OSI assuming responsibility for completing the procurement; entering into a contract with the successful system integrator; managing design, development, testing, pilot, and statewide implementation activities; being responsible for contract and financial management; and providing other needed services.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 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 about $3 million ($130 million General Fund) for the DPH as noted in the Table below and 3452 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 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.

Table: DPH Budget Overview

Fund Source	**2014-15**	**2015-16**	**2016-17**	**BY to CY**
	Actual	**Revised**	**Proposed**	**Change**
General Fund	$117,688,000	$129,352,000	$130,170,000	$818,000
Federal Trust Fund	$1,594,040,000	$1,755,820,000	$1,685,024,000	($70,796,000)
Special Funds & Reimbursements	$1,004,560,000	$1,090,276,000	$1,148,356,000	$58,080,000
Total Expenditures	**$2,716,288,000**	**$2,975,448,000**	**$2,963,550,000**	**($11,898,000)**
Positions	**3271.1**	**3377.1**	**3452.2**	**75.1**

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.

Issue 2: Oral Health Program

Oversight Issue. The 2014 budget included $474,000 ($250,000 General Fund and $224,000 in reimbursements, federal funds from the Department of Health Care Services) to establish a State Dental Director, add an epidemiologist, and provide related consulting services to re-establish a statewide oral health program. DPH proposed to develop a Dental Burden of Disease (Burden) report which would help identify dental health issues, disease burden, facts and figures of dental disease, and capacity to address the burden. The Burden report would be the foundation for the development of the State Dental Plan (Plan). The Plan would serve as the roadmap for California's short-term, intermediate, and long-term priorities, goals, and objectives to address dental disease burden and prevention. At the time, DPH proposed the following implementation timeline:

- By October 2014, establish DPH's Dental Team (State Dental Director, epidemiologist, and develop and execute consulting contracts).
- By December 2014, establish an Advisory Committee and Coalition.
- By December 2014, establish the Dental Program Website.
- By March 2015, publish the Dental Burden of Disease Report.
- By June 2015, publish the State Dental Plan.

This timeline and these activities to re-establish and reinvigorate the DPH's efforts on oral health have been delayed due to difficulties in hiring a State Dental Director. Almost a year later than originally proposed, on August 3, 2015, Dr. Jay Kumar was appointed as the State Dental Director. The delayed appointment of a State Dental Director deferred completion of the Dental Burden of Disease Report and the State Dental Plan. These documents are expected to be finalized almost a year from which originally proposed. An updated timeline is provided on the next page.

California Oral Health Program Timeline, as of February 9, 2016

Objectives and Activities	Status as of 4/14/15	Status as of 2/9/16
Program Leadership Establish Dental Leadership Team: July 2015		
1.1.a Recruit, hire and orient Dental Director	1/31/15	Completed 8/3/15
1.1.b Recruit, hire and orient Epidemiologist	Completed	Completed
1.1.2 Develop and execute two contracts (Cal EIS Fellow, California State University	Completed	Completed
1.1.3 Orient Cal EIS Fellow	Completed	Completed
1.1.4 Oversee administrative and fiscal activities	Ongoing	Ongoing
Partnerships and Coalition Establish Advisory Committee & Coalition: Sep. 2015		
2.1.1 Convene Dental Program Advisory Committee	6/30/15	Completed 8/27/15
2.1.2 Participate in Chronic Disease Branch Communications, Health Care Systems/Community Prevention Workgroups	Ongoing	Ongoing
2.1.3 Participate in Chronic Disease Branch Evaluation, Surveillance and Epidemiology Workgroups	Ongoing	Ongoing
2.1.4 Convene first Coalition Meeting	9/30/15	Completed 1/28/16
2.1.5 Convene an ongoing Coalition Workgroup to develop the State Dental Plan	9/30/15	Ongoing
2.1.6 Convene second Coalition Meeting	2/29/16	05/30/16
2.1.7 Develop and implement a Dental Program Communications Strategy	Completed 9/30/15	Will be updated 8/01/16
Capacity Assessment & Dental Program Website Establish Website: June 2015		
3.1.1 Assess current resources and strategies in dental policy, care systems, community prevention and communications	Ongoing	Ongoing
3.1.2 Assess current resources and strategies in dental surveillance/epidemiology	Completed	Completed
3.1.3 Create Dental Program website, with information resources	Completed	Completed
3.1.4 Finalize Capacity Report (result of assessments)	9/30/15	Completed 9/30/15
State Dental Plan Publish State Dental Plan by June 2016		
4.1.1 In conjunction with Coalition members, develop a Dental State Plan Framework	9/30/15	Completed 10/5/15
4.1.2 In conjunction with Coalition members, develop a Draft Dental State Plan	2/29/16	04/30/16
4.1.3 Finalize Dental State Plan	6/30/16	06/30/16
4.1.4 Implement plan, including benchmarks and evaluation measures		Ongoing
Surveillance/Epidemiology Publish Dental Burden Report: June 2015		
5.1.1 Assess current data sets	Completed	Completed
5.1.2 Analyze data and write narrative	Completed	Completed
5.1.3 Develop a Draft Dental Burden of Disease Report	Completed	Completed
5.1.4 Finalize Dental Burden of Disease Report	6/30/15	Under review

Evaluation **Develop Dental Program Evaluation Methods: June 2016**		
6.1.1 Develop a Dental Program Logic Model	4/30/15	Completed 4/30/15
6.1.2 Develop Dental Program Performance Measures	4/30/15	Completed 4/30/15
6.1.3 Track Dental Program Performance Measures and write Report	Ongoing	Ongoing
6.1.4 Report on Dental Program Performance Measures	6/30/16 & Ongoing	6/30/16 & Ongoing

Subcommittee Staff Comment and Recommendation—Oversight Item. As noted above, the core activities of this program have been delayed. This means that the implementation of innovative policies and strategies to improve the state's oral health condition are postponed.

DPH's Oral Disease Burden Report should contain delineated information about the Medi-Cal program, so that the state can understand how Medi-Cal enrollees' oral health conditions compare to the other California residents. It will be important for the State Dental Director and the Oral Health Program to proactively work with Medi-Cal's Denti-Cal program given that Medi-Cal serves about a third of the state's population.

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

1. Please provide an update on the Oral Health Program and highlight key accomplishments in the last year.

2. Is DPH's Oral Health Program working with the Department of Health Care Services (DHCS) to identify dental health issues, disease burden, facts and figures of dental disease, and capacity to address the burden related to the Medi-Cal program? Please explain.

3. How are you working with DHCS regarding the 1115 Waiver Renewal Application: Medi-Cal 2020's Dental Transformation Initiative? Please provide specifics.

4. Subcommittee staff requested a copy of the dental program performance measures (that were completed on April 20, 2015) and has not yet received them. What is the status of providing this information to the Subcommittee?

Issue 3: Laboratory Field Services – State Auditor's Report

Oversight Issue. On September 10, 2015, the State Auditor released a report on DPH's Laboratory Field Services (LFS) program. In this audit, the State Auditor found that LFS is "still not performing the oversight activities with which it has been entrusted and that its management of its responsibilities is inadequate." Specifically, it found that LFS:

- Only inspects about half of California labs, and it has not established a process to ensure that it becomes aware, in a timely manner, when out-of-state labs that are licensed in California fail required proficiency testing.

- Does not yet investigate all complaints against labs and has issued only a small number of lab sanctions in the past seven years; despite the number of labs it oversees.

- Made an unauthorized fee increase in January 2014 that resulted in labs overpaying it more than $1 million, and since 2008 it has collected more than $12 million in lab fees that it has not spent.

- Has missed opportunities to more effectively use its limited personnel by partnering with other organizations that could help it meet its workload obligations under state law.

To address these findings, the State Auditor recommends to eliminate the state's redundant oversight of labs (as federal requirements are similar to state requirements) and to ensure labs do not pay unnecessary or duplicative fees. The State Auditor recommends that the Legislature do the following:

- Repeal existing state law requiring that labs be licensed or registered by Laboratory Services and that Laboratory Services perform oversight of these labs. Instead, the state should rely on the oversight the federal government provides.

- Repeal existing state law requiring labs to pay fees for state-issued licenses or registrations.

Concerns Regarding Laboratory Personnel Licensing. In addition to the issues identified by the State Auditor, concerns have been raised that LFS's regulation of laboratory personnel is cumbersome and outdated, and is preventing qualified individuals from working in labs. DPH has been working on regulations to update this program since 2008. DPH anticipates promulgating these regulations two to three years from now. These regulations deal with the training, licensure or certification, and work scope of clinical laboratory personnel in 22 licensure categories and 10 trainee license categories, and the training and work scope of unlicensed laboratory personnel. The new regulations set and update requirements of education, training, and examination for initial licensure and renewal of licensure. They also set and update requirements for department approval of examinations, training programs, and continuing education programs for clinical laboratory personnel.

Background. LFS, within DPH, is responsible for overseeing clinical laboratories (labs) that analyze human specimens such as blood, tissue, and urine. Medical professionals use these analyses to make diagnoses and prescribe treatment. LFS' oversight responsibilities cover both labs located within California and labs located outside of the state that test specimens originating from within California. The state currently has licensed approximately 2,800 labs and registered approximately 19,300 labs;

the complexity of the tests the labs perform dictates whether they require licensing or registration. LFS' oversight responsibilities include inspecting licensed labs once every two years and periodically verifying the accuracy and reliability of their tests through a process called *proficiency testing*. It must also investigate complaints against both licensed and registered labs and may issue sanctions when it finds that a lab is out of compliance with state laws or regulations. All licensed labs must pay Laboratory Services an annual fee based on the volume of tests they perform, while registered labs must pay an annual flat fee.

In addition to licensing labs, LFS certifies and/or licenses the personnel who work in labs, including phlebotomists, cytotechnologists, medical laboratory technicians, clinical laboratory scientists trainees, clinical laboratory scientists, public health microbiologists, and clinical laboratory directors.

Subcommittee Staff Comment—Oversight Item. AB 1774 (Bonilla) has been introduced to repeal the laws requiring a clinical laboratory to be licensed and inspected by the department, including the licensing fee, as recommended by the State Auditor. Consequently, it appears that the issues regarding the licensure of labs could be addressed in the near future.

However, efforts to timely address the concerns regarding the licensure of laboratory personnel remain outstanding. Given DPH's past difficulties in promulgating regulations and the fact that DPH began work on these regulations in 2008, it is likely that the state is years away from modernizing its laboratory personnel licensure/certification program.

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

1. Please provide an overview of this issue and DPH's corrective actions to address the State Auditor's findings.

2. Are there risks in not having finalized the regulations regarding laboratory personnel?

3. What steps has DPH taken to expedite the promulgation of the regulations related to laboratory personnel licensure/certification? Has DPH considered sponsoring a bill to modernize this program?

Issue 4: Richmond Laboratory: Viral Rickettsial Laboratory Enhanced Upgrade

Budget Issue. DPH requests to reappropriate $3.8 million from a Capital Outlay Project approved in 2015-16 to upgrade the DPH's Bio-Safety Level 3 (BSL-3) certified Viral and Rickettsial Disease Laboratory. The upgrades were needed to ensure that DPH retains its BSL-3 Certification from the Federal Center for Disease Control and Prevention (CDC) and National Institutes of Health (NIH). According to DPH, the reappropriation is needed due to the project's delays that were beyond DPH or the Department of General Services' (DGS) control.

Background. At the time of construction (2000), the Richmond Campus VRDL laboratory was designed to meet the existing BSL-3 requirements as determined by the CDC and NIH. In response to world health concerns, in 2006 the CDC/NIH implemented enhanced requirement for BSL-3 certified laboratories. In response to the required BSL-3 enhancements, in 2015-16, DPH was funded with a $4.3 million Capital Outlay Project to upgrade the VRDL.

Below are the phases and funding allocation for this project:

Phase	Authority
Working Drawings	$534,000
Construction – A&E	$351,000
Construction – Contract	$2,796,000
Construction – Contingency	$196,000
Construction – Other	$456,000
Total	**$4,333,000**

After the enactment of the 2015-16 budget, DPH engaged the services of DGS to manage the project and in July 2015 DPH transferred $534,000 to DGS to fund the working drawing phase of the project.

Originally, the DGS schedule was to proceed into the construction phase in April/May 2016, which would then allow DPH to transfer the remaining ($3.8 million) funds to DGS. However, in August 2015, the State Fire Marshall's (SFM) Office redirected all SFM resources to addressing California fires throughout the state and suspended all reviews of construction plans, drawings, and documents. This effectively caused a 3-4 month delay in the project. The project's construction phase has been delayed to occur after July 2016. As a result, this request is to reappropriate the remaining funds ($3.8 million) for construction to 2016-17.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this request.

Issue 5: Timely Infectious Disease Outbreak Detection and Disease Prevention

Budget Issue. DPH requests $1.6 million General Fund in 2016-17, $2.1 million General Fund in 2017-18 and 2018-19, and 14.0 permanent positions, to provide ongoing support to protect California from infectious diseases through increased disease surveillance and laboratory capacity. The 14.0 positions will be phased-in.

According to DPH, this requested investment in the infectious disease laboratories will increase DPH's ability to address the emerging public health challenges presented by microbes that cannot be cured with available antibiotics, to provide laboratory testing for newly emerging infectious disease threats, to implement new technologies, and to improve the timeliness and completeness of outbreak detection in the state. DPH indicates it needs additional staffing resources and modernized equipment in the infectious diseases laboratories. As a result of new challenges, the laboratories are unable to meet the current needs of state and local disease control activities. Specifically, the laboratories are unable to provide timely testing of foodborne pathogens to identify and investigate outbreaks, to complete viral disease testing, to provide antimicrobial resistance testing to monitor the emergence of resistance and efforts to control resistance, and to fully implement new technologies that are becoming the national standard such as whole genome sequencing.

Requested Positions:

Position	Duties
4.0 - Public Health Microbiologist II	Increase foodborne pathogen testing, verify and validate molecular diagnostic tests and perform antimicrobial resistance testing and viral testing.
3.0 - Public Health Microbiologist Specialists	Increase foodborne pathogen testing, and carry-out quality assurance activities.
1.0 - Research Scientist II	Coordinate testing and reporting for emerging viruses.
5.0 - Research Scientist III	Increase foodborne pathogen testing, perform antimicrobial resistance testing, evaluate and introduce new technologies for antimicrobial resistance testing and genotyping. Carry out viral testing. Prepare technical reports and documents for informing and educating healthcare professionals and local public health staff.
1.0 -Research Scientist Supervisor I	Oversee foodborne pathogen testing, processing and reporting of antimicrobial resistance testing, and supervise research scientists, public health microbiologists and laboratory technicians.

Background. Infectious disease laboratories including the Viral and Rickettsial Disease Laboratory and the Microbial Disease Laboratory in DPH's Division of Communicable Disease Control, play three unique and critical functions: (1) detecting and confirming outbreaks (e.g., measles, salmonellosis, and drug resistant tuberculosis outbreaks); (2) monitoring and identifying emerging pathogens (e.g., Ebola, acute flaccid myelitis, middle-eastern respiratory virus, and novel influenza viruses); and (3) providing situational awareness and actionable intelligence to local partners (e.g., plague and norovirus outbreaks). In addition, DPH epidemiologists rely upon accurate and timely laboratory data and information to identify the source of outbreaks, evaluate disease transmission patterns, and conduct surveillance to monitor and control epidemics.

The infectious disease laboratories provide diagnostic testing for rare diseases, which offers valuable information to local public health departments, health care providers, and patients. The laboratories have a critical role as they work in close collaboration with many DPH disease control programs and local public health departments to provide laboratory support, technical assistance, and research for the development and maintenance of high quality local laboratory services. For counties without available public health laboratory services, DPH infectious disease laboratories function as the reference and local public health laboratory. Unlike commercial laboratories or smaller local public health laboratories, the scope of the DPH infectious laboratories differs as they provide a full, statewide testing menu on all 88 mandated reportable diseases that require laboratory confirmation. The infectious disease laboratories currently receive $16 million in General Fund and $2.9 million in Federal Funding to support 73.1 positions.

According to DPH, during the last decade DPH's infectious disease laboratories have faced new challenges posed by emerging and re-emerging infectious diseases, changing laboratory technology, and new federal regulatory and biosafety requirements. Workload in the laboratories has increased dramatically; due to outbreaks and new infectious disease threats, viral disease testing has more than doubled in the past four years. Over the same time period, the number of specimens submitted for testing to identify foodborne disease outbreaks has increased by more than 30 percent. This substantial increase in workload has impaired the ability of the laboratories to address other important laboratory challenges and to complete all needed testing in a timely manner. For example, the laboratories were unable to carry out 18 percent of the total viral disease testing submitted to DPH in 2014-15. Furthermore, roughly half (49 percent) of all the antimicrobial resistance testing submitted to the infectious disease laboratories for drug resistant gonorrhea, highly drug resistant organisms in health care facilities, and drug resistance in outbreaks was not completed due to insufficient capacity during the same time period. In addition, the laboratory was unable to carry out testing for respiratory viruses in 75 percent of the respiratory samples submitted.

Demands on the laboratories have increased as new infectious diseases have emerged to pose threats to public health. For example, Ebola virus, Middle Eastern Respiratory Syndrome, Coronavirus, and novel influenza viruses have required the DPH infectious diseases laboratories to develop and deploy new laboratory tests to local public health laboratories. In addition to the emerging and re-emerging infectious diseases, there are vaccine-preventable agents, bacterial toxins, bioterrorism, and pandemics that also pose a threat to public health and require DPH laboratories to develop more accurate and efficient diagnostic methods that improve capacity and readiness. DPH's laboratories need to develop and support statewide capacity for rapid detection of emerging diseases to enable effective public health response.

According to DPH, new molecular technologies, such as whole genome sequencing, are being introduced in public health laboratories at a rapid pace. This new technology will improve the timeliness of outbreak investigations and enhance control measures. The DPH infectious disease laboratories have fallen behind a number of other state public health laboratories in the introduction of whole genome sequencing in routine laboratory practice due to high capital costs and the need for specialized personnel. This capacity is needed to support work of local public health laboratories and DPH's disease control programs.

Additionally, DPH cites that a critical gap exists in the state's ability to protect California residents from foodborne illnesses. Laboratory testing of foodborne pathogens is critical for identification of foodborne outbreaks. State regulations require that diagnostic laboratories submit isolates of common foodborne pathogens to public health laboratories for strain typing. In 2014-15, the laboratory was unable to type 20 percent of foodborne disease specimens submitted for testing. One important element

of outbreak detection is timeliness. Delays in strain typing can lead to delays in outbreak detection and delays in implementing steps to remove contaminated food from the food supply.

According to DPH, these additional requested resources will enable it to address some of the current gaps in infectious disease laboratory capacity. Specifically, the funds requested in this BCP will enable DPH to:

- Test additional foodborne specimens in the state to identify additional foodborne outbreaks and prevent the spread of foodborne illness. These resources should be sufficient to close the current gap in foodborne testing of approximately 1,000 specimens per year.

- Establish a reference public health antimicrobial susceptibility testing unit.

- Introduce molecular tests for rapid confirmation of drug resistant organisms, and expand the use of new molecular test technology to expedite outbreak investigations.

- Enhance the Infectious Diseases Laboratory customer service system by integrating specimen tracking and result reporting into electronic systems, increasing the laboratory's ability to respond to surges and outbreaks, supporting regulatory compliance, and improving turn-around-time for testing results.

- Increase core capacity for viral testing, including the development of molecular testing on vaccine preventable diseases and surge testing for statewide outbreaks of public health concern. These resources will enable the laboratory to enhance viral testing during outbreaks to reduce the number of viral tests that are not completed and carry out more effective public health response.

Difficulties Recruiting and Retaining Laboratory Personnel. The department plans a phased-in approach to hiring the 14 positions due to the difficulties in hiring laboratory personnel and the high turnover in these positions. DPH indicates that from 2012 to 2015, there were approximately 19.0 permanent separations from laboratory positions at within the Division of Communicable Disease Control, which include transfers to other state departments, departures to private industry, and retirements. Several factors contribute to the high turnover rate: more competitive salaries are offered in the private sector and local public health laboratories within the Bay Area, and the relatively small pool of individuals who meet entry level qualifications to perform the specialized laboratory testing makes them highly sought after candidates for other positions.

Subcommittee Staff Comment and Recommendation—Hold Open. It is unclear that even with the proposed phased-in approach to hiring these positions, if the state will be successful in recruiting and retaining laboratory personnel, microbiologists in particular. For this reason, it is recommended to hold this item open as discussions continue on potential alternatives to ensure timely infectious disease outbreak detection and disease prevention.

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

1. Please provide an overview of this issue.

2. Please describe the changes DPH has implemented to address the difficulties in recruiting and retaining laboratory personnel.

Issue 6: Oversight of Licensing and Certification (L&C) Program

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

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

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

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

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

Budgets Address Problems. The 2014-15 and 2015-16 budgets took actions to address these concerns.

- **2014-15 Budget.** The Legislature adopted trailer bill language[1] that required L&C to:
    - Report metrics, beginning October 2014 and on a quarterly basis, on: (1) investigations of complaints related to paraprofessionals certified by DPH; (2) long-term care health facility complaints, investigations, state relicensing, and federal recertification surveys; and (3) vacancy rates and hiring within L&C.
    - Report by October 2016 the above information for all facility types.
    - Assess the possibilities of using professional position classifications other than health facility evaluator nurses to perform licensing and certification survey or complaint workload by December 1, 2014. See below for information on this report.

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

- Hold semiannual meetings, beginning August 2014, for all interested stakeholders to provide feedback on improving the L&C program to ensure that Californians receive the highest quality of medical care in health facilities.

- See the following website for the publication of this data: http://www.DPH.ca.gov/programs/Pages/CHCQPerformanceMetrics.aspx

- **2015-16 Budget.** The 2015-16 budget included:

  - **Workload.** An increase of $19.8 million in 2015-16 for 237 positions (123 positions became effective July 1, 2015 and 114 positions will begin on April 1, 2016), and an increase in expenditure authority of $30.4 million in 2016-17 from the L&C Special Fund to address the licensing and certification workload.

  - **Quality Improvement Projects.** An increase of $2 million in 2015-16 from the Internal Departmental Quality Improvement Account to implement quality improvement projects.

  - **Los Angeles County Contract.** An increase in expenditure authority of $14.8 million from the L&C Special Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County.

  - **Los Angeles County Contract Monitoring.** An increase of $378,000 from the L&C Special Fund and three positions, to provide on-site oversight and perform workload management, training, and quality improvement activities to improve the efficiency and effectiveness of the Los Angeles County contract licensing and certification activities. In order to begin the on-site oversight immediately, the department plans to administratively establish three positions in 2014-15.

  - **Complaint Investigation Timelines.** The Legislature adopted trailer bill language[2] to establish timeframes to complete complaint investigations at long-term care facilities. This language requires the department to do the following:

    - For complaints that involve a threat of imminent danger or death or serious bodily harm that are received on or after July 1, 2016, the department must complete the investigation within 90 days of receipt. This time period may be extended up to an additional 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.

    - For all other categories of complaints received on or after July 1, 2017, the department must complete the investigation within 90 days of receipt. This time period may be extended up to an additional 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this

2 SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015

extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.

- For all complaints received on or after July 1, 2018, the department must complete the investigation within 60 days of receipt. This time period may be extended up to an additional 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.

- Report on an annual basis (in the Licensing and Certification Fee report) data on the department's compliance with these new timelines.

- Beginning with the 2018-19 Licensing and Certification November Program budget estimate, the department must evaluate the feasibility of reducing investigation timelines based on experience implementing the timeframes described above.

- States the intent of the Legislature that the department continues to seek to reduce long-term care complaint investigation timelines to less than 60 days with a goal of meeting a 45-day timeline.

- **Notification for Hosptial Complaints.** The Legislature adopted trailer bill language to require the department to notify hospitals and complainants if there are extenuating circumstances impacting the department's ability to meet complaint investigation timelines. This notification would include the basis for the extenuating circumstances and the anticipated completion date.

- **Long-Term Care (LTC) Ombudsman Program.** The Legislature directed $1 million (one-time) from the State Health Facilities Citation Penalties Account to the LTC Ombudsman Program at the Department of Aging in 2015-16 and adopted trailer bill language to increase the L&C fee for skilled nursing facilities to generate $400,000 to support the LTC Ombudsman Program on an ongoing-basis. This increase in funds would be used to support skilled nursing facility complaint investigations and quarterly visits.

Report on the Use of Non-Registered Nurses in L&C Regulatory Activities. As noted above, SB 857 required DPH to provide a report to the Legislature assessing the possibilities of using professional position classifications other than registered nurses (RNs) to perform licensing and certification survey or complaint investigation workload in order to help evaluate if using different position classifications would help the program recruit and retain staff and address concerns with L&C. This report was due December 1, 2014 and was just received on February 22, 2016. According to the report, DPH found the following:

- **Importance of Using RNs as Surveyors.** The department believes RNs possess the technical, professional, and clinical expertise needed to appropriately evaluate patient care and safety, assess health facility operations in a highly regulated environment, interpret regulations,

interact with patients and facility staff, and apply the clinical judgment needed to perform licensing and certification surveys and complaint investigations. This includes serious patient care events that occur in health care settings, and the potential for those events to lead to situations that cause or are likely to cause serious injury or death (immediate jeopardy).

In the department, RNs normally investigate a complaint or ERI. Most complaint and ERI investigations involve clinical or clinically-related questions and issues. The investigations are multifaceted and include medical record reviews, interviews, and observations related to the allegations in the complaint or ERI. These activities include interviews with facility clinicians and patients whose physical and mental condition may be clinically compromised.

Using RNs allows the survey staff to respond to shifting circumstances that may occur during the course of an investigation. During a survey or an investigation, a surveyor may identify a patient safety issue that requires them to stop what they are doing to investigate, or an investigation may require more clinical judgment than was initially anticipated. Because RNs are competent to perform any survey task, they have the ability to fulfill any role on the survey team at any time. This allows the department to address shifting and immediate workload demands. Further, the increasing level of acuity of residents in general acute care hospitals and skilled nursing facilities requires a higher level of clinical skill among surveyors. Filling most surveyor positions with RNs reflects the nature of the department's workload, and the requisite background required to perform capably as a surveyor in all relevant situations.

- **Potential for Using Licensed Vocational Nurses (LVNs) to Perform Surveys or Complaint Investigations.** In the past, the department has hired LVNs in the health facilitator evaluator (HFE) I classification to perform survey and investigation work. This is the only classification in the HFE series performing survey and investigation work for which an LVN could meet the minimum qualifications. The current minimum qualifications for the HFET and the HFE I is a four-year degree in specified medical fields. Each two years of LVN experience can substitute for one year of education. Thus, an LVN would require eight years of experience to meet the minimum qualifications.

  When the pending HFE reclassification proposal[3] becomes effective, the HFET and HFE I classifications will be eliminated.

  Using information from the Department of Consumer Affairs, the department determined that approximately 130,339 LVNs are licensed in California, compared with over 500,000 RNs licensed in California. Given the education or experience requirements needed in addition to an LVN license, the lack of an appropriate civil service classification, and the small number of LVNs compared with RNs, the department determined that limiting the applicant pool to LVNs would likely not yield enough viable candidates to result in a notable impact on workload.

3 According to DPH, the proposed HFE classification series revision comprehensively addresses compaction, recruitment, and entrance requirements for the various classifications. The proposal requires all persons in the HFE series to possess a valid RN license, adjusts salary ranges to incorporate past pay differentials for various HFE classes to address salary equity and recruitment issues, eliminates the HFET and HFE I classifications, and creates a new, non-clinical classification series to perform the body of work currently performed by those classifications. The proposal is currently under review with the affected unions. When DPH obtains union concurrence, CalHR will calendar the reclassification proposal for State Personnel Board review.

- **Potential for Using Other Classifications to Perform Medical Information Breach Investigations.** The department had approximately 5,100 medical information breach cases pending investigation as of June 30, 2015. Medical breach investigations represent about 10 percent of the total annual complaints/ERIs received.

  Currently, the department uses HFENs as the primary investigators of medical information breaches. However, this type of investigation does not require the clinical expertise of an RN. Since July 1, 2014, the department has had a small staff of non-RNs investigating medical information breaches. Expanding this investigative staff with Associate Governmental Program Analysts (AGPAs) or Special Investigators may be an effective way to relieve some workload from HFENs, enabling them to focus their clinical expertise on survey and other complaint/ERI investigation work. The applicant pool for AGPAs and SIs is substantial. The AGPA classification is the journey-level analyst civil service classification used by departments statewide and the SI classification is also used statewide.

  In December 2015, using existing position authority, the department initiated a pilot program that will use 13 AGPAs or SIs spread across the six regions of the state to investigate medical information breaches. These AGPAs or SIs will address medical breach investigation workload in each of the 14 district offices and Los Angeles County but will not be physically located in every district office. The department proposes a three-year pilot to allow time to recruit and train the AGPAs or SIs and collect sufficient data to assess this model's effectiveness, as well as feasibility of expanding the program. The department will periodically provide updates in its November estimates on the pilot's progress.

Update on L&C's Efforts to Hire Nurse Surveyors. Since July 1, 2015, CHCQ has hired 108 Health Facilities Evaluator Nurses (HFENs), and 72 HFENs have separated from CHCQ. As of January 26, 2016, CHCQ has 70.5 vacant HFEN positions. CHCQ estimates there will be a turnover rate of approximately 20 percent in 2015-16, which is similar to past trends. CHCQ has worked closely with the department's Human Resources Branch (HRB) to improve efforts to hire L&C HFEN applicants. CHCQ funded a new position in HRB dedicated to work only on CHCQ personnel activities including pre-screening of applicants to ensure they meet minimum qualifications.

In order to fill the new HFEN positions, CHCQ sent contact letters to everyone on the HFEN certification list in July 2015 (approximately 600 letters). As a result, CHCQ received more than 175 applications between July and October. In November 2015, CHCQ sent approximately 1,500 contact letters to HFEN candidates, and has since received more than 300 applications. In August 2015, CHCQ also mailed over 500,000 post cards advertising HFEN positions to every registered nurse in California.

To ensure consistency and standardization among district offices, CHCQ established a fixed set of questions for all district offices to use for HFEN interviews. In addition, CHCQ encouraged district offices to partner with other closely located offices to conduct joint interviews. CHCQ designed these coordinated interviews to improve "customer service" for applicants and to reduce prior inefficiency where an individual received multiple interview requests from district offices because they indicated a willingness to work in several offices in their application.

CHCQ continues to gather feedback from the district offices to improve the hiring process. There are currently 32 pending offers to HFEN candidates. CHCQ is continuing to work on filling the remaining support and supervisory positions that were established July 1, 2015. CHCQ received 14 health facility evaluator II supervisor positions and currently has 12 vacancies. CHCQ received 14 program technician II positions and currently has 9 vacancies. CHCQ is currently and continuously reviewing applications and interviewing for HFENs and other positions.

Update on L&C's Oversight of the Los Angeles County Contract. As noted above, the 2015-16 contained funding and positions to improve the state's oversight of the Los Angeles County Contract. According to DPH, over the past 18 months, CHCQ has significantly increased its monitoring of Los Angeles County's (LAC's) work performance. Below are some of the actions CHCQ has undertaken:

- Developed specific workload tracking worksheets to ensure compliance with contracted work as established in the new three-year contract.

- Dedicated one Field Operations Branch Chief whose primary function is to oversee LAC performance.

- Hired a former L&C district manager as a retired annuitant to conduct ongoing oversight and monitoring of the Los Angeles County contract performance through onsite monitoring, statistical data analysis, and audit review of required federal and state survey workload, as well as, assessment of proper assignment of scope and severity, triaging, timeliness and completion of complaints and entity reported incident (ERI) investigations.

- Established the LA County Monitoring Unit (LACMU) and hired a HFE nurse supervisor with 2 HFEN nurse surveyors to conduct concurrent onsite quality review of the federal recertification survey process through a defined State Observation Survey Analysis (SOSA) process. [A SOSA survey is where one of DPH's trained HFENs observes an entire recertification survey to ensure proper survey protocols are used. The SOSA surveyor relays observations to LAC supervisors on areas needing improvement.]

- As of January 2016, conducted 11 SOSA surveys at selected skilled nursing facilities within the four LA District Offices and identified problems with the survey process involving sample selection, general investigation, and deficiency determination. The results from the SOSA surveys were shared with the LA County Health Facilities Inspection Division (HFID) managers and supervisors. CHCQ identified a need for additional training and developed a corrective action plan. CDPH and the federal Centers for Medicare and Medicaid Services will conduct a joint training in April 2016 to improve process and quality review outcomes.

- Conducted quality review and evaluation of complaints and ERI investigations by implementing quality improvement (QI) studies to review prioritization of complaints, investigative process, and principles of documentation.

- Developed and implemented a review tool, "Supervisor Worksheet for Complaint/ERI investigation by Surveyors," to document LAC supervisors review and discussion with survey staff of deficiency findings and citations.

- Conducted quality assurance audits on compliance with the abbreviated survey process, allegation prioritization, and standard level of review for principles of documentation for; intermediate care facilities, end stage renal disease facilities, and home health agencies.

- Conducted bi-monthly calls with individual LAC program managers to discuss work performance and enforcement actions.

- Conducted bi-monthly calls with the Health Facilities Inspection Division (HFID) branch chief, assistant branch chief and program managers to discuss ongoing operational issues and monitoring activities.

- Documented non-compliance with Licensing and Certification's policies and procedures, and requested a corrective action plan to address the problem and ensure compliance.

- Required LA County HFID supervisors and managers to participate in monthly District Administrators and District Managers (DA/DM) conference calls and required LAC managers to attend in-person, quarterly DA/DM meetings.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this program. It appears that L&C is making progress in hiring staff to meet the requirements of the 2015-16 budget and has taken steps to improve the state's oversight of the Los Angeles County contract.

As noted above, last year's budget included a one-time $1 million augmentation to the LTC Ombudsman Program using funds from the State Health Facilities Citation Account. This account still maintains a $7 million fund balance. The Legislature may want to consider providing another one-time augmentation to the LTC Ombudsman Program. As discussed last year, it is reasonable to assume that the ombudsman program's presence and advocacy on behalf of skilled nursing facility (SNF) residents improves quality of life for these residents and improves a SNF's compliance with state and federal laws.

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

1. Please provide a brief summary of the L&C estimate.

2. Please provide an update on L&C's efforts to hire and retain nurse surveyor staff.

3. Please provide an update on L&C's oversight of the Los Angeles County contract.

4. Please provide an update on L&C's status in regard to meeting the new complaint timeframe requirements that are effective July 1, 2016.

5. Please provide a summary of the findings from the report on using classifications other than HFENs to perform L&C workload.

Issue 7: L&C: Program Quality Improvement Projects

Budget Issue. DPH requests expenditure authority of $2 million from the Internal Departmental Quality Improvement Account to execute two contracts to implement program improvement recommendations. DPH will allocate $1.5 million to the redesign of the Centralized Applications Unit (CAU) IT systems, and $500,000 to the Health Facilities Consumer Information System (HFCIS) redesign.

DPH proposes to redesign the Central Applications Unit IT systems. This project would entail replacing substantially paper-based processes with information technology solutions that will allow recording and tracking of multi-level facility ownership structures, as well as on-line applications and reporting features. This redesign will also enable the center to be compliant with Affordable Care Act requirements, while also improving the quality and timeliness of services provided to facilities. Once complete, the redesign will enable the center to provide more accurate and timely information on facility ownership and compliance history. Further, the redesign will enable the Central Applications Unit to achieve greater staff efficiencies by fully centralizing all ownership tracking activities that currently take place in the Central Applications Unit, district offices, and Los Angeles County.

DPH also proposes to redesign the Health Facilities Consumer Information System. Established in 2008, the Health Facilities Consumer Information System provides consumers and patients access to information about the DPH's licensed long-term care facilities and hospitals throughout the state. The website provides profile information for each facility, as well as performance history including complaints, facility self-reported incidents, state enforcement actions, and deficiencies identified by Public Health staff; the system also allows consumers to submit complaints to Public Health electronically. According to DPH, the current system is outdated and not as user-friendly or accessible as many other public-facing consumer-centric websites.

Background. SB 541 (Alquist) Chapter 605, Statutes of 2008, established the Internal Departmental Quality Improvement Account. The account is funded by administrative penalties DPH imposes penalties against health facilities for violations that meet the definition of immediate jeopardy of death or serious harm to a patient. As of December, 2015, the Internal Departmental Quality Improvement Account fund balance is near $16 million.

In a June 20, 2012 letter, CMS required DPH to "conduct a comprehensive assessment of Public Health'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 Public Health's difficulty in meeting performance expectations." In response to CMS' concerns, L&C contracted with Hubbert System Consulting for an organizational assessment of its effectiveness and performance.

DPH received the contractor's final report in August 2014. The report contained 21 recommendations to "allow for meaningful, measurable improvements in the center's performance." DPH created a plan to implement the 21 recommendations, and is tracking the progress made toward fully implementing the recommendations.

In 2014-15, DPH received expenditure authority of $1.4 million from the Internal Departmental Quality Improvement Account and used these funds to hire consultants from The Results Group to conduct business process reengineering projects for its Central Applications Unit and Professional

Certification Branch. The center also contracted with a project manager and change consultant to facilitate and coordinate the multi-year implementation of the Hubbert Systems Consulting's 21 remediation recommendations.

In 2015-16, DPH received $2 million in expenditure authority from the Internal Departmental Quality improvement Account. DPH plans to spend $1.8 million of this appropriation to fund the following:

1. Contract with UC Davis to provide change and project management services to implement the Hubbert Systems Consulting recommendations. This contract provides two full-time consultants. This contract also provides for leadership development and change management training for CHCQ staff. CHCQ estimates spending approximately $500,000 in 2015-16 on this contract.

2. Purchase software to automate the processing of forms in the Centralized Applications Unit and the Professional Certification Branch. The cost of this purchase was $327,099.

3. CHCQ released a request of offer (RFO) in early December 2015 to evaluate and assist with CHCQ's retention and onboarding practices. The majority of responses to this solicitation were considered non-responsive. CHCQ re-released the RFO on February 4, 2016. CHCQ anticipates work starting on this contract by March 31, 2016. The estimated cost of this contract is $250,000, not all of which will be expended in 2015-16.

4. CHCQ released a RFO for recruitment services in December, 2015. CHCQ did not receive any bids for this project. The RFO was re-released on February 2, 2016. CHCQ anticipates work starting on this contract by March 31, 2016. The estimated cost of this contract is $250,000, not all of which will be expended in 2015-16.

5. CHCQ also completed work on a contract with UC Davis for work related to the Healthcare Associated Infections Program. The contract provided several infection prevention positions, and expired December 31, 2015. The total cost of this contract in 2015-16 is approximately $450,000.

6. CHCQ completed work on a contract with UC Davis to evaluate the adequacy of federal regulations in select facility types. The cost of this contract in 2015-16 is approximately $49,000.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

2. What have you learned from the current year contracts?

Issue 8: L&C: Timely Investigations of Caregivers

Budget Issue. DPH requests an additional $2.5 million in expenditure authority from the State Department of Public Health Licensing and Certification Program Fund to convert 18.0 existing two-year limited-term positions to permanent positions, and fund two additional positions for the Office of Legal Services, for a total of 20.0 positions to improve the timeliness of investigations of complaints against caregivers.

Background. DPH's Professional Certification Branch is responsible for the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensure of nursing home administrators. It is also responsible for the investigation of allegations involving health care professionals and the enforcement of disciplinary actions. There are over 200,000 active certified nurse assistant, home health aide, and certified hemodialysis technicians, and over 400,000 inactive applicants and certificate holders (hereinafter referred to collectively as caregivers). These caregivers provide approximately 80 percent of direct patient care activities for daily living in skilled nursing facilities licensed by Public Health, and may also provide direct care in residences through licensed home health agencies.

Federal and state laws require investigation of complaints against caregivers. DPH receives approximately 1,200 complaints annually alleging wrongdoing by caregivers, and as of December 31, 2015 had 160 open complaints from prior fiscal years and 538 from the current fiscal year, for a total of 698 open complaints. According to DPH, furloughs, vacancies, and outdated processes initially led to the number of open complaints in previous years. As a result of audits in 2013 and 2014 and internal and consultant-driven business process reviews, DPH has instituted a number of business process improvements. These improvements enabled staff to complete investigations of all pending complaints received prior to January 1, 2014, while continuing to assess and address current complaints based on severity.

According to DPH, despite the reduction in pending cases, it will be unable to keep current with the approximately 1,200 new cases received annually unless the 18.0 limited-term positions are made permanent. Augmenting the existing analysts with position and spending authority by converting the 18.0 two-year limited-term positions will allow DPH to improve the timeliness of complaint investigations from greater than one year to less than three months by fiscal year 2018-19.

Additionally, according to DPH, adding the two attorney positions to serve as the Professional Certification Branch's house counsel and litigation support will better represent DPH at administrative appeal hearings. DPH finds that the Professional Certification Branch needs dedicated house counsel and litigation support to prepare for and testify at these hearings and address the Administrative Law Judges' concerns about DPH's representation at these hearings.

One of the requested attorneys will provide litigation support at administrative appeal hearings. This attorney will provide legal expertise to the Professional Certification Branch in preparing pre-and post-hearing briefs, statements of issues, accusations, responses to discovery requests, and analyst and witness testimony for administrative appeal hearings. At some hearings, this attorney will appear and represent Public Health. The attorney will also provide on-going training to analysts regarding hearing protocol, legal grounds for objections, and introducing evidence. The second requested attorney will serve as the Professional Certification Branch house counsel. The house counsel will become familiar with the branch's work and issues. The house counsel will provide legal advice, review, and assistance

on disciplinary actions, regulations, policies and procedures, bill analyses, contracts, subpoenas, Public Records Act requests, and media responses. The house counsel will also assist the Professional Certification Branch in interpreting complex federal regulations related to requirements for professional staff in long-term care facilities (e.g., the federal registry and the national data bank for suspended and excluded providers). The house counsel will work closely with the administrative litigation attorney to provide consistent guidance to help ensure appealed disciplinary actions are upheld by the Administrative Law Judges.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

Issue 9: L&C: Licensing Fees

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

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

The fee rates are calculated as follows:

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

The department proposes to:

- Increase fees by up to 40 percent on those facilities that would have received an increase as a share of their percentage of the state's total workload.
- Keep fees at the 2015-16 level for those facilities that would have received a decrease as a share of their percentage of the state's total workload.

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

http://www.cdph.ca.gov/pubsforms/fiscalrep/Pages/LicenseFeeReports.aspx

Table: Proposed Health Facility License Fees

License Fees by Facility Type			
Facility Type	Fee Per Bed or Facility	2015-16 Fee	2016-17 Proposed Fee
Acute Psychiatric Hospitals	Bed	$ 319.90	$ 447.86
Adult Day Health Centers	Facility	$ 4,997.90	$ 6,241.53
Alternative Birthing Centers	Facility	$ 2,380.19	$ 2,380.19
Chemical Dependency Recovery Hospitals	Bed	$ 229.52	$ 321.33
Chronic Dialysis Clinics	Facility	$ 2,862.63	$ 3,407.02
Community Clinics	Facility	$ 862.03	$ 1,206.84
Congregate Living Health Facilities	Bed	$ 374.40	$ 524.16
Correctional Treatment Centers	Bed	$ 688.44	$ 963.82
District Hospitals Less Than 100 Beds	Bed	$ 319.90	$ 447.86
General Acute Care Hospitals	Bed	$ 319.90	$ 447.86
Home Health Agencies	Facility	$ 2,761.90	$ 2,761.90
Hospices (2-Year License Total)	Facility	$ 2,970.86	$ 2,970.86
Hospice Facilities	Bed	$ 374.40	$ 524.16
Intermediate Care Facilities (ICF)	Bed	$ 374.40	$ 524.16
ICF - Developmentally Disabled (DD)	Bed	$ 696.48	$ 975.07
ICF - DD Habilitative	Bed	$ 696.48	$ 975.07
ICF - DD Nursing	Bed	$ 696.48	$ 975.07
Pediatric Day Health/Respite Care	Bed	$ 180.49	$ 252.69
Psychology Clinics	Facility	$ 1,771.99	$ 2,480.79
Referral Agencies	Facility	$ 2,795.53	$ 3,728.78
Rehab Clinics	Facility	$ 311.22	$ 435.71
Skilled Nursing Facilities *	Bed	$ 377.77	$ 527.51
Surgical Clinics	Facility	$ 2,984.40	$ 4,178.16
Special Hospitals	Bed	$ 319.90	$ 447.86

Data Source: 2016-17 Licensing Fees Chart

* Fee includes the basic licensing fee plus an additional $3.35 in support of the Long Term Care Ombudsman Program.

The Center calculates state workload percentages for each workload activity by facility type. Workload activities include state licensing, federal certification, and initial state and federal certification, follow-up/revisits, complaints, and investigations. The following data are used to develop the workload percentages for each activity within each facility type:

- The number of open and active facility counts (licensure and federal certification workload survey activities only);
- The annualized workload frequency for each workload activity as mandated by either state or federal requirements;

- The standard average hours obtained from the Time Entry and Activity Management (TEAM) data. These data reflect the three-year average of hours required to complete each workload activity.
- The state funding percentage. This is the percentage charged to the L&C special fund based on the specific workload activity.

The specific workload for each facility can be found in the fee report cited above.

Subcommittee Staff Comment and Recommendation—Hold Open. No issues or concerns have been raised to subcommittee staff regarding these fee increases. It is recommended to hold this item open as discussions continue on the L&C program.

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

1. Please provide an overview of the changes in health facility fees.

Issue 10: Proposition 99 – California Tobacco Health Protection Act of 1988

Budget Issue. The Governor's budget projects $244.6 million in net revenue from Proposition 99 for 2016-17 and the following increases to various Proposition 99 accounts as a result of updated Proposition 99 revenue projections:

1. **Health Education**. An increase of $4,194,000 in the Proposition 99 Health Education Account. This includes a proposed increase of $200,000 for state operations, $1,916,000 for the media campaign, $250,000 for competitive grants, $410,000 for evaluation of, and an increase for local lead agencies of $1,418,000. The funds will be used for statewide and community education and media efforts aimed at preventing and reducing tobacco use, and to conduct surveillance and evaluation that assess the impact of the California Tobacco Control Program.

2. **Research Account.** An increase of $970,000 in Proposition 99 Research Account for state operations. This includes an $873,000 increase to Chronic Disease Surveillance and Research Branch and a $97,000 increase to the Environmental Health Investigations Branch. The funds will be used to continue improving cancer data production and quality assurance through automation, and conducting community-based research activities related to exposure and health effects from electronic cigarettes.

3. **Unallocated Account.** An increase of $822,000 in Proposition 99 Unallocated Account for state operations in the Environmental Health Investigations Branch. The funds will be used for advancing current plans for health equity and environmental justice projects and conducting asthma research and education.

Background. In November 1988, California voters approved the California Tobacco Health Protection Act of 1988, also known as Proposition 99. This initiative increased the state cigarette tax by 25 cents per pack and added an equivalent amount on other tobacco products. The new revenues were earmarked for programs to reduce smoking, to provide health care services to indigent persons, to support tobacco-related research, and to fund resource programs for the environment. The money is deposited by using the following formula: 20 percent is deposited in the Health Education Account (HEA); 35 percent in the Hospital Services Account; 10 percent in the Physician Services Account; five percent in the Research Account; five percent in the Public Resources Account; and 25 percent in the Unallocated Account (Revenue and Taxation Code 30124).

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

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

1. Please provide a brief review of this proposal.

Issue 11: Active Transportation Safety Program

Budget Issue. DPH requests $733,000 in reimbursement expenditure authority and an increase of 4.5 positions to implement the Active Transportation Safety Program with funds provided through an Interagency Agreement with the California Department of Transportation (Caltrans).

Background. The Active Transportation Program was created within Caltrans and funded by SB 99 (Committee on Budget and Fiscal Review), Chapter 359, Statutes of 2013, and AB 101 (Committee on Budget), Chapter 354, Statutes of 2013. It consolidated existing federal and state transportation programs, including the Transportation Alternatives Program, Bicycle Transportation Account, and State Safe Routes to School, into a single program with a focus to make California a national leader in active transportation. Caltrans has executed an interagency agreement with DPH's Safe and Active Communities Branch to be a part of the new program.

Since 2007, Caltrans had contracted with the University of California, San Francisco to operate a Safe Routes to School Technical Assistance Resource Center at a cost of approximately $700,000 annually. This amount supported five positions to provide trainings, technical assistance, and resources to local communities to help them develop and implement Safe Routes to School non-infrastructure programs throughout California. The Technical Assistance Resource Center was housed with, and overseen by, staff from the Safe and Active Communities Branch, who provided in-kind support for nearly eight years, with no contract or funding from Caltrans. The prior contract between Caltrans and University of California, San Francisco was operating on a no-cost extension and originally expired on September 30, 2015. Caltrans has sought to partner with the Safe and Active Communities Branch to be a major component in their new Active Transportation Program. The University of California, San Francisco staff have been involved in discussions about the transition of the contract between Caltrans and University of California, San Francisco to DPH, and have expressed no objections. Most of University of California, San Francisco's staff that have been providing these services to Caltrans are on the exam lists and are eligible and encouraged to apply for the newly established DPH positions.

Specific goals of the Active Transportation Program include reducing pedestrian and bicycle injuries and fatalities, reducing greenhouse gas emissions, improving air quality, increasing safe, physical activity among youth, and improving equity for disadvantaged communities.

According to DPH, Caltrans is committed to continuing technical support services provided by DPH to increase public health expertise in the implementation of its Active Transportation Program to ensure public health-related goals are met. Caltrans will transfer funding to DPH through an interagency agreement in the amount of $733,000 for the period July 1, 2016 to June 30, 2017, with annual renewal contingent upon budget reauthorization for the Active Transportation Program.

According to DPH, many of the statutorily required goals of Caltrans' Active Transportation Program have a direct connection and benefit to public health, including: increasing safety for non-motorized users; increasing mobility for non-motorized users; advancing the efforts of regional agencies to achieve greenhouse gas reduction goals (through reduction in vehicle miles traveled); enhancing public health, including the reduction of childhood obesity by increasing walking and bicycling to school through Safe Routes to School Programs; ensuring that disadvantaged communities fully share in program benefits (25% of program), and providing a broad spectrum of projects to benefit many types of active transportation users.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

Issue 12: Protecting Children from the Effects of Lead Exposure

Budget Issue. DPH requests an increase of $8.2 million annually ($1.4 million in state operations and $6.8 million in local assistance) for four years from the Childhood Lead Poisoning Prevention Special Fund and to establish seven positions to extend services to children who have been exposed to lead as now defined by a lower blood lead level by the Centers for Disease Control and Prevention (CDC).

Background California established a Childhood Lead Poisoning Prevention (CLPP) Program to prevent childhood lead exposure, set standards for testing children for blood lead, monitor laboratory reported blood lead test results, educate and counsel families about lead, provide public health nursing and environmental home inspections and follow-up services to children identified with the highest blood lead levels, and identify sources of lead exposure and seeing that they are corrected. The CLPP Program has been successful in reducing the number of children exposed to high levels of lead; however, direct case services could be expanded to a larger child population with lower lead exposure levels.

Direct services to children are provided by 43 local CLPP programs in 40 counties and three cities which contract with the CLPPB for funding. The state is responsible for services in the remaining 18 counties. Funding is provided to these local programs by CLPPB contract criteria based on their: population of high-risk, young, low-income children; number of children with evidence of increased lead exposure on blood testing; and the proportion of children living in older housing (often associated with lead exposure).

All blood lead tests are required to be reported to the CLPPB. Approximately 700,000 tests are reported each year by over 300 laboratories and processed by CLPPB to assure receipt of accurate and complete information, including identification and location of children who have increased blood lead levels needing services. Test results are stored in the CLPPB web-based data system and are viewable by local health jurisdictions. In 2012, approximately 650,000 individual children up to age 21 were blood lead tested in California (some children are tested more than once); about 600,000 were under age six.

Children with the highest blood lead levels ($\geq$ 20 micrograms per deciliter (mcg/dL) or persistent values of $\geq$15 mcg/dL) are currently deemed "cases" of lead poisoning requiring follow-up case management. Approximately 200 new children are identified as cases of lead poisoning each year.

Alerts are sent by the CLPPB data system to initiate interventions by public health nurses and environmental professionals to reduce lead exposure in these children. The nurses and environmental professionals make home visits to educate the family about reducing lead exposure and to carry out inspections to detect sources of lead. The children receive special health care referrals as needed and ongoing collaboration occurs with their health care providers. They receive follow-up treatment for two to three years to ensure that blood lead levels decline and remain low.

The CLPP Program has been successful in reducing the number of children exposed to high levels of lead. The annual number of children identified as cases of lead poisoning has decreased fivefold since the program began in the early 1990s and the percent of tested children identified with increased blood lead levels ($\geq$ 10 mcg/dL) has decreased more than twofold since complete laboratory reports of these blood lead levels became available in 2007.

The CDC recommends that an even lower blood lead level (≥5 mcg/dL) be used to define need for services for, and follow-up of, lead-exposed children. Most lead-exposed children with blood lead levels not high enough to be "cases," do not currently receive extensive services. They may receive some educational or home inspection services to decrease lead exposure, as resources allow. Approximately 12,500 children in 2012 were identified with blood lead levels that would not currently qualify them as lead poisoning cases, but are levels that are now known to be harmful. Numbers vary by year but only 4,200 to 6,400 of such children receive any services each year.

CLPPB is proposing to lower the blood lead levels defining a "case" of poisoning from a single blood lead ≥ 20 mcg/dL to ≥ 15 mcg/dL and changing the persistent values of ≥ 15 mcg/dL to ≥ 10 mcg/dL. The current, higher blood lead criteria being used to define a child as case of lead poisoning is based on the blood lead level delineated for these interventions by CDC in the 1990s and early 2000s. In 2004, the CDC described the need for case management services for blood lead levels of ≥ 10 mcg/dL because lower lead levels are associated with developmental delays, permanent loss of IQ, and behavioral disorders in infants and young children.

CLPPB is proposing to also implement the new CDC recommendations for monitoring and providing outreach, education, and basic services to all children identified with blood lead values ≥ 5 mcg/dL. The CDC in 2012 recommended that a lower reference blood lead level of 5 mcg/dL be used to define the need for services to see that additional lead exposure is prevented and follow up is provided to ensure that blood lead levels decline. This recommendation for providing services at lower levels has also been promoted by the American Academy of Pediatrics since 2013. With this proposal, children with blood lead levels lesser than or equal to 5 mcg/dL would not receive full case management services, but would receive follow-up services to reduce lead exposure, including family contact and educational outreach, and collaboration with the health care provider.

Services Currently Provided and Those Proposed

Blood Lead Level, in mcg/dL	Effects of Lead Exposure	Current Services Provided	Proposed Services
Single value ≥ 20 or Persistent values ≥15 to <20, at least a month apart.	Neurotoxin, includes all the effects at lower levels. Can also cause anemia, abdominal pain, kidney disease, cardiovascular disease, and at very high levels can cause seizures, coma, and fatalities.	Meets current definition of state case of lead poisoning. Full services required. This includes public health nursing home visits and environmental inspections, family education on sources of lead exposure, identification of sources exposing child, removal of these sources, correction of environment, coordination with health care provider, health referrals as needed, and follow-up until blood lead level declines.	Will continue to meet definition of state case of lead poisoning. Full services required. Services provided will be the same as for currently defined cases.
Single value ≥ 15, or persistent values of ≥ 10 to < 15, at least a month apart.	Neurotoxin, life-long health affects including: reduced IQ, behavioral disorders, decreased academic achievements. May also affect cardiovascular, immunologic, and endocrine systems.	No services currently required. As available resources in each jurisdiction allow, these children may receive some services, ranging from educational materials for the family, to contact with the health care provider, to home visits and inspections. Some children in this category are receiving contact and have blood lead monitored; limited numbers receive visits and inspections.	Will meet new definition of state case of lead poisoning. Full services, as are currently provided to cases, will be required.
Single value ≥ 5 to < 10.	Neurotoxin, life-long health affects including: reduced IQ, behavioral disorders, and decreased academic achievement.	No services currently required. As available resources allow, these children may receive some services, ranging from educational materials for the family, to contact with the health care provider, to home visits and inspections. Most children in this category are not receiving any services.	Full services will not be required but all children will receive some contact and educational outreach, collaboration with their health care providers, and monitoring to be sure blood lead values decline and do not increase further. As resources allow and trends in the child's lead level dictates, home visits and inspections will be provided.
Value <5.	No known safe level according to Centers for Disease Control and Prevention.	No services currently required. All children receive anticipatory guidance on the adverse effects of lead at well child visits and through statewide outreach and education.	No services required. All children receive anticipatory guidance on the adverse effects of lead at well child visits and through statewide outreach and education.

With the large increase in the number of children to receive services and be monitored to assure reduction in blood lead levels, DPH is requesting $900,000 annually from the Childhood Lead Prevention Special Fund to support seven positions for four years. The positions include: 1.0 Nurse Consultant III (Specialist); 1.0 Nurse Consultant II; and 2.0 Environmental Scientist positions that are needed to carry out direct case management and lead inspections and for statewide technical assistance and oversight of the increased statewide workload; 1.0 Associate Governmental Program Analyst position to perform blood lead test verification and monitor subsequent blood lead levels; 1.0 Research Scientist I position for data analysis and identification of populations needing services for blood lead values ≥ 5 mcg/dL; and 1.0 Associate Governmental Program Analyst position for oversight of expanded local contracts that cover the new workload.

CLPPB is also requesting $500,000 annually for four years beginning in 2016-17 in Information Technology services to modify and update its blood lead reporting, surveillance and case management system through an external contract or augmented reimbursement to DPH Information Technology Services Division, as available expertise dictates. The web-based, data system receives blood lead test results from laboratories, is viewable by the state and local jurisdictions, and is used to track blood lead tests and manage lead-exposed children. The changes will accommodate: 1) case management alerting functions at the lower case definition; 2) tracking of activities conducted for lower blood lead levels; increased data analysis and reporting; and, 3) improved identification and mapping of areas and populations at risk for lead exposure. It will allow for documentation of the services provided. Archiving of older blood lead values and case information will also be performed to increase data system efficiency.

The additional workload in the local jurisdictions is projected to involve public health nurses, environmental staff, and their support staff. The $6,800,000 for local assistance is projected for the increased work, using current case management and professional personnel allocations.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on the interaction with this proposal and the Medi-Cal program. According to the Administration, the Department of Health Care Services does not intend to submit a State Plan Amendment to reflect these changes for the Medi-Cal program. If the Medi-Cal program was updated to be consistent with this proposal, the state could draw down federal funds for these purposes.

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

1. Please provide an overview of this proposal.

2. How many more children to you expect to serve under this proposal?

Issue 13: California Environmental Contaminant Biomonitoring Program

Budget Issue. DPH requests two permanent positions and $350,000 from the Toxic Substances Control Account for two years. The positions were established as limited-term positions and are set to expire on June 30, 2016.

Background. Biomonitoring California was established through SB 1379 (Perata) Chapter 599, Statutes of 2006. The program is a collaborative effort involving DPH as the designated lead, the Office of Environmental Health Hazard Assessment (OEHHA), and the Department of Toxic Substances Control (DTSC). It receives technical advice and peer review from a Scientific Guidance Panel and input from the public.

Biomonitoring California's principal mandates are to: (1) measure and report levels of specific environmental chemicals in blood and urine samples from a representative sample of Californians, (2) conduct community-based biomonitoring studies, and (3) help assess the effectiveness of public health and environmental programs in reducing chemical exposures. Biomonitoring provides unique information on the extent to which people are exposed to a variety of environmental chemicals and on how such exposures may be influenced by factors such as age, gender, ethnicity, diet, occupation, residential location, and use of specific consumer products. This information is essential to inform policy decisions in public health and environmental protection (e.g., the reformulation and enhanced safety of consumer products under the Safer Consumer Product Regulations implemented by DTSC).

Biomonitoring California is funded through five special funds including the Toxic Substances Control Account (TSCA), the Air Pollution Control Fund (APCF), the Department of Pesticide Registration Fund (DPRF), the Childhood Lead Poisoning Prevention Fund (CLPPF), and the Birth Defects Monitoring Fund (BDMF). DPH has eight permanent staff positions for Biomonitoring California and eight limited-term positions created in 2014-15 (two positions ending on June 30, 2016) and 2015-16 (six positions ending on June 30, 2017).

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

Issue 14: Medical Marijuana (AB 243, AB 266, and SB 643 of 2015)

Budget Issue. DPH requests 37 positions and $12 million in funding from the Medical Marijuana Regulation and Safety Act Fund to be phased in between fiscal years 2015-16 to 2018-19 to begin the implementation of the mandated provisions specified in AB 266 (Bonta), Chapter 689, Statutes of 2015, AB 243 (Wood), Chapter 688, Statutes of 2015, and SB 643 (McGuire), Chapter 719, Statutes of 2015. DPH requests to phase-in these positions, as follows: six positions and $457,000 in reimbursement authority for 2015-16; eight additional positions and $3,438,000 in 2016-17; two additional positions and $2,520,000 in 2017-18; and the final 21.0 additional positions and $5,658,000 in 2018-19.

This request includes:

- A one-time appropriation to purchase laboratory equipment that will be needed during the development of testing methodologies and regulations. Total cost will be $1,180,000.
- On-going annual funding for reagents and consumables that will be utilized during the methodology development and on-going testing. Total cost will be $22,000 per year.
- A one-time appropriation of $270,000 for the purchase of vehicles for the Investigators/Environmental Scientists.
- On-going annual funds of $15,000 for vehicle maintenance and safety equipment.
- On-going annual funds of $30,000 annually for product sampling for enforcement purposes.
- On-going annual funds of $60,000 for equipment maintenance contracts.
- A one-time appropriation of $36,000 for Peace Officer Standards Training (POST) in 2018-19.
- On-going annual funds of $2,400 for on-going annual POST annual training.

This budget change proposal requests position authority and funding to develop regulations and standards for medical cannabis product manufacturers and testing laboratories. Once regulations have been developed, the department will move forward with the licensing of cannabis manufacturers, licensing and registration of testing laboratories and enforcement provisions. Implementation of these bills will be phased in over approximately three years.

Background. In 1996, voters approved the Compassionate Use Act (CUA), which allows patients and primary caregivers to obtain and use medical marijuana, as recommended by a physician, and prohibits physicians from being punished or denied any right or privilege for making a medical marijuana recommendation to a patient. In 2003, SB 420 (Vasconcellos), Chapter 875, Statutes of 2003, established the Medical Marijuana Program (MMP), which allows patients and primary caregivers to collectively and cooperatively cultivate medical marijuana. It also established a medical marijuana card program for patients to use on a voluntary basis.

Passed in 2015, AB 266 established the Medical Marijuana Regulation and Safety Act (Act) for the licensure and regulation of medical marijuana. Also passed in 2015, AB 243 and SB 643, in conjunction with AB 266, established the regulatory framework to regulate the cultivation, sale, testing, manufacturing and transportation of medical cannabis in California. AB 243 requires the licensing authorities to establish a scale of application, licensing, and renewal fees, based upon the cost of enforcement. All fees collected are to be deposited into the new Medical Marijuana Regulation and Safety Act Fund. In order to begin implementation of the bills, AB 243 authorized the Director of Finance to provide an initial operating loan from the General Fund or a Special Fund of up to $10 million and appropriates that money to the California Department of Consumer Affairs.

The departments impacted by these bills are the California Department of Consumer Affairs (DCA), the California State Board of Equalization (BOE), the California Department of Food and Agriculture (CDFA), the California Department of Industrial Relations (DIR), the California Department of Pesticide Regulations (DPR), State Water Resources Control Board (SWRCB), and the Department of Public Health (DPH). The administration of the Medical Marijuana Regulation and Safety Act will include the following roles:

- **Department of Consumer Affairs** will establish the Bureau of Medical Marijuana Regulation to administer, enforce, create, issue, renew, discipline, suspend, and or revoke licenses for the transportation, storage unrelated to manufacturing activities, and sale of medical marijuana within the state. The Bureau will issue licenses to distributors, transporters, and dispensaries.

- **California Department of Public Health** is required to adopt and enforce regulations for the licensing structure for cannabis manufacturers and the licensing and registration of testing laboratories which will require the establishment of new program staff within DPH. DPH is also required to develop standards for the production and labeling of all edible medical cannabis products and will work with CDFA on the development of a database that will be used to store and share relevant information on licensees and the tracking and tracing of regulated commodities.

- **California Department of Food and Agriculture** is required to create, issue, and suspend or revoke cultivation licenses. CDFA is required to promulgate regulations governing the licensing of indoor and outdoor cultivation sites, develop standards for the use of pesticides in cultivation, and maximum tolerances for pesticides and other foreign object residue in harvested cannabis and create an electronic database containing the electronic shipping manifests. Not later than January 1, 2020, CDFA, in conjunction with the Bureau, is required to make available a certified organic designation and organic certification program for medical marijuana. In consultation with the Board of Equalization, CDFA is required to adopt a system for reporting the movement of commercial cannabis and cannabis products.

- **Department of Pesticide Regulations** is required to provide guidance, in absence of federal guidance, on whether the pesticides currently used at most cannabis cultivation sites are actually safe for use on cannabis intended for human consumption. DPR, in consultation with CDFA, is required to develop standards for the use of pesticides in cultivation, and maximum tolerances for pesticides and other foreign object residue in harvested cannabis. DPR, in consultation with the SWRCB, is required to promulgate regulations that require that the application of pesticides or other pest control in connection with the indoor or outdoor cultivation of medical cannabis meets standards.

The act requires a distributor to ensure that a random sample of the medical cannabis or medical cannabis product is tested prior to distribution. Since this industry is currently unregulated, the number of dispensaries, manufacturers, growers, and potential testing laboratories is unknown. There are varying numbers of estimated medical marijuana dispensaries from different published websites ranging anywhere from 500 to 4,000. Based on the number of dispensaries and the potential demand for testing, DPH estimates that the number of testing laboratories that will seek licensure and registration in California could be approximately 100 testing laboratories. According to DPH, the 100 testing laboratories is a conservative estimate based on the number of certified laboratories in Colorado. California is a much larger state and has approximately seven times the population of Colorado. As of 2014, Colorado began requiring testing for retail marijuana and retail marijuana products prior to their sale. There are currently 17 licensed testing laboratories in Colorado, with an additional 23 licensed testing facilities that have received certification for other residual solvents testing. At this time, licensed medical marijuana businesses in Colorado can voluntarily test their products at licensed and certified marijuana testing facilities but such testing is not mandatory. The demand for licensed testing laboratories is expected to be higher in California to meet the expected testing requirements outlined in the act.

DPH will establish the Office of Medical Cannabis Licensing in order to implement the mandates of the new Medical Marijuana Regulation and Safety Act. DPH will implement the provisions of the new act over three phases. The office will provide overall policy guidance and oversight to ensure that the act is implemented in accordance with the statutory requirements. The office will be responsible for the development of the statewide standards, regulations, licensing procedures, and policy issues to license medical cannabis manufacturers and register and license testing laboratories in order to regulate the testing and manufacturing of medical cannabis and medical cannabis products in California. Staff will meet with DCA, BOE, DPR, CDFA, the California Health and Human Services Agency, and the Governor's Office to ensure coordination of regulations, licensing, and enforcement activities. The expectation in the act is that licenses will be issued beginning January 1, 2018. The act places protection of the public as the highest priority in the licensing, regulatory and disciplinary functions of the act.

The legislation authorizes the bureau to establish an advisory committee to advise the licensing authorities on the development of standards and regulations pursuant to the act, including best practices and guidelines to ensure qualified patients have adequate access to medical cannabis and medical cannabis products. DPH expects to be part of the advisory committee and this participation will require staff time. DPH expects that on average that there will be meetings scheduled for all licensing authorities on a monthly basis. Staff from the office will attend these meetings and will be required to prepare, document and distribute information to staff upon their return from these meetings. Beginning March 1, 2023 and on or before March 1 of each following year, DPH shall prepare and submit to the Legislature an annual report on the department's activities and post the report on its internet web site.

Office of Medical Cannabis Licensing. In Phase I, starting in 2015-16 DPH will hire the Office of Medical Cannabis Licensing Chief and the Research Scientist Supervisor II to plan, manage and direct all staff within the Medical Cannabis Manufacturing and Testing programs. DPH will also hire an attorney to provide guidance to the programs in the interpretation of the Act, and the development of the regulations.

In 2016-17, the Office of Medical Cannabis Licensing will hire the Staff Services Manager II (SSM II) to oversee the development of licensing procedures, cost methodologies, and program expenditures.

In 2016-17 a Staff Programmer Analyst will support the DPH's interface with CDFA and BOE as they adopt a system for reporting the movement of commercial cannabis and cannabis products throughout the distribution chain. Additionally, CDFA will create an electronic database containing the electronic shipping manifests. The database will be designed to flag irregularities for all licensing authorities to investigate. All licensing authorities may access the database and share information related to licensees, including social security and individual taxpayer identifications.

In Phase II (2017-18) an Associate Governmental Program Analyst (AGPA) will be hired to provide support for the Office with the regulatory public comment process, and overall development of the administrative aspects. In Phase III (FY 2018-19), an Executive Secretary will be added to provide the Office Chief and SSM II with administrative support once licensing and full program activities commence.

Testing Laboratories. The Act identifies 12 different licensing classifications dependent upon the type of medical cannabis business. Those include cultivation, manufacturing, testing, dispensary, distribution and transportation. DPH is responsible for manufacturing and testing licenses.

DPH is required to issue a Type 8 "testing" license classification to a testing laboratory. To accomplish this, the department will promulgate regulations governing the registration and licensing of testing laboratories. The testing laboratories will be required to register with the department and to renew that registration on an annual basis requiring that the department develop a process for laboratory registration. In order to develop the regulations and standards, DPH will develop standard methods, sampling procedures and validate testing methodologies. The standard method development will include testing requirements for medical cannabis, which includes testing for identifications of potential contaminants.

Phase I (2016-17) and Phase II (2017-18). In order to implement a registration and licensing program for testing laboratories and all testing requirements, DPH will begin by developing regulations and standards to address contaminant levels for the following areas: residual solvent or processing chemicals; pesticide residues; foreign material, such as: hair, insects or related adulterant; microbiological impurity; fungal toxins; heavy metals; whether the batch is within specification for odor and appearance; and volatile organic compounds. The regulation development for testing laboratories in Phases I and II will require a total of 5.0 Research Scientists in both chemical and microbiological capacities, and 1.0 AGPA will support scientific staff to purchase equipment, assist with the development of regulations, and coordinate contracts and maintenance for equipment and to assist with hiring and other administrative duties. This AGPA position will also be critical in assisting in the development of the licensing fees. DPH will conduct the following activities:

- Develop medical cannabis testing standards and methodologies for both chemical and microbiological contaminants.

- Develop requirements for standards for testing laboratories, personnel requirements, quality assurance and maintenance of records.

- Conduct scientific research of complex studies related to the safety of marijuana products and survey of other state's regulations and requirements. DPH will be required to perform research regarding any current existing analytical methodologies and also consult with other states that already have developed these standards and come up with similar protocols.

- Validate testing methodologies.

- Develop lists for required testing for drug potency, chemical contaminants, and microbiological contaminants.

- Develop a process for laboratory licensing and registration that will specify what requirements need to be met by testing laboratories for licensure and registration. For testing laboratories there are several requirements in the act that have to be met, including that the laboratory is accredited through International Standards Organization (ISO) standards.

- Develop methodologies for setting licensing fees.

- Develop procedures and regulations to enforce its duties under the act, to take disciplinary actions and suspend or revoke licenses of testing laboratories after an investigation and hearing.

- Develop registration and licensing procedures.

- Purchase of laboratory equipment. Equipment purchase will take place in 2016-17 as it can take up to six months to obtain equipment, set up and install, and train staff on how to utilize the equipment.

Phase III (2018-19 and on-going). Upon development and adoption of the regulations and standards, DPH expects to begin registering and licensing testing laboratories and also begin its supporting role as a reference laboratory for the medical cannabis manufacturing enforcement capabilities. This will require 1.0 Office Technician and an additional 4.0 Research Scientists to assist with performance of analysis testing of samples submitted by the medical cannabis manufacturing program during performance of enforcement responsibilities. Support will be needed to provide for ongoing testing capabilities including chain of custody documentation, oversight of samples received, sample preparation, analysis, data interpretation, and report writing providing details of the outcomes of the analysis.

The annual licensing and registration of testing laboratories will begin in 2018 and require that the Research Scientists review applications for personnel qualifications, quality assurance, and maintenance of records in accordance with the regulations and standards. The Research Scientists will also conduct inspections of testing laboratories with a schedule to be established in regulations, and work on any potential hearings actions related to the suspension or revocation of licenses, investigations and preparation for any potential hearings.

The establishment of methodologies and research for medical marijuana are new and will continue to evolve. The Research Scientists from Phase I and II in chemical and microbiological capacities will continue to perform permanent ongoing research and updates for testing methodologies and for updates to the standards of procedures and testing. Staff will prepare laboratory analysis reports including scientific research reports needed for the validation of testing of different contaminants.

Licensing of Manufacturers. AB 266 requires the department to adopt regulations for the licensing structure for cannabis manufacturers in order to regulate the manufacturing of medical cannabis in California. This requires that the department establish regulations, standards, and procedures for licensing medical cannabis manufactures. Licenses will be required to obtain a license and renew it on an annual basis. DPH will also be required to consult with CDFA on the development of a data system that will be used to store and share relevant information on licensees and the tracking and tracing of regulated commodities.

Phase I (starting in 2015-16) and Phase II (2017-18). In order to implement a licensing program for manufacturing of medical cannabis products, DPH will develop regulations and standards. The regulation development in Phases I will require a Staff Toxicologist, a Food and Drug Program Specialist and an AGPA. In Phase II, an additional AGPA will be phased in to begin the development of licensing desk procedures, development of applications and/or forms, create tracking records, metric development for licensing and enforcement activities, maintaining documentation, and providing analytical support.

Regulations, standards, and procedures will be developed for:

- Licensing of level 1 manufacturers (Type 6 license) which includes licensing of cannabis manufacturers sites that utilize nonvolatile solvents.
- Licensing of level 2 manufacturers (Type 7 license) for sites that utilize volatile solvents.
- Standards for the production and labeling of all edible medical cannabis products.
- Extraction and infusion methods.
- Inventory procedures.
- Transportation process.
- Quality control procedures.
- Inspection, sanitation and health and safety standards.
- Enforcement, disciplinary action, and suspension or revocation of licenses.
- Advertising, labeling, inspection process and sampling.
- Determining adulteration and misbranding are also needed for a comprehensive program to ensure safety for the public regarding this new commodity.
- Warnings about allergens.
- Source of date of cultivation and manufacture.
- Unique identifier information issued by CDFA.

Phase III (2018-19 and on-going). After the regulations have been developed, DPH will begin licensing the medical cannabis manufacturers and commence enforcement activities. A third AGPA and an Office Technician will be phased in to assist in budgeting, and other administrative duties (purchasing, developing and monitoring contracts, human resources, accounting, budgeting) and all other analytical administrative support. The 2 AGPAs from Phase I and II will oversee the licensing desk which will include processing incoming requests for customer support regarding the licensure process, process license paperwork and payments, track licensees, verify and validate licensees, and conduct associated administrative work.

An Environmental Program Manager (EPM) I and 2.0 unit supervisors will be hired to oversee field staff. The EPM I will supervise and direct the investigation and inspection of enforcement staff, coordination of the collection, and submission of samples for testing. DPH will need 10.0 Investigators/Environmental Scientists that will conduct the investigations and inspections of manufacturers and persons engaged in the manufacturing, storage, distribution, sale and advertising of medical cannabis products throughout the state. The investigations will include detailed and comprehensive physical inspections of buildings, as well as the inspection and thorough review of manufacturing processes, operating procedures, and records. Inspections include gathering of facts and samples, assessing compliance, issuing notices of violations, discussing observations and corrective actions with firm management; preparing in-depth inspection or investigational reports; and making recommendations regarding corrective action and appropriate disposition of cases based on adequacy of evidence or procedures.

There are varying numbers of estimated medical marijuana dispensaries from different published websites ranging anywhere from 500 to 4,000. Based on information from the Sunrise Questionnaire and the Emerald Growers Association, there are an estimated 40,000 cultivation sites throughout California. According to www.weedmaps.com, there are over 4,000 medical marijuana dispensaries operating within California. The act allows for cultivators (small) and dispensaries to also hold a manufacturing license. It is unknown at this time how many cultivators and dispensaries will request a license as a manufacturer. However, the department estimates that approximately 1,000 manufacturers will need to be licensed. The estimate of 1,000 manufacturers is also based on the 194 licensed manufacturers that Colorado currently has for an industry that is presumably much smaller than California's will be.

LAO Findings. The LAO generally finds that DPH is funding initial startup activities as required. However it identifies the following as issues for legislative consideration:

- ***Implementation Will Require Substantial Amount of Cross-Agency Coordination.*** The administration appears to be prioritizing communication and alignment of various efforts, but numerous activities will need to be coordinated across multiple departments. For example, at least three departments—CDFA, DPH, and DCA—will have to coordinate to develop regulations, licensing fee structures, and an IT system to track medical marijuana production from cultivation through distribution and sale.

- ***Implementation Will Require Substantial Amount of Coordination With Locals.*** The administration plans to actively engage with local governments, but aligning state and local policies and efforts will require ongoing communication and coordination. For example, DFW wardens will need to coordinate with local law enforcement and prosecutors to ensure investigations of cultivation sites are conducted safely, legally, and effectively.

- ***Ongoing Regulatory Costs Still Unclear.*** Amount of workload departments ultimately will experience depends on many unknown factors, including the eventual size of the regulated medical marijuana industry, the number of authorized dispensaries, and the scale of environmental impacts. Follow-up proposals are expected in the coming years, including for what could be a significant new IT project.

- ***Timely Implementation May Be a Challenge.*** Given scope of new responsibilities, departments may have difficulty promulgating regulations, developing fee structures, and crafting new policies and guidelines.

- ***Other Factors Could Change Landscape.*** The potential exists for factors outside of the Legislature's control to alter current plans for implementing these laws. For example, potential voter expansion of legalized marijuana use could change the regulatory role of the state, perhaps requiring additional resources or modified regulations. Alternatively, a change in federal drug policy could complicate the state's approach to overseeing medical marijuana production and use.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further review of this proposal. Additionally, the following should be considered:

- **Timely Regulation Development Likely Difficult.** DPH anticipates completing regulations by January 2018 (the statutory deadline), which is less than two years from now. DPH indicates that it has already begun its research, is consulting with other states that have implemented similar standards, and plans to hire an attorney who will be dedicated to working on the medical cannabis regulations. Despite these efforts, it is unclear how DPH will meet this deadline, not only because of DPH's past difficulties in promulgating regulations in a timely manner but also because this is a new industry for the department.

- **Opportunity to Create Public Health Surveillance System.** Given this crucial moment in the establishment of a regulatory framework to regulate the cultivation, sale, testing, manufacturing and transportation of medical cannabis in California, it is critical to consider what type of public health surveillance system is necessary to assure quality of the regulatory system. The Legislature may wish to consider working with DPH to establish a public health surveillance system (e.g., tracking of emergency room visits related to the use of medical marijuana) as part of implementation of this proposal.

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

1. Please provide an overview of this issue.

2. Please discuss what steps DPH is taking to ensure timely development of regulations.

3. Has DPH considered what type of public health surveillance system should be developed in conjunction with the implementation of these bills?

Issue 15: End of Life Option Act (AB 15 X2, 2015)

Budget Issue. DPH requests $323,000 from the Health Statistics Special Fund in 2016-17, $245,000 in 2017-18 and annually thereafter, and two permanent positions to meet the new mandate to establish the End of Life Option Act program as specified in AB 15 X2 (Eggman), Chapter 1, Statutes of 2015, Second Extraordinary Session. This funding will enable DPH to create a secure database to implement and administer the program and provide staffing for the required confidential program management and reporting duties.

Background. The State Registrar, the Director of DPH, the state is responsible for registering each live birth, fetal death, death, and marriage that occurs in California, and for providing certified copies of vital records to the public. DPH prepares and publishes de-identified public health data collected from registered certificates to its website and reports this data to various state and federal agencies.

The End of Life Option Act establishes a new program within DPH, and allows terminally ill adults seeking to end their life to request aid-in-dying drug from their attending physician. DPH will be responsible for receiving forms specified in statute, tabulating reported data, and preparing an annual statistical report.

DPH requests two permanent positions to perform confidential program and reporting duties, including (1) collect forms and data, enter reports received, and track program utilization and associated deaths; (2) follow-up with providers regarding incomplete or missing forms; (3) perform data analysis, cross-check decedent deaths with the list of prescribed participants, and draft various statistical reports; (4) prepare the annual report mandated by the bill; (5) maintain program information on the public website and respond to inquiries regarding program policy; and (6) update the website as needed, and make reporting forms available for download from the site.

DPH also requests funding to develop a secure database for this new program. Although the number of aid-in-dying cases is projected to be small, special protections for the data will be required because of the sensitivity of this information. One-time development costs for this secure database are estimated to be approximately $88,000, and ongoing yearly maintenance costs are expected to be $10,000.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

Issue 16: Collection of Data: Multi-Race or Multi-Ethnic Origin (AB 532, 2015)

Budget Issue. DPH requests $236,000 for fiscal year 2016-17 and $234,000 for fiscal year 2017-18 from the Health Statistics Special Fund to meet the new mandate to tabulate the data for both single and multiple race or ethnic designations in reports provided to other state departments as specified by AB 532 (McCarty), Chapter 433, Statutes of 2015.

Background. The State Registrar, the Director of DPH, is responsible for registering each live birth, fetal death, death, and marriage that occurs in California, and for providing certified copies of vital records to the public. The State Registrar is also required by law to permanently preserve vital records and to prepare and maintain a comprehensive and continuous index of all registered certificates. For birth, death, and fetal death, this is completed through the registration of vital events via web-enabled registries.

The issuance of death and birth certificates is a key process in generating data required by both the federal Centers for Disease Control and Prevention (CDC) and DPH to monitor the health of the population. California operates electronic birth, death and fetal death registration systems. Today, data on over 99 percent of these vital events is captured electronically at the time of registration. These systems enable DPH to turn vital record data into actionable public health information.

AB 532 establishes a new requirement for DPH programs that collect demographic data, prior to and no later than January 1, 2022, to provide forms that offer the option of selecting one more ethnic or racial designations. The bill also requires DPH to ensure that the data reported to any other state agency, board, or commission is neither tabulated nor reported without the number or percentage of respondents who identify with each ethnic or racial designation alone, and not in combination with any other ethnic or racial designation; those who identify with each ethnic or racial designation, whether alone or in combination with other ethnic or racial designations; those who identify with multiple ethnic or racial designations; and to comply with the federal guidance developed for the allocation of multiple race responses for use in civil rights monitoring and enforcement.

The new workload associated with AB 532 includes the need for development of new statistical coding of data to produce the strata specified for the data files, and to ensure the integrity and quality of the data produced. DPH will redirect two positions among its vacant authorized positions to meet the workload.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

Issue 17: Lesbian, Gay, Bisexual, & Transgender Disparities Reduction Act (AB 959, 2015)

Budget Issue. DPH requests one-time expenditure authority of $125,000 from the Health Statistics Special Fund to modify existing birth and fetal death registration systems and meet the new mandate to collect voluntary self-identification information pertaining to sexual orientation and gender identity as specified in the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act, AB 959 (Chiu), Chapter 565, Statutes of 2015.

Background. The State Registrar, the Director of DPH, is responsible for registering each live birth, fetal death, death, and marriage that occurs in California, and for providing certified copies of vital records to the public. The issuance of death and birth certificates is a key process in generating data required by both the Centers for Disease Control and DPH to monitor the health of the population. California operates electronic birth, death, and fetal death registration systems. Data on over 99 percent of these vital events is captured electronically at the time of registration. These systems enable DPH to turn vital record data into actionable public health information.

AB 959 establishes a new requirement for DPH programs that collect demographic data, as early as possible, but no later than July 1, 2018, to collect voluntary self-identification information pertaining to sexual orientation and gender identity. The statute requires DPH to use information voluntarily provided about sexual orientation and gender identity only for demographic analysis, coordination of care, quality improvement of its services, conducting approved research, fulfilling reporting requirements, and guiding policy or funding decisions. In addition, the bill requires that the data collection duties and reporting requirements are consistent with federal law, and that DPH protect the identity of individuals within small data sets by aggregating the data.

DPH requests a one-time special fund expenditure authority of $125,000 to comply with this new law and add new fields for voluntary self-identification information pertaining to sexual orientation and gender identity of parents. This funding is required to modify the existing electronic birth registration system, and would be accomplished by the system contractor, UC Santa Barbara, via an amendment to the current interagency agreement; and modify the existing fetal death registration system, via an amendment to the current contract with UC Davis.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

Issue 18: Office of AIDS (OA): AIDS Drug Assistance Program (ADAP) Update

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

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

1. ADAP-only clients, for whom ADAP pays 100 percent of the prescription drug costs because these clients do not have a third-party payer.

2. Medi-Cal Share of Costs clients, for whom ADAP pays 100 percent of the prescription drug cost up to the client's share of cost amount.

3. Private Insurance clients, for whom ADAP pays prescription drug co-pays and deductibles.

4. Medicare Part D clients, for whom ADAP pays the Medicare Part D drug co-pays and deductibles.

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

1. Non-Covered California private insurance – OA – Health Insurance Premium Payment Program (OA-HIPP)

2. Covered California private insurance – OA HIPP Covered California

3. Medicare Part D – OA Medicare Part D

See tables below for ADAP budget summary and caseload estimates.

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

	2015-16	2015-16	2016-17
Fund Source	**Budget Act**	**Revised**	**Proposed**
AIDS Drug Rebate Fund	$268.4	$178.1	$236.2
Federal Funds – Ryan White	$109.9	$138.1	$94.0
Reimbursements from Medicaid Waiver (Safety Net Care Pool Funds)	$18.2	$0.9	$0.0
Total	**$396.5**	**$317.1**	**$330.2**

Estimated ADAP Clients by Coverage Group

Coverage Group	2015-16	2016-17
	Clients	Clients
ADAP-only	12,404	11,419
Medi-Cal	191	174
Private Insurance	8,497	9,192
Medicare	8,706	8,615
Total	**29,798**	**29,400**

Estimated ADAP Clients by Coverage Group for Insurance Assistance Programs

Coverage Group	2015-16	2016-17
	Clients	Clients
OA - HIPP	1,047	895
OA- HIPP Covered California	2,019	3,074
OA – Medicare Part D	634	626
Total	**3,700**	**4,595**

Current Year and Budget Year Changes. Compared to the 2015 Budget Act, estimated expenditures for current year will be $317.1 million, which is a $79.4 million decrease. OA projects expenditures of $330.2 million in 2016-17, which a $66.4 million decrease compared to the 2015 Budget Act.

According to OA, these decreases are mainly due to ADAP clients continuing to transition from ADAP to Medi-Cal or enrolling directly in Medi-Cal, and ADAP clients continuing to transition to private health insurance.

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).

Federal HRSA Maintenance of Effort (MOE) for Ryan White CARE Act. The federal Health Resources and Services Administration (HRSA) requires states to have HIV-related non-HRSA expenditures. California's HRSA match requirement for the 2015 federal Ryan White Part B grant year (04/01/2015-03/31/2016) is $65,519,485.

Payment of Out-of-Pocket Medical Costs through OA-HIPP. As part of the 2014 budget, the Legislature adopted trailer bill language that allows OA-HIPP to pay for out-of-pocket medical expenses. OA anticipates this to begin in the spring of 2016.

ADAP Modernization. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015, updated financial eligibility criteria for ADAP and the Office of AIDS Health Insurance Premium Payment program to consider family size and to increase the income limit of $50,000 for these programs, which is estimated to be 447 percent federal poverty level (FPL) to 500 percent FPL or $58,350 for a single individual and $98,950 for a three-person household. OA estimates that this change will cause an additional 306 clients to enroll in 2015-16 and another 151 clients in 2016-17.

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

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

1. Please provide an overview of the ADAP budget.

2. Please provide an update on the transition of ADAP clients to Medi-Cal and Covered California.

3. Please provide an update on the implementation of 2014 trailer bill language to pay out-of-pocket medical costs through OA-HIPP.

Issues 19: Increase Access to HIV Pre-Exposure Prophylaxis (PrEP)

Budget Issue. DPH proposes to expend $2.6 million in federal funds ($1.4 million local assistance and $1.3 million state operations) in 2015-16 and $3.5 million ($1.8 million local assistance and $1.7 million state operations) in 2016-17, and requests the addition of five permanent positions, to implement a three-year Centers for Disease Control and Prevention (CDC) grant awarded to DPH on September 3, 2015.

A Section 28 Budget Letter, dated October 30, 2015, notified the Legislature of this grant and the related increase in current year federal fund authority.

Background. The Office of AIDS (OA) is funded by the CDC to provide HIV prevention services in California in order to achieve the three primary goals of the National HIV/AIDS Strategy: 1) reduce the number of people who become infected with HIV; 2) increase access to care and improve health outcomes for people living with HIV; and 3) reduce HIV-related health disparities. California ranks second only to Florida in the annual number of newly diagnosed HIV infections, and ranks second only to New York in the number of persons living with HIV infection.

The HIV Prevention Program provides CDC-funded services to the CDC-defined California Project Area. The California Project Area includes all California local health jurisdictions except the Los Angeles County Metropolitan Statistical Area, which includes the cities of Long Beach and Pasadena, and the San Francisco County Metropolitan Statistical Area, which includes the counties of San Mateo and Marin. These jurisdictions receive direct CDC funding. OA uses CDC funding to provide HIV prevention funding to the 18 remaining local health jurisdictions that represent 93 percent of the HIV prevalence in the California Project Area.

The HIV Prevention Program currently receives approximately $16 million annually in CDC cooperative agreement funding to provide the CDC-required activities of targeted HIV testing, linkage to HIV care, partner services, transmission prevention activities focused on HIV-positive persons, condom distribution, and routine, opt-out HIV testing in healthcare settings. The HIV Prevention Program currently has 24.0 authorized positions.

DPH will use both the new CDC grant funding addressed in this proposal and the ongoing $2 million state General Fund for PrEP Navigator Services to increase knowledge, awareness, and uptake of PrEP among Californians at highest risk for HIV acquisition. As specified in SB 75 (Committee on Budget), Chapter 18, Statutes of 2015, the $2 million General Fund dollars will be used to fund a PrEP Navigator Services Program, including local assistance funding disseminated through a competitive Request for Applications process to an entity in any county if that county meets certain specified eligibility criteria. By contrast, the CDC requires the federal grant funding addressed in this proposal be disseminated by the department to only four CDC-designated local health jurisdictions: San Diego, Orange, Alameda, and Riverside. The funded activities must meet CDC's specific requirements, including focusing on the target population of men who have sex with men and transgender persons at high risk for HIV infection, development and distribution of educational resources for clinical and non-clinical providers, and development of a training program for patient navigators who will assist patients with accessing PrEP in the eligible communities.

At the end of 2013, there were an estimated 121,060 persons living and diagnosed with HIV in California and reported to OA; however, the CDC estimates 11.3 percent of all persons living with HIV in California are unaware of their infection. Eighty-seven percent of persons diagnosed with HIV in California are male. While California has made progress in identifying people who are unaware of their HIV status, the state has been only minimally successful in reducing the annual number of newly diagnosed HIV infections statewide, from 5,469 in 2009 to 4,712 in 2013. Over 70 percent of new infections are among men who have sex with men. Approximately 25 percent of Californians newly diagnosed with HIV (1,220 people) were living in the CDC-determined eligible jurisdictions for this funding: San Diego, Orange, Alameda and Riverside. Of those newly diagnosed, 75 percent were men who have sex with men and 1.2 percent were transgendered persons.

PrEP is a new prevention tool for people at high risk for HIV acquisition that has been shown to decrease HIV infection. Prior to its use as an HIV preventative for those who are HIV negative, PrEP medication has been used by those who are HIV positive as an HIV antiretroviral medication for the past 11 to 14 years. Taken daily, and as long as the patient is at substantial risk for HIV acquisition, PrEP medication can reduce HIV acquisition by over 90 percent.

Twenty-four state, local, and territorial health jurisdictions were eligible to apply for this funding, including direct funding to the Los Angeles County and the San Francisco County Metropolitan Statistical Areas. The department applied for the funding on behalf of eligible California Metropolitan Statistical Areas/Divisions as determined by the CDC in order of HIV prevalence: San Diego, Orange, Alameda, and Riverside. Nationally, 12 jurisdictions received PrEP funding, including Los Angeles and San Francisco.

To implement the PrEP activities, DPH is requesting $3.5 million in federal funds and five permanent positions to meet the requirements of this grant opportunity. Of the five positions requested, four positions will be located in OA's HIV Prevention Branch, and the fifth position will be located in the Prevention Research and Evaluation Section of OA's Surveillance, Research, and Evaluation Branch. PrEP activities will include administering the funding at the state level, and determining in consultation with the eligible local health jurisdictions the most effective levels of funding. The CDC requires the use of these demonstration project funds to develop and provide the training and technical assistance for navigation and outreach services, and to develop and distribute educational resources for clinical and non-clinical private providers, local health department staff and community-based staff, as well as resources for consumers/patients.

The development and coordination of these education, outreach, and patient navigation services needs to be centrally developed by DPH so efforts are not duplicated, program activities are standardized, evaluation of local program components are independently evaluated, and resources are centrally administered.

Per CDC Request for Applications funding opportunity announcement, funding cannot be used to purchase PrEP medications.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this issue.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

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

All items were held open.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 10, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Theresa Pena

CONTINUED

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

5180 DEPARTMENT OF SOCIAL SERVICES – STATE HEARINGS DIVISION (SHD)

Issue 1: Overview – State Hearings Division

Background. State hearings, which are adjudicated by Administrative Law Judges (ALJs) employed through DSS, are used to provide due process to recipients of, and applicants for, many of California's health and human services' programs, including Medi-Cal, CalWORKs, CalFresh, and In-Home Supportive Services. When a recipient disagrees with a decision made by their local county welfare department, they are legally entitled to request a hearing to contest the decision. The *King v. McMahon* and *Ball v. Swoap* court decisions mandate that DSS provides recipients with timely due process for the adjudication of appeals hearings. Additionally, these court orders impose financial penalties on DSS for failing to adjudicate decisions within specified timeframes. The penalties are paid to the prevailing claimant. Federal mandates require that all requests for hearings be adjudicated within 90 days, or 60 days for CalFresh, of a recipient's request.

Penalty Structure. Under the court orders, the minimum daily penalty amount is $5.00 per day, or a minimum of $50, whichever is greater. However, if 95 percent of all decisions are not issued within the required deadlines in a given month, the daily penalty rate for that programmatic category increases by $2.50 over the penalty rate being paid to claimants the previous month. In contrast, if 95 percent of all decisions related to that particular program are issued on time in a given month, the corresponding daily penalty rate decreases by $2.50 from the penalty rate being paid the previous month. The maximum daily rate under the court orders is $100 per day.

According to the department, since August 1, 2013, the State Hearings Division is currently achieving a 95 percent overall timeliness each month, creating a steady decline in the daily penalty rate in each program area. As of January 2016, the penalty rate per day of a late decision was $47.50 for Medi-Cal, $5 for CalWORKs, $5.00 for CalFresh, and $57.50 for IHSS. Penalties levied on the state for untimely SHD adjudication in 2012-13 totaled $4.4 million. In contrast, through January 2016, penalties for FY 2015-16 total $55,980.

According to DSS, recent processing times, average penalties, and total penalties paid by program are listed below:

Program	Timeliness Requirement (In Days)	Average Processing Time of Late Cases (In Days)	Average Days Late	Average Penalty
CalFresh	60	81.09	21.09	$125.94
CalWORKs	90	104.28	14.28	$209.04
IHSS	90	101.57	11.57	$857.18
Medi-Cal	90	112.01	22.01	$1,478.60

State Hearing Penalties by Program for the Last 5 Fiscal Years

Total Penalties Paid by Program					
FY	**CalWORKs**	**CalFresh**	**Medi-Cal**	**IHSS**	**Total**
FY 10/11	$169,630	$67,988	$215,508	$231,320	$684,445
FY 11/12	$176,133	$59,170	$482,280	$389,158	$1,106,740
FY 12/13	$290,248	$54,175	$3,533,700	$541,717	$4,419,840
FY 13/14	$91,952	$8,807	$423,363	$71,133	$595,255
FY 14/15	$17,253	$5,080	$150,175	$68,295	$240,803
FY 15/16 YTD*	$1,220	$1,600	$35,272	$17,888	$55,980

The department notes several contributing factors to the increase in penalties from fiscal years 2008-09 through 2012-13, such as a 26 percent increase in overall workload and inadequate resources from a hiring freeze, furloughs, and retirements. The Medi-Cal spike was associated with Community-Based Adult Services cases and was one-time workload.

Recent Caseload Growth. The increased workload is resulting primarily from the implementation of the Federal Affordable Care Act (ACA). ACA workload will increase the amount of hearing decisions by over 10,400; a 55 percent increase over the FY 2012-13 workload. This growth is due to the increase hearing requests in Scope of Benefits and Medi-Cal redetermination appeals. The overall total is projected to increase from approximately 89, 200 hearing requests and 19,000 decisions in 2012-13 to 120,100 hearing requests and 27,500 decisions by the end of FY 2016-17.

Staff Comment. Prior resources to address the ACA caseload growth were approved as limited-term positions. It appears the ACA caseload will continue to grow in outyears.

Questions.

1. Please briefly provide an overview of the function of the state hearings division and the structure of the timeliness requirements and penalties for not meeting them.

2. Please describe the types of cases the majority of recipients are requesting hearings on.

Staff Recommendation. No action required.

Issue 2: BCP – State Hearings Division – Affordable Care Act Caseload

Governor's Proposal. The Administration requests to make permanent the extension of 56 limited-term positions to continue to provide the required due process for Medi-Cal and Covered California (Covered CA) recipients. These positions were approved as limited-term in FY 2014-15 to adjudicate appeals associated with the ACA. Specifically, the positions DSS seeks to make permanent are as follows:

- 3.0 Administrative Law Judge II (ALJ II) Supervisor
- 11.0 ALJ II Hearing Specialist
- 17.0 Administrative Law Judge (ALJ I)
- 5.0 Office Technician (Typing)
- 1.0 Office Assistant (Typing)
- 10.0 Management Services Technician (MST)
- 6.0 Staff Service Analyst/Associate Government Program Analyst (SSA/AGPA)
- 2.0 Staff Services Manager I (SSM I) and
- 1.0 Staff Service Manager IIs (SSM II)

DSS is also seeking permanent funding for 1.0 Associate Informations Systems Analyst (AISA) and 1.0 Office Technician (Typing). The cost for all 58 positions is approximately $7.3 million.

The ALJ II Specialist assists in the training and development of resource materials to meet the needs of the ALJ I's and shoulders the caseload associated with more complex hearings while assisting the ALJ II Supervisor and Chief Administrative Law Judge. The SSAs and SSM I assess the readiness of cases and interact with parties to reduce AJL time on these activities. Management Services Technician positions staff the ACA Bureau's Customer Service group, which is the first point of contact with the public and the processing of hearing requests. SSA/AGPA support staff performs prehearing functions. Office Technician and Assistant positions support post hearing functions and clerical support for ALJs.

Background. As of May 2015, 1.3 million Californians have active health insurance under Covered California. Under the ACA, California's expansion of Medi-Cal has increased by three million enrollees from 2013 to 2015. The impact of expansion of Medi-Cal has resulted in an 85 percent increase in the category of scope of benefit hearings, and a similar increase is anticipated from the category of Medi-Cal redeterminations.

There is also a workload increase anticipated with the implementation of the Resource Family Approval (RFA) program.

The State of California provides due processes to recipients of California public benefits, including Medi-Cal and Covered California, through hearings conducted by the State Hearings Division (SHD). Federal mandates require that all requests for hearings be adjudicated within 90 days of a recipient's request. Financial penalties are imposed on DSS for failure to adjudicate hearing decisions within the court-mandated time frames.

Due to the continually increasing ACA caseload and an inability to absorb this workload absent these positions, DSS asserts these positions are necessary to ensure timely due process for new Medi-Cal enrollees and Covered California consumers. The department notes that the conversion of limited-term positions to permanent status results in higher levels of staff retention and increased efficiency. DSS cites the increased efficiency from these positions as the primary reason they were able to meet the Federal 95 percent timeliness requirement and avoid penalties.

Staff Comment. Prior resources to address the ACA caseload growth were approved as limited-term positions. It appears the ACA caseload will continue to grow in outyears.

Questions.

1. Please briefly summarize the proposal.

2. Please discuss how the department's current estimates of ACA caseload growth and its impacts on the SHD have changed from when the original BCP was approved.

Staff Recommendation. Hold Open.

0530 HEALTH AND HUMAN SERVICES AGENCY, OFFICE OF SYSTEMS INTEGRATION

Issue 1: BCP – Appeals Case Management System (ACMS)

Governor's Proposal. The Administration requests an increase of $237,000 in Office of Systems Integration spending authority for the Appeals Case Management System (ACMS) project and the conversion of 7.0 existing state positions from limited-term to permanent. The conversion of these limited-term positions was previously approved in the Feasibility Study Report (FSR).

Background. The State Hearings Division (SHD) is a federal and state mandated organization that is responsible for ensuring due process for individuals who wish to appeal administrative decisions about benefits for public assistance programs, including Medi-Cal, Covered California, CalWORKs, CalFresh, and In-Home Supportive Services. The SHD conducts administrative hearings and resolves disputes of applicants and recipients.

The work of the SHD is supported by a mainframe application, the Appeals Case Management System (ACMS) which is housed at the Office of Technology in Sacramento, along with 21 ad-hoc applications. Collectively, these systems are known as the State Hearings System (SHS). The SHS tracks, schedules, and manages appeals requests received from all 58 counties. However, DSS indicates that the current SHS does not meet existing business requirements and will not be able to handle the continued increase in volume associated with the ACA implementation.

DSS submitted an FSR for an automated system that was approved by the California Department of Technology in January of 2014. One condition with this approval was that OSI would provide project management support for the project.

The 2014 Budget Act authorized 11.0 new state positions and $4.5 million in funding for the project. The 2015 Budget Act authorized an increase in $176,000 in OSI spending authority and the extension of a Senior Information System Analyst (SISA) position.

Below is the ACMS project timeline and a list of key action dates:

Action	Dates
Release of RFP	10/2015
Contract Execution	6/2016
System Planning	8/2016
System Design	12/2016
System Development and Configuration	4/2017
User Acceptance Testing	6/2017
Pilot Evaluation	9/2017
User Training	10/2017
System Implementation	11/2017
Project Closeout	12/2018

Staff comment. According to the Administration, the positions will enhance OSI's ability to perform project management, and increases the likelihood of the successful implementation of the State Hearings ACMS Project. This proposal appears consistent with a previously approved FSR and aligns OSI's authority to what is needed to continue managing the ACMS project

Questions.

1. Please briefly summarize the proposal.

2. Please explain how the proposed timeline for the ACMS project has changed.

Staff Recommendation. Approve.

5180 DEPARTMENT OF SOCIAL SERVICES - CALWORKS

Issue 1: Overview – CalWORKs

Governor's Proposal. The budget includes $5.4 billion in federal, state, and local funds for the program, and estimates an average monthly caseload of 508,000 families. The Governor's budget for CalWORKs does not propose any major policy changes.

The Child Poverty and Family Supplemental Support Subaccount provides funding for the grant impact of both the March 1, 2014 and April 1, 2015 five percent CalWORKs Maximum Aid Payment (MAP) increases and any subsequent grant increases when sufficient revenues are available. Prior year "base" funding is available to the counties immediately. The FY 2015-16 and FY 2016-17 funding, identified as "growth" in the budget tables, requires adequate upfront GF authority in the CDSS budget until subaccount funds are available directly to the counties.

In the *Child Poverty and Family Supplemental Support Subaccount - Growth*, $48.9 million will be available in FY 2015-16 and $60.9 million will be available in FY 2016-17. In the *Child Poverty and Family Supplemental Support Subaccount - Base*, $262.1 million will be available in FY 2015-16 and $241.5 million will be available in FY 2016-17.

Background. California Work Opportunities and Responsibilities to Kids (CalWORKs), the state's version of the federal Temporary Assistance for Needy Families (TANF) program, provides cash assistance and welfare-to-work services to eligible low-income families with children. In the last several years, CalWORKs has sustained very significant reductions and partial restorations (summarized below), as well as programmatic restructuring. Total CalWORKs expenditures are $7.2 billion (all funds, state General Fund is $1.4 billion) in 2015-16. The amount budgeted includes $5.4 billion for CalWORKs program expenditures (including grants, services, and child care) and $1.8 billion in non-CalWORKs programs. California receives an annual $3.7 billion TANF federal block grant. To receive TANF funds, California must provide an MOE of $2.9 billion annually. State-only programs funded with state General Fund are countable towards the MOE requirement.

Demographics of CalWORKs Recipients.[1] Around three-quarters of all CalWORKs recipients are children. Nearly half of those children are under the age of six. Ninety-two percent of heads of CalWORKs recipient households are women. Two-thirds of these households are headed by single women. Nearly half have an 11^{th} grade or less level of education, and ten to 28 percent are estimated to have learning disabilities. Around 80 percent of these adults report experiencing domestic abuse at some point.

[1] Context information comes from sample data collected by the Department of Social Services (DSS) and from studies in single or multiple counties, as summarized in *Understanding CalWORKs: A Primer for Service Providers and Policymakers*, by Kate Karpilow and Diane Reed. Published in April 2010; available online.

Caseload and Spending Trends. Prior to federal welfare reform in the mid-1990s, California's welfare program aided more than 900,000 families. By 2000, the caseload had declined to 500,000 families. During the recent recession the caseload grew; but at an estimated 563,500 families in 2012-13, it is not anywhere close to the levels of the early 1990s. Most recently, the caseload declined 2.8 percent in 2014-15, and from there is expected to continually decrease in 2015-16, and 2016-17 (to a projected 497,000 families). According to the California Budget Project, welfare assistance represented 6.8 percent of the state's overall budget (including federal, state, and local resources) in 1996-97, compared with 2.9 percent in 2011-12.

According to DSS, over one million children in 536,000 families are served.

Welfare-to-Work Program. Adults eligible for CalWORKs are subject to a lifetime limit of 48 months of assistance. Unless exempt for reasons, such as disability or caregiving for an ill family member, adults must participate in work and other welfare-to-work (e.g., educational) activities. Depending on family composition, these activities are required for 20, 30, or 35 hours per week. The program also offers supportive services, such as childcare and housing support. Effective January 1, 2013, clients are under the WTW 24-month clock, which provides 24 months of additional flexibility around how to meet work requirements, but after the initial 24-months, imposes stricter work requirements to receive assistance and a limit on the number of recipients who can.

Child-Only Caseload. In more than half of CalWORKs cases (called "child-only" cases), the state provides cash assistance on behalf of children only and does not provide adults with cash aid or welfare-to-work services. There is no time limit on aid for minors. In most child-only cases, a parent is in the household, but ineligible for assistance due to receipt of Supplemental Security Income, sanction for non-participation in welfare-to-work, time limits, or immigration status. In the remaining cases, no parent is present, and the child is residing with a relative or other adult with legal guardianship or custody.

CalWORKs child care. CalWORKs participants are eligible for child care if they are employed or participating in WTW activities. CalWORKs child care is administered in three stages:

- Stage 1. Provides care to CalWORKs families when first engaged in work or WTW activities, and is provided by the Department of Social Services (DSS).

- Stage 2. Once counties deem the family "stable," CalWORKs families move to this program. Families remain in Stage 2 until they have not received assistance for two years. The California Department of Education (CDE) administers this program.

- Stage 3. Families transition to this program after Stage 2. CDE also administers this program.

Stages 1 and 2 services are considered entitlements, whereas Stage 3 services are available based on funding levels. Families receiving CalWORKs assistance, those considered "safety net," or families who are sanctioned are not required to pay family fees.

Horizontal Integration of SAWS and CalHEERS. California's Statewide Automated Welfare System (SAWS) is made up of multiple systems which support such functions as eligibility and benefit determination, enrollment, and case maintenance at the county level for some of the state's major health and human services programs, including CalWORKs and CalFresh. The goal of the Horizontal Integration effort between the Covered California system (CalHEERS) and SAWS is to allow an applicant applying for health coverage online through Covered California to submit their CalWORKs or CalFresh application online at that time without having to re-respond to some of the questions already asked. CalHEERS will also sort applicants for likely eligibility for other social service programs based on whether the household income is over or under 200 percent Federal Poverty Level (FPL). This functionality is planned for implementation in July of 2016.

Major program changes. SB 1041 (Budget and Fiscal Review Committee), Chapter 47, Statutes of 2012, made significant changes to CalWORKs' welfare-to-work rules, including:

- Creation of a 24-month time limit with more flexible welfare-to-work activities[2] before the time limit has been reached and stricter requirements afterward (up to 48 total months).

- A two-year phase-out of temporary exemptions from welfare-to-work requirements for parents of one child from 12 to 24 months old or two or more children under age 6, along with a new, once in a lifetime exemption for parents with children under 24 months.

- Changes to conform state law to the number of hours of work participation (20, 30, or 35, depending on family composition) required to comply with federal work requirements.

Counties may provide extensions of the more flexible rules for up to six months for up to 20 percent of participants. This 20 percent extender is not a cap, but a target.

Early engagement. SB 1041 required DSS to convene stakeholder workgroups to inform the implementation of the above changes, as well three strategies intended to help recipients engage with the WTW component, particularly given the new time limits and rule changes, specifically:

- Expansion of subsidized employment

- The Online CalWORKs Appraisal Tool (OCAT), a standardized statewide WTW appraisal tool that provides an in-depth assessment of a client's strengths and barriers

- Family stabilization (FS), which is intended to increase client success during the flexible WTW 24-Month Time Clock period by ensuring a basic level of stability for clients who are in crisis, including: intensive case management and barrier removal services. These items are discussed in greater detail later in this agenda.

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

Monitoring results and outcomes. RAND Corporation will evaluate the enacted changes and provide the Legislature a report by October 1, 2017. In the interim, DSS must annually update the Legislature regarding implementation of the enacted changes related to the 24-month clock.

Summary of Major CalWORKs Changes
2008-2015

2008-09

- Suspend annual COLA

2009-10

- Suspend COLA
- Eliminate statutory basis for future COLAs
- Four percent grant cut
- Establish "young child" WTW exemption

2011-12

- Reduce adults' lifetime limit from 60 to 48 months
- Eight percent grant cut
- Suspend CalLearn intensive case management for teen parents
- Decrease earned income disregard form $225 to $112

2012-13

- Create 24-mo. flexible participation period with stricter federal requirements after 24 mo.
- Phase-in funding for CalLearn case management
- End "young child" WTW exemption and established a different one

2013-14

- Five percent maximum grant restoration, effective March 1, 2014
- Restore earned income disregard to $225

2014-15

- WINS starts Jan. 1, 2014
- Increase vehicle asset limit
- Five percent maximum grant restoration, effective April 1, 2015
- Housing Support enacted
- Expand eligibility to include former drug offenders

Federal Context and Work Participation Rate. Federal funding for CalWORKs is part of the Temporary Assistance for Needy Families (TANF) block grant program. TANF currently requires states to meet a work participation rate (WPR) for all aided families, or face a penalty of a portion of their block grant. States can, however, reduce or eliminate penalties by disputing them, demonstrating reasonable cause or extraordinary circumstances, or planning for corrective compliance. It is also important to note that federal formulas for calculating a state's WPR have been the subject of much criticism. For example, the federal government does not give credit for a significant number of families who are partially, but not fully, meeting hourly requirements.

California did not meet its federal WPR requirements for 2007 through 2013. The Administration for Children and Families accepted California's Corrective Compliance Plans to address the TANF WPR penalty for federal fiscal years 2008, 2009, and 2010. Penalty relief for all three years is contingent upon WPR compliance for FFY 2015. Preliminary data indicates that California's overall WPR for FFY 2015 is greater than the 50 percent threshold, likely eliminating $341 million in penalties tied to 2008 through 2010. California has submitted Corrective Compliance Plans for FFY 2011 and 2012 contingent upon WPR compliance in FFY 2016. The Administration is in the process of submitting a Corrective Compliance Plan for FFY 2013. The FFY 2013 plan is also contingent upon WPR compliance in FFY 2016.

At a joint Senate Human Services and Budget Subcommittee #3 hearing on March 10, 2014, an expert from the Center on Budget and Policy Priorities testified that no other state has ever been required to pay penalties.

Policy considerations. The Legislature may wish to examine the following issues related to CalWORKs programs:

- Grant levels. In 1996-97, a maximum grant for a family of 3 was $594, or 55 percent of federal poverty level (FPL). By comparison, in 2015-16, a maximum grant for a family of three is projected to be $704 or 42 percent of FPL. If maximum grant levels remained at 55 percent of FPL (using 1996-97 as the base year), the 2015-16 maximum grant level would be $920. Using 1996-97 as the base year, if grants had received no cuts or increases in the intervening years and received previously applicable cost-of-living adjustments (COLAs), the 2015-16 maximum grant level would be $1,050 or 63 percent of FPL.

- Maximum Family Grant (MFG) rule stipulates that a family's maximum aid payment will not be increased for any child born into a family that has received CalWORKs for ten months prior to the birth of a child. There is proposed legislation (SB 23) in the current session seeking to amend the MFG rule.

- Impact of the 24-month clock. The department estimates 1,790 cases will have reduced cash assistance by the end of 2015-16, growing to 11,650 cases by the end of 2016-17, resulting in savings of roughly $11 million.

Staff Comment. The LAO notes that this year's CalWORKs budget is largely caseload driven and proposes no new program changes, and recommends that caseload-related funding decisions be made

after the May Revision. Staff notes that the CalWORKs program has undergone a variety of grant reductions and program restructuring over the last decade both during times of economic downturn and recovery. "Early engagement" strategies have emerged to compliment the original "work first" approach that was the impetus of the CalWORKs program. As these early engagement components of the CalWORKs program, including OCAT and Family Stabilization, begin to see a return of data and increased utilization, the Legislature may wish to consider how "early engagement" and "work first" components can be further integrated and contribute to overall efforts to reduce poverty and help families in need.

Questions.

1. Please briefly summarize the CalWORKs program, including average grant amounts, recent legislative and policy changes, and caseload trends.

2. Please provide an update on the most recent 24-month clock data, including the number of families that will time out of the 24-month clock and the number who might be sanctioned for not meeting WTW requirements.

Staff Recommendation. No action required.

Issue 2: Oversight: Cal-Learn

Budget Issue. Cal-Learn costs are 100 percent federally funded through TANF, except for grants and services for the sanctioned caseload and recent noncitizen entrant (RNE) caseload. Specifically, the 2016-17 Governor's budget includes $367,000 federal funds for Cal-Learn bonuses, $85,000 for grant savings for the sanctioned caseload; and $14.5 million ($455,000 General Fund) for intensive case management. The department estimates that around 14 percent of the caseload will utilize transportation services, and 3.5 percent will utilize ancillary services.

Background. In 1998, the Cal-Learn program, which is a statewide program for pregnant and parenting teens in the CalWORKs program, became permanent. The program provides intensive case management, supportive services (e.g, child care, transportation, school supplies); and financial incentives to eligible teen recipients who are pregnant or parenting.

In the 2011-12 budget, the Cal-Learn program was suspended, except for bonuses paid for satisfactory progress and high school graduation. The program was restored beginning July 1, 2012.

Caseload. DSS estimates an average monthly caseload of 4,694 cases in FY 2015-16 and 3,077 cases for the budget year. There are around 75 RNE cases for FY 2015-16 and 49 cases for the budget year.

Key Dates

- **July 1, 2011:** Suspension of Cal-Learn begins.
- **June 30, 2012:** End of suspension of Cal-Learn.
- **April 1, 2013:** Cal-Learn fully restored.

Trends. Caseload decline has been consistent since FY 2010-11. Over the past three years alone, the total births among CalWORKs teen mothers dropped more than 40 percent. This decline is consistent with the overall trend in California of decreasing birth rates among teens.

Sanctions increased to 2.7 percent of caseload in FY 2014-15 from 1.9 percent in FY 2013-14. Satisfactory progress bonuses had a small decrease to 5.1 percent compared to 5.2 percent in FY 2013-14. Graduation bonuses remained consistent as a percent of the caseload over the five-year period.

Table 6E. Cal-Learn Average Monthly Participation and Outcomes: FY 2010-11 through FY 2014-15

	2011-12	2012-13	2013-14	2014-15
Total Monthly Participants	10,308	9,272	7,729	6,400
Satisfactory Progress Bonuses	486	405	404	329
Graduation Bonuses	149	140	108	86
Sanctions	233	250	149	173
Exemptions, Deferrals, and Good Cause[1]	123	64	38	38
Repeat Pregnancies/ Subsequent Births	N/A	64[2]	48[3]	28

Data Source: STAT 45 monthly reports
[1] Good Cause data collected beginning in July 2011 through March 2013.
[2] Data collected for FY 2012-13 Repeat Pregnancies includes April through June 2013 only.
[3] Repeat Pregnancies category and definition changed to Subsequent Births in June 2014.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the program and services, and update on caseload trends.

2. How does the department measures success in the CalLearn program?

Issue 3: Oversight: Housing Support Program

Budget Issue. The Budget Act of 2015 appropriates $35 million for Homeless and Housing Support Services, and the Administration proposes budgeting $35 million for 2016-17. This breaks down to $23 million in Federal Funds and $12 million General Fund.

Background. The CalWORKs Housing Support Program (HSP) was established in 2014 to provide evidence-based interventions to CalWORKs families that are homeless or at risk of homelessness. This funding allows County Welfare Departments to assist homeless families to quickly obtain permanent housing and provide wrap-around supports. Counties have the flexibility to design their own county-specific HSP plan to serve the needs of the community, but are required to use evidence-based models. It is anticipated that 44 counties will implement or expand an existing Housing Support Program in both 2015-16 and 2016-17.

The HSP recognizes rapid re-housing and targeted homelessness prevention programs as cost-effective strategies to help families exit or avoid homelessness and retain permanent housing. Other core components of a HSP include comprehensive and coordinated entry with community partners along a continuum of care, housing identification, rent and moving assistance, and focused case management. Examples of services provided are landlord outreach and engagement, housing search and placement, housing barrier assessment, legal services and credit repair.

Caseload. Statute allows all CalWORKs families to be eligible for HSP services, regardless of their asset or income levels, when a county finds that the family is experiencing homelessness or housing instability. For FY 2014-15, 5,567 families have been approved for the HSP and are receiving services such as temporary housing or assistance with locating permanent housing, along with intensive case management. 2,019 families have been permanently housed, with an average of 200 homeless families moving to permanent housing each month. From July 2015 through December 2015, 2,379 families were approved for HSP and 1,002 families were moved into permanent housing.

Staff Comment. Staff notes that the HSP was augmented in the previous budget cycle, from $20 million to the current $35 million. Also, the Senate "No Place Like Home" plan to address homelessness in the state includes an unknown augmentation of the Housing Support Program.

Questions.

1. Please provide an overview of the program and services.

2. What is the identified need for CalWORKs families who are homeless or at risk of homelessness? Is the program currently meeting this need?

3. Please discuss how the Homeless Assistance Program differs from the Housing Support Program. Are there different eligibility requirements?

Staff Recommendation. Hold open**.**

Issue 4: Oversight: AB 74: Early Engagement Strategies

Background. AB 74 (Chapter 21, Statues of 2013) enacted several provisions meant to engage CalWORKs families earlier and more extensively, and by doing so to eliminate some of the obstacles to long term self-sufficiency. Specifically, AB 74 enacted Expanded Subsidized Employment (ESE), the Online CalWORKs Appraisal Tool (OCAT), and Family Stabilization (FS). Funding for these programs in 2015-16 and 2016-17 is as follows:

Funding	FY 15-16	FY 16-17
Expanded Subsidized Employment (ESE)	$134 million Total Funds ($3 million General Fund)	$134 million Total Funds ($3 million General Fund)
Online CalWORKs Appraisal Tool (OCAT)	$14 million Total Funds ($308,000 General Fund)	$16 million Total Funds ($294,000 General Fund)
Family Stabilization (FS)	$29.8 million Total Funds ($672,000 General Fund)	$29.8 million Total Funds ($672,000 General Fund)

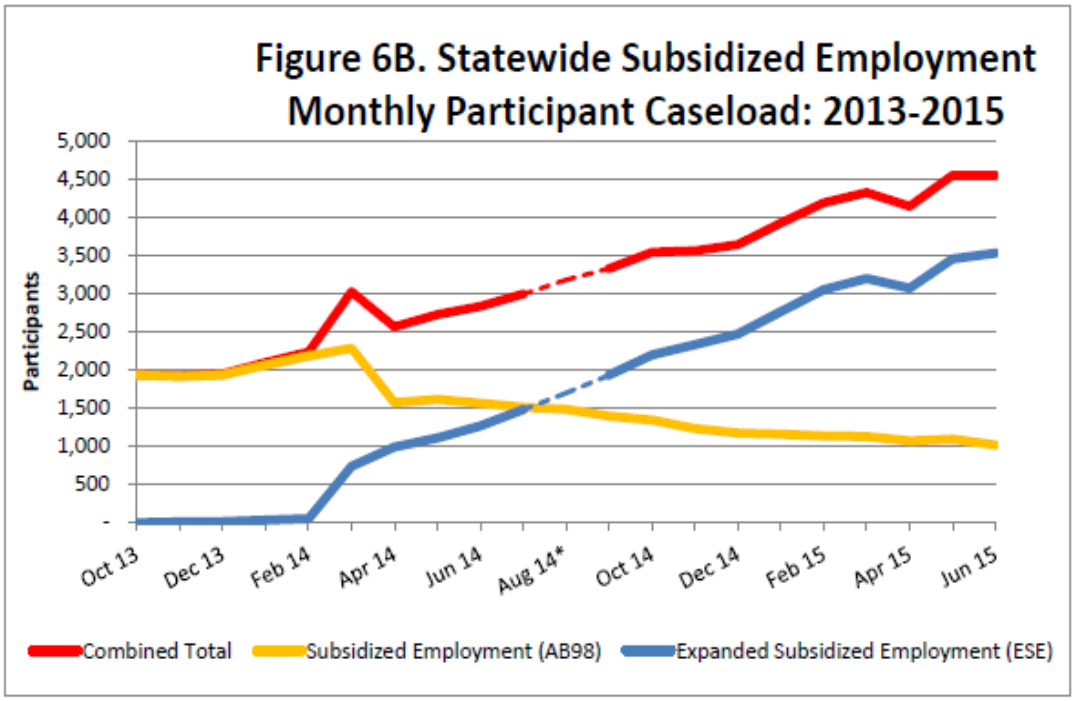
Expanded Subsidized Employment. Under subsidized employment, counties form partnerships with employers, non-profits, and public agencies to match recipients with jobs. Wages are fully or partially subsidized for six months to a year. While in an ESE placement, the CalWORKs recipient obtains specific skills and experience with the goal of obtaining permanent unsubsidized employment with the participating employer. Wages average $1000 per month, and average between $9.00 and $13.00 per hour.

The monthly cost-per-slot is estimated at $1,355 and includes subsidized wages and benefits, non-wage employer costs such as worker's compensation. Grant savings resulting from employment earnings are reinvested into the Expanded Subsidized Employment Program.

$134 million was allocated to 57 counties in FY 2014-15, and DSS projects that around 8,000 new jobs were anticipated for the same time period. Proposed funding for this program in FY 2015-16 and FY 2016-17 remains the same.

As of August 2015, 47 counties are participating in the program. In FY 2013-14, counties reported 714 out of 1,771 (40 percent) of recipients found unsubsidized employment after their time on Expanded Subsidized Employment. FY 2014-15 saw the participation of 7,798 new participants, and over 1,000 new recipients found unsubsidized employment after their time on Expanded Subsidized Employment in the first three quarters of FY 2014-15.

The following figures shows participants in both ESE and AB 98 subsidized employment programs, and shows an upward trend for subsidized employment activities.



*July – September 2014 data includes estimations to account for ESE data not reported from Los Angeles County for that period.

Questions.

1. Please provide an overview of the program.

2. How many subsidized employment placements have led to long-term, living-wage employment?

Online CalWORKs Appraisal Tool (OCAT). OCAT is a standardized statewide WTW appraisal tool that provides an in-depth assessment of a client's strengths and barriers, including: employment history, interests, and skills; educational history; housing status and stability; language barriers; child health and well-being; and, physical and behavioral health, including, but not limited to, mental health and substance abuse issues.

As of January 31, 2016, 37,642 OCAT appraisals had been completed with recommendations for supportive services:

- 24,185 recommendations for mental health services
- 16,687 recommendations related to domestic abuse, human trafficking, or sexual exploitation
- 28,085 clients indicated they were not working at the time of appraisal
- 5,586 clients were enrolled in education or training programs at the time of appraisal

The majority of counties are now fully utilizing OCAT, while a small number (less than five) are still in the process of implementing the tool.

The following table shows the growth in the utilization of OCAT:

Table 6C. OCAT Appraisals by Month: July through November, 2015

Month	Pre-July 3	July	August	September	October
New CalWORKs Appraisals That Used OCAT	848	1,316	2,977	5,208	6,494

Data Source: WTW 25 and WTW 25A.

As more data is provided by OCAT through continued use and enhanced reports, DSS anticipates that additional programs that are used by CalWORKs clients may benefit from the recommendation data, and that the data may be used to determine how to address unmet needs for services statewide and at the local level.

Questions.

1. Please provide an overview of the program, how the rollout and automation of OCAT is going, and an update on initial data that OCAT has provided.

2. Specifically, how many families are referred to the Family Stabilization program as a result of the OCAT assessment?

3. What are thoughts or plans on how to use OCAT data in relation to other CalWORKs programs? For example, how will the large proportion of mental health or domestic abuse recommendations translate into increased access to needed services?

4. How is the department working with the counties that have not yet fully implemented OCAT?

Family stabilization (FS). FS is intended to increase client success during the flexible WTW 24-Month Time Clock period by ensuring a basic level of stability for clients who are especially in crisis, including: intensive case management and barrier removal services for both adults and children. Clients must have a "Stabilization Plan" with no minimum hourly participation requirements. Six months of clock-stopping is available, if good cause is determined. Family Stabilization is a voluntary program, and counties were given flexibility to determine the services that are provided and individual program components. All 58 counties had fully implemented their FS programs as of June 2015.

California Department of Social Services — CalWORKs Annual Summary
Chapter 6: Recent Program Changes and Outcomes — January 2016

Table 6A. CalWORKs Family Stabilization Status Report: FY 2014-15

CalWORKs Family Stabilization (FS) Status Report[1] Fiscal Year 2014-15 (July 2014 vs. June 2015 comparison)		
July 2014	**June 2015**	**Participation**
598	2,107	Open FS cases.
314	1,319	FS cases active in FS only.
57	168	FS cases that transitioned to a WTW plan.
227	620	FS cases that participated concurrently in WTW activities.
165	722	FS cases that received good cause.
		Services
431	1,994	Total adults who received services.
143	940	Total children who received services.
95	476	Domestic Abuse
236	1,127	Mental Health
39	238	Substance Abuse
344	1,400	Other [2]
		Housing Support/Services
268	781	Total Homeless services provided.
982	4,022	Total FS services provided.

[1] Data retrieved from the FSP 14
[2] Examples of additional types of Other FS services provided by individual counties.
* The numbers in the chart above have been updated to reflect the most current data.

Cases have increased four-fold from 600 to 2,400 in December 2015. A similar increase in the number of adults receiving FS services was seen over this time period, and the amount of children receiving FS services grew seven-fold from 140 to over a thousand. The average length of time for a recipient on FS is between three and six months. Nearly 2,000 individuals successfully transitioned from an FS plan back to Welfare-to-Work between July 2014 and December 2015.

Questions.

1. Please provide an overview of the program, and discuss what new and different services Family Stabilization funding provides.

2. Does the department expect FS utilization to increase?

3. Please describe any patterns across counties as to why FS may be more or less likely used.

Monitoring results and outcomes. RAND Corporation will evaluate the enacted changes and provide the Legislature a report by October 1, 2017. In the interim, the Department of Social Services (DSS) must annually update the Legislature regarding implementation of the enacted changes related to the 24-month clock.

Staff Comment. As OCAT continues to provide more information, the Legislature may wish to closely monitor what this data is revealing about the assessed needs of CalWORKs recipients, and how programs such as Family Stabilization or Expanded Subsidized Employment can be used to further the goals of the CalWORKs program. The Legislature may also want to consider what, if any, additional, targeted reporting requirements may be helpful for the department to report to the Legislature.

Staff Recommendation. Hold open.

Issue 5: Trailer Bill Language # 615 – Approved Relative Caregiver (ARC) Child Support Pass-Through

Governor's Proposal. The Administration proposes to clarify that children participating in the Approved Relative Caregiver Program (ARC) should receive a $50 child support disregard.

The department notes that this language will create consistency between Welfare and Institutions Code (WIC) and Family Code (FC).

Background. WIC Section 11475.3 and FC Section 17504 both require that the first $50 of child support collected to be passed-through or "disregarded" to CalWORKs recipients before any money is distributed to federal, state, and county governments for child support recoupment. This rule does not apply to foster care recipients.

The ARC program provides an augmentation to the rate paid for non-federally eligible foster children who are placed with relatives in order to bring the total payment to relative caregivers up to the same amount as the foster family home rate paid for federally-eligible children. WIC Section 11253.4 as added by SB 79 (Committee on Budget and Fiscal Review, Chapter 20, Statutes of 2015) provides that a child in ARC is not subject to the provisions of Chapter 2 of Part 3 of Division the Welfare and Institutions Code that relate to CalWORKs. The purpose of this change was to waive certain CalWORKs statutes in relation to the availability of CalWORKs funding for the ARC program. Although WIC Section 11475.3 is contained in Chapter 2, DSS has concluded that the section relates to child support enforcement, rather than a CalWORKs rule subject to the statutory waiver.

However, the Department of Child Support Services (DCSS) is concerned that the change in SB 79 suggests that, for ARC participants, a disregard should not be distributed. DSS and DCSS have both agreed to clarify this point in statute.

Staff Comment. As the ARC program can be complex as it crosses over both CalWORKs and child welfare services, the department should clarify whether this trailer bill language applies all child support enforcement statutes to ARC and if so, the impacts to the ARC program.

Question.

1. Please summarize the proposal.

Staff Recommendation. Hold Open.

Issue 6: Trailer Bill Language #616 – County Sharing Ratio Alignment for the Safety Net, Fleeing Felon and Long-Term Sanction Populations

Governor's Proposal. The Administration proposes trailer bill language that seeks to align the county sharing ratio for specified populations.

The department notes that this is clean-up language and there is no cost associated with this trailer bill language.

Background. The CalWORKs program allows children to continue to receive assistance under certain conditions if the adult in their household does not qualify for CalWORKs cash aid. This population includes cases identified as Safety Net, Fleeing Felon or Long-Term Sanction, where adults have timed out of CalWORKs, are prohibited from CalWORKs assistance because they are identified as a fleeting felon, or have been in a sanction status for longer than 12 consecutive months.

Because the Safety Net, Fleeing Felon or Long-Term Sanctions populations include those whose cash aid under their former aid payment included federal funds, their funding ratios were established to reflect a lower county share of funding of 2.5 percent with a state share of funding of 97.5 percent. This alleviated the cost to counties for adults transitioning from being aided to unaided. However, Welfare and Institutions Code (WIC) section 15200 requires that the county's share of funding is five percent for programs after deducting any available federal funding. There is an inconsistency between WIC and current practice.

Staff Comment. This trailer bill language appears to be aligning statute with current practice.

Question.

1. Please summarize the proposal.

Staff Recommendation. Hold open.

Issue 7: Trailer Bill Language #618 – Eliminate the Temporary Assistance Program

Governor's Proposal. The Administration proposes to eliminate the Temporary Assistance Program (TAP).

The department notes that this language results in cost avoidance associated with the elimination of the program in FY 2016-17 and beyond.

Background. AB 1808 (Chapter 75, Statutes of 2006) required DSS to establish a voluntary TAP with state-only funds providing cash aid and other benefits to certain current and future CalWORKs recipients who are exempt from state work participation requirements. These recipients must be provided the same benefits as the CalWORKs program with no adverse impact by April 1, 2007. The TAP program was intended to increase the federal Temporary Assistance for Needy Families (TANF) work participation rate (WPR). Implementation was suspended due to obstacles associated with the federal child support distribution rules, and concerns that these issues would result in a potential negative effect on TAP recipients. Due to these concerns, implementation of the TAP has been repeatedly postponed, with the current implementation date as October 1, 2016, as established in SB 855 (Chapter 29, Statutes of 2014).

DSS claims that TAP is no longer necessary as they have adopted an alternate move-out strategy for removing safety net and long-term sanctioned cases from being included in the determination of the state's TANF WPR calculation.

Staff comment. In the past, the Legislature has made the decision to keep the TAP program as an option if it should become necessary in the future, and extend the sunset date. DSS has also implemented alternative strategies that have increased the WPR, such as the WINS program, which provides a $10 per month supplemental food benefit program for working families who are receiving CalFresh benefits but not receiving CalWORKs or TANF benefits.

Question.

1. Please summarize the proposal.

Staff Recommendation. Hold open.

Issue 8: Proposals for Investment

The CalWORKs program has undergone a variety of grant reductions and program restructuring over the last decade. The Legislative Analyst's Office will present a brief history of grants in the CalWORKs program in relation to poverty measures.

The subcommittee has received the following advocate requests related to the CalWORKs program:

Maximum Family Grant Rule

Budget Issue. Advocates request to repeal the Maximum Family Grant (MFG) rule.

Background. AB 473 (Brulte), Chapter 196, Statutes of 1994, prohibits an increase in CalWORKs aid based on an increase in the number of needy persons in a family due to the birth of an additional child, if the family has received aid continuously for the ten months prior to the birth of the child, as specified, or for longer than the gestational period of the new baby. If the family is not receiving aid for two or more months during the ten-month period preceding the birth of the child, the new child becomes eligible for aid in the CalWORKs benefit calculation. Additionally, the MFG rule does not apply if a family returns to CalWORKs after a break of two or more years during which the family did not receive any aid, provided aided children are still younger than 18 years old.

Based on information provided by the department, approximately 130, 000 children in 95,000 families are currently subject to the MFG rule.

Increase Grant Levels

Budget Issue. Advocates request to increase CalWORKs grants, ranging from 50 percent of the Federal Poverty Level (FPL) to over 100 percent of the FPL.

Background. The CalWORKs program sustained a volume of grant reductions in a time of significantly high caseloads during the Great Recession. In the last two years, two MAP restorations have been approved and will go into effect, although there will be no MAP increases in the budget year. For 2016-17, CalWORKs grant levels for a family of three are projected to be approximately $704 per month (42 percent of the FPL), whereas in 1996-97, an average maximum grant for a family of three was $594, or 55 percent of FPL.

Housing Support Program

Budget Issue. Advocates request an increase the CalWORKs Housing Support Program by $15 million General Fund, noting that the augmentation would serve an additional 3,800 children in 1,900 families.

Background. SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014, allocated $20 million for a new Housing Support Program (HSP) for eligible CalWORKs recipients. Counties were given the flexibility to design their own county-specific HSP plan to serve the needs of their community. The Budget Act of 2015 appropriates $35 million for Homeless and Housing Support Services, and the

Administration proposes the same level of funding for 2016-17. The program currently serves an estimated 9,000 children and 4,500 families. Please see page 17 of the agenda for additional background on the Housing Support Program.

Staff Comment and Recommendation. **Hold open.** Staff recommends the above item remain open.

Advocates have also raised the following CalWORKs issues:

- Restore the CalWORKs cost-of-living adjustment;
- Restore the 60-month time clock
- Reduce the number of sanctions and eliminate long term sanctions
- Prohibit sanctions when adult is meeting work participation
- Oppose TANF transfer to Student Aid Commission
- Repeal the Child Deprivation Rule for Two Parent Families
- Repeal limiting homeless assistance to once-in-a lifetime
- Make various changes to the Housing Support Program including adding several requirements for counties, prioritizing families experiencing domestic abuse, and giving counties discretion to extend rental assistance beyond six months
- Simplify the subsidized employment programs
- Require that counties direct families into Family Stabilization if they get a recommendation for mental, health, domestic abuse, sexual exploitation, human trafficking or homeless from OCAT
- Stop the 48 month time clock from running while the family is on Family Stabilization in addition to not running the 24 month flexible clock
- Add various reporting requirements regarding specific OCAT and Family Stabilization data

Issue 9: Overview – CalFresh

Governor's Proposal. The Governor's budget includes $2.0 billion ($0.7 billion General Fund) for CalFresh administration in 2016-17, a $38.8 million ($5.9 million General Fund) increase from the 2015-16 appropriation. This increase is largely attributable to revised caseload projections. The base CalFresh caseload is projected to increase 5.8 percent in the current year, and an additional 5.4 percent in 2016-17. The final CalFresh caseload, which is adjusted for caseload impacts not reflected in the base trend, is projected to reach an average of 1.9 million households in 2015-16 and 2.0 million households in 2016-17.

Background. CalFresh is California's name for the national Supplemental Nutrition Assistance Program (SNAP). As the largest food assistance program in the nation, SNAP aims to prevent hunger and to improve nutrition and health by helping low-income households buy the food they need for a nutritionally adequate diet. CalFresh food benefits are funded nearly exclusively by the federal government.

Californians are expected to receive $8.0 billion (all federal funds) in CalFresh benefits in 2015-16, rising to $8.5 billion in 2016-17. According to the U.S. Department of Agriculture's Economic Research Service, every $5 in new CalFresh benefits generates as much as $9 of economic activity (gross domestic product), which represents a multiplier effect of 1.79.

CalFresh benefits are provided on electronic benefit transfer (EBT) cards, and participants may use them to purchase food at participating retailers, including most grocery stores, convenience stores, and farmers' markets. In an average month in 2014-15, approximately $630 million in CalFresh food assistance was disbursed to around 4.4 million Californians. The current average monthly benefit per household is around $304 ($144 per person). Since 1997, California has also funded the California Food Assistance Program (CFAP), a corresponding program for legal permanent non-citizens, who are ineligible for federal nutrition assistance due to their immigration status. The proposed CFAP budget includes $79.5 million GF for food benefits, with an expected average monthly caseload of around 22,000 households (with about 52,000 recipients).

Eligibility and benefits. CalFresh households, except those with a member who is aged or disabled, or where all members receive cash assistance, must meet gross and net income tests. Most CalFresh recipients must have gross incomes at or below 200 percent of the federal poverty level (which translates to approximately $3,350 per month for a family of three) and net incomes of no more than 100 percent of the federal poverty level ($1,675 per month for a family of three), after specified adjustments. The average monthly benefit per household is around $304 ($144 per person).

Efforts to improve participation. In FFY 2013, the most recent period for which official measures are available[3], the participation rate for the working low-income population was 74 percent nationally. California's participation rate for the working low-income population was the lowest in the nation at an estimated 52 percent. California's overall participation rate was the third lowest in the nation at an

[3] *Reaching Those in Need: Estimates of State Supplemental Nutrition Assistance Program Participation Rates in 2013,* USDA, February 2016 (http://www.fns.usda.gov/sites/default/files/ops/Reaching2013.pdf)

estimated 66 percent while the national rate was 85 percent.[4] Reasons offered for California's poor performance with respect to CalFresh participation include, among others, a lack of knowledge regarding eligibility among individuals who are eligible, frustration with application processes, concerns about stigma associated with receiving assistance, and misconceptions in immigrant communities about the impacts of accessing benefits.

Efforts to increase participation include outreach to communities, in reach to families served by other nutrition and anti-poverty programs (like WIC), and streamlining customer service with more on-line and telephone access. In February 2016, California was recognized for these efforts and won a most improved Program Access Index award from the USDA for FFY 2014[5].

Several recently enacted program changes seek to improve CalFresh program participation. Some of those program changes include:

1. Elimination of fingerprint imaging requirement. AB 6 (Fuentes), Chapter 501, Statutes of 2011, eliminated the fingerprinting requirement, which was intended to prevent duplicate receipt of aid. However, fingerprint imaging created the perception of stigma and other measures were already in place to prevent duplicative receipt.

2. Semiannual reporting. Evidence suggested that a number of CalFresh households may leave the caseload after failing to correctly submit regular reports, only to reapply a few months later. AB 6 also amended the reporting requirement from three quarterly reports in a certification period to one report in a certification period.

3. Face-to-face interview waiver. All counties offer telephone interview in lieu of a face-to-face interview for intake and recertification appointments for CalFresh-only clients.

4. Drug and Fleeing Felon Eligibility. Effective April 1, 2015, the lifetime ban on CalFresh benefits for those convicted of certain drug felonies was lifted. In September 2015 the Food and Nutrition Service of the United States Department of Agriculture published new rules on the definition of fleeing felon that allow a majority of previously ineligible adults to become eligible for CalFresh benefits and were implemented in California on December 1, 2015.

[4] DSS has noted that the federal government does not count the state's "cash-out" policy for SSI/SSP recipients (whereby those individuals receive a small food assistance benefit through SSP and are not eligible for additional CalFresh benefits) in its participation rate. The Department estimates that the state's participation rate could be a few percentage points higher if many those individuals who would otherwise be eligible for CalFresh were counted as participating. The state would still have among the lowest participation rates in the nation.

[5] Program Access Index is the number of CalFresh participants divided by the estimated number of eligible people in California. The full USDA report, *Calculating the Supplemental Nutrition Assistance Program (SNAP) Program Access Index: A Step-by-Step Guide for 2014*, can be found at http://www.fns.usda.gov/sites/default/files/ops/PAI2014.pdf

Proposed Legislation

SB 1232 - This bill would require that a county that uses information contained in a consumer credit report for a determination of CalFresh eligibility or benefits must provide an applicant or recipient with a notice indicating that the verification or eligibility determination was based on information contained in a consumer credit report.

SB 904 - Existing federal law limits an able-bodied adult without dependents (ABAWD) participant to three months of CalFresh benefits in a three-year period unless that participant has met specified work participation requirements. The State can annually seek a waiver from this limitation, although individual counties have the option to decline participation in the waiver. This bill would require all counties to be included in the federal waiver of the ABAWD time limitation.

Staff Comment. This information is included for discussion purposes only. Research finds that food-insecure adults face higher risks of chronic diseases, like diabetes and hypertension, as well as depression and poor mental health. For children, food insecurity is also linked to poor academic outcomes.

Questions.

1. Please provide overview and summarize efforts to improve participation and results of current outreach efforts.

Staff Recommendation. No action required.

Issue 10: Drought Food Assistance Program

Governor's Proposal. As of June 1, 2015 the Drought Food Assistance (DFAP) program has received $33 million and has been funded through June 2016. The Administration is requesting $18.4 million General Fund to continue the program at current demand levels through the end of 2016-17.

Background. The CalFresh program is intended to help families prevent hunger, with emergency food programs as a safety net resource. To be eligible for food programs, a recipient must have income below 150 percent of federal poverty level, be a local resident, and use the food received in their personal home. DFAP is the temporary program developed in response to the Governor's Drought Emergency Declaration, and seeks to provide food assistance to drought-affected communities with high levels of unemployment.

Distribution timeline. DFAP food is provided by the California Emergency Foodlink, the non-profit DSS contractor which normally purchases and distributes USDA food statewide. Counties that will receive DFAP are those with unemployment rates that were above the state-wide average in 2013, and which have a higher share of agricultural workers than California as a whole. Receiving counties include Amador, Butte, Colusa, Fresno, Glenn, Imperial, Kern, Kings, Lake, Lassen, Madera, Merced, Modoc, Monterey, Riverside (Coachella Valley), San Benito, San Joaquin, San Luis Obispo, Santa Barbara, Santa Cruz, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Tulare, Ventura, Yolo, and Yuba. As of February 12, 2016, DFAP has provided over one million boxes to food banks that have distributed boxes to over 540,000 households.

Eligibility and content. Household DFAP eligibility is based on a self-certification process, whereby recipients identify themselves as the head of a household in an affected community where the household's unemployment or underemployment is directly related to the drought. DFAP food boxes are prepackaged, weigh approximately 25 pounds, and designed to provide food for a household of four people for about five days. Contents include, among others, spaghetti, pinto beans, apple sauce, green beans, corn, and tomato sauce.

Outreach. Participating food banks inform affected households of the location and availability of DFAP food distributions. Food banks are expected to collaborate with other local community organizations that may be engaged with these families. Eligible households with longer-term needs also will be offered information and assistance in applying for CalFresh.

Question.

1. Please briefly provide an overview and update of the drought emergency food assistance and outreach efforts.

Staff Comment and Recommendation. No action required.

Issue 11: BCP - Raising CalFresh Children Enrollment

Governor's Proposal. The Administration requests the establishment of five Staff Services Manager (SSM) Specialist positions as a dedicated traveling team of experts to provide data-informed assistance and direction to counties in CalFresh outreach and administrative business practices in order to increase the total number of children enrolled in CalFresh by 400,000 in two years.

Background. CalFresh in California's version of the federal Supplemental Nutrition Assistance Program (SNAP), which provides benefits to assist low-income households in purchasing food they need to maintain adequate nutrition levels. DSS administers CalFresh in California and oversees program operations at the county level. CalFresh is the largest program operated by DSS.

The majority of CalFresh is federally funded. However, California has historically had low participation rates in this program which has jeopardized federal funding. In recent years, the Administration has made it a priority to improve outreach efforts to various populations and has consequently seen a modest and growing increase in participation.

In 2012, 26.3 percent of children in California lived in food insecure households. Child food insecurity in California counties ranges from 18 to 39 percent of children. During the school year, nearly two million low-income children and youth receive free or reduced-price lunches through federally funded nutrition programs. Other programs in California, such as the Women, Infants, and Children (WIC) and CalFresh programs provide additional food support. Food banks and other programs also work to provide low-income children with food. However, CalFresh is the only state-funded year-round program designated for this purpose.

Staff Comment. The department notes that in order to increase the number of children enrolled in CalFresh, counties must be provided with additional strategies and help with outreach to this specific population. No issues or concerns have been raised to subcommittee staff at this time, and this proposal is consistent with past efforts to increase CalFresh participation.

Question.

1. Please summarize the proposal.

Staff Recommendation. Approve.

Issue 12: Trailer Bill Language #617 – Defining CalFresh Contracts as Cooperative Agreements

Governor's Proposal. The Administration proposes trailer bill language to restore the ability of CalFresh Outreach (CFO) contracts to be deemed as Cooperative Agreements and also deem the CalFresh Nutrition and Obesity Prevention Grant (known as SNAP-Ed) program contracts as Cooperative Agreements in order to align the programs with federal oversight agency expectations.

The department notes that there is no General Fund impact associated with this issue, and that this language allows the $125 million federal dollars already in the budget to be used as intended.

Background. The CFO and SNAP-Ed programs are 100 percent federally funded, and operate under guidance from the United Stated Department of Agriculture Food and Nutrition Service (USDA-FNS). DSS is designated as the state oversight agency for these programs. The CFO program was transferred from the California Department of Public Health (DPH) beginning in 2013. While at DPH, the CFO program awarded Cooperative Agreement contracts to Community Based Organizations (CBOs) under the Health and Safety Code to implement the statewide Outreach Plan. Cooperative Agreements allow for limited line-item budget adjustments without formal contract amendment. At the time of transfer, DSS did not know that Cooperative Agreements are not allowed under the Welfare and Institutions Code.

The department states that, absent this language and the flexibility it provides, federal funding may not be maximized. Two CFO contractors, the Catholic Charities and the California Association of Food Banks, have asked DSS to provide this flexibility so they can continue to run their programs.

Staff Comment. No issues or concerns have been raised to subcommittee staff at this time.

Question.

1. Please summarize the proposal.

Staff Recommendation. Approve.

Issue 13: Proposals for Investment

The subcommittee received the following requests for investment.

- State Emergency Food Assistance Program

Budget Issue. The California Association of Food Banks (CAFB) requests a $10 million General Fund appropriation for the State Emergency Food Assistance Program (SEFAP). Currently, there is no on-going General Fund dedicated for this use. In the 2013-14 fiscal year, the state Assembly donated $1 million for one-time use. The $10 million SEFAP request would be distributed to all counties based on the established formula for the distribution of Emergency Food Assistance Program, currently funded with federal dollars.

Background. The SEFAP funds provide additional flexibility to food banks, as they can purchase the items that they need to complement the types of foods that are currently available to them.

Staff Comment and Recommendation. Hold open. Advocates have also raised the following CalFresh issues:

- Increase funding for school breakfast meal reimbursements and start-up grants.

- Require CalFresh certification periods to the maximum period allowable under Federal law.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 10, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Theresa Pena

OUTCOMES

Item	Department	Action
5180	**Department of Social Services**	
Issue 1	Overview - State Hearings Division	Informational
Issue 2	BCP - Affordable Care Act Caseload	Hold Open
0530	**Health and Human Services Agency**	
Issue 1	BCP - Appeals Case Management System	Approve (3-0)
5180	**Department of Social Services**	
Issue 1	Overview - CalWORKs	Informational
Issue 2	Oversight - CalLearn	Hold Open
Issue 3	Oversight - Housing Support Program	Hold Open
Issue 4	Oversight - AB 74: Early Engagement Strategies	Hold Open
Issue 5	TBL #615 - ARC Child Support Pass-Through	Hold Open
Issue 6	TBL #616 - County Sharing Ratio Alignment	Hold Open
Issue 7	TBL #618 - Eliminate the Temporary Assistance Program	Hold Open
Issue 8	Proposals for Investment	Hold Open

CONTINUED

5180	**Department of Social Services**	
Issue 9	Overview - CalFresh	Informational
Issue 10	Oversight - Drought Food Assistance Program	Informational
Issue 11	BCP - Raising CalFresh Children's Enrollment	Approve (2-1)
Issue 12	TBL #617 - Defining CalFresh Contracts as Cooperative Agreements	Approve (3-0)
Issue 13	Proposals for Investment	Hold Open

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 17, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Michelle Baass

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4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview

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

The department achieves this mission by:

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

Budget Overview. The budget proposes expenditures of $76.6 million for DMHC. See table below for more information.

DMHC Budget Summary

Fund Source	2014-15	2015-16	2016-17
	Actual	Projected	Proposed
Federal Trust Fund	$461,000	$589,000	$0
Reimbursements	$1,861,000	$2,640,000	$1,609,000
Managed Care Fund	$52,316,000	$70,862,000	$75,038,000
Total Expenditures	**$54,638,000**	**$74,091,000**	**$76,647,000**

Timely Access Reports. The 2015 Budget Act included 25 permanent positions and $3,802,000 (Managed Care Fund) for 2015-16 and $3,594,000 (Managed Care Fund) for 2016-17 and ongoing to address the increased workload resulting from the implementation of SB 964 (Hernandez), Chapter 573, Statutes of 2014. SB 964 added the following new requirements:

- Review health plan compliance with timely access standards and make recommendations for changes on an annual basis.
- Review all full service and mental health plan networks for adequacy and availability of providers; separately for Medi-Cal, individual market, and all other markets.
- Review grievances submitted to health plans regarding network adequacy and timely access.
- Post approvals for waivers from, or alternate standards for, timely access requirements on website on and after January 1, 2015.
- Post findings from timely access compliance review on website beginning December 1, 2015.

DMHC's annual timely access report, required by SB 964, was not posted on DMHC's public website as of December 2015. According to DMHC, the report, which will include the DMHC's findings and recommendations with respect to health plans' compliance with the timely access appointment wait time standards from January 1, 2014 through December 31, 2014, is currently under review and will be shared publicly as soon as possible.

According to DMHC, this report analyzes a very large data set submitted by health plans. This data set includes the plans' assessment of whether enrollees are able to receive timely access to care, in compliance with the required standards. Almost all health plans collect this data by conducting surveys that measure the wait time for the next available appointment. DMHC's most recent timely access report will assess access to services based on health plan data that was submitted by health plans to the DMHC on March 31, 2015. However, following the March 31, 2015 submissions, the DMHC discovered that a large portion of the health plans had miscalculated their survey results. As a result, health plans were asked to re-calculate and resubmit their data to the DMHC and this caused in a delay in receiving the data. Given this delay, the DMHC required additional time to complete its report.

Subcommittee Staff Comment. This is an informational item.

Questions.

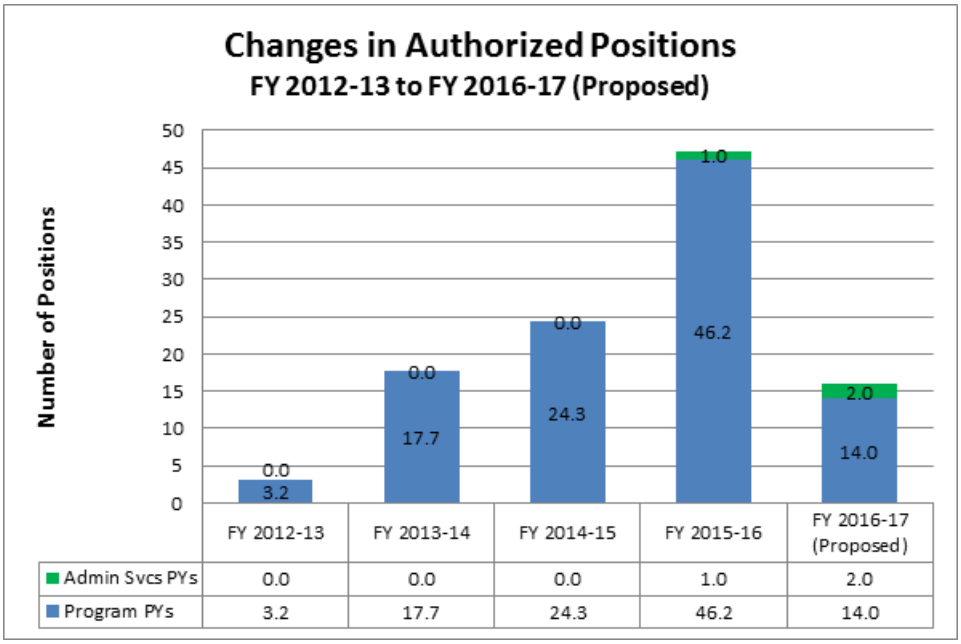
1. Please provide a brief overview of DMHC's programs and budget.

2. Please provide an estimated timeframe for the completion of the timely access report required by SB 964.

Issue 2: Infrastructure and Support Services

Budget Issue. DMHC requests two permanent positions and $247,000 for 2016-17 and $234,000 for 2017-18 and ongoing to ensure the DMHC can address the critical administrative workload resulting from program expansions resulting from the implementation of the Affordable Care Act (ACA) and conforming state legislation.

Since 2012-13, DMHC has grown from 349.6 to 442.0 authorized positions; an increase of 92.4 positions, a 26.4 percent increase. As shown in the chart below, the majority of the increase was for program staff and not administrative services staff (accounting, budgeting, human resources, business services, training). As of 2015-16, of the 92.4 positions, one position was for administrative services. If this proposal is approved, the percentage of administrative services staff granted compared to program staff over the last four fiscal years will increase to 3.2 percent.



	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17 (Proposed)
Admin Svcs PYs	0.0	0.0	0.0	1.0	2.0
Program PYs	3.2	17.7	24.3	46.2	14.0

Background. As a result of the enactment of the ACA and other legislation, the DMHC's programs have grown in excess of 25 percent over the past four years, with staffing levels increasing from 352.0 to 442.0. While budget change proposals were submitted to address the increased programmatic workload associated with the expansion of DMHC's oversight of managed health care plans, according to DMHC, sufficient positions were not requested to address the correlated workload increases in support services. Of the 130 positions created in the past four years, one position was earmarked for the Office of Administrative Services (OAS). The considerable expansion in a rapid timeframe has strained existing departmental resources in OAS as there have been no additional positions created to support department-wide efforts.

In order to meet workload requirements resources were redirected from other areas and temporary help enlisted. Even with these resources, according to DMHC, OAS still experienced difficulties completing assignments within designated timeframes. While OAS has prioritized certain less crucial tasks, the workload must be addressed. With the requested resources, the DMHC will not be able to

address its critical administrative activities in a timely manner. This will have a direct and immediate impact throughout DMHC's programs.

OAS is responsible for supporting staff by providing a considerable array of personnel (i.e., recruitment, retention, training, benefits, leave, reasonable accommodation, discipline issues); accounting (i.e., travel expense claims, payroll warrants and checks); and facility (i.e., ergonomic evaluations, telecom and repair requests) services. In addition to employee services, OAS is responsible for ensuring that departmental resources are utilized appropriately, in part by managing budget allotments against expenditures and projections. This also includes the coordination, review and approval of all related contracts, purchases, invoices, receipts, timesheets, duty statements, and classification justifications.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide a brief overview of this request.

Issue 3: End of Life Option Act (AB 15 X2, 2015)

Budget Issue. DMHC requests two-year limited-term expenditure authority of $244,000 for 2016-17 and 2017-18 to meet the department's operational needs in order to address the short-term workload resulting from the implementation of AB 15 X2 (Eggman), Chapter 1, Statutes of 2015, the End of Life Option Act.

Background. Existing state law authorizes adults to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of that adult's incapacity in accordance to a power of attorney for health care and guarantees terminally ill individuals certain care. When a health care provider diagnoses a patient with a terminal disease, the provider is required to notify the patient of his or her right to comprehensive information and counseling regarding legal end-of-life options, including (1) hospice care at home or in a health care setting; (2) a prognosis with and without the continuation of disease-targeted treatment; (3) the patient's right to refuse or withdraw from life-sustaining treatment; and (4) the patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care. Law also requires timely coverage of pain management drugs for terminally ill individuals and requires a plan that denies an experimental treatment to a terminally ill individual to provide information on covered alternative treatments and on the plan's grievance process, as well as an opportunity for the enrollee to attend a conference to discuss the matter with the plan. While existing California law requires all of the above components and options for end of life care, it does not authorize terminally ill individuals to obtain a prescription allowing them to self-administer aid-in-dying medications.

The End of Life Option Act authorizes adult California residents who meet certain qualifications and who have been determined by their primary care physician to be suffering from a terminal disease to, under specified conditions and procedures, request and self-administer an aid-in-dying prescription drug for the purpose of ending their life. AB 15 X2 also establishes the specified conditions and procedures that must be followed under this new law. The provisions of AB 15 X2 sunset on January 1, 2026.

AB 15 X2 does not specify whether health plans are required to cover aid-in-dying medication or how a health plan may decline to cover aid-in-dying medication. Due to the sensitive and controversial nature of aid-in-dying medication, DMHC expects a high level of public interest which, over the next two years, will result in its Office of Legal Service (OLS) conducting legal research, producing legal opinions, and promulgating one regulation package to clarify the issue of coverage.

To address this new workload, OLS requests limited-term expenditure authority so OLS may hire temporary help to perform the following short-term workload from July 1, 2016 through June 30, 2018:

- Attorney I - This position will review and process legal questions related to AB 15 X2. The review of legal questions encompasses all tasks necessary to compose the final determination and present to impacted or requesting divisions. In addition, this position will be responsible for the promulgation of regulations pertaining to AB 15 X2, which includes conducting stakeholder meetings, researching and analyzing policy concerns, drafting regulations, holding public hearings, and drafting the final rulemaking documents.

- Staff Services Analyst - This position will provide support and assist the Attorney I with tasks associated with AB 15 X2, such as promulgation of regulations and the drafting/filing of legal memoranda.

Projected Timeline For Regulation Development. In regard to the development of regulations for this proposal, DMHC indicates that it is in the research and evaluation phase. DMHC's projected timeline for regulations for this proposal is:

- By June 1, 2016—Complete research and evaluation.
- By June 1, 2016—Begin drafting regulatory language, if necessary.
- By July. 1, 2017—Begin formal rulemaking process, if necessary.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

Issue 4: Federal Mental Health Parity Ongoing Compliance Review

Oversight and Budget Issue. DMHC requests $529,000 for 2016-17 and 2017-18 for clinical consulting services to design new compliance filing instructions and forms, conduct review of plans' classification of benefits and nonquantitative treatment limits (NQTLs), and for resolving clinical issues arising in compliance filings associated with performing ongoing oversight of compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) and its Final Rules. These resources would be used for the initial front-end compliance reviews for new plans and new products.

According to DMHC, clinical consultants provide the specialized medical, mental health, and substance use disorder knowledge that is not available through the civil service system but is necessary for reviewing critical aspects of MHPAEA compliance, including the classification of benefits and NQTLs. The classification of benefits is a threshold issue that must be determined in a plan filing before the actuary can evaluate compliance in the financial requirements and QTLs, and before the attorneys can evaluate compliance in EOCs and other enrollee disclosures. Generally the clinical consultant team consists of one lead that is a non-clinician reviewer who drafts comment letters to plans, based on the clinical review conducted by three to four clinicians. The lead reviewer also coordinates the consultant team's workflow with that of the attorneys and actuary and participates in the teleconferences with the plans to resolve compliance matters.

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

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

In contrast, these rules require analysis of broader benefit classifications. Rather than a comparison of the applicable terms and conditions, the rules require extensive review of the health plans' processes and justifications for classifying benefits into six permissible classifications: (1) inpatient, in-network, (2) inpatient, out-of-network, (3) outpatient, in-network, (4) outpatient, out-of-network, (5) emergency care, and (6) prescription drugs.

After classifying all benefits into the six categories, health plans must then determine parity for financial requirements (e.g., deductibles, copays, coinsurance); quantitative treatment limitations (QTL) (e.g., number of visits, days of treatment) and nonquantitative treatment limitations. According to DMHC, the analyses of the health plans' methodology for determining compliance requires

extensive reviews that are beyond the DMHC's existing capacity and expertise. Moreover, the analyses required under the rules are data-intensive and require information the health plans do not routinely file with DMHC (e.g., methodologies to determine benefit classifications, projected plan payments, and rationale for application of NQTL). As such, implementation and enforcement of health plan compliance with the MHPAEA require the DMHC to undertake both an initial focused analysis and continuing evaluation of a new depth and breadth due to the complexities of this law and the inter-relationship with existing California mental health parity laws and EHB requirements.

2014 and 2015 Budget Resources for Federal Mental Health Parity. The 2014 budget included a one-time augmentation of $369,000 (Managed Care Fund) in 2014-15 for clinical consulting services to conduct initial front-end compliance reviews to ensure oversight of California's implementation of the MHPAEA and five positions to enforce these requirements. (The Legislature augmented DMHC's budget by $4.2 million to add 10 positions and consulting services to ensure enforcement of these requirements and the Governor vetoed five of the positions added by the Legislature, resulting in a net augmentation of five positions.)

The 2015 Budget Act authorized additional resources to further support onsite medical surveys of the plans affected by the MHPAEA. As a result, according to DMHC, sufficient resources exist to support the back-end component of MHPAEA compliance reviews; however, based on the results of the 2014-15 MPHAEA compliance project described below, existing resources will not be sufficient to perform the work attributed to the initial front-end reviews and associated actuarial duties.

The DMHC initiated monitoring of plan compliance with MHPAEA in the 2014-15 MHPAEA compliance project, which is anticipated to be completed during 2015-16. This project has been a focused review of one to fifteen standard individual and small group Exchange products and large group products to determine initial compliance within 26 plans' commercial coverage. One Attorney IV (the designated department-wide MHPAEA coordinator), one Attorney III, one Associate Governmental Program Analyst, and one Associate Life Actuary have been devoting time to this effort since 2014. Based on the results of this project to date, the DMHC anticipates a significant increase in workload associated with the ongoing monitoring and review of 28 complex filings and 125 routine filings of commercial products to ensure compliance with MHPAEA.

Status of Initial Front-End Reviews. Compliance reviews consist of two components: 1) front-end reviews, which are a review of documentation submitted by plans to ensure compliance with MHPAEA, and 2) back-end reviews, which are onsite reviews to verify plans are operating in accordance with compliance filings. As part of last year's proposal requesting resources, DMHC indicated that the initial front-end reviews would be completed by December 31, 2015. As noted in the chart below, six of the 25 plans have not yet completed this review. According to DMHC, these plans were far enough in the process to be able to address cost-sharing for mental health and substance use disorder services and disclose to enrollees any changes in cost share to ensure there is parity for these services as of January 1, 2016, as required by an all plan letter. Consequently, it has not taken any enforcement action again these plans.

Status of MHPAEA Initial Front-End Review Compliance Filings (as of March 7, 2016)

Health Plan	Status
Aetna Health of California	Open – May 2016
Alameda Alliance Joint Powers Authority	Closed – 11/5/2015
Blue Cross of California	Open – May 2016
California Physicians' Service	Open – April 2016
Chinese Community Health Plan	Closed – 12/11/2015
Cigna Healthcare of California	Open – May 2016
Community Care Health Plan	Closed – 12/11/2015
Contra Costa County	Closed – 12/28/2015
County of Ventura	Open – May 2016
Health Net	Closed – 7/21/2015
Kaiser Foundation Health Plan	Closed – 11/16/2015
LA Care Joint Powers Authority	Closed – 12/23/2015
Local Initiative Health Authority for LA County	Closed – 12/30/2015
Medi-Excel, SA de CV	Closed – 12/7/2015
Molina Healthcare of California	Closed – 1/15/2016
San Francisco Health Authority	Closed – 12/23/2015
San Mateo Community Health Plan	Closed – 12/11/2015
Santa Clara County dba Valley Health Plan	Closed – 12/29/2015
Santa Cruz-Monterey-Merced Managed Md. Care Commission dba Central California Alliance for Health	Closed – 12/11/2015
Seaside Health Plan	Closed – 12/24/2015
Sharp Health Plan	Closed – 1/29/2016
Sistemas Medicos Nacionales (SIMNSA)	Closed – 12/30/2015
Sutter Health Plan	Closed – 12/31/2015
United Healthcare of California	Open – April 2016
Western Health Advantage	Closed – 12/2/2015

Subcommittee Staff Comment—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. Please describe the status of the initial front-end reviews. Why has DMHC not taken any enforcement action against plans that have not completed their initial front-end reviews? How will this affect the timeliness of the next steps, including the back-end reviews?

3. Is the department on track to begin the second phase of the compliance review, on-site surveys, in April 2016?

4. Please provide an update on DMHC's engagement with mental health stakeholders.

Issue 5: Large Group Rate Review (SB 546, 2015)

Budget Issue. DMHC requests four permanent positions and $682,000 for 2016-17 and $644,000 for 2017-18 and ongoing to address the increased workload resulting from the implementation of SB 546 (Leno), Chapter 801, Statutes of 2015.

This request includes $106,000 for 2016-17 and $100,000 for 2017-18 and ongoing for contractor costs. In 2016-17, contractor costs consist of $6,000 for transcription services and $100,000 for actuarial consulting. In 2017-18 and ongoing, the contractor costs are for actuarial consulting.
The requested positions are as follows:

Program/Classification	
Office of Legal Services (OLS)	
Attorney III	1.0
Staff Services Analyst	1.0
Legal Secretary	1.0
Office of Financial Review (OFR)	
Associate Life Actuary	1.0
TOTAL	**4.0**

Background. The federal Affordable Care Act (ACA) requires rate review of individual and small group rate filings, but exempts large group rate filings. Health plans set rates for large groups in one of two ways. For a "larger" large group – a group with more than 500 covered lives (and in some cases more than 1,000 lives) – a health plan may base rates entirely on the claims experience of that group. For a "smaller" large group – a large group with less than 500 covered lives – a health plan would set rates using a formula comprised of a standard risk for all large employers (e.g., the base rate), additional factors that affect the base rate that are specific to that employer group (e.g., geographic region, industry, etc.), and the claims experience of the specific employer group.

Pursuant to the ACA, health plans must file a justification for an unreasonable premium rate increase, prior to implementation, and publicly disclose the information. A rate increase is subject to review if it is 10 percent or more for a 12-month period (or a more stringent standard set by the state). However, under the May 23, 2011, Rate Increase Disclosure and Review Final Rule (Final Rule), this requirement applies only to non-grandfathered individual and small group contracts and does not apply to large group contracts. The U.S. Department of Health and Human Services (HHS), the federal agency implementing the ACA's rate review requirements, determined large group rate review unnecessary because large groups are sophisticated purchasers and the premiums for most large groups are experience rated, based on the group's own claims experience.

In 2010, SB 1163 (Leno), Chapter 661, Statutes of 2010, implemented the ACA's rate review provisions in California. These provisions require health plans to file individual and small group rate changes 60 days prior to implementation and submit justification for an unreasonable rate increase, as defined by the ACA. SB 1163 went beyond federal law by requiring plans to file any rate change for unreasonable rate increases for large group contracts 60 days prior to implementation. However, the Final Rule, which was published after SB 1163 was enacted, does not apply to the large group market nor does it contain a definition for unreasonable rate increase that applies to large group contracts.

Also related to California's rate review is SB 1182 (Leno), Chapter 577, Statutes of 2014. Under SB 1182, health plans and health insurers must annually provide de-identified claims data at no charge to a large group purchaser that requests the information and meets specified conditions. This data is restricted to: (1) large group purchasers with an enrollment of more than 1,000 covered lives, with at least 500 covered lives enrolled with the plan or insurer providing the claims data, or (2) multi-employer trusts with an enrollment of more than 500 covered lives, with at least 250 covered lives enrolled in the plan providing the claims data. The threshold is set at 1,000 and 500 covered lives because there must be a sufficient number of covered lives to de-identify the claims information to protect the confidential medical information of individuals.

SB 546 establishes additional rate review requirements for the large group market. These requirements include:

Effective on or before October 1, 2016, and annually thereafter, health plans must file the following information aggregated for the specific health plan's entire large group market:

- Weighted average increase for all large group benefit designs during the preceding calendar year;
- Number and percentage of rate changes, as specified;
- Factors affecting the base rate and actuarial basis for those factors, as specified;
- Plan's overall annual medical trend factor assumptions for all benefits and by aggregate benefit category;
- Amount of the projected trend separately attributable to the use of services, price inflation, fees, and risk for annual policy trends by aggregate benefit category;
- Comparison of the aggregate per member per month costs over the prior five year period by specific category;
- Changes in enrollee cost-sharing, changes in enrollee benefits, and quality improvement efforts over the prior year; and
- Number of products covered by the information that incurred the excise tax. (The excise tax, otherwise known as the "Cadillac tax," refers to the requirement in the ACA that, effective for tax years after December 31, 2017, imposes a 40 percent federal tax on the aggregate cost of employer-sponsored coverage exceeding a statutory limit; $10,200 for individual coverage and $27,500 for self and spouse or family coverage.)

DMHC must conduct an annual public meeting regarding large group rates within three months of posting the aggregate information on DMHC's website to allow a public discussion of the reasons for the changes in the rates, benefits, and cost-sharing in the large group market.

Health plans must provide a written notice to a large group 60 days prior to a premium rate or change in coverage that includes the following:

- Whether the proposed rate is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange (Covered California) for the most recent calendar year for which the rates are final;
- Whether the proposed rate is greater than the average rate negotiated by CalPERS for the most recent calendar year for which the rates are final; and
- Whether the rate change includes any portion of the excise tax paid by the health plan.

In 2014, there were 8,872,834 enrollees in large group health plans regulated by the DMHC and there are currently 19 health plans participating in the large group market. Provisions of SB 546 require the DMHC to analyze data submitted by these health plans and conduct an annual public meeting to facilitate discussion around the changes in rates, benefits, and cost-sharing in the large group market.

Projected Timeline For Regulation Development. In regard to the development of regulations for this proposal, DMHC indicates that it is in the research and regulatory language development phase. In the interim, DMHC has issued informal guidance to the plans. DMHC's projected timeline for regulations for this proposal is:

- By Sept. 9, 2016—Publish notice of rulemaking.
- By Oct. 24, 2016—Public hearing (if requested).
- By Nov. 1, 2016—Approval by DMHC and send to Office of Administrative Law.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 6: Limitations on Cost-Sharing: Family Coverage (AB 1305, 2015)

Budget Issue. DMHC requests limited-term expenditure authority of $196,000 for 2016-17 and $188,000 for 2017-18 to meet the department's operational needs to implement AB 1305 (Bonta), Chapter 641, Statutes of 2015.

Background. DMHC regulates health plans under the provisions of the Knox Keene Health Care Service Plan Act of 1975, as amended (Knox Keene Act). As enacted by SB 639 (Hernandez) Chapter 316, Statutes of 2013, the Knox Keene Act requires non-grandfathered health plan contracts issued on or after January 1, 2015 in the small group market to include the annual out-of-pocket limit on Essential Health Benefits (EHB) described in the Affordable Care Act (ACA) and subsequent rules, regulations, or guidance. The Knox Keene Act also aligns the out-of-pocket cost limit for covered benefits that are EHB to this federal limit for non-grandfathered health plan contracts issued on or after January 1, 2015, in the large group market, to the extent that this limit does not conflict with federal law or guidance.

AB 1305 prohibits a health plan from imposing a maximum out-of-pocket limit for an individual within a family that is greater than the maximum out-of-pocket limit for individual coverage for that product. This provision aligns with and exceeds federal requirements.

AB 1305 also requires that if a non-grandfathered health plan contract for family coverage includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible for individual coverage for that product, except for a high deductible health plan (HDHP). The requirement would apply to non-grandfathered family coverage in the small group market beginning January 1, 2016, and in the large group market beginning January 1, 2017. This provision eliminates health plan contracts with aggregated family deductibles, in which an individual with a family HDHP must meet the family deductible before the plan covers any services, other than preventive services, for that individual.

In the case of HDHPs, the bill includes an exception to allow individuals to continue to qualify for Health Savings Accounts (HSA). Under federal law, an individual may qualify for an HSA only if the individual is covered under an HDHP. A family HDHP is an HDHP covering an eligible individual and at least one other individual. As explained in Internal Revenue Service (IRS) Publication 969, if either the deductible for the family as a whole or the deductible for an individual family member is less than the minimum annual deductible for family coverage, the plan does not qualify as an HDHP. For calendar year 2015, the minimum annual deductible is $1,300 for self-only coverage and $2,600 for family coverage. Thus, in 2015, a family HDHP must have an individual deductible of at least $2,600 or the plan does not qualify as an HDHP. (Specific deductible amounts change in subsequent years.) A family HDHP with an individual deductible below $2,600 would cause individuals to lose HSA tax savings.

Accordingly, AB 1305 provides that, in the case of a health plan contract meeting the federal definition of an HDHP, the deductible shall be the greater of either of the following: 1) the deductible for individual coverage under the plan contract, or 2) the amount required under federal law to qualify for an HSA, as updated by the IRS annually as indexed for inflation. This language prevents, in the case of a family HDHP, the individual deductible from being lower than the amount required under federal law for an individual to qualify for an HSA.

To address the workload resulting from AB 1305, DMHC's Office of Legal Services requests limited-term expenditure authority to perform short-term work from July 1, 2016, through June 30, 2018. These resources will be used to review and process legal questions related to AB 1305. Reviewing legal questions encompasses all tasks necessary to compose the final determination and presenting the information to impacted or requesting divisions, including the drafting/filing of legal memoranda. These resources will also allow the DMHC to develop and promulgate a regulation package to implement the new provisions contained in the bill.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

2. When does DMHC anticipate beginning the stakeholder process in regard to this policy?

Issue 7: Outpatient Prescription Drug Formularies (AB 339, 2015)

Budget Issue. DMHC requests limited-term resources of $733,000 for 2016-17; $700,000 for 2017-18; $558,000 for 2018-19; and $558,000 for 2019-20 to meet the department's operational needs in order to address the short-term workload resulting from the implementation of AB 339 (Gordon) Chapter 619, Statutes of 2015.

This request includes $196,000 in contracted consulting costs for 2016-17, 2017-18, 2018-19, and 2019-20 to assist DMHC offices with developing implementation standards and identifying health plan clinical standard deficiencies during the survey process.

Background. The passage of AB 339 builds on the federal guidance and existing general anti-discrimination provisions with more robust, specific, and enforceable parameters for drug benefit designs. AB 339 aligns with Covered California's current approach to address the high out-of-pocket costs for medically necessary drugs and incorporating a sunset date of 2020 for the out-of-pocket cost limitations and drug tiering provisions. AB 339 takes an appropriate measured approach in addressing the competing challenges of providing access to medically necessary drugs for consumers without severely hampering health plans' ability to contain costs through drug price negotiations. Moreover, AB 339 aligns with and incorporates new federal standards regarding the prescription drug Essential Health Benefits, including the requirements regarding pharmacy and therapeutics committees, formulary transparency, and reasonable access to retail pharmacies (rather than mail-order pharmacies). Adding these provisions to California law ensures they will be enforceable by the DMHC.

Additional provisions of AB 339 include:

- Requires health care service plan contracts (other than Medi-Cal managed care contracts) to cover medically-necessary prescription drugs, including medically-necessary single-tablet antiretroviral drug regimens for AIDS/HIV, except as specified.

- Limits cost-sharing for a 30-day supply of a prescription to no more than $250 (or $500 for a bronze-level plan or its actuarial equivalent for large group), except that an applicable deductible must be satisfied, as specified.

- Specifies formulary tier definitions for certain non-grandfathered individual or small group products.

The DMHC licenses and regulates health plans that provide full-service and specialty services to more than 25 million Californians. The DMHC regulates health plans under the provisions of the Knox Keene Act. To meet its mission of protecting consumer health care rights and ensuring a stable health care delivery system, the DMHC resolves grievances; conducts onsite medical surveys and financial exams; and reviews and approves plan contracts, disclosures, and vendor arrangements.

Currently, the DMHC regulates a total of 34 full service commercial and behavioral health plans that provide a prescription drug benefit. In order to implement AB 339, the DMHC is required to complete a compliance review of existing plans and any new license applicants as to their prescription drug formularies. Health plans may have a different prescription drug formulary for each of its product

types, which may result in each health plan submitting up to 15 different formularies. The extensive review of health plan filings will be performed by the DMHC's Office of Plan Licensing and Division of Plan Services. In addition, as a result of the passage of AB 339, DMHC's Office of Legal Services will need to draft new regulations to update the existing Title 28, CCR Section 1300.67.24, which imposes standards for outpatient prescription drug coverage, limitations, exclusions, and cost-sharing.

Office of Plan Licensing (OPL). OPL is responsible for assuring regulatory compliance of health plans with the Knox Keene Act and the Final Rules. This is accomplished by reviewing applications for licensure, material modifications to existing licenses, and amendments to existing licenses. This review includes requiring health plans to provide legally sufficient documentation of plan organization, disclosures, enrollee benefits, and other aspects of regulatory compliance.

The passage of AB 339 requires that each of the 34 affected health plans submit filings demonstrating compliance with its provisions. DMHC will need to analyze the various provisions of the bill, including whether the cost-sharing for this benefit is within the parameters set forth in the bill, the health plans' formularies do not discourage enrollment of individuals with health conditions or reduce the generosity of the benefit for enrollees with a particular condition in a manner that is not based on a clinical indication or reasonable medical management practice, and verify that the health plans are defining the formulary tiers appropriately. In order to facilitate compliance with AB 339, OPL must review the health plans' Evidences of Coverage (EOCs), Disclosure Forms, combined Evidences of Coverage/Disclosure Forms that contain pharmacy benefits, policies and procedures, and prescription drug formularies for each of the health plans' products.

Ongoing workload consists of the oversight of health plans' compliance with the additional mandated prescription drug requirements and the review of any new license applications for compliance with the language of AB 339. To facilitate the compliance project and review the prescription drug benefit offered by full service health plans, OPL is requesting limited-term resources to perform the following workload from July 1, 2016, through June 30, 2020:

- 3.0 Associate Governmental Program Analysts (Temporary Help – July 1, 2016 to June 30, 2020). These analyst positions will be responsible for the creation and ongoing maintenance of the formulary template for health plans to utilize, filing tracking, serve as the DMHC liaison between clinical consultants and plans, coordinate transfer of documents to clinical consultants for review, coordinate filing teleconferences between the DMHC and clinical consultants, and conduct initial filing review of plan submissions to identify issues and deficiencies with the filings.

- Pharmacy or Clinical Consultant (Limited-term – July 1, 2016 to June 30, 2020). DMHC will need to retain either a pharmacy or clinical consultant to develop standards and communicate to health plans what constitutes reasonable cost-sharing and what must be provided to show it does not discourage the enrollment of individuals with health conditions nor reduce the generosity of the benefit for enrollees with a particular condition. Based on similar clinical consulting contracts, OPL estimates the ongoing costs to be approximately $46,000 per year.

Division of Plan Surveys (DPS). DPS, part of DMHC's Help Center, is responsible for conducting routine medical surveys of each licensed full service and specialty health plan as required by the Knox Keene Act, as well as non-routine investigative medical surveys as deemed necessary by DMHC's Director. DPS anticipates retaining a clinical consultant during the survey process to assess health plan

compliance related to the bill's clinical standards and to make revisions to the applicable audit tool or Technical Assistance Guide (TAG) and associated worksheets. DPS is requesting the following resources:

- Clinical Consultant (Limited-term – July 1, 2016 to June 30, 2020). The clinical consultant will be responsible for the one-time review and revision of the TAG and file review worksheets for use during routine medical surveys and dissemination of training materials to affected plans. The consultant will conduct an assessment of each health plan to verify that prescriptions for medical conditions are not all placed in the highest cost tiers within the formularies, draft deficiencies, and provide clinical follow-up to assess whether the plans corrected deficiencies. Based on similar consulting services contracts, DPS estimates contracting costs to be approximately $150,000 per year.

Office of Legal Services (OLS). OLS conducts legislative and legal analyses for the DMHC; leads rulemaking activities, including pre-notice stakeholder engagement, research and analysis, drafts regulatory language, conducts public hearings, responds to comments, and files regulation package(s) with the Office of Administrative Law; and responds to Public Records Act and Information Practices Act requests.

OLS anticipates conducting legal research and producing legal opinion memoranda pertaining to AB 339 between January 1, 2016, and June 30, 2018, as this bill is central to the DMHC's enforcement of anti-discrimination laws prohibiting prescription drug benefit designs that may potentially reduce the benefits for chronically ill individuals. OLS also anticipates promulgating one regulation package in order to update the existing regulation governing cost-sharing, limitations, and exclusions of coverage for prescription drugs (title 28, California Code of Regulations, Section 1300.67.24). OLS is requesting the following resource:

- Attorney I (Temporary Help – July 1, 2016 to June 30, 2018). This position will be responsible for reviewing and processing legal questions related to AB 339. The review of legal questions encompasses all tasks necessary to compose the final determination and present to impacted or requesting divisions. In addition, this position will be responsible for the promulgation of regulations pertaining to AB 339, which includes conducting stakeholder meetings, researching and analyzing policy concerns, drafting regulations, holding public hearings, and drafting the final rulemaking documents.

Projected Timeline For Regulation Development. In regard to the development of regulations for this proposal, DMHC indicates that it is in the research and evaluation phase. DMHC's projected timeline for regulations for this proposal is:

- By June 1, 2016—Complete research and evaluation.
- By June 1, 2016—Begin drafting regulatory language.
- By Jan. 1, 2017—Begin formal rulemaking process.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. When does DMHC anticipate beginning the stakeholder process in regard to this policy?

Issue 8: Provider Directories (SB 137, 2015)

Budget Issue. DMHC requests eight permanent positions and $1,436,000 for 2016-17; $1,366,000 for 2017-18; and $1,181,000 for 2018-19 and ongoing to address the increased workload resulting from the implementation of SB 137 (Hernandez) Chapter 649, Statutes of 2015.

This request includes $153,000 for 2016-17; $153,000 for 2017-18; and $77,000 for 2018-19 and ongoing for the Office of Enforcement's (OE) expert witness and deposition costs for enforcement trials. This request also includes limited-term expenditure authority of $89,000 for 2016-17 and 2017-18, enabling DMHC's Office of Technology and Innovation (OTI) to address short-term IT-related setup activities.

The requested positions are as follows:

Program/Classification	
Office of Legal Services (OLS)	
Attorney I	1.0
Office of Plan Licensing (OPL)	
Attorney I	1.0
Associate Governmental Program Analyst	1.0
Division of Plan Surveys (DPS)	
Attorney I	1.0
Associate HCPSA	1.0
Office of Enforcement (OE)	
Attorney III	1.0
Office of Financial Review (OFR)	
Corporations Examiner	1.0
Office of Administrative Services (OAS)	
Associate Governmental Program Analyst	1.0
TOTAL	**8.0**

Background. Existing state law requires health care service plans (health plans) to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area. Since 2001, when AB 938 (Cohn), Chapter 817, Statutes of 2001, was enacted, state law has also included requirements related to health plans' provider directories. With the enactment of the Affordable Care Act (ACA), the accuracy of provider directories has never been more important as the ACA has enabled hundreds of thousands of individuals who formerly lacked health coverage to obtain health coverage for the first time. Since the ACA requires health plans to cover individuals who formerly could not obtain coverage due to their health problems, health plans have focused on other ways to control costs. One way health plans have attempted to control costs is to develop products with 'narrow networks,' which have fewer provider options, but still achieve network adequacy. Consequently, there may be even greater variation in a health plan's provider networks than in the past, with some networks having more limited provider options than others.

Understandable and accurate provider networks enable consumers to make important decisions and are fundamental components to allow enrollees timely access to health care services. SB 137, effective July 1, 2016, establishes clear and specific requirements for publishing and maintaining health plans' provider directories, including content, updating and reporting standards. To achieve this, SB 137 includes the applicable controls and requirements, and provides the DMHC and California Department of Insurance (CDI) with the responsibility to develop uniform provider directory standards that health plans and providers must follow. SB 137 also gives the DMHC the authority to enforce the law and take action if a health plan or provider is found to be non-compliant.

The requirements of SB 137 apply to all full service and specialty health plans including Medi-Cal managed care plans and includes the following provisions:

- Health plans must require their contracting providers, when they are no longer accepting patients, to direct potential enrollees to the health plan for additional assistance in finding a different provider and to inform the DMHC of the possible inaccurate information in the directory.
- Health plans must publish and maintain provider directories on their public website, with information on contracting providers that deliver health care services to the health plan's enrollees.
- Health plans must reimburse enrollees for any amount beyond what the enrollee would have paid for in-network services, if the enrollee reasonably relied on the provider directory.
- Mandates specific requirements and timelines for health plans to actively investigate reports of inaccuracies in their directories and sets forth triggers for when a provider must be removed from the directory. The specific requirements and timeframes include:
    - Health plans must update their provider directories throughout the year based on specified criteria.
    - Health plans must, at least annually, review and update all of their provider directories in their entirety. As part of the annual update, health plans are required to send notices to providers at least annually, or once every six months for individual health professionals who are not affiliated with a physician group. The notice must include all of the products the provider is contracted to provide services for as well as a warning that failure to respond may result in a payment delay.
    - Providers must respond within 30 days to notices from health plans confirming the information the health plan has for that provider is correct or with updated information.
    - If the provider does not respond to the health plans request for information within 30 days, the health plan has 15 business days to verify the provider's information in writing, electronically or by telephone.
    - If the health plan cannot verify the provider's information, they must notify the provider 10 days in advance that the health plan will be removing the provider from their directory. This 10-day notice will also contain a second warning to the provider that failure to verify their information may result in a payment delay.
- Based on the providers' responses as well as upon receipt and verification of information indicating that updates are necessary, health plans must revise provider information as part of their weekly online directory update and their quarterly updates for printed directories. Other triggers identified in SB 137 for such updates include:
    - Reports from enrollees or potential enrollees that the provider directory contains inaccurate information.
    - Changes from providers outside of the annual or semi-annual affirmation process discussed above, such as address changes.

- In addition to health plans removing providers from directories when they cannot verify the providers information, they must also remove providers when:
    - The provider has retired or has ceased to practice.
    - The provider or provider group is no longer contracted with the health plan.
    - The contracting provider group has informed the health plan that the provider is no longer associated with the provider group and is no longer under contract with the health plan.
- Instead of requiring a health plan to file its entire provider directory annually with the DMHC to review, it now requires health plans to annually submit their policies and procedures explaining how they will comply with the law and develop an accurate provider directory. This approach is consistent with how the DMHC currently reviews health plan requirements.

These provisions enable providers to receive information from the health plans to identify under which plan products they are contracted to provide services – an issue that providers have consistently raised with respect to their inability to ensure their information is accurate.

SB 137 requires the DMHC to create uniform standards for provider directories on or before December 31, 2016. Because these standards are expected to require health plans to make significant system changes, the provisions requiring regulatory guidance will go into effect by July 31, 2017, or 12 months after the provider directory standards are developed, whichever occurs later. One of the significant standards will include the process for referring a patient to hospitals and other providers and the way information is presented in the directories.

SB 137 also places a direct obligation on providers to report their information to the health plans and allows health plans to delay payment to incentivize provider responses when requested for the provider directory.

SB 137 allows health plans to delay payment for one month in the event the provider does not respond to the required request for directory information verification. For providers reimbursed by capitation, the health plan cannot delay more than 50 percent of the total capitation rate for the next scheduled capitation payment. For providers reimbursed via claims, the health plan can delay claims payments for up to one calendar month beginning on the first day of the following month.

In order to address the concern of compliance with the new authority to delay payment, SB 137 requires the DMHC to include a review of the health plan's compliance with this provision in its routine financial examinations of the health plans, which occur every three to five years.

Currently, the DMHC regulates a total of 74 full service and 49 specialized health plans that contract with providers to deliver services to enrollees and that maintain provider directories in accordance with current law. According to DMHC, implementation of SB 137 creates additional workload for all DMHC offices as its provisions require changes to existing departmental processes, such as routine medical surveys, financial reviews, and licensure. In addition to process changes, the DMHC anticipates additional workload resulting from SB 137 due to an increased number of requests for information and enforcement case referrals, additional staff, and the necessary completion of legal memoranda and regulation packages.

Office of Legal Services (OLS). OLS conducts legislative and legal analyses for the DMHC; leads rulemaking activities, including pre-notice stakeholder engagement, research and analysis, drafts

regulatory language, conducts public hearings, responding to comments, and files regulation package(s) with the Office of Administrative Law; and responds to Public Records Act and Information Practices Act requests. To perform the additional workload required by SB 137, OLS requests the following permanent positions:

- Attorney I. This position will be responsible for the promulgation of regulations and completion of legal memoranda and review of legal questions related to SB 137. The review of legal questions encompasses all tasks necessary to compose the final determination, including gathering data, researching applicable law, conducting staff meetings, crafting a position, briefing management, and presenting to impacted or requesting divisions.

Office of Plan Licensing (OPL). OPL is responsible for assuring regulatory compliance of health plans with the Knox Keene Act and the Final Rule, which includes licensing health plans and approving changes to the licensee and its operations such as provider, vendor, and subscriber contracts; provider networks; utilization management processes; quality assurance systems; and financial viability. In order to facilitate ongoing review of SB 137 compliance for each of the 74 full service and 49 specialized health plans, OPL is requesting the following permanent positions to perform the additional ongoing workload:

- Attorney I. This position will be responsible for conducting legal research to determine criteria and requirements for implementation of the provider directory process requirements; leading interdepartmental meetings related to implementation of the review process; developing and maintaining a structure for review of compliance of each health care service plan, including checklists, spreadsheets, and templates for use during filing reviews; designing and updating filing review guidelines for internal review; performing comprehensive review of submitted filings, including a summary of the filing, coordinating with other divisions (e.g., the OFR) to review submitted documents, preparation of appropriate comments, legal analysis of the filing for compliance, and compiling documentation support referrals to the OE.
- Associate Governmental Program Analyst. This position will be responsible for assisting with the analysis and implementation of provider directory process requirements, including developing and maintaining a structure for compliance implementation; creating and maintaining a weekly tracking report to document health plan compliance issues and status of completion of annual filings; coordinating the initial review of each health plan's initial filing and subsequent amendments for any administrative issues and deficiencies; assisting with compiling documentation in preparation for drafting referrals to the OE; and participating in trainings outlining compliance review processes and updates reflecting changes in the law.

Division of Plan Surveys (DPS). DPS, part of DMHC's Help Center, is responsible for conducting routine medical surveys of each licensed full service and specialty health plan on a triennial basis as required by the Knox Keene Act, as well as non-routine investigative medical surveys as deemed necessary by DMHC's director. As part of that survey, DPS conducts a review to assess if health plan processes ensure access and availability of health care services. Presently, DPS reviews health plan provider directories for compliance with existing laws as a part of this review. DPS anticipates the scope of this review will expand with the implementation of SB 137 and is requesting the following permanent positions to perform the additional ongoing workload:

- Attorney I. This position will be responsible for assisting with the survey process, including survey preparation, developing the survey strategy, and providing legal review of deficiencies; providing legal review of corrective actions during follow-up surveys; and reviewing revisions to the applicable audit tool or Technical Assistance Guide (TAG).

- Associate HCSPA. This position will be responsible for analyzing each of the health plan's processes and informational flows to facilitate compliance with SB 137 during the survey, monitoring corrective actions and conducting follow-up surveys, and drafting revisions to the applicable audit tool or TAG.

Office of Enforcement (OE). OE handles the litigation needs of the DMHC, representing the department in actions to enforce the managed health care laws and in actions that are brought against the department. Cases may be referred to OE by other DMHC programs that review the activities of health plans for compliance with the Knox Keen Act.

OE has historically received individual complaint referrals for an inadequate network from the Help Center and has treated these referrals as a "track and trend" opportunity, unless substantial harm was identified. DPS has also referred a small number of matters, which are more complex in nature. OE anticipates an increase of approximately 15 annual referrals in 2016-17 and 2017-18 from other DMHC programs as SB 137 provides specific provisions to compare a health plan's actions against to determine if a violation has occurred resulting in a more concise remedy, with one referral going to trial. Based on two provider network inadequacy cases OE is currently prosecuting and its experience prosecuting similarly large-scale cases, it is expected SB 137-related referrals will be complex as each case involves a review of each provider contract, database change process, and the protocols and procedures to change databases. These prosecutions can be extremely time and document-intensive.

According to DMHC, this workload cannot be absorbed by current staffing and will require the following permanent position and contract resources to perform the additional ongoing workload:

- Attorney III. This position will be responsible for evaluating enforcement referrals, drafting/sending investigative discovery, recommending a course of action based on evidence received and violations found, and all activities associated with trials/hearings. Trial/hearing activities include preparing course of resolution; preparing law and motion prosecution and defense; pre-trial preparation; researching applicable law, potential violations, and potential defenses to prosecute action; trial/hearing attendance; post-trial briefing; and enforcement of verdict/order.
- Expert Witness/Consultant and Trial Costs. OE anticipates at least three expert consultants will be needed to address the issues raised by these referrals at a cost of approximately $45,000 per contract for a total of $135,000 per fiscal year. These expert consultant contracts are not necessarily related to trial needs, but will be necessary to provide OE with expert opinions on new issues SB 137 raises. In addition to expert consultants, associated trial costs include payment of witnesses travel to and from court, trial resources (discovery expenses, court reporters, copying costs, exhibit preparation), and travel expenses. OE estimates the following associated trial costs: exhibit preparation at approximately $1,000; six administrative discovery depositions per year at approximately $2,000 per deposition (for a total of $12,000); and trial-related travel expenses of approximately $5,000. Total cost is $153,000 per year for 2016-17 and 2017-18. Beginning in 2018-19, a decline in SB 137-related referrals of approximately five to 10 per year is anticipated as the health plans become more familiar with SB 137 requirements. Conversely, trial expenses will level off to approximately $77,000 and remain steady at that rate thereafter. These estimates are based on actual costs incurred for similar trials OE has conducted.

Office of Financial Review (OFR). Division of Financial Oversight (DFO), part of OFR, monitors and evaluates the financial viability of health plans to facilitate continued access to health care services

for the enrollees/patients of California. This is accomplished by reviewing financial statements; analyzing financial arrangements and other information submitted as part of the licensing, material modification, and amendment process; and by performing routine and non-routine examinations.
In order to perform the additional ongoing workload involved with reviewing health plan compliance with SB 137, DFO is requesting the following permanent position to perform the additional ongoing workload:

- Corporations Examiner. This position will be responsible for performing claims sampling analyses, reviewing claims for compliance with SB 137, writing a final report on findings, and performing the review of capitation withholds and including any exceptions in a report for each health care service plan every three years. On an annual basis this position will review health plan records submitted to the DMHC regarding delay of payment of provider claims/capitation, review and approve/deny plan policies and procedures regarding the withhold of payments of claims/capitation to providers, and review plan records submitted to the DMHC each time a health plan withholds the payment of claims/capitation to a provider.

Office of Administrative Services (OAS). OAS encompasses all departmental support services functions with the exception of information technology. These functions include accounting, budgeting, human resources, training and organizational effectiveness, and business management. While the program areas of the DMHC expand, resources to support the programs should also increase. Program expansion due to the passage of SB 137 results in additional hiring activities; the processing of employee-related transactions, such as personnel transactions, travel expense claims, and trainings; contracts and procurements, etc. In order to obtain sufficient resources to handle the workload resulting from SB 137 and to support the additional positions requested in this proposal, OAS is requesting the following permanent position to perform the additional ongoing workload:

- Associate Governmental Program Analyst (AGPA). This position will address the increased workload in the support services functions, such as processing contracts and procurements, preparing budget allotments, managing expenditures, processing accounting transactions and related documents, coordinating job-related training, conducting tasks associated with hiring and human resources issues, and coordinating facility-related accommodations and requests.

Office of Technology and Innovation (OTI). The Division of Support Services (DSS), a division within the OTI, provides support services for and procurement of desktops, laptops, and the associated suite of productivity software. This division is also responsible for staffing the IT Help Desk to respond to both PC administrators and DMHC employees for problem resolution; providing administration for databases and the Exchange/Outlook email application; maintaining DMHC's network, file and printer servers, and application servers; and enabling the security of data through the implementation of virus detection software and intruder detection.

The implementation of SB 137 requires an increase in IT-related support services to address the needs of the additional positions requested in this proposal and related programmatic workload. DSS is requesting two-year limited-term resources to provide the DMHC with sufficient IT-related services to manage the increased workload resulting from SB 137. Resources will be used to support the IT Help Desk and respond to highly complex issues; prepare IT equipment for survey, refresh equipment, maintain the equipment storage room; support critical outages; maintain employee access; creating network accounts; and processing change requests, service requests, incidences and maintenance tasks.

Projected Timeline For Regulation Development. In regard to the development of regulations for this proposal, DMHC indicates it is working with the California Department of Insurance (CDI) to

develop uniform provider directory standards. These standards will be Administrative Procedures Act-exempt until January 1, 2021. DMHC also indicates that it is preparing to start the informal stakeholder process. DMHC's projected timeline for regulations for this proposal is:

- By July 31, 2016—Complete informal stakeholder process.
- By Dec. 31, 2016—Develop uniform provider directory in conjunction with CDI.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. When does DMHC anticipate beginning the stakeholder process in regard to this policy?

3. Has DMHC provided a "check list" to health plans providing guidance on what needs to be completed by the July 1, 2016 deadline to publish and maintain provider directories? If not, when does DMHC anticipate providing this guidance?

Issue 9: Vision Services (AB 684, 2015)

Budget Issue. DMHC requests two permanent positions and $308,000 for 2016-17 and $292,000 for 2017-18 and ongoing to address the increased workload resulting from the implementation of AB 684 (Alejo) Chapter 405, Statutes of 2015.

The requested positions are as follows:

Program/Classification	
Office of Legal Services (OLS)	
Attorney I	1.0
Office of Plan Licensing (OPL)	
Attorney I	1.0
TOTAL	**2.0**

Background. AB 684 authorizes the establishment of landlord-tenant relationships between a registered dispensing optician (RDO), an optometrist, and an optical company, as long as the lease agreement includes specified conditions. Additionally, AB 684 authorizes an RDO or optical company to operate, own, or have an ownership interest in a health care service plan (health plan) licensed under the Knox Keene Health Care Service Plan Act of 1975 (Knox Keene Act), as amended, if the health plan does not directly employ optometrists who provide services to enrollees. This legislation establishes a three-year period for the transition from direct employment of optometrists to lease arrangements.

Optometrists are health care providers licensed under the California State Board of Optometry who perform eye examinations and write prescriptions for eyeglasses and contact lenses. After receiving a prescription, consumers may get their prescriptions filled by optometrists and ophthalmologists (medical doctors) who sell eyewear as part of their practice, or consumers may get their prescriptions filled by RDOs. RDOs are technicians licensed under the Medical Board of California who fit consumers with glasses and contact lenses.

AB 684 resolves long-standing legal disputes between optometrists and optical chain stores. Existing California law has strict prohibitions on relationships between optometrists and RDOs. California laws Business and Professions Code Section 655 currently prohibits optometrists and RDOs from having any financial interest or landlord-tenant relationship with each other and prohibits an optometrist from having any financial interest or landlord-tenant relationship with entities engaged in the manufacture or sale of lenses, frames, and other optical products. Business and Professions Code Section 2556 currently prohibits RDOs from advertising the services of an optometrist or ophthalmologist. It also prohibits an RDO from directly or indirectly employing, or maintaining on or near the premises used for optical dispensing, an optometrist or ophthalmologist. These Business and Professions Code prohibitions are intended to ensure that optometrists' professional decisions are not influenced by commercial interests.

National optical chain stores operate under a "co-location" business model where consumers can obtain an eye examination from an optometrist located at, or near, a retail store where eyeglasses or contact lenses may be purchased. In the 1980s, the parent companies of these optical stores created

affiliate companies which obtained Knox Keene licenses to provide optometric services. Health and Safety Code Section 1395 provides that a health plan licensed under the Knox Keene Act may employ, or contract with, health professionals licensed under the Business and Professions Code, and that a Knox Keene licensee may directly own and operate, through its professional employees or contracted licensed professionals, offices and subsidiary corporations to provide health care services to the plan's enrollees. Thus, optical store companies obtained Knox Keene licenses as a shield against Business and Professions Code Sections 655 and 2556. However, after years of legal challenges, California courts definitively ruled that a Knox Keene license does not exempt optometrists and RDOs from these Business and Professions Code prohibitions, and federal courts ruled that these prohibitions do not violate federal law. Although unsuccessful, these challenges resulted in a moratorium on enforcement of these Business and Professions Code prohibitions from 2006 until 2013.

In the past year, the DMHC has discovered that a number of Knox Keene Act licensed vision plans are currently operating in a manner that would violate the above referenced Business and Professions Code Sections. AB 684 allows these vision plans to continue to operate as health plans with little or no modifications to their current business models, thereby preserving the model of vision coverage that millions of Californians have come to rely upon with no reduction in consumer protections.

At present, the DMHC regulates three specialized vision plans that operate under a "co-location" business model. However, the "co-location" vision plan model does not completely fit the description of a Knox Keene health plan, which the Health and Safety Code defines as an entity that provides health care services in exchange for a prepaid and periodic charge. The three Knox Keene vision plans that operate under the "co-location" model assume little or no risk, and primarily serve individuals rather than groups.

AB 684 repeals existing Business and Professions Code prohibitions that cause optical companies operating under a "co-location" business model to be in violation of California law, allowing an RDO or optical company to operate or own a health plan as long as the health plan does not directly employ optometrists to provide services to health plan enrollees. The plan can employ an optometrist as a clinical director to conduct utilization review and quality assurance activities. Furthermore, a health plan, optometrist, RDO, or an optical company can execute a written lease with an optometrist, as long as the practice is owned by the optometrist, every phase of the practice is under the optometrist's exclusive control, and the optometrist's leased space is separate and distinct, in addition to numerous other requirements. The lease agreement could require an optometrist to provide optometric services at the leased space during certain days and hours, and the agreement could restrict the optometrist's sale of products (frames, lenses, contact lenses) offered by the leaseholder. AB 684 outlines detailed terms of a permissible lease agreement and provides that the Board of Optometry may inspect any individual agreement.

Until January 1, 2019, AB 684 prohibits an individual, corporation, or firm which was operating as an RDO before the effective date of the bill, or an employee of such an entity, from being subject to any legal or disciplinary action for engaging in the conduct prohibited by Business and Professions Code Sections 655 and 2556, except as specified. This provision offers a safe harbor for individuals and corporations now operating under the "co-location" business model and gives them time to adjust their current business models to conform to the provisions of the bill.

Currently, the DMHC licenses and regulates 12 vision plans that provide coverage to approximately 13 million Californians. The passage of AB 684 will require the DMHC to conduct an in-depth review to

ensure existing plans are in compliance with Business and Professions Code Sections 655 and 2556 as amended by AB 684.

In addition, the resolution of the longstanding legal conflict over the enforcement of these Business and Professions Code sections will result in additional plans seeking Knox Keene licensure. Under AB 684, if a RDO or optical company wants to operate or own a health plan, that health plan must be licensed by the DMHC under the Knox Keene Act. Given this requirement, over the next three years the DMHC expects to receive six to eight applications from entities wanting a specialized vision health plan license; to date, two pre-filing conferences have already been scheduled.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

0530 OFFICE OF SYSTEMS INTEGRATION (OSI)

Issue 1: CalHEERS

Budget Issue. OSI requests an increase of $8 million in expenditure authority and two permanent positions in 2016-17 related to the transfer of 58 California Healthcare Eligibility, Enrollment and Retention (CalHEERS) staff to OSI from Covered California. The costs will continue to be reimbursed by Covered California and the Department of Health Care Services (DHCS).
OSI proposes to increase its full day-to-day Project Management (PM) of the staff and activities and continue to provide oversight services for the design, development, implementation and operation and maintenance of the project.

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

CalHEERS is the information technology system that is used to support this application process. The primary business objective of CalHEERS is to provide a 'one-stop shop' to determine eligibility for California's health coverage programs offered by the Exchange and the Department of Health Care Services. CalHEERS is jointly sponsored by the Covered California and DHCS. The CalHEERS project has acquired Accenture, LLP as a prime vendor to develop the CalHEERS solution that will support the implementation of a statewide healthcare exchange.

Currently, Covered California retains the project staff for CalHEERS, including the recruitment and management of positions. Both program sponsors, Covered California and DHCS, have determined that having a third party, like OSI, manage the day-to-day activities of the project would be beneficial to both sponsors. OSI would be able to apply best practices and lessons learned from both current and prior engagements in order to provide greater efficiencies to the Project and allow the program departments to focus on the program needs and how best to accommodate those needs within the project.

The staff would become employees of OSI, but would remain at their current physical location at the project office and continue to perform the same functions. These 58 positions form the entire project team across the following functional areas and are in addition to the six project positions already authorized for OSI:

- Executive Management – 3.0 staff
    - Project Director
    - Assistant Project Director
    - Executive Assistant
- Operational Readiness - 12.0 staff
- System Development - 16.0 staff
- Operations - 9.0 staff
- Project Management Office - 13.0 staff

- Procurement - 5.0 staff

In addition, two positions and an increase in OSI expenditure authority of $265,201 is being requested to provide direct administrative support as a result of both the proposed addition of 58 new positions to the OSI organization and increased project workload.

24-Month Roadmap. In February 2015, CalHEERS established a 24-month roadmap of mission-critical automation needs. This roadmap is intended to be a comprehensive plan delineating major CalHEERS system initiatives and related partner's system critical events to enable overarching strategic and tactical planning by each system organization and sponsors. This roadmap was developed in response to concerns raised regarding the processes by which stakeholder input is provided to and considered by the CalHEERS project to aid decision-making, coordination, and rollout of system changes.

No Independent Validation and Verification (IV&V) Contract. In 2015, both CalHEERS project sponsors, Covered California and DHCS, began transitioning IV&V services to a combination of internal staff and external entities, as the project sponsors believed that such services could be adequately and competently performed by a mix of both civil service staff and independent contractors. To that end, the CalHEERS project established a quality assurance team that includes both external quality assurance consultants and state staff. Also in 2015, Covered California entered into a contract with an expert in cost estimation to perform independent verification of costs for change requests.

According to the federal Department of Health and Human Services, IV&V services should be performed by parties not directly engaged in the development of the project with the purpose of assessing the correctness and quality of a project's product. Typically IV&V reviews, analyzes, evaluates, inspects, and tests the project's product and processes. This analysis includes the operational environment, hardware, software, interfacing applications, documentation, operators, and users to ensure that the product is well-engineered, and is being developed in accordance with customer requirements. IV&V provides management with an independent perspective on project activities and promotes early detection of project/product variances. This allows the project to implement corrective actions to bring the project back in-line with agreed-upon expectations.

Subcommittee Staff Comment and Recommendation—Hold Open. Improvements in communication and stakeholder engagement have occurred in the last year, such as involving consumer advocates in user acceptance testing and conducting summits with relevant stakeholders before releases of new functionality into CalHEERS. However, concerns continue to be raised regarding the transparency with which project decisions are made and the identification of risks and schedule variances. For example:

- New 24 Month Roadmap Format Lacks Details. The most recent version of the 24-month roadmap only contains a timeline through September 2016 (i.e., it does not provide a 24-month projection of changes to CalHEERS). Consequently, it is unclear how the project is planning for changes post-September or what changes will not be completed by September 2016. Additionally, the newly formatted roadmap does not contain the level of detail needed to understand what is included in each release nor a section identifying pertinent stakeholder comments related to each change request. This new version of the roadmap is not as transparent and makes it difficult for stakeholders, including legislative staff, to quickly understand the status of implementation of new functionality into CalHEERS.

- End of IV&V Services Concerning. CalHEERS decision to end the IV&V contract is concerning in that the IV&V vendor provided an independent assessment of project status and risks. It is not clear how the quality assurance team or internal efforts are able to make this independent and transparent assessment. At the time this agenda was published, OSI was not able to provide information specifying how it was accomplishing this function.

  The Legislature recognized the need to design and implement CalHEERS within a short time frame. To facilitate its completion by the federal deadline of January 1, 2014, the Legislature approved a streamlined approach that expedited the implementation of the project, as opposed to requiring the project to comply to the typical information technology (IT) reporting requirements, such as maintaining an IV&V contract throughout the development phase for a project this size. However, given that that the state has met the deadline to develop this system, it is not clear if the project should continue to be exempt from the typical IT reporting requirements.

Questions.

1. Please provide an overview of this proposal.

2. Please explain how the transfer of these positions from Covered California to OSI will improve project management and oversight of CalHEERS. Please explain who will take responsibility for project outcomes.

3. Advocates have used DHCS stakeholder meetings and Covered California Board Meetings to attempt to obtain more details on the project schedule and to provide input on the order of programming priorities. Please explain how this will continue if CalHEERS oversight moves to OSI?

4. Why did the format of the CalHEERS 24 month roadmap change? Has OSI received any feedback about this format change? Why doesn't the 24 month roadmap project farther than September 2016? Shouldn't the roadmap be a dynamic instrument?

5. Did OSI have any role or recommendation in regard to Covered California and DHCS ending its IV&V contract? How is OSI ensuring that IV&V-like activities are occurring at CalHEERS?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

The Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering personal health care services to eligible individuals. DHCS's programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost-effective manner. DHCS programs include:

- ***Medi-Cal.*** The Medi-Cal program is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 12 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, low-income people with specific diseases, and, as of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level.

- ***Children's Medical Services.*** The Children's Medical Services coordinates and directs the delivery of health services to low-income and seriously ill children and adults; its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Child Health and Disability Prevention Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations, and it includes: Indian Health Program; Rural Health Services Development Program; Seasonal Agricultural and Migratory Workers Program; State Office of Rural Health; Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program; Small Rural Hospital Improvement Program; and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. As adopted in the 2011 through 2013 budget acts, the DHCS oversees the delivery of community mental health and substance use disorder services, reflecting the elimination of the Departments of Alcohol and Drug Programs and Mental Health.

- ***Other Programs.*** DHCS oversees family planning services, cancer screening services to low-income under-insured or uninsured women, and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program, and the Prostate Cancer Treatment Program.

See following table for DHCS budget summary information.

DHCS Fund Budget Summary

Fund	Actual	Estimated	Proposed
	2014-15	2015-16	2016-17
General Fund	$17,443,508,000	$18,055,383,000	$19,556,037,000
Federal Trust Fund	53,049,859,000	61,266,825,000	54,669,584,000
Special Funds and Reimbursements	11,714,355,000	15,701,091,000	13,480,475,000
Total Expenditures (All Funds)	**$82,207,722,000**	**$95,023,299,000**	**$87,706,096,000**
Positions	**3455.4**	**3399.4**	**3342.9**

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

Questions.

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

Issue 2: Medi-Cal Estimate

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 $85 billion ($19 billion General Fund) which reflects a General Fund increase of about $1.4 billion above the Budget Act of 2015. See following table for a summary of the proposed Medi-Cal budget.

Medi-Cal Local Assistance Funding Summary

	2015-16	2016-17	
	Revised	**Proposed**	**Difference**
Benefits	$87,917,900,000	$80,481,300,000	($7,436,600,000)
County Administration (Eligibility)	$3,973,900,000	$4,100,400,000	$126,500,000
Fiscal Intermediaries (Claims Processing)	$485,500,000	$456,700,000	($28,800,000)
Total	**$92,377,300,000**	**$85,038,400,000**	**($7,338,900,000)**
General Fund	$17,645,900,000	$19,084,100,000	$1,438,200,000
Federal Funds	$61,036,400,000	$54,046,500,000	($6,989,900,000)
Other Funds	$13,695,000,000	$11,907,700,000	($1,787,300,000)

Caseload. The Governor's budget assumes total annual Medi-Cal caseload of 13.5 million for 2016-17. This is a 1.5 percent increase over the revised caseload estimate of 13.3 million for 2015-16.

Medi-Cal 2020. California's 1115 Waiver Renewal, called Medi-Cal 2020, was approved by the Centers for Medicare and Medicaid Services on Dec. 30, 2015. Medi-Cal 2020 will guide the state through the next five years to transform the way Medi-Cal provides services to its 12.8 million members, and improve quality of care, access, and efficiency. Some of the key programmatic elements of Medi-Cal 2020 are:

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME). This program builds on the success of the state's Delivery System Reform Incentive Program (DSRIP), which was the first such transformation effort in the nation. Under PRIME, Designated Public Hospital (DPH) systems and District Municipal Public Hospitals (DMPHs) will be required to achieve greater outcomes in areas such as physical and behavioral health integration and outpatient primary and specialty care delivery. Additionally, PRIME requires DPHs to transition managed care payments to alternative payment methodologies, moving them further toward value-based payment structures over the course of the waiver. PRIME offers incentives for meeting certain performance measures for quality and efficiency. Over the course of the five-years, federal funding for PRIME for DPHs is $3.27 billion, and for DMPHs is $466.5 million.
- Global Payment Program (GPP). This is a new program aimed at improving the way care is delivered to California's remaining uninsured. GPP transforms traditional hospital funding for DPHs from a system that focuses on hospital-based services and cost-based reimbursement into

a value-based payment structure. Under the GPP, DPHs are incentivized to provide ambulatory primary and preventive care to the remaining uninsured through a value-based payment structure that rewards the provision of care in more appropriate settings. This new approach to restructuring these traditional hospital-focused funds allows California to better target funding for the remaining uninsured and incentivize delivery system change, focusing on the provision of primary and preventive care, and shifting away from avoidable emergency room and hospital utilization.

- Dental Transformation Initiative (DTI). For the first time, California's Waiver also includes opportunities for improvements in the Medi-Cal Dental Program. The DTI provides incentive payments to Medi-Cal dental providers who meet certain requirements and benchmarks in critical focus areas such as preventive services and continuity of care. Over the course of the waiver, up to $750 million in annual funding is available under DTI.
- Whole Person Care (WPC) Pilots. Another component of Medi-Cal 2020 will allow for county-based pilots to target high-risk populations. The overarching goal of the WPC pilots is the integration of systems that provide physical health, behavioral health, and social services to improve members' overall health and well-being, with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC pilots may also choose to expand access to supportive housing options for these high-risk populations. The waiver renewal authorized up to $1.5 billion in federal funding over the five-years; WPC pilot lead entities will provide the non-federal share.

In addition to these programs, Medi-Cal 2020 continues authorities for the Medi-Cal managed care program, Community-Based Adult Services, the Coordinated Care Initiative (including CalMediConnect), and the Drug Medi-Cal Organized Delivery System. The renewal also contains several independent analyses of the Medi-Cal program and evaluations of the waiver programs, including an assessment of access in the Medi-Cal managed care program and studies of uncompensated care in California hospitals.

LAO Findings on Medi-Cal Caseload and Estimate. The LAO finds that the Medi-Cal caseload projections appear reasonable. However, the LAO raises two budget issues related to Medi-Cal. First, the ACA makes the development of Medi-Cal caseload projections especially challenging. The LAO finds that with the caseload estimates are more uncertain than in the past, due to the ACA, and the Legislature should take this into consideration when reviewing the budget. The LAO also recommends that the Legislature require DHCS to report at May Revision hearings on how the most recent data on caseload and redeterminations have informed and changed caseload projections.

Secondly, various significant fiscal uncertainties might affect the overall Medi-Cal budget. The LAO includes detailed discussion of the potential fiscal impacts of: (1) the status of the Hospital QAF; (2) recently proposed federal Medicaid managed care regulations; (3) the new federal 1115 Waiver; (4) ACA expansion costs; and (5) the future of the federal Children's Health Insurance Program (CHIP) funding. The LAO recommends that the Legislature extend the Hospital QAF and generally consider these significant cost pressures and uncertainties in the course of analyzing and making decisions about the budget.

Number of Pending Medi-Cal Applications. In January 2015, a superior court judge ruled that DHCS had not complied with its duty to make Medi-Cal eligibility determinations within the required 45 day timeframe. At one point in 2014, over 900,000 Medi-Cal applications had not been processed. Since then, DHCS implemented improvements and received federal CMS approval to allow for an

accelerated enrollment process through August 2015. As noted below, there are now about 22,000 applications that have not been processed within the 45 day timeframe, which represents about 1.6 percent of the applications received during the time period noted below. It is unknown how this number compares to the processing timeframes prior to federal health care reform, as this information was not previously reported by counties.

Applications over 45 days from August 1, 2015 to March 2, 2016

	Count*
46 to 50 Days	3,478
51 to 55 Days	1,466
56 to 60 Days	1,067
61 to 75 Days	2,073
76 to 90 Days	4,485
91 to 120 Days	3,536
121 and higher days	6,574
Total	**22,679**
Adults (19 and older)	16,892
Children (under 19)	5,787
Total	**22,679**

*The number of pending applications reflected in this chart includes duplicates and non-responders.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item as updated caseload estimates will be provided at the May Revision.

Questions.

1. Please provide a brief overview of the Medi-Cal caseload estimate.

2. Please provide a brief overview of Medi-Cal 2020.

3. Please provide an update on the backlog of Medi-Cal applications.

Issue 3: County Eligibility Administration Funding and Trailer Bill

Budget Issue. The budget continues to provide an additional $169.9 million ($57 million General Fund) in 2016-17 and 2017-18 to counties to administer the Medi-Cal program. According to the Administration, this augmentation provides the funding to address the ongoing increased workload as a result of the significant caseload growth since the federal Affordable Care Act (ACA) implementation.

Additionally, the Administration proposes trailer bill language to suspend the cost-of-living adjustment (COLA) provided to the counties as part of the annual state budget allocation for county administration in 2016-17. The Administration finds that the COLA is not necessary given the augmentations (discussed above) provided in response to ACA implementation. The proposed trailer bill language also deletes outdated language referencing the Healthy Families Program which transitioned to Medi-Cal in 2013-14.

Background. DHCS provides funding for county staff and support costs to perform administrative activities associated with the Medi-Cal eligibility process. Welfare and Institutions Code Section 14154 states the Legislature's intent to provide the counties with an annual COLA. However, the COLA has been suspended since 2009-10.

The way in which the counties process eligibility determinations for the Medi-Cal program changed due to the implementation of the federal Affordable Care Act (ACA) beginning January 2014. The 2013-14 budget allocated $143.8 million (total funds) in additional funding to the counties for implementation of the new ACA requirements. The budget provides for county administration funding of $390 million total funds in 2014-15, $485.3 million total funds in 2015-16, and $655.3 million total funds in 2016-17 for the implementation of the ACA. These funds are allocated above and beyond the counties' baseline county administration funding, which is $1.3 billion in 2016-17.

Once ACA implementation stabilizes, the state and the counties will work collaboratively to develop a new methodology for county administrative funding pursuant to SB 28 (Hernandez and Steinberg), Chapter 442, Statutes of 2013. SB 28 directed DHCS to convene a workgroup to create a new methodology for budgeting and allocating funds for county administration of the Medi-Cal program no sooner than 2015-16.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 4: Medi-Cal Eligibility Systems Workload (AB 1 X1, 2013)

Budget Issue. DHCS requests $3,683,000 ($1,788,000 General Fund) to support the ongoing policy and system initiatives required by AB 1 X1 (Pérez), Chapter 3, Statutes of 2013, the federal Affordable Care Act (ACA). This request includes three-year limited term funding of $3,047,000, and four permanent positions.

Background. The ACA implemented comprehensive health insurance reforms that seek to hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care. As required by the ACA, states were to either create a health insurance exchange or use the federal exchange. The ACA require exchanges to be operational by January 1, 2014.

In 2012-13, DHCS obtained 12.0 two-year limited positions to support the planning, design, development, implementation, and ongoing maintenance of the Medi-Cal eligibility and enrollment system changes and integration with the California Health Benefit Exchange and county eligibility consortia systems. In 2014-15, the 12.0 positions were extended for another two-year term. In addition, in 2014-15, DHCS received eight two-year limited term positions for other implementation efforts, such as the use of the Modified Adjusted Gross Income (MAGI) methodology; simplifications to the annual renewal and change in circumstances processes for Medi-Cal beneficiaries; the use of electronic verifications of eligibility criteria both at initial application and redeterminations of eligibility; and performance standards for DHCS, Covered California, and the Statewide Automated Welfare Systems (SAWS).

These resources (20 positions) are set to expire June 30, 2016. However, according to DHCS, these resources are needed in anticipation of the continuous workload resulting from CalHEERS system changes. Additionally, DHCS is responsible for the development of 16 regulatory packages over the next several years and accompanying policy guidance which continues to impact technology solutions for DHCS.

In addition, DHCS requests for permanent positions as part of contract conversion (of 23 contract consultants) related to information technology services. The contracted IT services have included business and systems analysis, design, testing, and project management support. Much of the work these consultants are performing today is ongoing workload and will continue permanently for DHCS. This workload will include batch processing, streamlining manual processes, automating to the furthest extent possible, ongoing data cleanup, and synchronization of data between CalHEERS and SAWS.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 5: Outreach and Enrollment Extension

Budget Issue. DHCS requests two-year limited-term special fund resources of $435,000 ($217,000 Special Deposit Fund and $218,000 federal funds) to address the workload performed by existing limited term positons that will expire on June 30, 2016. These resources are needed to support the implementation, maintenance and oversight of the Medi-Cal outreach, enrollment, and renewal assistance work that must be carried out to meet the requirements specified in AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, Sections 70 and 71, and SB 18 (Committee on Budget and Fiscal Review), Chapter 551, Statutes of 2014 and as extended by SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015.

The resources will be used to address workload related to collaborating with the counties, the County Medical Services Program (CMSP) Governing Board and community-based organizations in conducting outreach and enrollment activities for hard to reach populations that may be eligible for Medi-Cal, as well as renewal assistance for current Medi-Cal beneficiaries.

Background. The Affordable Care Act (ACA) changed the application and renewal process for the Medi-Cal program and implemented new coverage groups based on an income methodology referred to as Modified Adjusted Gross Income (MAGI). The ACA also mandated Medi-Cal application and renewal simplifications for individuals seeking and retaining coverage; however, Medi-Cal also continues to maintain policies and procedures based on rules that are unchanged by ACA and have been in place for several decades, generally referred to as non-MAGI. The existence of new eligibility groups subject to new eligibility rules while retaining existing Medi-Cal rules and coverage groups has resulted in challenges for individuals seeking and retaining coverage for which they were otherwise eligible. One new aspect of MAGI income methodology that has caused Medi-Cal applicants and beneficiaries some confusion is the need to provide information concerning their income, tax filing status, and tax dependent status.

In response to these changes, The California Endowment (TCE) provided funds, as described below, for the purpose of providing outreach and assistance to uninsured Californians seeking coverage, and retaining eligible individuals with in-person application and renewal assistance:

- Pursuant to AB 82, Section 70, funding in the amount of $28 million ($14 million Special Deposit Fund and $14 million federal funds) for the purpose of providing payments to application assisters as compensation for their efforts in assisting individuals apply and become eligible for Medi-Cal.
- Pursuant to AB 82, Section 71, funding in the amount of $25 million ($12.5 million Special Deposit Fund and $12.5 million federal funds) to the funds for the purpose of outreach to, and enrollment of, targeted Medi-Cal populations. DHCS provides counties with specified grant amount and requires the funded entities to partner with a network of community-based organizations to reach underserved communities.
- Pursuant to SB 18, funding in the amount of $12 million ($6 million Special Deposit Fund and $6 million federal funds) for the purpose of providing Medi-Cal renewal assistance to existing Medi-Cal beneficiaries.
- Pursuant to Section 5 of SB 101 (Committee on Budget and Fiscal Review), Chapter 361, Statutes of 2013, DHCS is authorized to use the funds available to cover the administrative costs.

Covered California had an Interagency Agreement with DHCS, that provides funding for the payments to Certified Enrollment Entities (CEEs) and Certified Insurance Agents (CIAs) for in-person enrollment assistance for individuals who enroll in Medi-Cal and for costs to administer the application assistance program. Beginning July 1, 2015, Covered California implemented a new payment model for the CIAs and will no longer be providing application assistance payments to CEEs and CIAs for applications with Medi-Cal eligible individuals received after June 30, 2015. Covered California currently holds contracts with more than 900 CEEs and nearly 15,000 CIAs. Because DHCS does not have resources to contract with individual CEEs and CIAs and has not fully expended the funds for application assistance for Medi-Cal eligible individuals, the remaining funds for the application assistance program will be transferred to the county outreach and enrollment grants and will be allocated to counties in a manner determined by DHCS.

Based on current enrollment trends, DHCS estimates it will pay out an additional $7.3 million through June 30, 2015. Approximately $2.5 million (9 percent) in remaining funding will be transferred to the county outreach and enrollment grants. These figures represent a portion of the total combined $28 million received from TCE and matching federal funds, which would provide additional funding for county outreach and enrollment grants currently performed by counties and community-based organizations (CBOs). In addition, recent legislation, SB 75, has further extended the timeframe for which DHCS may continue the two programs, from June 30, 2016 to June 30, 2018.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 6: Newly Qualified Immigrants

Budget Issue. The budget includes $83.9 million ($31.8 million General Fund) in savings related to shifting newly eligible New Qualified Immigrants (NQI) populations to Covered California beginning January 1, 2017 pursuant to SB X1 1 (Hernandez), Chapter 4, Statutes of 2013.

Background. The federal Personal Responsibility and Work Opportunity Act (PRWORA) specified that federal financial participation (FFP) is not available for full-scope Medi-Cal services for most qualified nonexempt immigrants during the first five years they are in the country. Currently, FFP is only available for emergency and pregnancy services. California law requires that legal immigrants receive the same services as citizens and pays for other services with 100 percent General Fund.

Effective January 1, 2014, the federal Affordable Care Act (ACA) allow states to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL), referred to as the optional expansion group. Additionally, the ACA established online health insurance exchanges. Covered California, California's health insurance exchange, determines an applicant's eligibility for federally subsidized health coverage. Individuals with incomes below 400 percent FPL are eligible for federal subsidies to help offset the monthly premium costs.

Beginning with the 2016-17 Covered California open enrollment, which is expected to start in October 2016, DHCS will begin transitioning optional expansion childless adult NQIs who have been in the country less than five years from Medi-Cal into Covered California. Coverage (under Covered California) is expected to begin in January 2017. DHCS will pay for all out-of-pocket expenditures and will provide Medi-Cal fee-for-services for services that are not covered by Covered California (such as dental care).

Covered California plans to design this health coverage similar to its implementation of the special ACA requirements related to American Indians and Alaskan Natives.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised by consumer advocates that DHCS has not provided sufficient opportunity to review the details of this transition implementation or sufficient opportunity to comment on notices of actions to individuals who will be impacted by this transition.

Questions.

1. Please provide an overview of this issue.

2. Please describe how the department is engaging with stakeholders on this transition.

3. Please provide a timeline for the activities needed to implement this transition.

Issue 7: Denti-Cal Oversight

Oversight and Budget Issue. DHCS requests four full-time permanent positions and $503,000 ($222,000 General Fund) to address current and anticipated increases in Denti-Cal workload due to ongoing efforts in connection with the findings and recommendations of the California State Auditor (CSA) and the federal Office of Inspector General audits regarding questionable billing for pediatric services.

California State Auditor Findings and Recommendations. A December 2014 California State Auditor (CSA) audit of the Denti-Cal program found that, while the number of active providers statewide appears sufficient to provide services to children, some counties may not have enough providers to meet the dental needs of child beneficiaries. CSA found the utilization rate for Medi-Cal dental services by child beneficiaries is low relative to national averages and to the rates of other states. CSA's analysis of federal data from federal fiscal year 2013 (October 1, 2012 through September 30, 2013) shows that California had the 12th worst utilization rate for Medicaid children receiving dental services among 49 states and the District of Columbia (data from Missouri was unavailable). According to the data, only 43.9 percent of California's child beneficiaries received dental services in federal fiscal year 2013 while the national average for the 49 states and the District of Columbia was 47.6 percent.

CSA stated a primary reason for low dental provider participation rates is low reimbursement rates compared to national and regional averages and to the reimbursement rates of other states CSA examined. For example, California's rates for the 10 dental procedures most frequently authorized for payment within the Medi-Cal program's FFS delivery system in 2012 averaged $21.60, which is only 35 percent of the national average of $61.96 for the same 10 procedures in 2011.

CSA made 24 recommendations to improve Denti-Cal. Since the release of this report, DHCS has fully implemented 15 of these recommendations. See table below for more information.

California State Auditor Recommendations, Status as of February 2016

#	Recommendation	Status
1	To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015: establish criteria for assessing beneficiary utilization of dental services.	Fully Implemented
2	To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015: establish criteria for assessing provider participation in the program.	Fully Implemented

3	To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015: develop procedures for identifying periodically counties or other geographic areas in which the utilization rate for child beneficiaries and the participation rate for providers fail to meet applicable criteria.	Fully Implemented
4	To ensure that child beneficiaries throughout California can reasonably access dental services under Medi-Cal and to increase child beneficiary utilization and provider participation, Health Care Services should take the following steps for the fee-for-service delivery system by May 2015: immediately take action to resolve any declining trends identified during its monitoring efforts.	Pending
5	To help increase the number of providers participating in the program's fee-for-service delivery system, Health Care Services should improve its identification and implementation of changes that minimize or simplify administrative processes for providers. These changes should include revising its processes pertaining to dental procedures that require radiographs or photographs.	Pending
6	To ensure that the influx of beneficiaries resulting from recent changes to federal and state law is able to access Medi-Cal's dental services, Health Care Services should take these steps: continuously monitor beneficiary utilization, the number of beneficiaries having difficulty accessing appointments with providers, and the number of providers enrolling in and leaving the program.	Fully Implemented
7	To ensure that the influx of beneficiaries resulting from recent changes to federal and state law is able to access Medi-Cal's dental services, Health Care Services should take these steps: immediately take action to resolve any declining trends identified during its monitoring efforts.	Pending
8	To ensure that Medi-Cal's child beneficiaries have reasonable access to dental services, Health Care Services should immediately resume performing its annual reimbursement rate reviews, as state law requires.	Fully Implemented
9	To make certain that access to dental services for child beneficiaries is comparable to the access available to the general population in the same geographic areas, Health Care Services should immediately adhere to its monitoring plan.	Pending
10	To make certain that access to dental services for child beneficiaries is comparable to the access available to the general population in the same geographic areas, Health Care Services should also compare its results for measuring the percentage of child beneficiaries who had at least one dental visit in the past 12 months with the results from the three surveys conducted by other entities, as its state plan requires.	Pending
11	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: direct Delta Dental to submit annually a plan that describes how it will remedy the dental access problems in the State's underserved areas and in California's border communities.	Fully Implemented

12	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: direct Delta Dental to contract with one or more entities to provide additional dental services in either fixed facilities or mobile clinics in underserved areas, as its contract requires.	Fully Implemented
13	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: increase Delta Dental's access to beneficiary address information and require it to contact beneficiaries residing in underserved areas directly to make them aware of the program's benefits.	Fully Implemented
14	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: review Delta Dental's outreach activities and implement measurable objectives for its outreach unit.	Fully Implemented
15	To improve beneficiary utilization rates and provider participation under the program's fee-for-service delivery system, Health Care Services should immediately take the following actions: require Delta Dental to develop a dental outreach and education program and to submit an annual plan by the end of each calendar year.	Fully Implemented
16	To ensure that the State pays only for deliverables performed by Delta Dental under the terms of its contract, Health Care Services should immediately take these steps: ensure that the financial manual and invoices are consistent with contract language.	Fully Implemented
17	To ensure that the State pays only for deliverables performed by Delta Dental under the terms of its contract, Health Care Services should immediately take these steps: develop and implement tangible measurements to evaluate Delta Dental's performance of all functions under the contract.	Fully Implemented
18	To comply with state contracting laws that protect the State's interests, Health Care services should implement future contract amendments via appropriate channels, including state contracting procedures.	Fully Implemented
19	To ensure that it reports in the CMS-416 an accurate number of child beneficiaries who received specific types of dental services from the centers and clinics, Health Care Services should continue working on a solution to capture the details necessary to identify the specific dental services rendered.	Pending
20	To make certain that it meets the requirements of the new state law and that its performance measures are accurate, Health Care Services should do the following: establish the provider-to-beneficiary ratio statewide and by county as performance measures designed to evaluate access and availability of dental services and include this measure in its October 2015 report to the Legislature.	Will Not Implement
21	To make certain that it meets the requirements of the new state law and that its performance measures are accurate, Health Care Services should do the following: require that the provider field in its data systems be populated in all circumstances.	Fully Implemented

22	To make certain that it meets the requirements of the new state law and that its performance measures are accurate, Health Care Services should do the following: correct the erroneous data currently in its data warehouse and fix its process for transferring data from its mainframe to its data warehouse.	Fully Implemented
23	To ensure that Health Care Services and its fiscal intermediaries reimburse providers only for services rendered to eligible beneficiaries, Health Care Services should do the following: Obtain Social Security's Death Master File and update monthly its beneficiary eligibility system with death information.	Pending
24	To ensure that Health Care Services and its fiscal intermediaries reimburse providers only for services rendered to eligible beneficiaries, Health Care Services should do the following: Coordinate with the appropriate fiscal intermediaries to recover inappropriate payments made for services purportedly rendered to deceased beneficiaries, if necessary.	Pending

Dental Rate Review. DHCS must annually review reimbursement levels for Medi-Cal Dental Services (Denti-Cal). As noted by the CSA report, DHCS had not undertaken this review in several years. In response to the CSA report, DHCS published a rate review in July 2015. To undertake this analysis, DHCS compared reimbursement rates of the top 25 most utilized Denti-Cal Fee-For-Service (FFS) procedures, with other comparable states' Medicaid programs, in addition to the commercial rates from five different geographic regions around the nation. According to the rate review, Denti-Cal pays an average of 86.1 percent of Florida's Medicaid program dental fee schedule, 65.5 percent of Texas', 75.4 percent of New York's, and 129.2 percent of Illinois'.

2015 Denti-Cal Provider Outreach and Utilization Improvement Plan. In response to a CSA finding that DHCS develop measurements to evaluate Delta Dental's performance as the fiscal intermediary of Denti-Cal, DHCS and Delta Dental developed a provider outreach and utilization improvement plan for efforts in 2015-16. The outreach and recruitment efforts are focused on the following 23 counties that failed to meet the licensed dentist to general population ratio, consistent with the provider participation measurement developed through stakeholder consultation:

	County	Classification
Tier 1	Amador	Extremely Below Standard
	Humboldt	Far Below Standard
	Inyo	Far Below Standard
	Calaveras	Far Below Standard
	San Francisco	Far Below Standard
	Mendocino	Far Below Standard
	Marin	Far Below Standard
Tier 2	Tehama	Below Standard
	Contra Costa	Below Standard
	San Mateo	Below Standard
	Placer	Below Standard
	Nevada	Below Standard
	Del Norte	Below Standard
	Butte	Below Standard
	San Luis Obispo	Below Standard
	Monterey	Below Standard
	Shasta	Below Standard
	Mariposa	Below Standard
	Alameda	Below Standard
Tier 3	Santa Clara	Barely Below Standard
	Yuba	Barely Below Standard
	Napa	Barely Below Standard
	Siskiyou	Barely Below Standard

Counties that are classified as "Extremely Below Standard" are defined as meeting zero percent to 30 percent of the standard, "Far Below Standard" as meeting 31 percent to 60 percent of the standard, "Below Standard" as meeting 61 percent to 90 percent of the standard, and "Barely Below Standard" as meeting 91 percent to 99 percent of the standard. Based on the various levels below the general population standard, Delta Dental will take a "tiered" approach, initially targeting the top seven counties that fall into the "Extremely Below Standard" and "Far Below Standard" as Tier 1, counties "Below Standard" as Tier 2, and counties "Barely Below Standard" as Tier 3 during 2015-16. However, Delta Dental will be conducting outreach to all identified counties failing to meet the general population standard in 2015-16.

Delta Dental's general provider outreach strategy is designed as a multipronged approach. Delta's approach will include collaboration with the California Dental Association and local professional societies, specialist societies, state and county agencies, and health organizations to develop solutions

in provider shortage areas in California and to obtain possible recruitment venues for new providers. Moreover, Delta will work with dental schools and registered dental hygienist in alternative practice programs to encourage students to work in underserved communities and participate in the Denti-Cal program once they graduate and acquire the appropriate licensure. In addition, Delta will focus on educating the enrolled provider population of the support services available to them as enrolled providers.

Delta Dental and the Department of Health Care Services will evaluate progress towards meeting the goals established in the plan on a quarterly basis.

Elimination of Dental Provider Payment Reductions. The 2015 Budget Act included an augmentation of $60 million and trailer bill language to eliminate the ten percent Medi-Cal payment reductions pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, for dental providers effective July 1, 2015. The rate review noted above was completed before the implementation of this restoration. DHCS has seen a significant increase in the number of claims submitted (services rendered) since July 2015. For example, for children age 0 to 21, there were 525,915 FFS claims for June 2015 and 851,145 FFS claims in July 2015. See table below for summary of FFS monthly claims.

Dental FFS Monthly Utilization by Claims Count

	Ages 0-20	Ages 21+
September 2014	511,572	386,312
October 2014	671,249	532,281
November 2014	493,962	359,477
December 2014	449,610	329,239
January 2015	540,793	390,201
February 2015	516,293	358,942
March 2015	580,092	396,098
April 2015	576,920	382,952
May 2015	496,867	353,794
June 2015	525,913	366,276
July 2015	851,145	496,637
August 2015	821,587	481,960
September 2015	715,016	470,074
October 2015	746,225	474,794

New Fiscal Intermediary (FI) and Administrative Services Organization (ASO) Contract. DHCS released request for proposals (RFPs) for separate FI and ASO procurements for dental services. (Delta Dental is the current combined FI and ASO contractor. This contract is effective until July 1, 2017.) Proposals were due to DHCS on February 26, 2016. DHCS plans to make the award announcements in May 2016 so that "takeover" activities could begin July 1, 2016.

The selected FI contractor will be responsible for the takeover, operation, and eventual turnover of the California Dental Medicaid Management Information System (CD-MMIS), and for effective and efficient auto adjudication of claims and related documents for federal and state users of the system. DHCS intends for the selected contractor to take over the existing CD-MMIS and operate it to the satisfaction of state and federal regulations and requirements for FI services for Medi-Cal and other

state health programs that provide dental services. Programs that currently utilize CD-MMIS for dental claims, Treatment Authorization Requests (TARs) processing and other dental related services include Medi-Cal, California Children's Services Program (CCS), the Genetically Handicapped Persons Program (GHPP) and the Regional Center consumers.

The selected ASO Contractor will be required to operate with the dental FI contractor using the existing CD-MMIS. The ASO contractor will be responsible for the administrative functions that were previously done under the single contract with Delta Dental and consists of monitoring and maintaining systems related to the operations portion of providing services to Medi-Cal beneficiaries. Those responsibilities include TARs and adjudicated claim service lines processing, maintaining the telephone service center, and providing outreach efforts to both maintain and increase utilization.

Background. DHCS is responsible for overseeing the provision of dental services to Medi-Cal beneficiaries through two different delivery systems: Dental Fee-for-Service (FFS) and Dental Managed Care (DMC). Under the FFS model, DHCS contracts with a dental FI to provide dental care to over 11,500,000 Medi-Cal beneficiaries statewide. Under the DMC model, DHCS contracts with several DMC plans that provide dental care to over 800,000 Medi-Cal beneficiaries in Sacramento and Los Angeles counties. The Medi-Cal Dental Program is funded at a minimum of 50 percent federal financial participation (FFP) for both the DMC and FFS contracts. FFP in the state Medicaid dental program is contingent upon compliance with CMS requirements. Additionally, Medi-Cal's dental program is working towards advancing the following CMS goals:

- Increase by 10 percentage points the proportion of children enrolled who receive a preventive dental service; and
- Increase by 10 percentage points the proportion of children age six to nine enrolled who receive a dental sealant on a permanent molar tooth.

The Medi-Cal dental program has continued to see an increasing number of beneficiaries enroll in the program particularly in connection with the Affordable Care Act that became effective January 1, 2014. Additionally, select adult optional dental benefits were restored effective May 1, 2014 for approximately 5,000,000 adults. As a result of these changes, expanded responsibilities have been required by CMS and the Legislature which include but are not limited to:

- Monitoring and reporting of 11 FFS performance measures. The 2014 FFS report, which was required to be posted by October 1, 2015, can be found at: http://www.denti-cal.ca.gov/WSI/Bene.jsp?fname=FFS_perf_meas
- Monitoring and reporting on dental managed care performance measures. The next report is due to the Legislature on March 15, 2016 and DHCS indicates that it is working toward releasing the report on April 1, 2016. Past reports can be found at: http://www.denti-cal.ca.gov/WSI/ManagedCare.jsp?fname=dental_managed_care_plan_util
- Monitoring and reporting of grievances and outcomes.
- Monitoring and reporting on access to care.
- Regularly establishing and updating appropriate quality and access criteria and benchmarks.
- Consulting with the stakeholder community to ensure appropriate measures are being considered and that potential access issues are recognized and corrected proactively.

Budget Change Proposal Positions Requested. In response to the concerns raised by CSA, the following resources are requested:

- Beneficiary Services Unit (BSU). One associate governmental program analyst is requested to supplement BSU. This unit is responsible for tasks such as: monitoring the Beneficiary Dental Exception (BDE) phone line which provides assistance to Sacramento dental managed care beneficiaries who are unable to secure access to services through their dental managed care plan, processing and responding to general telephone and written correspondences from fee-for-service beneficiaries; processing and approving beneficiary state hearing cases pursuant to statute; processing and approving of beneficiary reimbursement cases (Conlan); analyzing access to care data and developing access and utilization reports for the department and its stakeholders; coordinating the department's beneficiary outreach campaign(s); and analyzing the fiscal intermediary and dental managed plans' adherence to contractual requirements related to beneficiary services.

  In its 2014 audit of the Medi-Cal Dental program, CSA recommended DHCS establish criteria for assessing beneficiary utilization, establish procedures for periodically identifying geographic areas where utilization fails to meet established criteria, and implement actions to resolve any declining trends identified during its monitoring efforts. The BSU is currently working with stakeholders to finalize the department's criteria for assessing utilization and will use the final criteria to perform ongoing monitoring of utilization throughout the state. As areas with low utilization rates are identified, the BSU will be responsible for establishing mitigation strategies to include targeted beneficiary outreach and education efforts within underserved areas to expand beneficiary knowledge of the Medi-Cal dental program and importance of timely dental care. The BSU will also be responsible for reporting utilization rates publicly on a quarterly basis.

  CSA also recommended that DHCS monitor the number of beneficiaries having difficulty accessing appointments with providers. The BSU will be responsible for performing this monitoring and reporting any issues identified to DHCS leadership and stakeholders. The BSU will need to develop survey instruments and processes for periodic data collection on beneficiary access and will also be responsible for performing monthly reporting of referral data on timely appointment access collected via the Denti-Cal Telephone Service Center.

- Provider Services Unit (PSU). One analyst is requested to support the expansion of the PSU, which is responsible for monitoring the provider network, including outreach, utilization review, monitoring of the Surveillance and Utilization Review Subsystem (S/URS), program integrity operations, provider enrollment functions, provider referral list operations, and provider support and training. An important responsibility of this unit is the ability to effectively counteract fraud within the provider network and ensure the timely enrollment of prospective providers, including the ability to immediately suspend and/or dis-enroll suspected fraudulent providers, and the option to re-enroll such providers after suspension.

- Analytics Group. Two positions are requested to increase the capabilities of the analytics group. The analytics group is responsible for performing Tableau software system revisions to facilitate ongoing reporting of beneficiary utilization data based on the newly developed criteria for assessing utilization (including modifications/additions to data stratification e.g. age/ethnicity/etc.). The analytics group will also be responsible for pulling data required for assessment of provider participation and regional deficiencies in the Denti-Cal network. This group will be responsible for the research, data pulling, and analysis of this rate study and will need to ensure that the factual comparative information put forth from the rate study not only

comply with the requirements of state law but also serves to inform and provide the Legislature with a clear picture of how California's rates compare to like states across a multitude of data sets.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. Please provide a brief status update on the corrective actions DHCS has already taken in regard to the CSA findings.

3. Please provide a review in the changes in utilization since the elimination of the AB 97 reductions in July 2015.

4. Please provide a brief update on Delta Dental's performance with regard to the outreach plan.

5. Please discuss how the Medi-Cal 2020 Waiver's Dental Transformation Initiative will address the concerns that have been raised regarding this program.

Issue 8: AB 85 Health Realignment

Budget Issue. DHCS requests one permanent position and expenditure authority of $845,000 ($423,000 General Fund), of which $734,000 would be three year limited-term, to address the ongoing administration of AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, as amended by SB 98 (Committee on Budget and Fiscal Review), Chapter 358, Statutes of 2013.

Background. With the implementation of federal Affordable Care Act (ACA) in January 2014, it was assumed counties would have fewer costs associated with providing care for low-income populations since the state was assuming responsibility for the administration of health care reform. It was further expected that state costs would increase, while county costs would decrease. To address this shift, AB 85 laid out a process by which transfer amounts were identified, and county health realignment funds were redirected from counties to the Department of Social Services (CDSS) to offset the cost of CDSS programs.

All counties were affected by this process and each county elected a one-time option to either accept a reduction of 60 percent, or show that a lesser reduction would be appropriate based on cost experience of the uninsured programs in their counties using a formula developed by the state and the counties. DHCS is required to use the formula to calculate an annual redirection amount, and to perform interim and final reconciliations of data. For the counties that elected the formula option, statute requires these calculations occur annually until 2023 or until the interim redirection calculation is within 10 percent of the final reconciliation amount and the final reconciliations for two years in a row are within five percent of each other.

Additionally, AB 85 placed specific member enrollment requirements on managed care plans to ensure continuity of care and post ACA monitoring. The bill requires DHCS to work with managed care plans to ensure Designated Public Hospitals (DPH) are paid at least cost for their new Medi-Cal eligible population.

DHCS is also required to provide a hearing process to adjudicate disputes from a variety of DHCS programs, and AB 85 allowed counties to appeal their final reconciliations. DHCS attorneys and analysts represent DHCS in virtually all Office of Administrative Hearings and Appeals (OAHA) cases. Workload related to AB 85 appeals is expected to continue along with final reconciliations.

The Safety Net Financing Division (SNFD). The SNFD administers fee-for-service Medi-Cal and supplemental payments for uncompensated care. The Hospital Uninsured Demonstration and Subacute Section (HUDSS) calculates the redirection of county health realignment funding, monitors subacute facilities, and administers some of the financing for the State's 1115 waivers. HUDSS requests one permanent position to continue calculating county redirection amounts.

According to DHCS, working with counties to identify transfer amounts is a sensitive process because it involves a shift of funds from counties to the state. This position would work to ensure there is an appropriate level of review and accountability in place. In order to do that, and in order to ensure that calculations and estimates are not delayed, HUDSS needs to maintain the three analyst positions currently working on this process (of which one is the limited-term position). With the assistance of auditors, these positions review county cost and revenue data three times a year. The analyst positions also calculate redirection amounts for all 58 counties three times a year during the interim process, the

interim reconciliation process, and the final reconciliation process. In addition to calculating the interim redirection amount for County Medical Services Program counties and for counties who did not choose the formula, the three analyst staff also split the 24 counties who chose the formula. The formula option requires extensive review of large amounts of data used in a technical and complex calculation. Existing staff are working at capacity to handle this workload.

Office of Legal Services (OLS). In order to continue to support OLS Health Care Financing and Rates (HCFR) and the increased workload due to the implementation of AB 85 Realignment, OLS requests three year limited-term resources to assist in the processing of legal work and documents. According to DHCS, the resources will assist HCFR not only in the development and maintenance of the necessary AB 85 Realignment financing structure, contract documents, and certifications required to meet federal requirements, but also the other Medi-Cal funding areas that are impacted by AB 85, such as the 1115 Demonstration Waiver, the Disproportionate Share Program, and the Safety Net Care Pool Funding for the Designated Public Hospitals.

Capitated Rates Development Division (CRDD). The CRDD requests three-year limited-term resources to perform rate development associated with AB 85. CRDD provides oversight for risk adjustment and rate setting involving Medi-Cal managed care beneficiaries. CRDD staff conducts and reviews the most complex data analyses and computations using advanced statistical methods. Staff research and develop default enrollment methodologies and maintain complex projection models used to analyze the impact of proposed default enrollment methodologies.

Managed Care Quality and Monitoring Division (MCQMD). The MCQMD requests three-year limited-term resources in the Plan Management Branch to address workload associated with the realignment of county funds. The resources will allow MCQMD to conduct research to determine the data requirements necessary for the implementation of AB 85, analyze available data and determine a process to procure data not readily available to DHCS. The resources will be used to meet division standards for accuracy, completeness and quality. The resources will allow MCQMD to respond to questions from counties related to AB 85, the transitioning of new beneficiaries into Medi-Cal and the process of assigning these individuals to a primary care provider. In addition, these resources will be used to monitor compliance with the new requirements and monitor the adequacy of the network.

Audits & Investigations (A&I). A&I requests three year limited-term resources for the Designated Public Hospitals (DPHs) P-14 workbook audits. The Financial Audits Branch (FAB) is responsible with ensuring the financial integrity of the DHCS health programs. Financial audits are conducted to ensure that institutional Medi-Cal providers claims for services that are appropriate and are in compliance with the federal Medicare and state Medi-Cal Program laws and regulations. An institutional provider is defined as; acute care hospitals, long-term care providers, federally qualified health centers, and adult day health care centers.

SNFD and the California Association of Public Hospitals (CAPH) developed the P-14 workbook to facilitate the claims through the "Funding and Reimbursement Protocol for Medicaid Inpatient Hospital Cost, Disproportionate Share Hospital Uncompensated Care Cost, and Safety Net Care Pool Hospital Uncompensated Care Cost Claiming." This claiming protocol is laid out in Attachment F of the Special Terms and Conditions of California's current Demonstration 1115 Waiver. The P-14 audits are integral to final reconciliation process as defined in AB 85 because all P-14 workbooks must be audited and approved before final settlements are made.

As of June 30, 2015, FAB has a six year backlog (fiscal years 09,10,11,12,13,14) of P-14 reconciliations that have not been completed. Without additional resources, FAB will be unable to eliminate the existing backlog. This could put future federal funds in jeopardy because CMS has requested that DHCS take steps to complete the final reconciliations in a timely manner. As the Public Safety Net System Global Payment for the remaining Uninsured proposal in Medi-Cal 2020 involves DSH and SNCP funding, A&I will need these resources to handle workload of the new waiver as well. If reconciliations for the current waiver cannot be completed, oversight and auditing will be delayed for Medi-Cal 2020, jeopardizing the success of the renewed waiver and its associated funds.

Use of the P-14 is expected to continue to track public hospital data for Medi-Cal 2020 proposals, specifically the global payment for the uninsured. Auditing workload for Medi-Cal 2020 is likely to be even more strenuous than the current workload as CMS has recently stressed closer regulation of Safety Net Care Pools. The requested resources will enable DHCS to claim current waiver and Medi-Cal 2020 funds in a timely manner. The resources will also assist in helping complete the waiver final reconciliations in a timely manner and help ensure other rate setting and cost settlement audits meet the department's quality standards and mandated due dates.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. With the proposed resources, how long will it take to address the backlog in P-14 reconciliations? Does CMS consider this timeline timely?

Issue 9: Federally Qualified Health Centers Pilot (SB 147, 2015)

Budget Issue. DHCS requests three-year, limited-term expenditure authority of $240,000, to support the implementation, administration, and evaluation of an alternative payment methodology (APM) pilot for select California Federally Qualified Health Centers (FQHCs), pursuant to the requirements of SB 147 (Hernandez), Chapter 760, Statutes of 2015. One-time contract authority of $300,000 is requested in 2017-18, to prepare an evaluation of the pilot. The contract will be funded 50 percent federal funds and 50 percent reimbursement from a foundation. For 2017-18, DHCS requests expenditure authority of $540,000 ($120,000 General Fund, $270,000 federal funds, $150,000 reimbursement).

Background. In 1989, the U.S. Congress established FQHCs as a new provider type. FQHCs are public or tax-exempt entities which receive a direct grant from the federal government under Section 330 of the Public Health Service Act, or are determined by the federal Department of Health and Human Services to meet the requirements for receiving such grants. Federal law defines the services to be provided by FQHCs for Medicaid purposes and included special payment provisions to ensure that they would be reimbursed for 100 percent of their reasonable costs associated with furnishing these services. One of the legislative purposes in doing so was to ensure that federal grant funds are not used to subsidize health center or program services to Medicaid beneficiaries. State Medicaid programs must pay for covered services provided by FQHCs. There are over 820 FQHC locations (FQHCs may have more than one clinic location) in California. County health system clinics have also obtained FQHC status.

Federal Medicaid payments to FQHCs are governed by state (Medi-Cal in California) and federal law. In December 2000, Congress required states to change their FQHC payment methodology from a retrospective to prospective payment system (PPS). This federal law change established (for existing FQHCs) a per-visit baseline payment rate equal to 100 percent of the center's average costs per visit incurred during 1999 and 2000 which were reasonable and related to the cost of furnishing such services. States are required to pay FQHCs a per-visit rate, which is equal to the baseline PPS payment rate, increased each year by the Medicare Economic Index (MEI), and adjusted to take into account any increase or decrease in the scope of such services furnished by the FQHC during that fiscal year. Under PPS, state Medicaid agencies are required to pay centers their PPS per-visit rate (or an APM, discussed below) for each face-to-face encounter between a Medicaid beneficiary and one of the FQHC's billable providers for a covered service.

For Medi-Cal patients, DHCS is required to reimburse an FQHC for the difference between its per-visit PPS rate and the payment made by the plan. This payment is known as a "wrap around" payment. The wrap-around rate was established to comply with federal and state regulation to reimburse a provider for the difference between their PPS rate and their Medi-Cal reimbursement.

FQHCs and Rural Health Clinics (RHCs) are both reimbursed under the PPS system. The average ($178.14) and median ($157.24) PPS rate paid to an FQHC and RHC in 2014-15 is considerably higher than the most common primary care visit reimbursement rates in Medi-Cal, but it also includes additional services not included in a primary care visit. Because FQHCs are required to receive an MEI adjustment to their rates under federal law, and because of their role in providing primary care access to the Medi-Cal population, FQHCs have been exempted from the Medi-Cal rate reductions.

SB 147 calls for a pilot project using an APM where FQHCs would receive per-member per-month (PMPM) payments from the health plan, and would no longer receive a "wrap around" payment from DHCS. CMS has indicated a state may accept an FQHC's written assertion that the amount paid under the APM results in payment that at least equals the amount to which the FQHC is entitled under the PPS.

The proposed APM pilot project will comply with federal APM requirements and DHCS will file a State Plan Amendment (SPA) and seek any federal approvals as necessary for the implementation. The SPA will specify that DHCS and each participating FQHC voluntarily agrees to the APM.

The clinic specific PMPM capitation payment would be determined by utilizing visits data from historical years for members who are assigned to the clinic as the primary care provider, in the Categories of Aid (COA) selected for the pilot. This rate setting methodology, which establishes a PMPM for assigned members based on average annual visits, has precedence in its similarity to a methodology agreed upon between the plans and DHCS in establishing initial rates for Community-Based Adult Services (CBAS) centers. These clinic specific PMPM capitation rates would be set according to actuarial principles that are used to set Medi-Cal managed care rates, which means using historical base year data, and applying appropriate trend rates and program changes, similar to how the FQHC component of the Medi-Cal managed care plan rates are set.

In accordance with SB 147, the department is mandated to apply for the pilot through a state plan amendment, oversee and administer the program over its three-year (at minimum) life, and assist in conducting an evaluation.

To implement SB 147, DHCS requests the following:

- $300,000 ($150,000 reimbursement and $150,000 federal funds) for an evaluation of the FQHC APM pilot. The evaluation shall be completed and provided to the appropriate fiscal and policy committees of the Legislature within six months of the conclusion of the pilot project in those counties that are included in the initial pilot project implementation. As mentioned, the evaluation will be funded by foundation funds and a foundation has already expressed an expectation in writing that they will continue to provide financial support to the state for this APM pilot project effort.
- Three-year limited-term resources to assist in the implementation and administration of the APM pilot. The workload supported by these resources will include:
  - Drafting and filing the state plan amendment (SPA) and seek any federal approvals as necessary for the implementation of the APM pilot; draft and prepare any follow-up legislative documents related to the pilot.
  - Establishing the APM pilot application and readiness process, prepare for deputy review, and send out application to potential clinic sites and plans.
  - Reviewing FQHC site applications and readiness submissions and provide detailed analysis and determination of qualification for pilot.
  - Participating in and prepare materials for APM pilot stakeholder workgroup meetings that concern but are not limited to policy, data, rate setting, alternative encounters, and contracting.
  - Notifying viable FQHC sites and plans of candidacy and coordinate their acceptance into the program, as well as any associated administrative needs.

- Coordinating with pilot plans, clinics, and consultants to receive and assist in analyzing data for purposes of rate development and any other aspects of the APM pilot.
- Working with the Department's Capitated Rates Development Division and Health Care Financing section to prepare and submit rates to the Centers for Medicare and Medicaid Services (CMS); send notifications to plans and clinics of the rate when approved by CMS.
- Assisting in any APM pilot payment adjustments that may occur, as well as adjustments to the PPS rate for participating FQHCs, including changes resulting from a change in the MEI or any change in the FQHC's scope of services.
- Assisting in obtaining contracting for the evaluation of the pilot and conduct research on transitioning the FQHC APM methodology from a pilot to a statewide program.
- Providing and assisting in any other department oversight and administration of the pilot as outlined in the SB 147.
- If needed, post information regarding the pilot on the DHCS website.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue, including information on the plans and clinics expressing interest in participating.

Issue 10: Health Homes Activities

Budget Issue. DHCS requests three-year limited-term expenditure authority of $1,031,000 ($516,000 federal funds, $515,000 Special Deposit Fund), in support of the Health Homes Program (HHP), beginning July 1, 2016. Included in the request is three-year, limited-term contract funding for a total of $775,000 ($275,000 for year 1, $275,000 for year two, and $225,000 for year three).

Background. AB 361 (Mitchell), Chapter 642, Statues of 2013, authorizes DHCS to implement the Affordable Care Act (ACA) Section 2703 Medicaid Health Home Program (HHP) Services benefit for members with chronic conditions with the goal of improved health outcomes from Medi-Cal's most vulnerable beneficiaries. The HHP will provide enhanced care coordination benefits. It is anticipated that implementing the HHP will reduce state Medi-Cal costs by decreasing avoidable emergency department and inpatient stays, and improving health outcomes for vulnerable Californians. The authorization to implement is permissive, is not time-limited, and may be based on DHCS's determination of program fiscal and operational viability. DHCS began further analysis and development work on AB 361 in the spring of 2014. The earliest possible program implementation will be in 2016. Under ACA Section 2703, states may adopt the HHP benefit and receive a 90 percent federal match for program services for two years. After two years, the federal match converts to 50 percent.

AB 361 specifies that DHCS may only implement the HHP if prior and ongoing projections show no additional General Fund monies will be used to fund the program's administration, evaluation, and services. DHCS may use General Fund monies to operate the program if ongoing General Fund costs for the Medi-Cal program do not result in a net increase. In January 2013, The California Endowment (TCE), Board of Directors approved a $25 million commitment in each of the first two years to provide the 10 percent non-federal match for program services. TCE has not only agreed to provide funding for program services, but also funding for state operations activities. In addition, TCE is currently providing the non-federal matching funds for an ongoing $500,000 Title XIX grant from CMS for ACA Section 2703 Health Homes planning, received in 2011.

The California Health Care Foundation (CHCF) is fully funding the Center for Health Care Strategies (CHCS) to assist DHCS with technical assistance on national health home best practices, CMS policy, and a roadmap for program development and decision points.

SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015 established the Health Home Program Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds to be used for HHP implementation.

The following are the general DHCS work activity milestones for this project:

- August/November 2014, April/July-November 2015: Develop and conduct processes to ensure stakeholder engagement and participation. It is anticipated that stakeholder engagement will continue throughout the SPA development and initial phases of implementation in each geographic area. AB 361 allows for stakeholder participation in the department's design process for the required program evaluation, and requires the department to consider consultation with stakeholders on the development of the geographic criteria, beneficiary eligibility criteria, and provider eligibility criteria for any related SPAs.

- October 2015 – March 2016: Develop and obtain approval for any necessary waiver amendment or SPA. Submit the first proposed SPA, for implementation in a specified initial geographic region(s). Additional SPA submissions may be needed for each additional geographic program implementation.
- October 2015 – June 2016: Establish a contract and parameters for program evaluation. Per AB 361, DHCS must complete a HHP evaluation within two years after implementation, submit a report to the Legislature, and allow stakeholders to participate in the process to design the evaluation.
- January 2016: Ongoing rate development activities over at least three annual rate development cycles, depending on staging of geographic implementations; liaising with contractor as necessary.
- Mid 2016-17: Implementation of the health home optional benefit.
- Calendar year 2019: Adopt emergency regulations no later than two years after implementation of the HHP.

Subcommittee Staff Comment and Recommendation—Hold Open. The health home option, with a 90 percent match, was first authorized in 2010 under the federal Affordable Care Act (ACA). Senator (then Assembly Member) Mitchell first authored legislation to implement it in 2012, but did not move the bill forward to the Governor at the request of the Administration even though there would be no General Fund impact and a foundation had offered to put up the matching funds. The bill was reintroduced in the following year as AB 361.

Questions.

1. Please provide an overview of this issue.

2. Please explain why it has taken so long for DHCS to implement this and to agree to take advantage of the health home option.

Issue 11: Medi-Cal Electronic Health Records Staffing

Budget Issue. DHCS requests three-year limited-term resources of $403,000 ($41,000 General Fund) for the Medi-Cal Electronic Health Record (EHR) Incentive Program to provide extensive data analysis, policy analysis, enrollment and eligibility support, and pre- and post-payment audits and investigations for program eligible managed care and fee for service providers. The federal Centers for Medicare and Medicaid Services (CMS) has approved 90 percent federal funding participation (FFP) for these requested resources.

Background. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes the outlay of federal money estimated to be approximately $4.5 billion for California and $45 billion nationally for Medicare and Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade and meaningfully use electronic health records (EHR) in accordance with the Act's requirements. HITECH has resulted in a significant increase in provider adoption and use of EHR systems, leading to desired health care improvement, and an overall improvement in public health.

The HITECH Act authorizes state Medicaid programs to directly administer Medicaid EHR Incentive Programs. The state's Medi-Cal EHR Incentive Program is integral to patient safety and quality of care by incentivizing Medi-Cal providers to adopt, implement, or upgrade and use EHRs in a meaningful way. On October 26, 2009, DHCS submitted a funding request to CMS that was approved for $2.8 million to establish Office of Health Information Technology (OHIT) and to provide funding for a consulting contract to begin the State Medicaid Health Information Technology Plan (SMHP) process. The Medi-Cal EHR Incentive Program is a multi-year program that began on October 3, 2011 for Eligible Hospitals, November 15, 2011 for Groups/Clinics, and January 3, 2012 for Eligible Providers. The Medi-Cal EHR Incentive Program is currently scheduled to operate through December 31, 2021.

DHCS OHIT has authorized more than 20,000 incentive payments to over 17,000 providers and 260 hospitals. This has resulted in more than $1 billion in 100 percent FFP incentive payments made to date. DHCS expects to distribute between $100 and $200 million per year for the remainder of the program. Recently updated landscape assessment data indicate there are likely another 15,000 providers who are, or will become eligible for the program. DHCS has estimated approximately $2 billion will be distributed to providers and hospitals over the course of the program.

OHIT requests three-year limited-term resources equivalent to staffing of 3.0 positions. The requested resources would not result in an increase in General Fund expenditure, as these resources would be covered under the total annual general fund expenditure previously authorized under law for state administrative costs associated with implementation of the Medi-Cal EHR Incentive Program.

Recent Federal Notification On Expanded Availability of HITECH Funds. On February 29, 2016, CMS issued updated guidance indicating that HITECH federal funds would now be available to support Health Information Exchange (HIE) onboarding and systems for behavioral health providers, long term care providers, substance abuse treatment providers, home health providers, correctional health providers, social workers, and others. These funds may also support the HIE on-boarding of laboratory, pharmacy or public health providers. DHCS indicates that it is assessing the recently released guidance and is evaluating next steps.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. Please provide a brief overview of the recent federal guidance expanding the incentive program. How is DHCS planning for this expansion?

Issue 12: Health Insurance Portability and Accountability Act Compliance and Monitoring

Budget Issue. DHCS requests the conversion of eight limited-term positions to permanent effective July 1, 2016. The requested expenditure authority for this conversion is $1,202,000 ($240,000 General Fund). The positions are necessary to continue existing efforts, maintain compliance with current federal and state regulations, address new Health Insurance Portability and Accountability Act (HIPAA) rules, provide support for growth in the Capitation Payment Management System (CAPMAN), and continue to strengthen oversight of privacy and security protections for members served by DHCS programs.

Background. The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 have been updated repeatedly since their inception. The most recent changes demonstrate that HIPAA will continue to evolve as technology, policy capabilities, and standards are developed and refined in the health care environment. DHCS must respond to HIPAA changes with an ongoing process to evaluate and implement the latest industry standards for the safe and secure exchange of electronic health care information. DHCS has developed and maintained staffing levels to respond to HIPAA through a series of eight Budget Change Proposals (BCPs) or Spring Finance Letters (SFLs) that have continued to extend formerly approved limited-term positions since HIPAA efforts began at DHCS in 2000. HIPAA will continue to advance and grow in order to make health administration more efficient, secure, and standardized. DHCS needs an ongoing organization, with sufficient permanent staff and resources, to successfully lead and coordinate these efforts.

According to DHCS, recent federal directives have highlighted the need for permanent HIPAA resources, particularly in the areas of Medicaid Information Technology Architecture (MITA), new healthcare standards and operating rules, and capitation program system development, maintenance, and operations.

- MITA: The Centers for Medicare & Medicaid Services (CMS) introduced MITA in 2005 as an initiative to guide states to improve the operation of their Medicaid programs through the implementation of an enterprise framework of business, information, and technical standards. On April 14, 2011, CMS significantly elevated the importance of MITA by issuing new final regulations under sections 1903(a)(3)(A)(i) and 1903(a)(3)(B) of the Social Security Act. The final regulations contained new standards and conditions that must be met by states in order for Medicaid technology investments (including traditional claims processing systems, as well as eligibility systems) to be eligible for the enhanced (90 percent) federal financial participation. To enable conformance to MITA, DHCS is required to submit an annual State self-assessment (SS-A) which includes a "Road Map" that outlines DHCS' progression and new initiatives that will lead to a higher level of MITA maturity. On April 14, 2015, CMS released proposed regulations that further strengthen MITA and place additional requirements on state Medicaid agencies, including: use of updated standards and additional conditions in order to obtain federal funds for Medicaid information technology; demonstrated progress toward seamless coordination and interoperability with other federal and state agencies; improved performance testing and demonstrated results; a requirement for mitigation plans for all major systems functionalities; and documentation that will enable re-use of software developed with federal funds.
- New Health Care Standards and Operating Rules: The Affordable Care Act (ACA) contained several significant and still to be implemented HIPAA-related changes, including more

frequent updates to HIPAA regulations, new operating rules, new transaction standards, new health plan certification requirements, and considerably higher penalties for non-compliance. Collectively, compliance with the new and existing HIPAA regulations requires significant efforts within DHCS to assess impacts, design and adapt policies and regulations, define business rules, test changes with providers and other business partners, and remediate information technology systems.

- Growth in CAPMAN: The DHCS Office of HIPAA Compliance (OHC) is responsible for the management of the CAPMAN system, which supports federal regulations that require California to maintain member benefit enrollment and accounting for all capitated payments made to managed health care plans. This is a very large and extremely complex IT system responsible for approximately 83 percent of all Medi-Cal payments per month. CAPMAN replaced a manual process to calculate and pay managed care plans in July 2011. Since the initial implementation of CAPMAN, Medi-Cal managed care has experienced phenomenal growth. This growth is attributed to two components: 1) Medi-Cal expansion emanating from the Affordable Care Act; and 2) moving Medi-Cal members from fee-for-service to managed care. When the system was developed there were approximately 3.5 million Medi-Cal members in managed care. Currently there are over 9 million Medi-Cal members in managed care, representing an increase of 257 percent. In addition to the growth in members, the complexity of payment methodologies has increased, and will continue to increase, as DHCS includes additional services in the premium (e.g., long term care services and support).

DHCS requests to convert eight limited-term positions to permanent to coordinate and carry out the workload required by HIPAA rules and updates. All of the requested HIPAA positions are eligible for enhanced federal financial participation. According to DHCS, failure to adequately staff for this workload has several negative implications, including the risk of significant federal compliance penalties, limited ability to respond to changes in managed care plan capitation payment policy, and inability to adhere to previous commitments around improved efficiency in DHCS technology systems that help administer California's Medicaid program.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised that Public Record Act requests have been delayed because of the workload related to HIPPA compliance review of these requests.

Questions.

1. Please provide an overview of this issue.

2. Does the department have sufficient resources related to HIPAA review of Public Record Act requests to meet the response timeframes specified in law (24 days)? Is there a backlog of these requests due to HIPAA review?

Issue 13: Third Party Liability Recovery Workload

Budget Issue. DHCS requests $1,136,000 ($284,000 General Fund) and 10.0 permanent, full-time positions to address a growing workload and to increase savings. Federal and state laws and regulations mandate that Medi-Cal recover expenditures in personal injury cases involving liable third parties so that Medi-Cal is the payer of last resort. (The state received an enhanced federal participation rate of 75 percent.)

According to DHCS, current staffing levels are insufficient to complete a thorough and timely analysis and processing of the growing case volume. Within one year of the January 1, 2014 implementation of the Affordable Care Act (ACA), Medi-Cal enrollment increased by 38 percent. This enrollment increase is correlated with the 70 percent increase in Casualty Insurance Operations (CIO) cases.

Background. Title XIX of the Social Security Act requires the State Medicaid agency (Medi-Cal) to seek reimbursement for beneficiaries whose medical bills were caused by a liable third party. Federal regulations require Medi-Cal to avoid payment of claims where third party coverage is available and to initiate post-payment recovery processes. State law requires the department to impose liens on a beneficiary's personal injury settlements and make recoveries, thereby, that Medi-Cal is the payer of last resort.

Attorneys, county welfare agencies, and insurance companies must notify the department of tort actions involving a Medi-Cal beneficiary. CIO staff review Medi-Cal expenditures paid for injury-related services, then file liens for recovery against any settlement, judgment, or award. The department has three years to obtain recovery from the notice of settlement, judgment, or award on CIO cases. All funds recovered through any of the Third Party Liability and Recovery Division (TPLRD) recovery programs are recycled back into the Medi-Cal program to assist in the care of other medically needy individuals, effectively abating General Fund expenses.

Following the implementation of the ACA, Medi-Cal enrollment increased from 8.6 million in December 2013 to 13.3 million in November 2015, a 54 percent increase. From July 2013 through December 2013, prior to ACA implementation, CIO received on average 3,536 new case referrals per month. The growth in incoming case referrals accelerated after the implementation of ACA. The average number of incoming case referrals reached 5,983 during the months of January through July 2015. This represents an increase of nearly 70 percent compared to the volume prior to ACA implementation.

All incoming cases are reviewed for eligibility and other factors. Those where recovery is deemed prudent and necessary are set up for processing by an analyst. From January 2014 through July 2015, CIO experienced 70 percent growth in its active caseload (cases in research status and those awaiting payment), increasing from 18,527 to 31,480 cases. The rapid growth created a "bottleneck" effect, which partly contributed to the increase in the caseload.

TPLRD requests 10.0 permanent full-time positions to address the increasing workload and to recover Medi-Cal expenditures in personal injury cases involving liable third parties, thereby ensuring that Medi-Cal is the payer of last resort, as mandated by federal and State laws and regulations.
CIO projects that, by June 30, 2016, caseload will increase to 35,856, or 48 percent beyond its current staffing capacity.

In 2012-13, CIO collection staff collected $33.4 million ($16.7 million General Fund). Assuming the average collections hold, according to DHCS, adding 10.0 additional positions to CIO should result in an additional $7.8 million ($3.9 million General Fund) in annual CIO recoveries. The recovery for 2014-15 was $35.8 million. If the requested positions are approved, the additional revenue would be acquired gradually, as the collection efforts are increased and cases reach settlements and come to a resolution in the form of payment. CIO estimates that the entire projected additional revenue of $7.8 million will be acquired by 2017-18.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 14: Eliminate Workers' Compensation Information Sunset - Trailer Bill Language

Budget Issue. DHCS proposes trailer bill language to eliminate the sunset provision and indefinitely extend the Department of Industrial Relations (DIR) authority to supply work-related injury or claim data from the Workers' Compensation Information System (WCIS) to the DHCS.

Background. DHCS is responsible for enabling compliance with state and federal law related to the legal liability of third parties to pay for a Medi-Cal beneficiary's health care, so that the Medi-Cal program is the payer of last resort. DHCS contracts with outside vendors to process worker's compensation (WC) claims and to recover Medi-Cal costs from settlements arising from work-related injuries where a liable third party exists.

In 1981, Welfare and Institutions (W&I) Code Section 14124.81 et seq. directed the state to enter into two pilot project contracts for WC third party recoveries. Initial recoveries made under these contracts consisted entirely of reimbursements from contested cases; claims filed against an insurance carrier or employer who has not accepted liability for the injuries sustained. These cases are identified using data from the Workers' Compensation Appeals Board.

In 2010, DHCS learned that DIR also compiled data on non-contested WC cases (i.e., claims filed against an insurance carrier who has accepted liability for the injuries sustained) in the WCIS. AB 2780 (Solorio), Chapter 611, Statutes of 2010, sponsored by Health Management Systems (a WC contractor) amended Labor Code Section 138.7 to authorize DHCS to "obtain and use individually identifiable information, as defined for the purposes of seeking recovery of Medi-Cal costs incurred by the state for treatment provided to injured workers…" However, that bill included the sunset provision date of January 1, 2017 and revisions to LC 138.7 that would become operative on January 1, 2017 if the WCIS provisions sunset.

In May 2012, DHCS entered into an interagency agreement with DIR to secure a data transfer of the WCIS file in order to identify non-contested WC cases. In November 2014, this interagency agreement was extended through June 30, 2019, and allows DHCS's WC contractor to create liens and recover from settlement awards for non-contested cases, which they otherwise would not have been able to do. Removing the sunset date provision as proposed would allow DHCS to maintain compliance with state and federal law and sustain current recovery levels, benefitting the Medi-Cal population with minimal administrative costs to the General Fund.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Issue 15: Supplemental Drug Rebates Cleanup Trailer Bill Language

Budget Issue. DHCS requests trailer bill language to make minor technical changes to Welfare and Institutions (W&I) Code §14105.436 and §14105.86 as amended by SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014. These technical changes will correct non-sequential lettering errors and inconsistent and erroneously omitted language in order to accurately preserve the intent and purpose of SB 870, to collect supplemental drug rebate revenues for certain prescription drugs based on drug utilization from all eligible Medi-Cal programs.

According to DHCS, if left uncorrected, the errors may lead to a misinterpretation of the intent of SB 870 and place the state at risk of losing supplemental drug rebate revenues.

Background. SB 870 extended the state's authority to collect state supplemental drug rebates based on drug utilization data from all Medi-Cal programs, including fee-for-service (FFS) and managed care plans (MCPs). SB 870 applies to certain prescription drugs, including, but not limited to, drugs used to treat hepatitis C, HIV/AIDS, cancer, and hemophilia.

Prior to SB 870, DHCS had the authority to collect state supplemental drug rebates based on drug utilization data from FFS and county organized health systems only. SB 870 provided new authority to DHCS to invoice manufacturers of contracted drugs and collect state rebates based on utilization data from all MCPs for prescription drugs subject to coverage policies and where DHCS reimburses MCPs through separate capitated rate payments or other supplemental payments.

SB 870 amended three sections of the California Welfare and Institutions Code, revising the description of utilization data to determine state rebates: §14105.33 (pertaining to state rebates and contracts with drug manufacturers), §14105.436 (pertaining to HIV/AIDS and cancer drug rebates), and §14105.86 (pertaining to blood factor rebates).

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: **Senate Subcommittee #3 on Health & Human Services**
Thursday, March 17 (Room 4203)

All items were held open.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

April 7, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

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5160 DEPARTMENT OF REHABILITATION

Issue 1: Overview

The Department of Rehabilitation (DOR) works in partnership with consumers and other stakeholders to provide direct services and advocacy resulting in employment, independent living, and equality for individuals with disabilities. DOR seeks to assist over 100,000 Californians with disabilities to obtain and retain competitive employment in integrated settings, and to maximize equality and ability to live independently in their communities of choice. With a proposed FY 2016-17 budget of $443.9 million ($59.9 million General Fund) and 1,876 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 2014-15.

Fund Source	2014-15 Actuals	2015-16*	2016-17
General Fund	**$ 58,389**	**$59,780**	**$59,894**
Traumatic Brain Injury Fund	$947	$1,004	$1,202
Vending Stand Fund	$804	$2,361	$2,361
Federal Trust Fund	$348,226	$370,370	$372,772
Reimbursements	$6,487	$7,680	$7,680
Total Expenditures	**$414,853**	**$441,195**	**$443,909**
Positions	1,796.4	1,762.4	1,778.4

* FY 2015-16 are projected figures

Eligibility. When the department does not have enough funds to serve all applicants who are deemed eligible for services, the federal government requires DOR to use an Order of Selection (OOS) process, under which the department must serve people with the most significant disabilities first (all those in the "most significantly disabled" category will be served first, followed by those in the "significantly disabled" category and then the "disabled category"). DOR has been operating under an OOS since 1995. Within each category, DOR serves individuals according to date of application. If placed on a waiting list, DOR consumers receive information and referral services and may ask for their priority category to be re-evaluated if they have experienced a change in severity of disability. The DOR has offered in-plan services to all consumers on the waitlist on six occasions since 2011, the last time on November 30, 2015. Currently, the DOR has eight consumers on its waiting list.

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

- Vocational Rehabilitation (VR). The Vocational Rehabilitation Services Program delivers vocational rehabilitation services to persons with disabilities through vocational rehabilitation professionals in district and branch offices located throughout the state. DOR has cooperative agreements with state and local agencies (education, mental health, and welfare) to provide unique and collaborative services to consumers.

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

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

- Traumatic Brain Injury (TBI). In coordination with consumers and their families, seven service providers throughout California provide a coordinated post-acute care service model for persons with TBI, including supported living, community reintegration, and vocational supportive services.

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

The DOR has prioritized its efforts by creating eight internal workgroups comprised of policy, program staff, and field staff, under the guidance of the directorate and directed by an executive team member, to determine how to provide services to consumers, under the new federal requirements, without increasing ongoing resource expenditures, as WIOA does not authorize new funding. DOR's activities include:

- Conducting public forums on specific subject areas impacting the Vocational Rehabilitation program (eleven held to date).

- Incorporating input from consumers, community partners, the State Rehabilitation Council and advisory bodies, and other stakeholders, including government representatives, into policies and new processes.

- Sharing DOR data with the California Workforce Investment Board to submit the Unified State Plan by April 1, 2016.

- Collaborating with the Employment Development Department, Department of Developmental Services, Department of Education, one-stop operators and the workforce investment boards to identify consistent practices to better serve individuals with disabilities and increase employment outcomes, with a greater focus on early intervention with youth.

- Reaching out to high school students, in collaboration with local education agencies and developing requests for proposal for contractors to hold summer academies at which high school students will receive new Pre-Employment Transition Services including work experiences.

Final Regulations are anticipated in the summer of 2016, and DOR expects to fully implement all WIOA requirements by July 2017. Additionally, the department is making continuous improvements in approaches to increase outcomes for individuals with disabilities, increase income, and maximize potential for eligible individuals with significant disabilities with the goal of moving from dependence to independence.

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

STATE PENALTY FUND AND TBI FUND REVENUE

State Fiscal Year	State Penalty Fund	TBI Fund
FY 06-07	$167,589,106	$1,105,546
FY 07-08	$167,483,359	$1,104,936
FY 08-09	$162,260,219	$1,070,492
FY 09-10	$157,883,929	$1,041,716
FY 10-11	$165,532,414	$1,091,926
FY 11-12	$137,101,778	$809,181
FY 12-13	$128,975,874	$849,834
FY 13-14	$122,346,996	$807,753
FY 14-15	$116,632,580*	$769,383*
FY 15-16	$40,972,883*	$269,202*

* Year-to-date revenue as of January 2016.

Annually, DOR funds services for approximately 2,400 individuals through the seven TBI program sites, as well as 1,300 through the Independent Living Centers. DOR provides direct services to an additional 1,300 individuals with TBI through its Vocational Rehabilitation Program.

The department is not aware of programs at risk of closure. However, the State Penalty Fund is decreasing. The department is seeking additional funding opportunities, such as federal grants, to stabilize the funds available through the RFA process. To date, however, the department has been unsuccessful at identifying a stable funding source for the TBI programs.

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

In Fiscal Year 2015-16, the Legislature funded the DOR's request for $3.11 million in federal fund authority for up to 31 work incentive planners (WIPs) to fully implement the Work Incentives Planning Services Program statewide. At the time, the California Foundation for Independent Living Centers (CFILC) raised concerns that the department's use of federal funds could put Independent Living Center (ILC) funding at risk, because if reimbursements fall below projected figures, the department would first pay costs related to personnel, superseding ILC funding. Through negotiations with budget staff, the department, Agency, Finance, and CFILC, provisional language was included to clarify that DOR could only hire up to the 31 requested positions if they had the available federal funds, and that ILC funding would not be jeopardized.

The department has since hired and trained all 31 WIPs. The WIPs provide financial literacy and benefits planning services to eligible consumers who receive Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits. Training for the WIPs included the Work Incentives Practitioner Credential course from Cornell University and was completed in August 2015. To date, these 31 WIP staff have provided services to 3,498 SSI/SSDI consumers in the 'Job Ready' case status.

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.

Issue 2: Update: California PROMISE Initiative Grant

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

Background. The SSI/State Supplemental Payment programs provide cash assistance to around 1.3 million Californians, aged 65 or older (28 percent), who are blind (one percent), or who have disabilities (71 percent), and meet federal income and resources limits. Grants under SSI are 100 percent federally-funded. The current maximum grant amount for individuals is approximately $889 per month ($733 SSI + $156 SSP), which is roughly 90 percent of the federal poverty level (FPL). For couples, the maximum grant amount is $1,496 per month ($1,100 SSI + $396 SSP), which is equal to 113 percent of FPL.

As the lead coordinating agency for CaPROMISE, DOR is responsible for statewide leadership, oversight, administration, and coordination of the grant. DOR partners with five other state departments[1] and 21 Local Educational Agencies (LEAs) to coordinate services, direct outreach, recruitment, and involvement of, 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 USD
11. Compton USD
12. Long Beach USD
13. Elk Grove USD
14. Whittier Union HSD
15. Irvine USD
16. San Diego USD

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

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

CaPROMISE Activities, Targets, Timelines with Benchmarks

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

To date, DOR has completed the following:

- Partnered with five state departments.
- Contracted with 21 Local Education Agencies (LEAs) and one community organization in the coordination of services, direct outreach, recruitment, and involvement of SSI recipients and their families.
- Received the Health and Human Services Institutional Review Board approval and Social Security Administration clearances for 106 program staff.

- Provided training to 65 career service coordinators including benefits planning training and certification from Cornell University.

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

Questions.

1. Please provide an update on the implementation of the proposal, including but not limited, the enrollment and recruitment process and the status of the staff hiring at the department.

Issue 3: BCP: Workforce Innovation and Opportunity Act: Competitive Integrated Employment

Governor's Proposal. The Administration is requesting 11 permanent full-time positions to establish a new Vocational Rehabilitation Service Delivery (VRSD) team through redirection of $1.5 million in federal funds that are currently used for group employment placement services. Under the WIOA, the DOR can no longer close the record of services for a consumer who is in non-competitive employment, such as group employment services. The requested positions are as follows:

2.0 Office Technician (General)
1.0 Staff Services Manager I
3.0 Staff Services Analyst (General)
5.0 Senior Vocational Rehabilitation Counselor

Background. The Workforce Innovation and Opportunity Act (WIOA), which was signed into law on July 22, 2014, mandates that effective July 22, 2016, employers may not pay subminimum wage to individuals with disabilities unless the employer can show that the individual has received counseling from DOR before hire. WIOA also requires that DOR provide additional counseling, training, and other resources.

Prior to WIOA, as required by the Rehabilitation Act of 1973, DOR sent all individuals in subminimum wage placements an annual automated letter informing the individual of the opportunity to reopen their case and progress to a competitive individual placement. However, under the Rehabilitation Act as amended by WIOA, this requirement has been expanded in terms of the information required, the frequency of counseling, and the scope of individuals who must receive services from DOR.

Currently, DOR does not have the capacity to meet these new requirements.

Staff Comment. In order for DOR to meet new WIOA requirements, the department will need the requested resources to address the increasing workload in this area. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please summarize the proposal.
2. Please explain what previously funded activities the redirection of funds impacts.

Staff Recommendation. Hold Open.

Issue 4: BCP: Resources for Federal Grant and RSA-911 Reporting

Governor's Proposal. The Administration requests five permanent full-time positions funded through the redirection of $653,000 in existing Federal Funds, previously used for consulting services, to address the increased workload mandated by the U.S. Department of Education (USDOE) and the Rehabilitation Services Administration (RSA). The requested positions are as follows:

1.0 Staff Programmer Analyst (Specialist)
1.0 Senior Accounting Officer (Specialist)
2.0 Associate Governmental Program Analyst
1.0 Research Program Specialist I

The department notes that lack of compliance with federal requirements could result in enforcement action, including the loss of federal funds. There are no required changes to statute or regulations.

Background. DOR is the designated state agency responsible for administration of the vocational rehabilitation program and the independent living program. These programs are largely funded by eight federal grants.

Recent decisions by the USDOE and the RSA relating to the DOR's vocational rehabilitation (VR) grant and the newly enacted Workforce Innovation and Opportunity Act (WIOA) Performance Management, Information and Reporting System and VR Case Services Report, have increased the mandated workload in accounting, budgeting, information systems, federal reporting, and oversight of DOR's federal grants. In addition, the WIOA Performance Management Report is an entirely new requirement for DOR. The department does not have the current staff resources to address these mandated changes.

Staff Comment. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please summarize the proposal.
2. Please explain what previously funded activities the redirection of funds impacts.

Staff Recommendation. Hold Open.

Issue 5: BCP: Traumatic Brain Injury (TBI) Supplemental Funding

Governor's Proposal. The Administration is requesting a one-time allocation of $360,000 to the TBI Fund from the Driver Training Penalty Assessment Fund.

Background. TBI Fund revenues stem from penalties paid for various violations of California's Vehicle Code. However, the State Penalty Fund (SPF) is facing declining revenues and the current allocation of 0.66 percent will not be sufficient to fund all TBI functions mandated by statute. This proposal provides continued minimum funding for the critical support services provided by the TBI network as well as associated administrative costs.

In FY 2014-15, DOR received a one-time allocation of $500,000 from the Driver Training Penalty Assessment Fund to augment the TBI Fund. At the time, it was thought that the Medicaid Home and Community-Based Services (HCBS) waiver would generate additional funding; however, it was determined that the HCBS waiver was not a viable source of funding. The department points out that this proposal is consistent with use of the Driver Training Penalty Assessment Fund to support other programs funded through the State Penalty Fund.

LAO Comment. The Legislative Analyst's Office (LAO) notes that the request for supplemental funding for Traumatic Brain Injury Fund is a temporary fix to a larger problem. The LAO provides the following comments, "Given that various state funds receiving criminal fine and fee revenue have been facing financial difficulty for years, the Legislature has few options beyond approving the Governor's proposed short-term solutions for addressing the operational shortfalls and insolvency in these state funds in 2016-17. However, to permanently address the recurring problem, the LAO recommends the Legislature implement ongoing, systemic changes to the state's criminal fine and fee system."

Staff Comment. Staff notes that there does appear to be an immediate need for funding the TBI program in the current budget cycle, and that a BCP for a one-time allocation of funds from the Driver Training Penalty Assessment Fund was previously approved in FY 2014-15. However, staff agrees with LAO comments that there is a larger issue that needs to be addressed regarding the SPF and how the TBI program is funded in the long-run to avoid on-going one-time allocations. This issue will likely be addressed at a future hearing in Subcommittee No.5 on Corrections, Public Safety and the Judiciary.

Questions.

1. Please summarize the proposal.
2. How will this proposal impact other programs funded by the Driver Training Penalty Assessment Fund?
3. What alternatives for funding has the department explored recently? Is the department currently pursuing any alternatives?

Staff Recommendation. Hold Open.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

April 7, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

OUTCOMES

Item	Department	Action
5160	**Department of Rehabilitation**	
Issue 1	Overview	Informational
Issue 2	Update: California PROMISE Initiative Grant	Informational
Issue 3	BCP: WIOA: Competitive Integrated Employment	Hold Open
Issue 4	BCP: Resources for Federal Grant and RSA-911 Reporting	Hold Open
Issue 5	BCP: Traumatic Brain Injury Supplemental Funding	Hold Open

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, April 7, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Part B

Consultant: Michelle Baass

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.

4100 STATE COUNCIL ON DEVELOPMENTAL DISABILITIES

Issue 1: Overview

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

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

SCDD Budget Summary (dollars in thousands)

Fund Source	2014-15	2015-16	2016-17
Federal Trust Fund	$6,636	$7,112	$7,128
Reimbursements	$4,041	$4,352	$4,361
Total	**$10,677**	**$11,464**	**$11,489**
Positions	77	**78**	**78**

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

Activity	2014-15	2015-16	2016-17
Planning and Administration	$2,070	$2,294	$2,299
Community Program Development	$228	$260	$260
Regional Offices and Advisory Committees	$8,379	$8,910	$8,930

Planning and Administration: The council is responsible for developing and implementing a state plan containing goals, objectives, activities, and projected outcomes designed to improve and enhance the availability and quality of services and supports to individuals with developmental disabilities and their families. The appointed council members engage in policy planning and implementation to ensure system coordination, monitoring, and evaluation.

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

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

Role in Transitioning Developmental Center Residents into the Community. SCDD employs individuals in the developmental centers (DC), one position at Canyon Springs Community Facility, 2.5 positions at Sonoma DC, 2.5 positions are Fairview DC, and three positions at Porterville DC. These individuals work with approximately 30 percent of the DC population (those individuals who do not have active family members, for example) and recruit volunteer advocates to assist them.

The SCDD advocates participate in all stages of community transition for the resident. This is a state-funded activity, required by statute, through a contract with the Department of Developmental Services. The volunteer advocate attends meetings where community placement is initially discussed to the final transition review meeting. Volunteer advocates tour potential homes to assure that the home is accessible and suitable for consumers. Advocates confirm that the consumer is compatible with the peers living at the home. The advocates inform the interdisciplinary team including the regional center case manager of any issues, barriers, or concerns regarding the potential placement.

Subcommittee Staff Comment and Recommendation—Information Item.

Questions.

1. Please provide a brief overview of the council and budget.

2. Please explain SCDD role's in helping developmental center residents transition to the community. How are issues identified during this transition process shared with the Department of Developmental Services?

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Overview

The Department of Developmental Services (DDS) oversees the provision of services and supports to over 290,000 persons with developmental disabilities and their families, pursuant to the provisions of the Lanterman Developmental Disabilities Services Act, also known as the Lanterman Act, (Division 4.5 of the California Welfare and Institutions Code). The Lanterman Act establishes an entitlement to services and supports for Californians with developmental disabilities.

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

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

Special Session. On June 19, 2015, the Governor convened a special session of the Legislature to consider and act upon legislation related to the managed care organization (MCO) tax and to "increase oversight and the effective management of services provided to consumers with developmental disabilities through the regional center system," among other provisions.

As part of the special session, on February 29, 2016, the Legislature adopted, and the Governor later signed, a package of ongoing spending proposals in AB 1 2X (Thurmond), Chapter 3, Statutes of 2016, that appropriates $287 million General Fund for various increases to RCs and community services providers for 2016–17. (This new General Fund spending would leverage an estimated $186 million in additional related federal funds.) Most of the additional General Fund spending, about 60 percent, is for salary and/or benefit increases for community service providers' staff that devote most of their time to providing direct care to consumers. On March 18, 2016, DDS sent a survey to a randomly selected sample of regional center-funded community-based providers that will be the basis of information for the state to determine the exact amount of a direct wage and benefit pass-through for direct care workers. See table below for details on the funding included in AB 1 2X.

AB 1 2X also requires documentation and new reporting requirements by RCs and providers to (1) provide information to DDS to determine the allocation of many of these spending increases (including through a random sample survey of providers to be completed in April 2016) and (2) ensure program accountability regarding the use of these funds. This reported data would include, for example, the number of RC service coordinators receiving salary and/or benefit increases and information on staff turnover. Additionally, the legislation requires DDS to submit to the Legislature, by March 2019, a rate study addressing the sustainability, quality, and transparency of community–

based services for individuals with developmental disabilities.

Figure 8

Summary of Special Session Spending Augmentations in AB2X 1 (Thurmond)

(In Millions)

Enacted Spending Proposal[a]	General Fund Appropriation	Fixed Appropriation (Y or N)[b]
Community Services Staff Providing Direct Services to Consumers. Rate increases, as determined by DDS, for enhancing wages and benefits for community service provider staff who spend a minimum of 75 percent of their time providing direct services to consumers. Rate increases would only apply to services for which rates are set by DDS or through negotiations between RCs and service providers, as well as supported employment services and vouchered community services. (Employees of the Community State Staff Program are excluded.)	$169.5	Y
RC Staff Salaries and/or Benefits. Increases for RCs to provide RC staff salary and/or benefit increases as allocated by DDS. Would exclude RC unfunded retirement liabilities and RC executive staff.	29.7	Y
RC Administration. RC operations increase, as allocated by DDS, for administration, including for clients' rights advocates contracts.	1.4	Y
Provider Administration Costs. Rate increases, as allocated by DDS, for rates set by DDS or through negotiations with the RC and provider as well as supported employment services and vouchered community-based services.	9.9	Y
5 Percent Rate Increase for Supported Living and Independent Living Services. Five percent increase to rate in effect on June 30, 2016.	18.0	N
5 Percent Rate Increase for In and Out-of-Home Respite Services. Five percent increase to the rate authorized and in operation on June 30, 2016 for family-member provided respite services and in-home respite service agency rates.	10.0	N
5 Percent Rate Increase for Transportation. Five percent rate increase to rates for transportation services in effect on June 30, 2016.	9.0	N
Competitive Integrated Employment Program. Requires DDS to establish guidelines and oversee a program to increase paid internship opportunities for individuals with developmental disabilities that produce outcomes consistent with a consumers Individual Program Plan, as specified, to include incentive payments for supported employment services providers that meet certain goals.	20.0	Y
11.1 Percent Rate Increase for Supported Employment. Provides an 11.1 percent rate increase for supported employment by restoring rates to levels in effect in 2006.	8.5	N
Resources to Support Bilingual RC Staff, Training, and Education Efforts. Provides a fixed amount to implement recommendations and plans to promote equity and reduce disparities in the purchase of services that may include pay differentials supporting bilingual RC staff, cultural competency training, parent education efforts, and other activities.	11.0	Y
Rate Increases for Certain Intermediate Care Facilities (ICFs). Provides a 3.7 percent rate increase to the reimbursement rates in effect in the 2008-09 rate year for dates of service on or after August 1, 2016 for ICFs for the developmentally disabled and continuous nursing care. Implementation subject to federal approvals for related federal funding. Effective for dates of services on or after August 1, 2016.	[d]	
Exemption From Retroactive Reductions for Distinct Part Skilled Nursing Facilities. Prohibits the Department of Health Care Services from implementing or seeking retroactive reductions or reimbursement limitations for services provided by skilled nursing facilities that are distinct parts of general acute care hospitals for dates of service on or after June 1, 2011 and on or before September 20, 2013.	[d]	
Total General Fund Appropriation	**$287.0**	

[a] Spending augmentations effective July 1, 2016, unless otherwise noted.

[b] If a fixed appropriation, total rate increases provided cannot exceed total appropriation amount. Therefore, year-to-year amounts would not vary based on utilization. Amounts for spending that are not fixed will likely vary year-to-year based on utilization such as for transpiration services.

[c] Spending changes also impact the Department of Rehabilitation budget not included in appropriation.

[d] Spending changes impact the Department of Health Care Services budget not included in appropriation.

DDS = Department of Developmental Services and RC = Regional Center.

Source: The Legislative Analyst's Office

Consumers' Rights Advocacy. The department contracts with the State Council on Developmental Disabilities for developmental center resident advocacy, as discussed earlier in the agenda, and Disability Rights California's Office of Clients' Rights Advocacy (OCRA) to provide clients' rights advocacy for people with developmental disabilities who are regional center consumers. Clients' rights advocates help people who have developmental disabilities and their families get the services they need. Such services can include representation in administrative hearings, training about their rights, and investigation into denial of rights in facilities.

Budget Summary. The budget proposes for DDS expenditures of $6.4 billion ($3.8 billion General Fund), a net increase of $394 million (6.6 percent) over the updated current year budget. See table below for more information.

Regional centers are anticipated to serve an average caseload of 291,507 individuals in the current year, and 303,266 individuals in the budget year, an increase of 11,759 or 4.03 percent. It is estimated that developmental centers will house 1,011 residents in 2015-16 and 847 residents in the budget year, a reduction of 164 or 16 percent.

Department of Developmental Services Funding Summary

	2015-16	2016-17	Difference	Percent Change
Community Services	$5,335,142	$5,774,088	$438,946	8.2%
Developmental Centers	574,160	526,037	-48,123	-8.4%
Headquarter Support	46,018	49,609	3,591	7.8%
Total	**$5,955,320**	**$6,349,734**	**$394,414**	**6.6%**
General Fund				
Community Services	$3,129,340	$3,426,912	$297,572	9.5%
Developmental Centers	348,778	307,481	-41,297	-11.8%
Headquarter Support	29,857	32,673	2,816	9.4%
Total	**$3,507,975**	**$3,767,066**	**$259,091**	**7.4%**

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

1. **Audit Findings.** The budget includes $42.5 million General Fund in 2015-16 and $3.8 million General Fund in 2016-17 in payments to the Department of Health Care Services related to audit findings of inappropriate claiming of federal funds. DDS intends to transfer excess expenditure authority for purchase of services in the current year (as lower costs are anticipated) to support the repayment of federal funds as a result of developmental center audits.

2. **Current Year Supplemental Appropriation.** The Administration indicates that it will likely seek a supplemental appropriation in the current year for $3.3 million General Fund as a result of non-level-of-care and level-of-care staffing adjustments, costs to support the acute crisis center at the Sonoma Developmental Center, and additional costs associated with the closure of the Sonoma Developmental Center.

3. **Caseload and Utilization.** The budget includes a $235 million ($149 million General Fund) increase in regional center operations and purchase-of-services (POS) in 2016-17. The major increases in POS services are within the day programs, support services, in-home respite, health care, and miscellaneous budget categories to reflect updated expenditure data and projected consumer population growth. The budget reflects a $43.4 million ($68.6 million) decrease in regional center expenditures for 2015-16, a 0.82 percent decrease, as a result of expenditure growth occurring at a slightly slower pace than previously estimated.

4. **Minimum Wage Increase.** The budget includes $124.7 million ($70.1 million General Fund), an increase of $62.4 million ($35 million General Fund), in POS to fund the requirements of AB 10 (Alejo), Chapter 351, Statutes of 2013, that increased the state minimum wage from $9.00 to $10.00 effective January 1, 2016.

5. **Transition of Behavioral Health Treatment (BHT) Services to Medi-Cal.** The budget includes a $4.5 million ($2.2 million General Fund) decrease in POS to reflect a reduction in expenditures for consumers who began receiving BHT services in September 2014 as a Medi-Cal benefit, pursuant to SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014. The transition of BHT services for regional centers consumers began in February 2016 and is occurring on a phased-basis.

Savings from Closing Developmental Centers. As required by SB 82 (Committee on Budget and Fiscal Review), Chapter 23, Statutes of 2015, the budget includes information related to the estimated savings from closing down developmental centers and the costs to develop community resources and oversee closure activities. SB 82 stated the Legislature's intent that savings derived from developmental center downsizing and closure benefit persons with developmental disabilities living in the community. DDS does not identify any savings related to closures, but instead $98 million ($76.1 million General Fund) in expenditures necessary to develop community resources and implement closure-related activities. In 2015-16, DDS estimates $8.8 million ($4.9 million General Fund) in savings related to position reductions at developmental centers and $137.7 million ($108.2 million General Fund) in expenditures related to community development and closure activities. According to the department, as experienced in the closure of the Lanterman Developmental Center, savings are not realized until the developmental center is actually closed as there is a need to maintain a base level of developmental center staffing and infrastructure.

Subcommittee Staff Comment and Recommendation—Information Item. It is anticipated that the May Revision will contain proposals related to the implementation of changes adopted in the special session, such as headquarters staff increases.

Questions.

1. Please provide a brief overview of the department and budget.

2. Please provide an update on the implementation of the special session legislation.

3. What is the status of the departments' contracts for consumer rights advocacy? When will these contracts expire? Has the department released the request for proposal (RFP) for the regional center consumer rights advocacy contract? If not, when is it expected that the RFP will be released and the contract awarded?

Issue 2: Closure of Developmental Centers

Oversight and Budget Issue. The budget proposes the following related to the closure of the developmental centers.

1. **Headquarters Resources for Developmental Center Closures.** DDS requests $2.1 million ($1.8 million General Fund), eight new positions, and the redirection of five vacant positions for staffing and contract resources needed to support the continued efforts for the closure of the Sonoma Developmental Center and the initial closure efforts for the Fairview Developmental Center and the Porterville Developmental Center -General Treatment Area (GTA).

   According to DDS, these additional resources will oversee the accelerated movement of consumers from the developmental centers (DCs) into the community and the closure of facilities. This workload includes, but is not limited to, developing community facilities and consumer programs, supporting layoff activities, resolving workers compensation cases, reconciling payroll and benefits, ensuring accuracy of financial records and reporting, supporting information technology (IT) activities, conducting equal employment opportunity (EEO) investigations, and collaborating and communicating closure plans and progress with stakeholders.

   This proposal specifically requests to hire or redirect vacant positions as follows:

   - Community Services Division
     - One Nurse Consultant III – Specialist
     - One Community Program Specialist II
     - Two Dental Consultant I

   - Administrative Support
     - One Senior Accounting Officer (via redirection)
     - One Associate Personnel Analyst
     - One Senior Personnel Specialist
     - Two Associate Governmental Program Analyst (via redirection)
     - One Systems Software Specialist II

   - Office of Human Rights and Advocacy Services
     - One Associate Governmental Program Analyst (via redirection)

   - Director's Office
     - One Associate Governmental Program Analyst (via redirection)

   In addition to the staffing, this proposal requests contract funding of $486,000 General Fund for services including $236,000 for dedicated licensing resources from the California Department of Social Services (CDSS) Community Care Licensing Division; and $250,000 to expand the current scope of DDS' mortality analysis, as well as provide training and technical assistance to regional centers and service providers to mitigate special incidents in the community.

2. **Development of Community Resources.** The budget includes $146.6 million ($127.2 million General Fund) to assist in the development of community resources for placement of current developmental center residents. This includes $24.5 million for Sonoma Developmental Center, $29.7 million for Fairview Developmental Center, and $24.6 million for Porterville Developmental Center. See table below for details.

Table 1: Community Placement Plan (CPP) 2016-17 Funding Summary

	Sonoma	Fairview	Porterville	Regular CPP	Total
Operations	$3,616,000	$1,212,000	$606,000	$15,265,000	$20,699,000
Purchase of Services					
Start-Up[1]	$10,637,000	$25,575,000	$21,950,000	$27,265,000	$85,427,000
Assessment[2]				$1,500,000	$1,500,000
Number of Consumers				878	878
Placement[3]	$10,247,000	$2,886,000	$2,063,000	$22,824,000	$38,020,000
Number of Consumers	54	24	17	145	240
Deflection[4]				$1,000,000	$1,000,000
Number of Consumers				70	70
Total	**$24,500,000**	**$29,673,000**	**$24,619,000**	**$67,854,000**	**$146,646,000**

[1]Start-Up – These expenditures are related to development of new facilities, new programs, and program expansion.
[2]Assessment – These expenditures are for individualized and comprehensive identification of consumer supports and services needed for stabilized community living.
[3]Placement – These expenditures are for the phase-in of consumers to community settings based on consumer-specific information.
[4]Deflection – These expenditures are for related services needed to deflect the admission of individuals into developmental centers.

With this additional funding, DDS anticipates building additional community capacity for 102 Sonoma DC residents, 170 Fairview DC residents, and 131 Porterville-GTA DC residents.

3. **Closure Activities.** The budget includes $18 million ($12 million General Fund) to resolve open workers' compensation claims, inventory and archive clinical and historical records, execute an independent monitoring contract as stipulated by the federal government, and relocate residents and their personal belongs.

4. **Developmental Center Staffing Adjustments.** The budget includes an $8.8 million ($4.9 million General Fund) decrease and a total reduction of 129.2 positions (63.1 level-of-care and 66.1 non-level of care) based on an estimated population decline of 188 developmental center residents transitioning into the community. This reduction reflects adjustments to staffing for specialized support and closure activities.

5. **Assessment of Sonoma DC Property.** Through an April Spring Finance Letter, the Administration requests $2.2 million General Fund to contract with the Department of General Services for an assessment of the Sonoma DC property, buildings, and clinical records. These funds would be used to complete the second and third phase of an environmental site

assessment and architectural historical evaluation of Sonoma DC. DDS proposes to use current year funds of $190,000 to complete the first phase initial site assessments. According to the Administration, these assessments will help determine: (1) the property value, (2) restrictions on land use, and (3) the potential cost of future investments on the property.

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

AB 1472 (Committee on Budget), Chapter 25, Statutes of 2012, imposed a moratorium on admissions to DCs except for individuals involved in the criminal justice system and consumers in an acute crisis needing short-term stabilization. The DC resident population has dropped from a high of 13,400 in 1968, with thousands on waiting lists for admission, to 1,038 as of December 23, 2015. Consistent with the recommendations of the *Plan for the Future of Developmental Centers in California* and the call for the transformation of DC services, the 2015 May Revision proposed to initiate the closure planning process for the remaining developmental centers.

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

Historically, the department has received federal Medicaid funds for operation of the DCs. However, this past year the California Department of Public Health (CDPH), acting on behalf of the Centers for Medicare and Medicaid Services (CMS), terminated the ICF/DD Provider Agreement for Sonoma due to ongoing non-compliance with the federal conditions of participation. In response, the department negotiated with CMS, and entered into a settlement agreement to extend the provider agreement for Sonoma until July 2016 with the option for reconsideration to extend the termination date to July 1, 2017. CDPH notified both Fairview and Porterville-GTA that they will be decertified effective December 1, 2015, and subsequently the termination dates were extended to April 15, 2016. DDS has appealed these actions and is currently in negotiations with CMS for settlement agreements for Fairview and Porterville-GTA. If DDS is unable to negotiate settlements with CMS for these three centers for 2016-17, $92.4 million in federal funds would be lost ($33.6 million for Porterville, $32.4 million for Fairview, and $26.4 million for Sonoma). If DDS in unable to negotiate a settlement agreement for Fairview and Porterville-GTA in the current year, an estimated monthly $2.7 million for Fairview and $2.8 million for Porterville in federal funds would be lost.

The 2015-16 budget includes funds for the initial development of community residential and non-residential resources to serve residents of Sonoma, as well as regional center and headquarters funding to support the activities related to the safe closure of Sonoma by the end of 2018. More specifically,

the 2015-16 budget provides $49.3 million ($46.9 million General Fund) for additional Community Placement Plan (CPP) funding to begin developing community resources to support the transition of Sonoma DC residents, as well as to contract with an independent risk management company to conduct data analysis, training, and technical assistance in mitigating consumer risks.

Of the base (regular) and DC closure related CPP funds, all of the funds have been allocated to the RCs except for $778,165 in SDC related funds. DDS is currently receiving requests from some of the six RCs to utilize those funds. Approximately 75 percent of the RC's projects have been awarded (based on updates through 2/29/2016). DDS has communicated with the six SDC RCs about allowing enough time to either 're-RFP' a project or propose to repurpose funds for an alternative project. All 2015-16 projects need to be awarded and have the funds encumbered by June 30, 2016.

The 2015-16 budget also includes $1.3 million General Fund and seven positions at DDS headquarters to supplement the current administration of the CPP, and to develop the necessary resources to support the closure of Sonoma by the end of calendar year 2018. Finally, the 2015-16 budget reauthorized five headquarters positions that supported the Lanterman DC closure, and redirected them as permanent positions in headquarters for the support of the statewide DC downsizing and closure activities.

Senate Oversight Hearing on DC Closures. On February 23, 2016 the Senate Human Services Committee and Senate Budget Subcommittee No. 3 held a joint oversight hearing on the proposed closures of developmental centers. At this hearing, stakeholders and DDS discussed the lessons learned from previous closures of developmental centers in California, examined the proposal for the closure of Sonoma Developmental Center, currently before the Legislature, and discussed issues associated with the proposed closures of Fairview Developmental Center and the general treatment program at Porterville Developmental Center. Additionally, panelists reviewed the process for moving persons from a developmental center to the community, how the department will maintain quality services and supports for persons residing at developmental centers throughout the closure process, how the resources at the developmental centers will be utilized following closure, how the department will ensure the quality, stability and appropriateness of services and supports provided to persons once they have moved to the community, and the role of the state in providing safety net services for all Californians with developmental disabilities in crisis or in need of a placement of last resort once the developmental center option is no longer available.

Legislative Analyst's Office (LAO). Because of a continued risk of losing additional federal funding and the inherent uncertainty and challenges in addressing this risk, the LAO withholds recommendation on the Governor's federal funding assumptions pending additional information from the Administration. The LAO recommends the Legislature request DDS to report at budget hearings on:

- The DDS' progress in meeting the terms and conditions of the Sonoma settlement agreement, including specific milestones met; findings from recent DPH surveys and court monitor reviews and their potential impact on federal funding; and next steps towards extending federal funding through June 2017.
- The status of settlement negotiations with the federal government regarding Fairview and Porterville DCs as well as findings from any recent DPH surveys and reviews and their potential impact on federal funding.

Additionally, the LAO notes that it supports the Administration's proposal in concept to provide additional CPP funding tied specifically to the closure of the three DCs, but withhold recommendation on the specific amounts pending additional and updated information.

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature is in receipt of the Administration's proposed closure plans for the three DCs, the issues discussed below should be considered as the Legislature evaluates and modifies these closure plans through the budget process.

1. Closer Monitoring of Community-Based Services Development and Transition Planning for Developmental Center Movers is Needed. In the current year, DDS projected that 202 consumers would transition out of developmental centers. As of December 31, 2015, only 62 consumers had transitioned (five from Canyon Springs, 15 from Fairview, 28 from Porterville, and 14 from Sonoma). The budget projects that 240 residents will transition from developmental centers to community based services in 2016-17.

The transition of consumers involves not only the physical development of residential capacity, but also transition planning between the consumer, the regional center, and the developmental center. DDS, regional centers, and many stakeholders appear confident that sufficient funding was included in the 2015-16 and is proposed to be included in the 2016-17 budget to develop the needed residential capacity. Additionally, DDS has indicated that lesson's learned from the closure of the Agnews and Lanterman DCs has provided insight on managing and tracking completion of these residential projects. The table below describes the types of residential projects proposed to be developed for the Sonoma residents.

Table 2: Projected Number of Beds Being Developed by Facility by Regional Center For Sonoma Developmental Center Consumers As of January 31, 2016

		Projected Number of Beds Being Developed by Facility Type				
Regional Center	**Sonoma DC Consumers**	**ARFPSHN**	**SRF**	**EBSH**	**ICF**	**Total**
Far Northern	10	5	26			31
Alta California	47	25	47	8		80
North Bay	84	40	44	20		104
Golden Gate	87	24	83		6	113
East Bay	116	49	36	16		101
San Andreas	10		8	12		20
Total	**354**	**143**	**244**	**56**	**6**	**449**

ARFPSHN - Adult Residential Facility for Persons with Special Healthcare Needs
SRF - Specialized Residential Facility
EBSH - Enhanced Behavioral Supports Home
ICF - Intermediate Care Facility

For these facilities, DDS has provided a seasonal timeline for estimate completion of these projects. As noted below, DDS projects that almost all of the residential developments will be completed by the summer of 2018 (before the planned closure of Sonoma DC).

Table 3: Sonoma Developmental Center
Residential Development Seasonal Timeframe for Completion
As of February 29, 2016

Regional Center	2015				2016			
	Spring	**Summer**	**Fall**	**Winter**	**Spring**	**Summer**	**Fall**	**Winter**
ACRC	0	0	0	0	6	1	2	2
FNRC	0	0	1	0	2	4	0	1
GGRC	0	0	0	0	2	2	0	0
NBRC	0	0	0	3	2	3	0	2
RCEB	0	0	0	0	2	1	2	1
SARC	0	0	0	0	0	1	0	0
Total	**0**	**0**	**1**	**3**	**14**	**12**	**4**	**6**
	2017				**2018**			
	Spring	**Summer**	**Fall**	**Winter**	**Spring**	**Summer**	**Fall**	**Winter**
ACRC	11	0	0	3	0	0	0	0
FNRC	0	0	0	1	0	0	0	0
GGRC	18	0	0	0	5	0	0	0
NBRC	0	2	0	0	6	12	0	0
RCEB	17	0	0	3	0	0	0	0
SARC	0	3	0	1	0	0	0	1
Total	**46**	**5**	**0**	**8**	**11**	**12**	**0**	**1**

However, in terms of transition planning for Sonoma residents, it appears that only six percent of the Sonoma residents have begun any type of transition activity. As shown in the chart above, in the spring and summer of 2016, 26 residential projects will be completed. However, it is highly unlikely, given the transition planning noted below, that very many individuals would transition this spring and summer.

Additionally, as discussed in detailed at the oversight hearing in February, stakeholders highlighted the need for the state to pay for beds that are "on hold" for a person transitioning out of a developmental center if the transition process takes longer than anticipated. It is unclear how the Administration is considering this as it plans for the development of residential capacity and transitioning planning.

Table 4: Sonoma Developmental Center
Status of Transition Planning by Regional Center
As of March 1, 2016

SDC Transition Activity

As of 3-1-16	ACRC	FNRC	GGRC	NBRC	NLARC	RCEB	RCRC	SARC	SCLARC	TCRC	VMRC	NF	ICF		Grand Total
Current Pop	45	10	85	88	1	113	6	9	1	1	3	158	204	0	362
Of the current population, number who have had initial activity (e.g., Meet & Greet) only	0	1	4	3	0	2	0	0	0	0	0	9	1	0	10
Those who have had initial activity and a Transition Planning Meeting (TPM)	0	0	1	0	0	0	0	0	0	0	1	0	2	0	2
Those who have had a TPM and have an identified placement/scheduled move date	1	0	1	1	0	6	0	0	0	0	1	2	8	0	10

These numbers are as of 2/29/2016 and DO NOT INCLUDE STAR Home

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

Subcommittee staff notes that DDS has hired (as a retired annuitant) the former executive director of the Agnews Developmental Center. As part of previous closures, he played a key role in developing and implementing special managed health care provisions by working with the Department of Health Care Services, the regional centers, and the health plans. He also directly supported closure activities at the developmental center site. He is now performing similar duties for the closures of the three remaining developmental centers. While this appears to be a step in the right direction, it will be important for specific proposals to be identified and implemented timely.

3. Details on Crisis Services Capacity and "Placement of Last Resort" Are Not Yet Available. DDS proposes to continue to operate the Southern and Northern STAR (Stabilization, Training, Assistance, and Reintegration) crisis homes at Fairview DC and Sonoma DC, respectively, during the closure process. However, the closure plans do not set forth the Administration's proposal for ensuring access to crisis services post closure. The Administration has noted for months that it is open to discussions regarding the need to develop additional crisis capacity and "placements of last resort;" however, it appears they are no further along in these discussions. Similarly, with the closing of state-

run DCs, it is important to understand and specify how the state will maintain its role in providing residential services to those whom private sector vendors cannot or will not serve. The Fairview and Porterville closure plan indicate that this issue will be discussed and analyzed through the work of the Developmental Task Force beginning in April 2016.

In addition to ensuring development of crisis capacity, it will be important to ensure that reports of injuries, death, restraint usage, and incidents of seclusion, for example, be reported to the federally mandated protection and advocacy agency.

4. No Budget Proposal on Supports for Developmental Center Employees. The proposed closure plans indicate that DDS is committed to the implementation of employee supports that promote workforce stability and provide opportunities for employees to determine their future. The plans also note that the department will explore the possibility of retention bonuses, state service credit opportunities, and the ability to guarantee positions or specialized training for employees that stay through the end of a closure. However, the budget does not include any proposals related to supports for developmental center employees. The Legislature may wish to engage the department in discussions on any additional supports that may be needed to ensure a smooth transition and to encourage that these professionals who have developed an expertise continue to work with persons with developmental disabilities.

Questions.

1. Please provide an overview of these proposals.

2. Please provide an overview of the Fairview DC and Porterville GTA DC closure plans. How do these plans differ from the Sonoma DC closure plan?

3. Please provide a status update on discussions with CMS regarding settlement agreements for Fairview DC and Porterville DC and an update on discussions with CMS regarding an extension of the Sonoma DC settlement agreement.

4. How does DDS track and synch up resident transition planning and residential project completion? Why hasn't more transition planning for SDC residents occurred given that it is projected that 26 residential facilities will be completed this spring and summer? Is the department on track to transition 202 DC residents into the community in the current year?

5. Is the Administration considering the need to pay for beds that are "on hold" for a person transitioning out of a developmental center if the transition process takes longer than anticipated? Please explain.

6. Please provide an update on discussions about crisis capacity development and identifying "placements of last resort." What is the Administration's timeline for identifying a concrete proposal to address these issues?

7. Please provide an update on policies DDS plans to implement regarding ensuring access to specialized medical services. What is the Administration's timeline for identifying concrete proposals to address this issue?

8. Please provide an update on the Administration's plan to explore the possibility of retention bonuses, state service credit opportunities, and the ability to guarantee positions or specialized

training for employees that stay through the end of a closure. What is the timeline for specific proposals on this?

9. Can DDS please provide the Subcommittee with the information included in tables 2, 3, and 4 for Fairview DC and Porterville-GTA DC?

Issue 3: Porterville Developmental Center – Upgrade Fire Alarm System

Budget Issue. The budget requests $6.5 million General Fund for the construction phase of a project to purchase and install a new fire alarm system (FAS) in 10 buildings (nine consumer utilized and one administrative building) at the Porterville Developmental Center in Tulare County.

Background. The preliminary plans and working drawings phases were funded in the 2015-16 budget. According to DDS, this project continues to be a critical infrastructure improvement and code compliance need for Porterville Developmental Center's consumers, staff, and visitors. This project will integrate with the existing new 96 bed facility FAS, and will provide an updated FAS to the secure treatment facility, the administration building, and transition residences.

The estimated total costs for this project is $7,314,000 and includes:

- Preliminary plans - $309,000
- Working drawings - $493,000
- Construction - $6,512,000

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide a brief overview of this proposal.

Issue 4: Oversight of Regional Centers and Community-Based System

Oversight Issue. The Lanterman Act establishes regional centers as private, non-profit agencies, each directed by the policies and decisions of a locally established board of directions. The intent is of this is that these boards and centers are in the best position to understand the needs of the community. While it is important that the services provided by the regional centers reflect the needs of the community, the Lanterman Act establishes a statewide entitlement and it is the responsibility of DDS to ensure that this entitlement is provided in the most effective and efficient means possible.

As shown in the chart below, regional center expenditures have grown from $4.1 billion in 2012-13 to $5 billion in 2015-16, a 22 percent increase. Regional center caseload has grown from 270,601 in 2012-13 to 282,805 in 2015-16, a 12.1 percent increase. While some of this growth in expenditures can be attributable to the transition of individuals from developmental centers to the community and the aging of this population, DDS does not systematically present the reasons for this growth in any budget documentation. Nor does DDS publically provide detailed or analytical regional center caseload or expenditure information.

Regional Center Expenditures Changes from 2012-13 to 2015-16

	Amount Increased	Percent Increased
Operations	$74,363,531	14.49%
Purchase-of-Service	$836,517,668	23.34%
Total	**$910,823,414**	**22.22%**

Additionally, as shown in the chart below, there is great variance in the per capita spending by regional center. For example, the Central Valley Regional Center's per capita expenditure in 2015-16 is $13,929 and Golden Gate Regional Center's per capita expenditure is $29,977. It is likely that a significant portion of this per capita spending difference is related to the costs-of-living differences between the central valley and the Bay Area. The regional centers located in Los Angeles County have a per capita spending variance of about $7,100 (with Westside Regional Center's per capita expenditures at $21,436 and Harbor Regional Center's per capita expenditures at $14,282), where cost-of-living differentials are less significant.

Table: Regional Center Expenditures and Caseload, 2012-13 - 2015-16

	2012-13					2013-14				
	Operations	POS	Total1	Caseload	Per Capita Cost	Operations	POS	Total1	Caseload	Per Capita Cost
Alta California	$33,000,235	$255,473,701	$288,473,936	17,477	$16,506	$34,646,782	$265,221,280	$299,868,062	18,107	$16,561
Central Valley	30,105,401	158,857,892	188,963,293	15,063	12,545	31,974,835	169,368,143	201,342,978	15,588	12,917
East Bay	32,076,924	270,323,094	302,400,018	15,822	19,113	33,092,281	279,138,044	312,230,325	16,239	19,227
Eastern L.A.	19,555,068	141,135,682	160,690,750	9,205	17,457	20,484,458	151,887,797	172,372,255	9,518	18,110
Far Northern	14,046,299	98,506,415	112,552,714	6,496	17,326	14,580,770	103,303,740	117,884,510	6,577	17,924
Frank Lanterman	16,241,702	105,039,197	121,387,389	7,977	15,217	17,495,911	114,847,688	132,447,008	8,438	15,696
Golden Gate	18,730,404	178,476,348	197,206,752	7,927	24,878	19,419,268	189,568,802	208,988,070	8,219	25,427
Harbor	23,226,052	113,848,222	137,139,285	10,656	12,870	24,293,285	122,117,175	146,472,172	11,030	13,279
Inland	47,824,838	251,678,479	299,692,486	24,873	12,049	50,761,457	266,305,339	317,236,161	26,299	12,063
Kern	15,432,485	126,500,003	141,932,488	6,843	20,741	15,891,276	127,300,338	143,191,614	6,964	20,562
North Bay	16,473,169	127,888,292	144,361,461	7,518	19,202	17,270,066	136,775,668	154,045,734	7,661	20,108
North L.A.	34,211,467	254,669,177	289,003,365	18,102	15,965	36,282,816	273,679,248	310,075,257	18,873	16,430
Orange	31,317,007	237,109,785	268,584,824	17,151	15,660	31,620,058	253,752,997	285,510,751	17,263	16,539
Redwood Coast	7,920,459	69,856,048	77,776,507	2,933	26,518	8,191,224	72,583,103	80,774,327	3,010	26,835
San Andreas	27,378,133	270,742,446	298,120,579	13,471	22,131	28,425,067	283,938,411	312,363,478	13,983	22,339
San Diego	37,942,454	223,360,043	261,302,497	19,715	13,254	39,824,735	237,624,586	277,449,321	20,606	13,464
San Gab/Pomona	22,595,419	143,568,072	166,265,875	11,036	15,066	23,947,434	151,504,034	175,548,289	11,579	15,161
South Central	22,583,779	125,443,012	148,147,883	10,791	13,729	24,268,190	135,655,699	160,039,708	11,321	14,137
Tri-Counties	24,758,475	185,138,266	210,006,516	11,459	18,327	25,456,866	194,173,730	219,737,113	11,715	18,757
Valley Mountain	21,618,287	120,323,216	141,941,503	10,499	13,520	22,258,172	124,016,290	146,274,462	10,767	13,585
Westside	16,211,333	126,595,677	142,899,746	7,249	19,713	16,845,132	135,692,474	152,623,275	7,500	20,350
Gross Total	**$513,249,390**	**$3,584,533,067**	**$4,098,849,867**	**252,263**	**$16,248**	**$537,030,083**	**$3,788,454,586**	**$4,326,474,870**	**261,257**	**$16,560**

[1]Includes about $1 million for Family Resource Centers and Early Intervention Program.

	2014-15					2015-16[2]				
	Operations	POS	Total1	Caseload	Per Capita Cost	Operations	POS	Total1	Caseload	Per Capita Cost
Alta California	$36,121,089	$282,775,732	$318,896,821	18,785	$16,976	$37,513,955	$309,019,642	$346,533,597	19,499	$17,772
Central Valley	33,093,097	183,862,378	216,955,475	15,931	13,618	34,261,883	197,929,060	232,190,943	16,670	13,929
East Bay	35,012,715	296,803,112	331,815,827	16,709	19,859	36,946,782	331,133,897	368,080,679	17,607	20,905
Eastern L.A.	21,312,601	163,211,768	184,524,369	9,903	18,633	22,317,784	170,535,900	192,853,684	10,437	18,478
Far Northern	15,037,279	109,644,691	124,681,970	6,727	18,535	15,666,371	120,002,146	135,668,517	7,023	19,318
Frank Lanterman	18,313,743	126,620,284	145,039,465	8,714	16,644	18,922,589	133,514,995	152,543,022	9,033	16,887
Golden Gate	20,101,119	204,670,333	224,771,452	8,348	26,925	20,613,769	233,589,272	254,203,041	8,481	29,973
Harbor	25,234,681	135,192,606	160,490,209	11,213	14,313	26,066,551	141,241,070	167,370,543	11,719	14,282
Inland	54,180,496	304,018,953	358,372,136	27,634	12,969	55,886,277	334,529,061	390,588,025	29,222	13,366
Kern	16,862,788	131,610,042	148,472,830	7,256	20,462	16,708,737	142,726,226	159,434,963	7,485	21,301
North Bay	17,927,901	147,030,667	164,958,568	7,787	21,184	18,593,044	166,187,704	184,780,748	7,901	23,387
North L.A.	38,166,927	296,690,129	334,972,469	19,734	16,974	39,968,370	317,218,871	357,302,654	20,921	17,079
Orange	34,496,887	273,796,321	308,433,605	17,996	17,139	36,487,434	285,057,674	321,685,505	18,809	17,103
Redwood Coast	8,647,477	76,277,275	84,924,752	3,121	27,211	9,185,800	79,465,407	88,651,207	3,301	26,856
San Andreas	29,575,330	299,483,212	329,058,542	14,485	22,717	30,742,894	321,411,168	352,154,062	15,051	23,397
San Diego	42,306,351	258,074,407	300,380,758	21,475	13,987	44,231,719	280,583,893	324,815,612	22,870	14,203
San Gab/Pomona	25,341,195	165,340,880	190,780,795	11,871	16,071	26,019,548	176,204,070	202,322,338	12,170	16,625
South Central	26,375,132	152,616,062	179,109,285	12,066	14,844	26,392,679	159,954,549	186,465,319	12,198	15,287
Tri-Counties	26,941,434	207,881,080	234,931,121	12,115	19,392	27,955,802	220,974,902	249,039,311	12,639	19,704
Valley Mountain	23,296,004	133,923,754	157,219,758	11,060	14,215	24,421,467	145,945,733	170,367,200	11,716	14,541
Westside	17,894,510	150,016,738	167,998,598	7,671	21,900	18,709,466	153,825,495	172,622,311	8,053	21,436
Gross Total	**$566,238,756**	**$4,099,540,424**	**$4,666,788,805**	**270,601**	**$17,246**	**$587,612,921**	**$4,421,050,735**	**$5,009,673,281**	**282,805**	**$17,714**

[1]Includes about $1 million for Family Resource Centers and Early Intervention Program.

[2]Includes allocations as of August 21, 2015. A total of $5,273,588,000 is expected to be allocated in 2015-16 ($620,137,000 for operations and $4,468,704,000).

Additionally, the current system does not provide a mechanism to easily and systematically evaluate the outcomes achieved with these expenditures. While DDS maintains performance contracts with each regional center, the goals and metrics included in these contracts, such as "more adults live in home settings" and "passes DDS audit," do not evaluate the quality of services provided or the outcomes of these services (such as improved quality of life, prevention of secondary conditions, and slowing decline of activities of daily living).

DDS has maintained a consumer satisfaction survey (the National Core Indicators survey), but it is not clear how the results of these surveys were used to hold regional centers accountable for performance, as the last posted survey for children is for 2012-13 and 2011-12 for adults.

Unanticipated Rate Adjustments & Health and Safety Exemptions. State law provides for a mechanism for regional centers to obtain written authorization from the department granting certain rate increases to protect consumer's health and safety. Information required as part of this request includes capacity, proposed rate and supporting justification, an explanation of the health and safety basis of the request and ramifications of a denial, and a signed statement from the regional center executive director that he/she concurs with the information and request being submitted. Although the department does not track the amount of time spent on this process, generally, it takes about 60 days from the date received to the date notifying the vendor of the decision. The following table summarizes the unanticipated rate adjustments, as a result of the unanticipated rate adjustment process.

Summary of Unanticipated Rate Adjustment Requests

	Submitted	Approved	Expenditures for Approved Requests	Denied
FY 2012-13 Totals	6	0	$0	6
FY 2013-14 Totals	16	7	$28,213	9
FY 2014-15 Totals	803	265	$75,406,156	538
Grand Total	**825**	**272**	**$75,434,369**	**553**

Of the 803 requests received in 2014-15, 439 were submitted as a result of the increase in the state minimum wage, effective July 1, 2014, resulting in 257 approved requests.

LAO. The LAO recommends the Legislature require DDS to develop a multiyear strategic plan for RC system financing reform. The LAO thinks that such a plan would formally acknowledge financing challenges that currently exist, provide direction and expected solutions by which to address these challenges, and provide a benchmark for the Legislature to evaluate future budget and policy proposals over time. Further, the LAO thinks such a plan could provide more accountability and transparency to the Legislature and the public in the development of a new financing structure for the RC system. The LAO recognizes that meaningful financing reform will take many years to accomplish and by having a reform plan, the Legislature will be in a better position by which to evaluate progress in meeting reform goals, make necessary adjustments, and ultimately ensure that what moves forward meets the requirements of the consumers served by the RC system.

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature should consider the following as mechanisms to improve oversight of regional center performance and outcomes of the community-based system:

- **Implement a Quality and Performance Dashboard.** The Legislature may want to consider establishing a quality dashboard for regional centers. The Department of Health Care Services (DHCS) maintains a "Medi-Cal Managed Care Performance Dashboard" that it publishes quarterly. This dashboard contains comprehensive data on a variety of measures including enrollment, health care utilization, appeals and grievances, network adequacy and quality of care by health plan. Information contained in the dashboard assists DHCS and its stakeholders in observing and understanding both individual and statewide managed care plan performance.

- **Report Consumer Complaints.** DDS maintains processes for consumer rights complaints and language access complaints, for example, but does not publically report the number and nature of these complaints. The Legislature may want to consider requiring DDS to publically report on this information by regional center on an annual basis.

- **Require More Detail in Publically-Available Budget Documents.** The current budget documents do not include any details on the caseload or the level of funding per regional center. This type of information should be easily available to the Legislature and public. The Legislature may consider directing the department to include certain basic information regarding regional center expenditures and caseloads and information regarding health and safety waiver exemption requests in its budget documentation.

The goal of these mechanisms would be to advance understanding among policy makers and stakeholders of the performance of regional centers and the community-based developmental services system and to establish a method for ongoing monitoring of system. This would also allow for the ability to identify program trends, risk areas, and successes.

Questions.

1. Please briefly explain how DDS maintains oversight of regional centers and the community-based developmental services system.

2. Is there currently a formalized process for the public, stakeholders, or experts to comment on regional center performance or outcomes from the community-based developmental services system?

3. What data is publically available to allow for general oversight of regional center performance?

4. Concerns continue to be raised indicating that the Health and Safety Waiver exemption process is cumbersome, how is DDS working to streamline this process? Does DDS plan to review this process in light of the rate study included as part of the special session?

Issue 5: Fiscal and Program Research Unit

Budget Issue. DDS requests $923,000 ($630,000 General Fund) for seven new permanent positions and the redirection of one vacant position to establish a Fiscal and Program Research Unit. This unit will provide fiscal and programmatic analyses to assist the department's response to external requests for data and information related to the regional center and developmental center programs, as well as inform accurate, reliable, data-driven decisions.

The purpose of the Fiscal and Program Research Unit will be to compile, research, and analyze data, and prepare reports and information to respond to requests for information. The unit will also develop analytic products to inform policy and assist the department in achieving its mission. The Fiscal and Program Research Unit will provide fiscal and programmatic insight and analysis for the development of accurate, reliable, and data-driven responses, recommendations, and solutions.

To staff the new unit, DDS requests seven new permanent positions and funding to support one vacant redirected position, as follows:

- 1.0 Research Manager II
- 1.0 Research Program Specialist II
- 1.0 Research Program Specialist I
- 1.0 Research Analyst
- 1.0 Associate Information Systems Analyst (Specialist)
- 1.0 Staff Information Systems Analyst (Specialist)
- 1.0 Data Processing Manager II
- 1.0 Office Technician (Redirected Vacant Position)

Background. DDS does not currently have staff dedicated to research and analysis. Other departments that are similarly-sized as DDS have research units and are able to respond to informational requests in a timely manner. In addition, those departments are able to proactively analyze programmatic information, service trends, and other data, as well as conduct in-depth analyses to assist in programmatic decision-making. As DDS' overall expenditures and consumer base continues to grow, the lack of data and analysis of available information is a growing concern. The establishment of an enterprise research and analysis unit will give the department more transparency and improve decision making with solid data.

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

LAO. The LAO recommends approval of this proposal. It finds the request for additional staff and related resources to support in–house analytical and data capacity is warranted. The LAO also recommends that the Legislature identify goals and possible deliverables for this new unit. In thinking about what priorities and possible deliverables might be, the LAO recommends the following key questions and issues for the Legislature's consideration:

- What data gaps exist that could help improve DDS oversight and program operations and how might this new unit address these gaps? How will recent changes to reporting requirements for RCs and providers as part of special session legislation help address these gaps?
- What data and analysis should this new unit provide publically and how often?
- How will this new unit work with other key sister agencies, such as DHCS, California Department of Education (CDE), and DPH, in efficiently leveraging data, research, and analytical capacity?
- How will this new research unit help support reform efforts for RC operations and provider rates?

Subcommittee Staff Comment and Recommendation—Hold Open. DDS's proposal to create a fiscal and program research unit is worthwhile. Many other health and human services departments have similar units and provide valuable research to guide policy decisions. According the proposal, the primary function of the unit would be to compile, research, and analyze data; prepare reports; and develop analytic products to inform policy and assist DDS in achieving its mission. The Legislature may want to specify metrics and analyses that it wants regularly reported. For examples:

- **Analysis of Disparities in Regional Center Services.** DDS and regional centers are required to annually collaborate to compile data in a uniform manner relating to POS authorization, utilization, and expenditure by regional center and by specified demographics including age, race, ethnicity, primary language spoken by consumer, disability, and other data. Additionally, as required by SB 82, annual performance objectives are included in DDS's contract with each regional center to measure progress in reducing disparities and improving equity in POS expenditures.

  A review of 2014-15 data, indicates that in most regional centers, the per capita expenditures for "white" consumers aged 22 years and older is higher than expenditures for Asian, African-American, or Latino. There has not been an analysis of the causes of these differences or even an investigation into the differences. The Legislature may want to direct this new research unit to analyze this data and develop methodologies to link these data to future policy changes.

- **Transparency in Regional Center Per Capital Expenditure Variances.** As discussed earlier in the agenda, there are significant variances in the per capita expenditures by regional center expenditures. The Legislature may want to direct this new research unit to evaluate these differences and to publically provide analysis as to the reason for these variances.

- **Analysis Linking Caseload Demographics to Trends in Regional Center Expenditures.** DDS collects various types of data on demographics, diagnosis, and service utilization; however, linking and analyzing this information for purposes of understanding budgetary trends and changes does not routinely occur. The Legislature may want to require certain analytics related to explaining budgetary changes.

Questions.

1. Please provide an overview of this proposal.

2. Has the department considered specific metrics that it plans to annually review and report out on? What are they?

Issue 6: Federal Fair Labor Standards Act Implementation

Oversight and Budget Issue. The budget includes $86.5 million ($46.7 million General Fund), an increase of $54.2 million ($29.2 million General Fund), in purchase of services to reflect full year implementation of the federal Fair Labor Standards Act (FLSA) to include home care workers in overtime compensation.

Background. Effective October 1, 2015, new regulations by the federal Department of Labor revised the implementation of FLSA to include home care workers, also known as personal care assistants, in overtime compensation.

SB 856 (Committee on Budget and Fiscal Review), Chapter 30, Statutes of 2014 authorized a 5.82 percent rate increase for in-home respite agency services, personal assistance, and supportive living services, which was scheduled to begin on January 1, 2015, to implement FLSA. However, given court actions, this rate increase did not go into effect until December 1, 2015. There are no hour caps on overtime for DD providers, as compared to the overtime caps on In-Home Supportive Service (IHSS) hours, for example.

SB 82 (Committee on Budget and Fiscal Review), Chapter 23, Statutes of 2015 requires DDS to report at budget hearings on the impact of the federal Fair Labor Standards Act on individuals with developmental disabilities.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised that implementation of FLSA could negatively impact some DD consumers. Although a DD rate increase was provided specifically for FLSA purposes, some providers are eliminating overtime expenditures and instead hiring additional workers. For consumers with significant needs, continuity of support and consistency of a worker are critical for wellbeing and good outcomes.

Although the Lanterman Act requires regional centers to use generic services (e.g. IHSS, Medi-Cal, public school, California Children's Service) when available, with implementation of FLSA, generic services (e.g., IHSS) may not be appropriate for a consumer's need for staff continuity and staff expertise. Consideration could be given to guiding regional centers during the individual program plan process to evaluate if generic services are appropriate and if not appropriate the consumer would not be required to utilize those services.

Questions.

1. Please provide an overview of this proposal.

2. As required by SB 82, please provide an update on the impact of FLSA on individuals with developmental disabilities.

Issue 7: Home and Community-Based Services (HCBS) Federal Requirements

Budget Issue. DDS requests the following to comply with new federal Home and Community-Based Services regulations:

1. Headquarters - $483,000 ($330,000 General Fund) and four positions to support the immediate workload associated with the state's transition plan and direct regional center and service provider efforts to comply with the Centers for Medicare and Medicaid Services' (CMS) new regulations for Medicaid-eligible home and community-based settings. The new, comprehensive regulations create additional workload for planning, training, assessing, and reporting activities to demonstrate compliance by March 2019 in order for the state to maintain the current level of $1.7 billion annually in federal financial participation reimbursements for purchase of services (POS) expenditures.

2. Regional Center Operations - $1.6 million ($0.9 million General Fund) to fund 21 program evaluator positions within the regional centers to ensure HCBS program settings are integrated into the community.

3. Purchase of Services (POS) - $15 million ($11 million General Fund) to fund modifications to some service providers' programs that will be necessary for compliance with HCBS regulations.

4. Budget Bill Language – Provisional budget bill language requiring regional centers to report annually to the department the number of providers receiving these funds.

5. Trailer Bill Language – Placeholder trailer bill language expressing the Legislature's intent to enact Legislation to implement changes necessary to comply with the HCBS regulations.

Background. Recent federal and state actions have articulated a growing preference for the delivery of services and supports that best promote integration and self-direction for persons with developmental disabilities. The implementation of these new initiatives will require a significant shift in how services and supports are provided in California. For example, under new federal home and community-based waiver and state plan regulations (that go into effect in March 2019) waiver-funded services must meet certain criteria, including:

- The setting is integrated and supports full access to the greater community;
- The setting is selected by the individual from among options that include non-disability-specific settings and an option for a private unit in a residential setting;
- Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes, but does not regulate, individual initiative, autonomy, and independence in making life choices; and,
- Facilitates individual choice regarding services and supports, and who provides them.

CMS Has Not Yet Approved State's Transition Plan. On November 16, 2015, the Centers for Medicare and Medicaid Services (CMS) sent a letter to the Department of Health Care Services

(DHCS), the lead state agency on this issue, indicating that further information regarding, among other things, the settings impacted by the new HCBS rule, the timelines for many of the milestones outlined within the statewide transition plan (STP), and the state's plan for relocating beneficiaries, if needed. Additionally, CMS noted that:

> *The state has omitted from the STP several key details about the site-specific assessment process including: when provider self-surveys will be completed, how the state will ensure responses from providers, how beneficiary surveys will be matched to provider assessments, how beneficiary and provider surveys will be used to identify settings that require on-site assessment, an estimate of the number of on-site assessments, how the state will ensure coordination across on-site assessments, and how the on-site assessment tool would be used to categorize compliant and non-compliant settings.*

LAO. Overall, the LAO finds that the Governor's proposal for positions and community resources to begin compliance efforts in response to the new federal HCBS rules is a critical next step towards ensuring federal funding for services in the future. However, because the level of resource requirements for RC service providers to achieve compliance is highly uncertain and likely subject to change as described in their analysis, the LAO withholds recommendation on the aspect of the Governor's proposal that provides transition support funding to the provider community pending additional information from the administration.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised by providers that the state has not provided sufficient direction on how these new federal rules may impact the various types of providers. While the state is still awaiting direction from CMS, it is essential that state departments, communicate as soon as possible what needs to change and the processes that will be developed to measure and ensure compliance with the new HCBS rule. Clear guidance on what is needed to come into compliance and the state's commitment of resources to support programs to move towards compliance is essential to successful implementation of this new rule.

Additionally, concerns have been raised that the state has not taken a proactive approach in discussions and negotiations with CMS.

This item will also be heard under the Department of Health Care Services (DHCS), as DHCS is ultimately responsible for ensuring California's compliance with these federal regulations.

Questions.

1. Please provide an overview of these proposals.

2. What is the timeline for the submittal of a revised statewide transition plan to CMS?

3. Is DDS prioritizing settings that it will assess? If so, using what criteria? If not, why not?

Issue 8: Self Determination Program

Oversight Issue. Concerns have been raised about the continued delays in implementation of the Self Determination Program (SDP). DDS originally submitted the SDP waiver application in December 2014 and has been working through CMS questions and concerns since then.

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

Background. SB 468 (Emmerson), Chapter 468, Statues of 2013 establishes a statewide self-determination program, under which consumers are provided with individual budgets and the ability to purchase services and supports that are consistent with their individual program plan (IPP) and with the assistance of a financial manager. The SDP program must be consistent with the new federal HCBS regulations discussed earlier in this agenda. Under the provisions of SB 468, participation will be limited to 2,500 individuals for the first three years of implementation.

The department has worked with a stakeholder workgroup to design and submit a federal waiver application to the Centers for Medicare and Medicaid Services (CMS). However, on December 11, 2015, the state received a letter from CMS requesting additional information before the waiver could be approved. It is unknown at this time when federal approval will occur.

DDS indicates that is it changing its approach with regard to which services would be included as part of SDP. Originally, DDS did not limit the scope of services and settings that would be included in SDP, with the goal of offering all services and supports that are currently available. However, DDS now indicates that it is working with stakeholders on defining services and settings that are likely already compliant with federal HCBS setting rules (as discussed in the previous agenda item) in the hopes of implementing SDP in a timelier manner.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an update on the status of the resubmittal of the SDP application. What key milestones must be completed prior to resubmittal? What is the timeline for these milestones?

2. Please explain how and why DDS is narrowing the scope of services that would be included in SDP. What has been the feedback from stakeholders and CMS on this new approach?

Issue 9: Four-bed Alternative Residential Model Homes

Budget Issue. The budget includes:

1. $46 million ($26 million General Fund) to help transition and establish smaller alternative residential model (ARM) four-bed homes for regional center consumers living outside their family. Originally, this model was based on six-bed homes.

2. Provisional budget bill language requiring regional centers to report annually to the department the number of facilities receiving these rates.

3. Trailer bill language to establish a rate schedule for residential community care facilities vendored to provide services to a maximum of four persons with developmental disabilities. This trailer bill language also prohibits regional centers from authorizing any residential service-level changes, if the change would increase state costs.

DDS indicates that there are 4,233 ARM community care facilities (CCFs), serving 21,118 consumers. Of these, 1,618 operate four beds or less and would be eligible for this funding.

Background. The ARM rate structure for CCFs was established in 1988-89. The resulting schedule established 14 rate levels based on the amount of support required by the residents. At the time this rate structure was developed, the rates were based on the assumption that there were six residents in each home. Therefore, all overhead and staffing costs were split six ways to determine the per-resident rate. Over the last several years, a large number of smaller (three to four bed) facilities have been developed based on regional center and consumer preferences. This small facility is also in line with the federal preference toward more individualized settings.

LAO. The LAO recommends the Legislature approve the Governor's new ARM rate proposal in concept, pending additional information on the expected impact and implementation details of this proposal. The LAO finds that this proposal is a reasonable way to meaningfully target spending given the proposal's general alignment with state and federal policy and probability that this change would address an area where there are capacity concerns. The LAO notes that depending on additional information about the current operational environment of these facilities and consumers they are serving, as well as details on how this proposal would be implemented, the Legislature may wish to make modifications to the Governor's proposal to target these providers differently from what is presented by the Governor.

Subcommittee Staff Comment and Recommendation—Hold Open. The current ARM rates, which were based on six residents per facility, do not provide adequate funding for smaller facilities. However, it is unclear how the Administration has budgeted for the number of facilities with five or more beds who might transition to four beds or less given the enhanced rate. Consequently, it is not clear if this projected amount is the total amount available for the establishment of this rate or if it the minimum amount needed to pay this enhanced rate.

Questions.

1. Please provide an overview of this proposal.

2. Does this request for funding represent the total amount available regardless of the number of facilities (i.e., is this a cap)?

Issue 10: Consumer Program Coordinators Funding

Budget Issue. The budget includes $17 million ($12 million General Fund) to fund additional regional center (RC) consumer program coordinator positions to reduce caseload ratios and improve case management functions. Regional center case management services are eligible for federal funding participation for consumers enrolled under the Home and Community-Based (HCBS) waiver. It is estimated that this proposed funding would support the addition of about 200 coordinator positions, about one-third of what is estimated to meet federal caseload ratio requirements.

The budget also includes provisional budget bill language requiring regional centers to report annually to the department the number of staff hired with these additional funds and the effectiveness of these funds in reducing average caseload ratios.

Background. The Association of Regional Center Agencies, in a 2013 report, found that a number of regional centers are not meeting caseload ratio requirements under the HCBS waiver, putting California at risk for a loss in federal funding.

LAO. The LAO recommends approval of the Governor's proposal for increased funding to support improvements in service coordinator–to–consumer ratios and case management functions. The LAO notes that because the Governor's proposal would not support staffing changes sufficient to bring RCs into full compliance with all required caseload ratios, federal funds could still be at risk related to HCBS waiver consumers. While special session actions taken by the Legislature could help mitigate some of this risk, that risk remains to some degree to the extent that RCs are not meeting caseload requirements for HCBS consumers. The LAO recommends the Legislature direct the Administration to report at budget hearings on the benefits, trade–offs, and implementation issues of targeting caseload ratio requirements where federal funds are at risk.

Subcommittee Staff Comment and Recommendation—Hold Open. According to the Administration, at this point it is not requesting the total number of projected coordinators to meet federal caseload ratio requirements because it wants to consider the impact of this proposal and actions taken during the special session (e.g., wage increases for direct care staff) to get a better understanding for the need for these positions.

Given the potential loss of federal funding for not meeting federal ratio requirements, it is unclear why DDS is not requiring regional centers to use this increased funding to address ratio requirements under the HCBS waiver. The Legislature may wish to consider modifying the budget bill language to require regional centers not only report the number of staff hired with the additional funds and the effectiveness of these funds in reducing average caseload ratios, but also information justifying why a regional center, if it chooses, uses this funding for non-HCBS coordinators.

Questions.

1. Please provide an overview of this proposal.

2. Why is DDS providing flexibility on how regional centers can use this funding? Why not direct the funding to address HCBS-related ratio requirements?

Issue 11: Increased Vendor Audit Coverage

Budget Issue. DDS requests $952,000 ($650,000 General Fund) to permanently establish and retain the funding for seven full-time positions previously established as limited-term for the Vendor Audit Section. According to DDS, retaining these positions will enable the department to continue audit coverage and oversight of the more than $4.6 billion in vendor payments that are disbursed each fiscal year within the developmental services system.

According to the department's Vendor Audit Section Work Plan, the section has the capacity to conduct 31.5 audits annually with existing resources, including the seven limited-term positions. Per the audit work plan, the section will focus its efforts on vendors with expenditures in excess of $1 million, which comprises 71 percent of total purchase-of-services (POS) expenditures. There are 852 vendors that meet this threshold and DDS proposes to audit 31.5 of these vendors annually (3.6 percent of vendors with expenditures in excess of $1 million).

Background. The department's Vendor Audit Section is responsible for conducting billing, staffing, contract, expenditure, and whistleblower audits of the more than 30,000 vendors (non-duplicated number of vendors using tax identification numbers) utilized by regional centers (RCs) to provide services and supports to individuals with developmental disabilities. The audits include Medi-Cal providers, and expenditures reimbursed by the federal Home and Community-Based Services (HCBS) Waiver.

In response to budget limitations in the early 1990s, DDS eliminated its audit function. Since that time, DDS has incrementally restored its audit function and increased audit capacity. Most recently in fiscal year 2014-15, the department received seven limited-term positions and funding to address a large backlog of vendor-related whistleblower complaints and increased cases of fraud, waste, and abuse. Currently, there are a total of 35 positions in the audit branch; 14.0 authorized positions to conduct the mandated biennial audits of the twenty-one regional centers; 18.0 positions to conduct vendor audits, and three positions that provide overall management and support services for both RC and vendor audits.

With the addition of the seven limited-term positions in 2014-15, the section initiated 20 vendor audits, plus 17 audits stemming from whistleblower complaints; a 48 percent increase from the prior year. As the section reduces the backlog of whistleblower complaints, it will direct resources to regular vendor audits.

Subcommittee Staff Comment and Recommendation—Hold Open. According to DDS, in the last five years, $25 million in incorrect billings has been identified through vendor audits. Subcommittee staff has requested the LAO to look into what a reasonable level of audit coverage may be for vendors and to assist in the evaluation of whether or not more resources should be directed for this purpose.

Questions.

1. Please provide an overview of this proposal.

2. Of the $25 million in incorrect billings identified through vendor audits in the last five years, how much has been collected or recovered from the vendors?

3. What is the policy reason for not auditing more vendors?

Issue 12: Repeal Prevention Resources and Referral Services Program Statute

Budget Issue. The Governor proposes trailer bill language to repeal obsolete authority for the Prevention Resources and Referral Services (PRRS) program as eligibility for the Early Start program was restored in effective January 1, 2015.

Background. The Prevention Resources and Referral Services (PRRS) program, operated by Family Resource Centers (FRCs), was established in 2011 to provide resource and referral services for children who were not eligible for the Early Start program due to eligibility changes enacted in 2009. With the reversal of these eligibility changes effective January 1, 2015, the children formerly served in PRRS are again eligible for the Early Start program. As a result, the Governor's Budget reflects that the funds ($2 million General Fund) previously allocated to PRRS, are now allocated to the FRCs to provide support for the Early Start program.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

Issue 13: Standards Authorizing Medical Services by Regional Centers

Oversight Issue. The Lanterman Act currently requires regional centers to use generic services when available. Medical and dental services covered by generic resources, such as Medi-Cal, health plan(s) or private insurance, cannot be purchased by regional centers for consumers enrolled in these insurance plans without proof of denial from the insurance provider and the regional center determines that an appeal by the consumer or family of the denial does not have merit. Regional centers may pay for medical or dental services pending a final administrative decision on the appeal if the family provides verification that an appeal is being pursued.

This policy was implemented in the 2009-10 budget in order to achieve General Fund savings and address the state's budget crisis. At the time, it was estimated that $18.4 million ($17 million General Fund) would be saved through this policy as consumers would use generic services. Estimates and methodology to evaluate if these cost savings were realized are not available.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised that this policy presents a cumbersome process for families and delays provision of needed medical care. According to the state's federally-mandated protection and advocacy agency (Disability Rights California), one of the most frequent requests of their Office of Clients' Rights Advocacy is assistance on how to access Medi-Cal services and that these requests usually involve a regional center denying service until a Medi-Cal hearing is requested and resolved. During the last year, this office assisted 281 regional center consumers/families with Medi-Cal issues. Of these, 128 had issues regarding access to Medi-Cal services. In addition to these cases, it is unclear how many consumers/families who are denied service by Medi-Cal and regional center and forego the provision of the service.

Simplification of this process, by no longer requiring the pursuit of an appeal, could assist regional center consumers and individuals transitioning from developmental centers receive timely medical services. If Medi-Cal denies a service and the regional center pays for the service, as long as this service is covered under the 1915(i) state plan program or 1915(c) waiver program, the service eligible for federal financial participation. (Services covered by Medi-Cal and not under the state plan program or waiver program include physician services and inpatient services.)

Questions.

1. Please provide an overview of this issue.

2. Does DDS have an updated estimate for the General Fund savings associated with this policy?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, April 7 (Room 4203)

All items were held open.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEES No. 1 and 3

Senator Marty Block, Chair
Senator Benjamin Allen
Senator John M. W. Moorlach

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

Thursday, April 14, 2016
9:30 a.m. or Upon Adjournment of Session
State Capitol, Room 4203

Consultants: Samantha Lui and Elisa Wynne

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.

GOVERNOR'S BUDGET

The budget includes $3.6 billion total funds ($948 million federal funds; $1.7 billion Proposition 98 General Fund; and $998 million non-Proposition 98 General Fund) for child care and early education programs. For specific information by program, see tables below.

Child Care and Preschool Budget
(Dollars in Millions)

Program	Governor's Budget
CalWORKs Child Care	
Stage 1	$394
Stage 2	$422
Stage 3	$316
Subtotal	**$1,132**
Non-CalWORKs Child Care	
General Child Care	$450
Alternative Payment	$255
Other	$31
Subtotal	**$736**
Preschool-Age Programs	
State Preschool	--
Transitional Kindergarten	--
Preschool Quality Rating Improvement System Grant	--
Proposed Block Grant	$1,654
Totals	**$3,600***

*$3.6 million reflects the subtotals plus an additional $79 million for support programs.

2016 Child Care and Preschool Subsidized Slots

Program	Description	2015 Budget Act	Proposed Slots for 2016-17	Percent Change
CalWORKs (based on estimated caseload)				
Stage 1	Provides cash aid and services to eligible families. Begins when a participant enters CalWORKs.	44,154	42,995	-3%
Stage 2	When the county deems a family "stable." Participation in Stage 1 and/or Stage 2 is limited to two years after an adult transitions off cash aid.	50,971	49,777	-2%
Stage 3	When a family expends time limit in Stage 2, and as long as family remains otherwise eligible.	35,845	36,335	1%
Subtotals for CalWORKs child care		**130,970**	**129,107**	**-1%**
Non-CalWORKs (based on proposed number of slots to be funded)				
General Child Care	State and federally-funded care for low-income working families not affiliated with CalWORKs. Serves children from birth to 12 years old.	28,738	42,134	47%
Alternative Payment	State and federally-funded care for low-income working families not affiliated with CalWORKs. Helps families arrange and make payment for services directly to child care provider, as selected by family.	32,852	29,344	-11%
Migrant Care	Serves children of agricultural workers.	3,060	3,064	0%
Care for Children with Severe Disabilities	Provides supervision, therapy, and parental counseling for eligible children and young adults until 21 years old.	105	105	0%
Subtotals for non-CalWORKs care		**64,755**	**74,647**	**15%**

Preschool and TK programs				
State Preschool	Part-day (PD) and full-day (FD) care for 3 and 4-year old children from low-income families.	98,956 PD 58,504 FD	0	-100%
Transitional Kindergarten	Eligible children are 5 years old between Sept. 2 and Dec. 2.	83,000	0	-100%
Early Ed. Block Grant	Restructures funding for above programs into a to-be-defined block grant.	0	251,409	100%
Subtotals for Preschool/TK programs		**240,460**	**251,409**	**5%**
Total		**436,185**	**455,163**	**4%**

Source: Legislative Analyst's Office 2016

The Governor's proposed changes for early education and child care are more fully discussed in the following agenda issues.

6100 DEPARTMENT OF EDUCATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Governor's Budget: Early Care and Education Block Grant

Panelists: Jessica Holmes, Department of Finance
Virginia Early, Legislative Analyst's Office

Budget Issue. The Governor's budget proposes to consolidate Proposition 98 funding from California State Preschool Program (CSPP) ($880 million), transitional kindergarten (TK) ($725 million Proposition 98 General Fund), and the Preschool Quality Rating and Improvement System Grant (QRIS) ($50 million Proposition 98 General Fund) tocreate a $1.65 billion block grant, intended to benefit low-income and "at-risk" preschoolers, as locally defined. Funds from the new block grant would be appropriated to local educational agencies (LEAs) and, potentially, other entities that currently offer CSPP to operate a developmentally-appropriate preschool program. According to the Administration, the proposal would build on the tenets of the Local Control Funding Formula (LCFF) and distribute funding based on factors, such as population and need, to ensure funds are equitably distributed to schools with large populations of disadvantaged children. The budget provides a hold-harmless provision, ensuring that no LEA will receive less funding under the block grant than under prior funding models. Of note, the proposal does not move funds currently supporting the wrap component of full-day state preschool provided by non-LEAs into the block grant. In addition, the Governor's proposal does not shift $33 million in CSPP funds that support preschool programs at 55 community colleges.[1]

The Governor's budget includes placeholder trailer bill language, which will be refined in the May Revision.

Background. Since February 2016, the Administration has hosted four stakeholder meetings to solicit feedback on the following: (1) who will be prioritized for services and how to define eligibility criteria and "at risk" children; (2) program structure, such as class size, teacher ratios, and curriculum; (3) role of private providers; (4) distribution of future funding; and (5) accountability measures. In addition to the stakeholder meetings, the Administration provided a period of public comment, via mail and e-mail, which ended March 15, 2016. In general, the Administration noted that most comments centered on the following key themes: local governance, continued role for private providers, regional income eligibility issues, quality, and the transition period. The Administration indicates they will refine their proposal and provide additional detail in the May Revision, based on feedback received from the stakeholder meetings.

In response to requests from stakeholders, the Administration provided additional clarity in the spring on a limited set of topics. On timing, the Administration makes clear its goal to establish a programmatic structure for the Block Grant as part of trailer bill for the 2016 Budget Act, and a year of transition time is anticipated in 2016-17, before full implementation takes place in 2017-18. The

[1] Care offered at community colleges are often preschool programs for community college students' children, and also serve as a lab school for students training to become teachers or aides.

Administration also notes its intention to hold harmless the Proposition 98 guarantee for any statewide average daily attendance changes, due to the block grant proposal and that early education program reforms are needed before additional funding is provided to the system.

LAO Analysis. The LAO is generally supportive of the proposal to simplify the preschool program by consolidating fund sources and programs and focusing on low income, at risk, and disabled children. However, the LAO suggests the Governor's proposal, which allows local determination of income eligibility, may result in different levels of service for similar children across the state. Finally, the LAO notes that the Governor's proposal to hold LEAs harmless in funding would lock-in funding levels not currently based on need, which may undermine the Administration's goal of moving to funding based on need.

The LAO recommends the state create a system that includes:

- One consolidated funding stream that includes state preschool, transitional kindergarten, QRIS, as well as the $33 million in preschool funds that support preschool programs at community colleges.

- Specific eligibility criteria for students served by the new preschool block grant. The LAO suggests a reasonable approach would be to provide preschool to all four-year olds from families with incomes below 185 percent of the federal poverty level or who are otherwise at risk, or have a disability.

- Funding allocated to providers based on the number of eligible children participating in the program. Any hold harmless provision under this scenario would be transitional in nature.

- Options for full-day preschool programs for children from low-income working families, and a streamlined eligibility verification process that occurs annually at the beginning of the school year.

- Program requirements for the inclusion of developmentally-appropriate activities in preschool programs, and minimum staffing requirements, such as teachers must have some education in child development.

- Basic reporting requirements for providers to collect student demographic information such as race, gender, family income and disability status.

As part of any restructuring proposal, the LAO notes that the Legislature would need to consider who will provide services, how funds will be disbursed, what system of oversight and accountability should be put in place, and depending on the system, how to best transition from the current system.

Staff Comments. Absent the detail anticipated in the May Revision, the subcommittees may be unable to fully consider the Early Childhood Education Block Grant proposal. Instead, the subcommittees may wish to consider broad principals of how to construct an intentional and intuitive early care system. In particular, the last two budgets included significant investments in supporting quality programs, including professional development opportunities for instructors and aides. The subcommittees may wish to consider how accountability measures, linked to quality, that ensure

developmentally-appropriate curriculums, enriching environments for children, and support for professionals can be included in budget discussions.

In addition, the Administration's proposal distinguishes the provision of child care and early education, stating that "child care is to support the gainful employment of working families", while noting that the goals of the Early Education Block proposal include implementing pre-kindergarten education programs. As academic literature supports the social, cognitive, and developmental benefits of investing in early childhood interventions, advocates and early education professionals have invested heavily in incorporating more developmentally-appropriate curriculum, and supporting instructors in the child care system. The subcommittees may wish to consider how these differing perspectives on child care may influence the tenor of the proposal's development.

Staff Recommendation. Hold open for further discussion.

6100 DEPARTMENT OF EDUCATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 2: Oversight: AB 104 Report on Streamlining Child Care and Early Education Systems

Panelists: Virginia Early, Legislative Analyst's Office
Debra Brown, CDE

Background. Assembly Bill 104 (Budget Committee), Chapter 13, Statutes of 2015, a budget trailer bill, directed members of the Alternative Payment Program Stakeholder Group and the Direct Service Program Providers Stakeholder Group, with the facilitation of the California Department of Education (CDE), to provide finalized recommendations to the Legislature, by April 1, 2016, to streamline data and other reporting requirements for child care and early learning providers that contract with the CDE to provide state preschool and other state subsidized child care and early learning programs under the *California Code of Regulations*, Title 5. The recommendations include:

- Create a single-reimbursement rate system based on the most recent regional market rate (RMR) that includes provisions for variance in cost across regions and has a hold harmless component.

- Move from a child care contract system to a grant system with a five year cycle for application, monitoring and technical assistance.

- Provide for twelve-month eligibility. This means that a lead agency shall re-determine eligibility for services no sooner than twelve months after the initial determination.

- Simplify definitions for parent employment to full-time (30 or more hours per week) and part time (less than 30 hours per week). Create additional categories for fixed and variable work schedules.

In addition the group recommended a series of changes to the reimbursement structure, contracting process, documentation process for families, and determination of need eligibility. Many of these changes are identified as changes that could be made with no cost.

Staff Comments and Recommendation. The item is included for discussion purposes, and no action is needed at this time.

Questions

1. Please describe CDE's existing authority to implement specified provisions. Which recommendations need legislative action? What may be done through regulations?

6100 DEPARTMENT OF EDUCATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 3: Governor's Budget - TBL: Child Care Vouchers

Panel I: Jessica Holmes, Department of Finance
Virginia Early, Legislative Analyst's Office
Debra Brown, California Department of Education

Panel II: Catherine Goins, Assistant Superintendent, Early Education and Administration, Placer County Office of Education
Rick Richardson, President and CEO, Child Development Associates, Inc., San Diego

*Panel II will address Issues 1 and 3

Budget Issue and Trailer Bill Language. The Governor's budget proposes trailer bill language that requires the Department of Education to develop a plan to transition, over the next five years, contracted funding into vouchers. Approximately two-thirds of California's child care is voucher-based care, meaning a voucher is provided to a family who chooses its own provider.

LAO Analysis.

- **Creates flexibility.** The Governor's voucher proposal would create additional flexibility for families in selecting the child care setting that best meets their needs and that a conversion to voucher over an extended period, such as the five years proposed by the Governor would minimize disruption to the families and providers.

- **Possible loss of slots.** However, the LAO also notes the proposal may result in a loss of slots for children who need developmentally-appropriate care, as providers accepting vouchers are not required to include developmentally-appropriate care. Converting to vouchers would be more expensive than the current contract system and the LAO estimates an additional $25 million to $70 million, depending on what type of care families chose.

The LAO is supportive of the Governor's proposal to have CDE develop a transition plan, but recommends providing additional parameters. Specifically, the LAO recommends that in year one, the state create a new reimbursement rate structure, monitoring system, program standards, and regulations. In year two, the state would apply the rate to existing voucher slots, beginning converting contract slots to vouchers, begin equalizing services across the state, create a new central eligibility list and provide one-time funds to support implementation. In years three to five the state would complete the conversion of slots and equalization of services.

In addition, the LAO recommends to:

- Create one voucher-based system for general child care and migrant child care.

- Prioritize migrant child care, either in one voucher system or to be served in a stand-alone voucher system.

- Require all centers and family child care homes that serve children from birth through age three, provide developmentally-appropriate activities.

- Direct CDE to develop standards for children birth through age three.

- Provide similar levels of access across the state. The LAO provides two options: 1) adjust funding levels to serve the same level of eligible families in each county, or 2) adjust funding to serve all families under a certain percentage of state median income (SMI).

- Make eligibility criteria and reimbursement rates transparent. This would include linking eligibility to the most recent SMI information (LAO recommends the 65 percentile of the 2014 SMI) and creating one reimbursement system that includes three tiers to reflect cost differences between counties.

- Establish oversight and accountability measure to provide information for policymakers and stakeholders, such as a new central eligibility list to track demand for child care and regional monitoring systems to inspect and monitor centers and family child care homes.

Staff Comments. The Legislature may wish to consider how this proposal will impact access and affordability of care for families, that may currently, despite similar characteristics, receive different funding and opportunities. The state's current rate reimbursement structure poses challenges to transparency, quality, and efficiency. Despite recent investments to the reimbursement rates for both voucher-based care (RMR) and for direct-contractors (SRR), providers indicate that they are still at-risk of closing. The Legislature may wish to consider how to create a funding structure that recognizes the quality investments of a given program, and also provides parents with clear information on the actual value amount of the voucher.

Also, the CDE indicates it may need additional information, such as timeline, detail, and what broad components should be included in the plan, from the Administration. The Legislature may wish to consider incorporating the learned lessons from the AB 104 workgroup (discussed on page 9) to this proposed trailer bill process.

Staff Recommendation. Hold open for further discussion.

6100 DEPARTMENT OF EDUCATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 4: Federal Child Care and Development Block Grant

Panelists: Jessica Holmes, Department of Finance
Virginia Early, Legislative Analyst's Office
Debra Brown, CDE
Debra McMannis, Director of Early Education and Support Division, CDE
Pat Leary, Department of Social Services
Kim Johnson, Department of Social Services

Background. The Child Care and Development Block Grant (CCDBG) supports subsidized child care programs, direct service, and alternative payment contract types, including CalWORKs Stage 3 and General Child Care. In 2015-16, California received $573 million in CCDBG funding and Department of Finance estimates that in 2016-17, the state will receive $583 million. On November 19, 2014, President Obama reauthorized the CCDBG. Some of the provisions of the reauthorized CCDBG include: annual monitoring inspections of both licensed and license-exempt providers; implementing 12-month eligibility for children in subsidized child care; increasing the Regional Market Rate to the reimbursement ceilings identified in the most recent market rate survey; increasing opportunities for professional development; adding topics to health and safety trainings; and creating a disaster preparedness plan. Most, but not all of the provisions became effective when the reauthorization was signed.

Although California may have several years to implement these changes, some policies and practices were intended to be in place by March 2016. The Office of Child Care (OCC) formally extended the submission of the 2016-18 Child Care Development Fund State Plan until March 11, 2016 – an extension from the original due date of June 30, 2015. Pursuant to the reauthorization of CCDBG, the state must also document its level of compliance, and plans for compliance, with new federal requirements. However, there remains concern that the federal block grant funds are insufficient to meet new requirements and to maintain current service levels.

State Plan. Each state must complete a triennial CCDF State Plan, which describes how requirements are met, or the process by which states plan to meet the requirements. Traditionally, the State Plan is due to the federal OCC by June 30 every other year. Given the unique circumstances of this reauthorization year, the federal government has granted all states a nine-month extension to March 1, 2016. A first draft of the 2016-18 State Plan was posted on the California Department of Education's (CDE) Web site in late 2015. In order to gather stakeholder and public input on the 2016-18 CCDF State Plan, a public hearing was held on January 9, 2015. A stakeholder input process was initiated in February 2015, to obtain feedback from the field of child care providers, contractors and advocates as to how they would like the implementation to take shape, and what structures exist to support implementation in an efficient and cost-effective manner. Topical input sessions related to the major areas of implantation (annual licensing inspections, professional development, etc.) were hosted at the California Department of Education to solicit information and feedback. CDE submitted the state plan to the OCC on March 11, 2016. Based on an initial review, the state plan was returned as incomplete. CDE is currently working with their federal liaisons to determine next steps.

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

- Regional Market Rate (RMR) Survey. All states must conduct a statistically valid and reliable survey of the market rates for child care services every two years that reflects variations in the cost of child care services by geographic area, type of provider, and age of child. States must demonstrate how they will set payment rates for child care services in accordance with the results of the market rate survey. AB 104 (Budget Committee), Chapter 13, Statutes of 2015, beginning October 1, 2015, requires CDE to implement ceilings at the 85th percentile of the 2009 Regional Market Rate Survey, reduced by 10.11 percent, then increased by 4.5 percent. If a calculated ceiling is less than the ceiling provided before January 1, 2015, then the ceiling from the 2005 Regional Market Survey will be used. The licensed-exempt child care provider ceilings will be 65 percent of the Family Child Care Home ceilings, beginning October 1, 2015. Guidance from the Office of Child Care (OCC), dated March 25, 2015, suggests that states must use the most current market rate survey to set rates.

- Annual Monitoring Inspections. In California, the Department of Social Services Community Care Licensing (CCL) issues licenses for child care facilities. Many providers are license-exempt, such as neighbors, kith, or kin. The CCDBG reauthorization requires that licensed providers and facilities paid for with CCDF funds must receive at least one pre-licensure inspection for compliance with health, safety, and fire standards, as well as annual unannounced inspections of each child care provider and facility in the state for compliance with all child care licensing standards. License-exempt providers and facilities must have at least one annual inspection (Section 658E(c)(2)(K)(i)). Currently, CCL must visit a facility at least once every three years – a frequency that does not meet the new federal requirement. Currently, there is not a state agency charged with conducting inspections of homes of the approximately 32,000 license-exempt providers in the state.

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

  Existing state law[2] allows for 12-month eligibility for child care services. However, Section 18102 of the Title 5 Regulations requires contractors to inform families of the family's responsibility to notify the contractor within five calendar days of any changes in family income, family size, or the need for services. There is some debate as to whether California's current eligibility provisions will meet the new federal requirement.

[2] California Education Code Section 8263(b)(1)(C)

Many of the changes required to meet federal standards would require legislative action, and CDE is currently working with federal officials on how to proceed with the state plan. At this point, CDE reports the federal government has not yet indicated what sanctions, if any, will be placed on the state in the case of non-compliance. Finally, CCDBG statute allows for states to request waivers if they are unable to comply with federal requirements under specified circumstances. CDE continues to pursue possible waiver options.

Staff Comment. In light of significant federal changes, and absent additional federal funding to implement policies, the Legislature may wish to consider how families' access may be adversely impacted by these requirements; how these requirements align with priorities for child care and early education and the Governor's proposed plans; and how CDE should move forward with responding to requests from the federal government for specific state actions.

Staff Recommendation. This item is informational and included for discussion. No action is required at this time.

Questions

1. LAO/DOF: How much does the state receive in CCDBG funding? How much of this funding, by percentage, represents the state's total child care budget?

2. CDE: Please describe recent conversations with the federal Region IX. Are other states in a similar situation as California?

3. DOF: How does CCDBG impact, or inform, the structure of the Governor's budget proposals?

6100 DEPARTMENT OF EDUCATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 5: Oversight: CalWORKS Child Care

Panelists: Todd Bland, Deputy Director of the Welfare-to-Work Division, Department of Social Services
Kim Johnson, Branch Chief, Child Care and Refugee Program, DSS
Ryan Woolsey, Legislative Analyst's Office
Tyler Woods, Department of Finance
Frank Mecca, County Welfare Directors Association

Background. AB1542 (Ducheny), Chapter 270, Statutes of 1997, eliminated seven former welfare-related childcare programs and consolidated them into the three-stage CalWORKs child care programs. CalWORKs child care seeks to help a family transition smoothly from the immediate, short-term child care needed as the parent starts work or work activities to stable, long-term child care. CalWORKs Stage 1 is administered by the county welfare departments; Stages 2 and 3 are administered by Alternative Payment Program (APP) agencies under contract with CDE. The three stages of CalWORKs child care are defined as follows:

- Stage 1 begins with a family's entry into the CalWORKs program. Clients leave Stage 1 after six months or when their situation is "stable," and when there is a slot available in Stage 2 or 3.

- Stage 2 begins after six months or after a recipient's work or work activity has stabilized, or when the family is transitioning off of aid. Clients may continue to receive child care in Stage 2 up to two years after they are no longer eligible for aid.

- Stage 3 begins when a funded space is available and when the client has acquired the 24 months of child care after transitioning off of aid (for former CalWORKs recipients).

Historically, caseload projections have generally been funded for Stages 1, 2, and 3 in their entirety – although Stage 3 is not technically an entitlement or caseload-driven program. There had been considerable turmoil in the Stage 3 program since Governor Schwarzenegger first vetoed all of its funding in 2010. In 2011, the program was effectively capped.

Staff Comments. Child care advocates and the Legislature have expressed concern about the consistently low utilization rates for CalWORKs child care. Although CalWORKs Stage 1 and Stage 2 – and effectively, Stage 3 – are funded entitlements, the statewide utilization rate, based on the number of Welfare-to-Work (WTW) participants with an age-eligible child, is at most, only 30 percent.[3] Contributing factors to the low rate remain unclear. A typical anecdote that attempts to account for this is: when a family first applies into the CalWORKs program, the client uses kith or kin to care for the child during initial appointments; and, after stable employment is identified and when care is needed, to avoid complicated paperwork, a client may choose to keep his or her pre-existing arrangement with

[3] Total number of Stage 1 and Stage 2 families that receive TANF/number of adults participating in a WTW activity with an age-eligible child.

kith or kin and receive care, outside of the CalWORKs child care. As such, previous recommendations from the child care community include offering child care at various points during a client's interaction with the CalWORKs program, including during the initial Online CalWORKs Assessment Tool (OCAT), which is a universal initial assessment provided to clients to identify any possible barriers. DSS notes that a forthcoming RAND study (interim results expected by Spring 2016) will provide more information about child care use.

The chart (below) displays statewide allocations versus expenditures of counties' single allocation for FY 2014-15. In it, child care appears under-expended, despite its current allocation.

FY 2014-15	Allocation	Expenditures*	% of Allocation Spent	2.5% Adjustment**	Adjusted % of Allocation Spent
Eligibility Admin	$517,836,763	$619,885,076	119.17%	$635,382,203	122.70%
Child Care	$374,241,198	$311,223,552	83.16%	$319,004,141	85.24%
Cal Learn	$25,834,000	$25,463,619	98.57%	$26,100,209	101.03%
Employment Services	$1,025,856,124	$819,441,381	79.88%	$839,927,416	81.88%
Total	**$1,943,768,085**	**$1,776,013,628**	**91.37%**	$1,820,413,969	**93.65%**

* As of the report date, only two quarters of adjustment claims have been submitted by the counties so the amounts reflected here in the expenditures column may increase.

** CDSS assumes an additional 5% in expenditures from the adjustment claims process, so a 2.5% adjustment is made here to reflect the remaining two quarters of claims.

In discussions with DSS, the department states funding amounts are not related to a higher or lower utilization rate. With respect to the above data, DSS cautions from drawing conclusions that a county is not providing child care due to redirecting administrative funding or other areas of costs. In county-by-county data, staff finds that some counties do overspend in administrative costs and underspend in child care, while other counties overspend in child care. To compound the issue, counties can ensure needs are met through mid-year redistributions of the single allocation.

Staff Recommendation. This item is informational and included for discussion. No action is required at this time.

Questions

1. DSS: What action is the department undertaking to improve, and better understand, the causes and effects of a low CalWORKs Stage 1 caseload utilization? Are there common themes the department has observed that can be addressed to improve utilization?

2. CWDA: Last year, the subcommittees discussed a number of other CalWORKs changes that could have contributed to low utilization rates. What practices have been incorporated since last year to improve clients' ability to access child care?

3. DSS: If not funding, by what other measures can the state determine whether a county is effectively offering child care (e.g., at the appropriate time) for families, and that families have the information needed to effectively access care?

6100 DEPARTMENT OF EDUCATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 6: Proposals for Investment

The subcommittees received the following budget requests for consideration. For context, in addition to the following proposals, the Budget Subcommittee No. 3, on April 21, 2016, will consider proposals that assist foster parents and caregivers access subsidized child care.

6A. California Legislative Women's Caucus

Panelist: Senator Hannah Beth Jackson, District 19, Chair, California Legislative Women's Caucus

Budget request. The Legislative Women's Caucus requests funding to improve access and quality of child care and early learning. Specifically, the request includes (1) one-time quality and support investments; (2) increase license-exempt rates from 65 percent to 80 percent; (3) increase RMR to the 85th percentile of the 2014 survey; (4) increase SRR rates in counties where the SRR is below the 85th percentile of the 2014 RMR survey; (5) ensure 12-month eligibility and update income guidelines; and (6) 25,000 slots, with emphasis for zero to three year olds.

6B. 12-month eligibility, SMI, rates, slots

Panelist: Patti Prunhuber, Senior Policy Attorney, Child Care Law Center

Budget request. The Child Care Law Center "supports the full $800 million in child care and early education requested by the Legislative Women's Caucus," including (1) adopting a 12-month eligibility period; (2) updating the state median income (SMI) eligibility guidelines to the more recent SMI and exit ceilings to 85 percent of the SMI; (3) expand infant/toddler slots by 25,000; (4) increase all reimbursement rates and transition to a single rate structure; and (5) increase license-exempt rates from 65 percent to 80 percent.

6C. Early Care and Education Apprenticeship

Panelist: Dion Aroner, SEIU

Budget request. SEIU requests $1.4 million General Fund, over three years, to fund a three-year pilot to fund training and wage increases for 150 participants (center-based workers, licensed family child care providers, and license-exempt providers) in Los Angeles County. The participants may access free college-level coursework, receive paid job training, and receive higher levels of credentials.

6D. Consumer Education Database

Panelist: Linda Asato, California Child Care Resources & Referral (R&R) Network

Budget request. Children Now, the R&R Network, and Child Care Alliance of Los Angeles request one-time $15 million General Fund to build a consumer education and child care enrollment system and to fix existing data inconsistencies. Specifically, the funding will be to create a website; include disaster preparedness functions to notify child care providers of emergencies and communications with emergency response teams for parents who are unable to contact providers; and build out county-level centralized eligibility lists.

6E. License Exempt Rates

Panelist: Donna Sneeringer, Director of Government Relations, Child Care Alliance of Los Angeles

Budget request. The Child Care Alliance of Los Angeles proposes to increase the licensed family child care rate and adopt accompanying trailer bill language to require CDE and DSS align all components, including the part-time hourly rate, of license-exempt care with statutory requirements.

6F. Quality Rating Improvement System (QRIS)

Panelist: Erin Gabel, Deputy Director, External & Government Affairs, First 5 California

Budget request. Children Now and First 5 California request increasing the QRIS block grant by $25 million and to make permanent, and augment from $25 million to $35 million, the infant toddler QRIS block grant.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

April 21, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

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

0530 HEALTH AND HUMAN SERVICES AGENCY/OFFICE OF SYSTEMS INTEGRATION
5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 1: Overview – Child Welfare Services – New System (CWS-NS)

Budget issue. The Governor's budget includes $10.7 million total funds ($4.6 million GF) for the CWS-NS Project in the current year and $12.1 million total funds ($5.2 million GF).

Background. Child Welfare Services/Case Management System (CWS/CMS) was fully implemented and transitioned to its operational phase in 1998. DSS has overall responsibility for the system, including providing project and program direction to the Office of Systems Integration (OSI). OSI provides information technology expertise and is responsible for implementation and day-to-day operations of the system. The current contract for CWS/CMS runs through November 2016, with potential extensions of up to three years. Currently, the CWS/CMS does not meet the Statewide Automated Child Welfare Information System (SACWIS) requirements.

The Child Welfare Services – New System (CWS-NS) Project will replace the aging CWS/CMS with a new solution that meets current CWS business practices, as well as SACWIS requirements necessary to retain federal funding. The CWS-NS Project is intended to bring the system into compliance with state and federal laws and regulations, make the system easier to use for CWS workers, result in enhanced data reliability and availability, allow user mobility, and automate system interfaces with other state partners to enable data sharing. In November 2015, DSS and OSI announced that the CWS-NS Project will use an Agile procurement and design/development approach, where instead of building a monolithic, one-time solution, where the implementation of the IT system does not begin until all phases of the project are complete. Under the Agile approach, a Request for Proposal (RFP) is broken into a set of smaller modules that can be delivered in a short period of time. Analysis, design, coding, and testing continue for each module until the entire IT system is complete. Instead of contracting with a single vendor, a separate vendor is selected for each model.

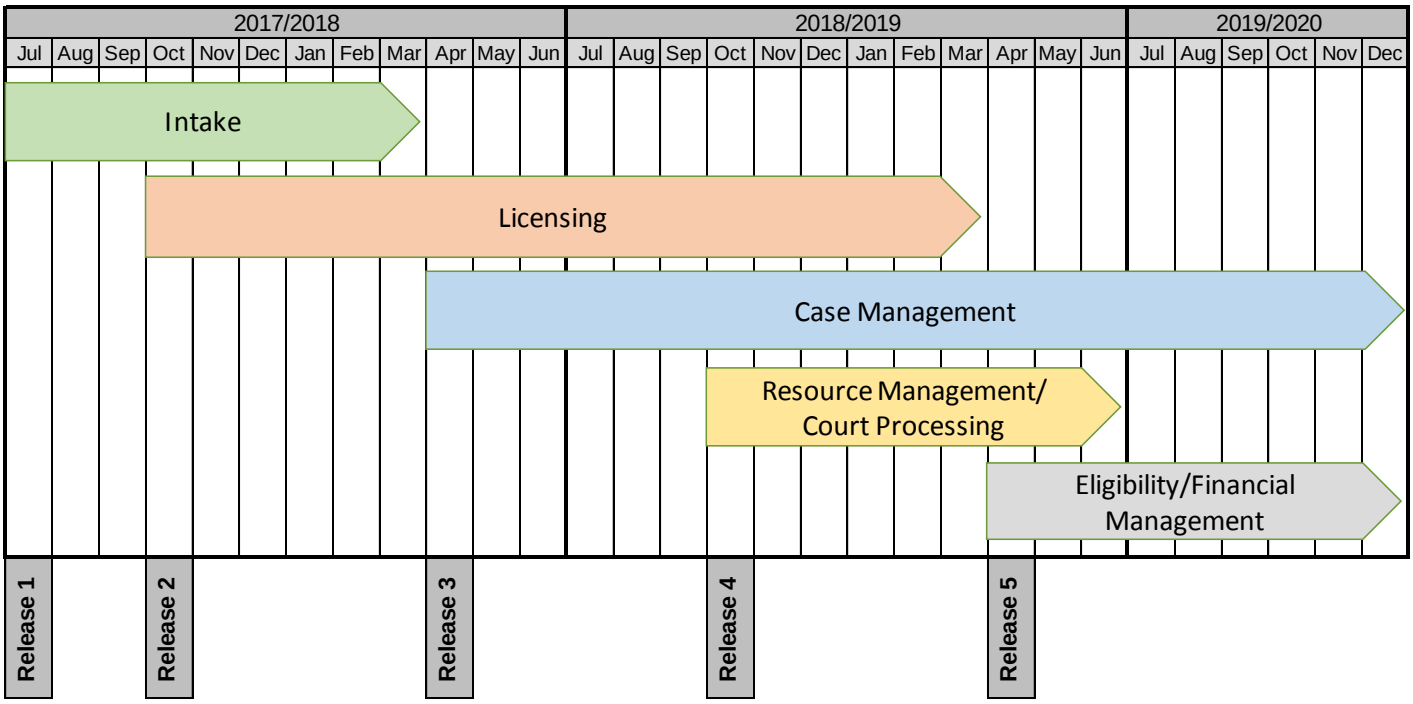
The following table shows total estimated one-time project costs, expenditures to date (July 2013 through March 2016) and the remaining budget balance:

Project Costs

Total Estimated One-Time Cost	Expenditures to Date	Remaining Balance
$397,918,394	$22,825,584	$375,092,810

Compared to continuing to operate the current system and making necessary changes to it, however, the Administration estimated that the state will realize savings by completing the CWS-NS system because of its reduced maintenance and operations costs.

The new timeline for the CWS New System Project is below:



DSS and OSI are required to provide monthly project updates to the Legislature and stakeholders. DSS and OSI have fulfilled this reporting requirement through a combination of written reports and in-person briefing.

Legislative Analyst's Office (LAO) Comments. In their publication "The 2016-17 Budget: Child Welfare Services – New System", the LAO notes that there are both potential benefits and risks in adopting the Agile approach:

- Agile implementation is much more flexible than the traditional implementation approach because it provides IT projects with the opportunity to address challenges with one module without compromising other aspects of the IT project. This flexibility allows for functions to be completed and deployed to users more quickly.

- Where in a traditional implementation, system users would have to adapt to changes only one, in agile implementation, system users have to adapt to changes as each module is implemented.

- The Agile approach may increase vendor interest and participation, since there are a limited number of vendors with the expertise to design and implement IT systems for large projects that are implemented under the traditional approach.

- At the conclusion of the project, all modules must work together to fully meet the objectives of the project. Since there are likely multiple vendors for the various modules, this will require increased coordination.

The LAO recommends that the Legislature revise the project's reporting requirements to reflect the planned shift from the traditional to an agile implementation approach.

Staff Comment and Recommendation. Hold Open. Given that the Agile approach is new for the state in many ways, and that the CWS-NS Project is so critical to CWS operations, the Legislature should consider what level of oversight is necessary and what reporting will be needed.

Questions.

1. OSI: Please summarize the current CWS-NS timeline and project costs.

2. OSI: Please explain the Agile approach and steps you are taking to mitigate any inherent risks in this new approach.

3. OSI and DSS: How are the department and OSI working to ensure the system stays on-course? How are the department and OSI working with stakeholders?

Issue 2: Budget Change Proposal: Child Welfare Services New System Project

Governor's Proposal. The Administration requests one new permanent position, the conversion of eight limited-term positions to permanent, and a net increase of $171,000 in the Office Of Systems Integration (OSI) spending authority for the Child Welfare Services – New System (CWS-NS) Project.

Background. The OSI and DSS have been working for some time to develop a new system to replace the CWS/CMS, which does not provide all functional capabilities required, is outdated, and is cost prohibitive to maintain and operate. The CWS-NS Project will implement an updated, web-based computing infrastructure that should have more flexibility. The department notes that CWS-NS, due to its modern architecture and underlying commercial-off-the-shelf platform, is projected to be less costly to maintain and enable upgrades and enhancements to be deployed more quickly.

OSI requests the follwing positions in order to be successful throughout the planning and procurement phase:

Attorney III: OSI does not currently have a dedicated attorney for the CWS-NS Project. This position will address any legal issues that arise.

Redirected CWS/CMS Positions: In 2016-17, the CWS-NS Project will begin county preparation for the transition to CWS-NS. The OSI proposes to leverage existing CWS/CMS staff that already work with the counties and perform similar services. They note that the impact of this redirection on CWS/CMS should be minimal.

Converting Limited-Term to Permanent: OSI asserts that the conversion of the limited-term positions to permanent is necessary to ensure that the CWS-NS project is procured, developed and implemented appropriately and consistently staffed. They note that the use of limited-term positions makes it difficult to recruit and retain qualified staff.

Staff Comment and Recommendation. Hold Open. Staff notes the importance of having legal representation during the various activities of IT project implementation.

Questions.

1. DSS: Please provide an overview of the proposal.

Issue 3: Spring Finance Letter: Child Welfare Services New System Project

Governor's Proposal. The Administration requests an augmentation of $32.1 million in combined state and federal funding for DSS local assistance costs, as well as $28.66 million in expenditure authority for OSI to develop and implement CWS-NS. This funding will be available until project completion and reviewed on an annual basis. Budget bill language (BBL) is also being requested which will allow for increased project funding beyond the appropriation authority, funds to be transferred to state operations for project related activities, and provides various reporting requirements.

Background. In November 2015, the state changed its typical procurement approach from a monolithic, multi-year Request for Proposal (RFP) to pursue an agile development aproach for numerous smaller modules of functionality reflecting the same ultimate scope as the prior efforts.

The department notes that it requests additional resources for the CWS-NS project in light of uncertainty in the Agile development process, and the need to be flexible in administrative processes and contracting, and uncertainty in vendor competition and performance.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please summarize the proposal and related BBL.

2. Please provide more context as to why the BBL flexibility to transfer between items is necessary.

Issue 4: Proposals for Investment

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

- Child Welfare Services Automation Trailer Bill Language

Budget Issue. The County Welfare Directors Association of California (CWDA) proposes trailer bill language (TBL) that would codify the new Agile approach to CWS automation by (1) requiring DSS, OSI and CWDA to jointly seek resources to enable the necessary level of engagement by counties in the Agile development and maintenance process; (2) require that counties have a voting seat on all governance bodies; (3) require that existing CWS/CMS operations functionality be maintained and not decommissioned until the full statewide implementation of the CWS-NS in all counties; and (4) requires the continuation of existing monthly updates to the Legislature and stakeholders on efforts to develop and implement CWS-NS and regularly scheduled quarterly forums offered to provide project updates to stakeholders and legislative staff.

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

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)

Issue 1: Overview

The CWS system includes child abuse prevention, emergency response to allegations of abuse and neglect, supports for family maintenance and reunification, and out-of-home foster care. The total funding for CWS is estimated to be approximately $5 billion for 2016-17.

The core of CWS is made up of four components:

- Emergency Response: Investigations of cases where there is sufficient evidence to suspect that a child is being abused or neglected.
- Family Maintenance: A child remains in the home, and social workers provide services to prevent or remedy abuse or neglect.
- Family Reunification: A child is placed in foster care, and services are provided to the family with the goal of ultimately returning the child to the home.
- Other Placements: Provides permanency services to a child who is unable to return home and offers an alternative family structure, such as legal guardianship or independent living.

Caseload trends. There has been a significant decline in the foster care caseload over the last 15 years. Caseload has declined more than 47 percent from 108,159 in 2000 to 57,266 in 2015. The department attributes part of the caseload decline to prevention efforts for out-of-home care and back-end efforts for permanency placements.

Demographics of children in foster care. Research documents how children and youth, who experience foster care and those who emancipate from care, are at risk for challenges related to education, health, and mental health. As of January 1, 2015, of the 66,969 children currently in care, around forty percent have been in care less than a year; around 23 percent have been in care for nearly two years; and roughly fifteen percent have been in care for longer than five years.

The following table, based on January 2016 data from U.C. Berkeley, displays the percentage of ethnic or racial representation of a child in foster care by placement type.

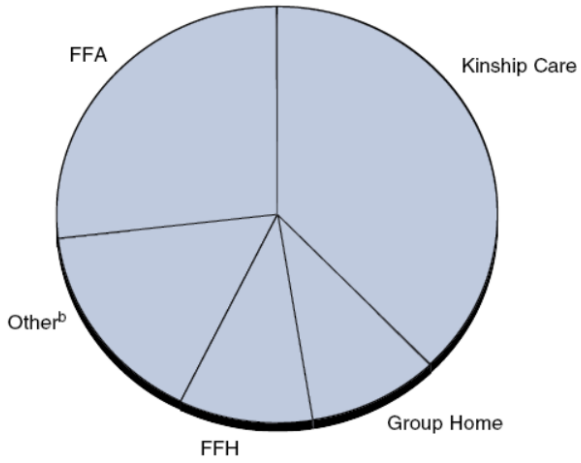
Placement Type	Black	White	Latino	Asian/Pacific Islander	Native American
Pre-Adopt	16.7%	21.3%	58.5%	2.9%	0.6%
Kinship	19.8%	21.7%	54.7%	1.8%	1.6%
Foster Home	21.4%	27.3%	47.2%	2.1%	1.3%
FFA	18.9%	24.1%	53.3%	2.2%	1.0%
Court Specified	21.3%	36.0%	37.6%	3.1%	1.9%
Group Home	29.5%	24.0%	43.1%	2.0%	1.0%
Shelter	19.8%	24.6%	47.6%	2.4%	1.6%
Non-FC	34.0%	19.3%	44.4%	1.4%	0.5%
Transitional Housing	36.1%	24.1%	35.6%	3.1%	0.9%
Guardian Dependent	39.1%	12.6%	45.7%	1.7%	0.9%
Guardian Other	30.0%	25.1%	39.3%	2.3%	2.8%
Runaway	25.5%	17.3%	54.2%	0.9%	1.8%
Trial Home Visit	17.8%	23.4%	53.7%	4.4%	0.7%
Supervised Independent Living Placement	25.5%	22.6%	47.0%	3.2%	1.5%
Other	25.4%	19.6%	50.7%	2.4%	1.7%

Placement options. There are four major temporary placement types — kinship care, foster family home (FFH), foster family agency (FFA), or group home:

- Kinship care refers to when a foster child is placed with a relative for care and supervision, known as the least restrictive and most family-like option
- Foster family homes (FFHs) are licensed residences that provide for care up to six children
- Foster family agencies (FFAs) are private, nonprofit corporations intended to provide treatment and certify placement homes for children with higher level treatment needs
- Group homes (GH) are licensed to provide 24-hour non-medical residential care in a group setting to foster youth from both the dependency and delinquency jurisdictions

Figure 9

Distribution of Foster Children by Selected Placement Type[a]



[a] Data Source: University of California, Berkeley California Child Welfare Indicators Project.
[b] "Other" includes foster children living in placements other than the four selected placements, for example, children placed in Supervised Independent Living Placements and Transitional Housing. The category excludes children placed with guardians who nevertheless have an open child welfare case.

FFH = foster family home and FFA = foster family agency.

(http://www.lao.ca.gov/Publications/Report/3351)

Placement costs. Group home placements constitute approximately 10 percent of foster care placement and represent a significant portion of total foster care costs. Group home rates are based on the level of care and services provided, ranging from $2,391 to $10,130 per month.

	Kin Caregivers				
	Relative Caregivers	Non–Relative Caregivers	Foster Family Homes	Foster Family Agencies	Group Homes
Foster care payment rate	$369 or $688–$859[a]	$688 – $859	$688 – $859	$688 – $859	$2,391 – $10,130[b]
Supplemental caregiver payments	Specialized Care Increment[c]	Specialized Care Increment[c]	Specialized Care Increment[c]	$189	—
Supplemental provider payments	—	—	—	$912 – $1,012	—

[a]Relative caregivers caring for a child who is ineligible for federal financial participation and who live in a county that has chosen not to participate in the Approved Relative Caregiver Program receive the $369, CalWORKs child–only rate. All other relative caregivers receive the basic rate.

[b]Unlike home–based care providers who primarily receive a rate based on the age of the child, group home rates are determined by the level of services they provide. Rate Classification Level (RCL) 14 is the highest level and most costly group home; RCL 1 is the least costly. Children are assigned to group homes based on the level of their service needs.

[c]The specialized care increment is a monthly supplemental payment available to kin and foster family homes caregivers at the county option for the care of children with elevated needs.

(http://www.lao.ca.gov/Publications/Report/3351)

2016-17 Governor's Budget: Average Monthly Grants

2016-17 Governor's Budget: Average Monthly Grants for FY 2016-17	
Group Home	$8,597
Foster Family Agency	$2,133
Adoption Assistance	$1,016
Foster Family Home	$967
Federal Guardian Assistance	$837
Kinship Guardian Assistance	$762
*Grants include FY 2016-17 CNI COLA	

Length of stay. According to the department's 2014 CWS Realignment Report, for the largest age group category, 13-17 years old, of the 4,737 children, the majority (45 percent) move out of group home placements in less than 12 months, longer stays (12-36 or more months) comprise the remaining 55 percent (2,619). From 2009 to 2013, the total number of children and youth placed in group homes for the same population dropped from 7,033 to 6,188. DSS estimates that more than two-thirds of children placed in group homes remain there longer than two years. Specifically, around 3,000 children and youth are in group homes for more than one year; of these, 1,000 have been in group home for more than five years.

Licensing. The Community Care Licensing Division licenses facilities, including foster family homes, foster family agencies (who, in turn, certify individual foster families), and group homes. All facilities must meet minimum licensing standards, as specified in California's Health and Safety Code and Title 22 Regulations. Among those requirements, group homes must provide youth with direct care and supervision, daily planned activities, food, shelter, transportation to medical appointments and school, and at least a monthly consultation and assessment by the group home's social worker and mental health professional, if necessary, for each child. Currently, the department must visit all homes and facilities at least once every five years with an additional random sample of 30% of homes and facilities each year. The 2015-16 Governor's budget included resources to improve regulatory oversight by increasing the frequency of inspections of Community Care licensed facilities throughout the state. Changes to inspection frequency for Children's Residential will go into effect in two stages. During Stage 1, beginning in January 2017, all children's residential homes and facilities will be inspected once every three years with an additional random sample of 30% of facilities. During the final stage, beginning in January 2018, all children's residential homes and facilities will be inspected once every two years with an additional random sample of 20% of facilities.

Performance measures and accountability. The federal Administration for Children and Families (ACF) conducts Child & Family Services Reviews (CFSRs) of states' child welfare systems, which include measures of outcomes related to the safety, permanency, and well-being experienced by children and families served. The state is currently in Round 3 of the Federal CFSR. The statewide assessment was submitted on March 25, 2016 and the case review portion began April 1, 2016. A new Program Improvement Plan is expected to be negotiated early in calendar year 2017. Round 2 of the CFSR was conducted in 2008 with the Program Improvement Plan that was successfully completed in 2012.

The Child Welfare System Improvement and Accountability Act also created a statewide accountability system that became effective in 2004. It includes 14 performance indicators monitored at the county-specific level and a process for counties to develop System Improvement Plans (SIPs).

Realignment. The 2011 public safety realignment and subsequent related legislation realigned child welfare services and adoptions programs to the counties, transferring nonfederal funding responsibility for foster care to the counties. In addition, over the last several years, the state increased monthly care and supervision rates paid to group homes, foster family homes, and foster family agency-certified homes, as a result of litigation. The 2011 realignment funding reflects state General Fund (GF) costs for the following programs, which may also receive other matching funds.

Prior to the 2011 realignment, DSS estimated the costs associated with meeting federal and state requirements for the estimated numbers of children and families to be served as part of the annual budget process. Under the 2011 realignment, the total funding for CWS is instead determined by the amount available from designated funding sources (a specified percent of the state sales and use tax and established growth allocations) that are directed to the counties and corresponding matching funds. Both before and after realignment, certain CWS expenditures, including payment rates for care providers that are statutorily established, are provided on an entitlement basis.

Trailer bill provisions in 2012-13 additionally established programmatic flexibility that allows counties, through action by boards of supervisors after publicly-noticed discussion, to discontinue some programs or services that were previously funded with only General Fund, including, clothing allowance and specialized care increments added to provider rates and Kinship Support Services programs.

Roles of the state and counties. DSS is responsible for oversight, statewide policy and regulation development, technical assistance, and ensuring federal compliance. Prior to realignment, the state was also at risk for the full costs of any federally-imposed penalties stemming from federal Child and Family Service Reviews. Under realignment, counties, whose performance contributed to an applicable penalty, must pay a share of the penalty if realignment revenues were adequate to fully fund the 2011 base, and if they did not spend a minimum amount of allocated funding on CWS.

Required reporting on realignment. Pursuant to SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, DSS must report annually to the Legislature on April 15 outcome and expenditure data, as well as impacts of CWS and Adult Protective Services program realignment. Reports must also be posted on the department's website. The 2015 Child Welfare Services Realignment Report[1] found the following:

- Child welfare practices of investigating referrals within policy timeframe continue to remain above state standards.

- There has been a significant decline in the foster care caseload. Caseload has declined more than 45 percent from 108,159 in 2000 to 57,679 in 2015.

- Between 2009 and 2014, the number of children for whom the first placement is with a relative/kin increased from 16 percent to 25 percent, while the proportion of children placed in group homes decreased from 18 percent to 13 percent.

[1] The full report can be accessed here: http://www.cdss.ca.gov/cdssweb/entres/pdf/CWRealignmentReport2015.pdf

- Among children entering care for the first time, the proportion exiting to reunification within 36 months of entry increased from 58 percent in 2006 to 60 percent in 2011. Among children entering care for the first time ever, between 2008 and 2013, the proportion who reunified within 12 months of entry decreased from 41.1 percent in 2008 to 34.6 percent in 2013.

- The proportion of children re-entering foster care within a year increased form 11.1 percent in 2008 to 12.3 percent in 2013.

The department continues to have discussions with legislative staff as well as the County Welfare Director's Association (CWDA) in order to clearly delineate county child welfare services expenditures for federally-required services, state optional programs, adult protective services, county case management, as well as the expenditures for counties participating in the Title IV-E Project.

Reports of Child Near-Fatalities. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states receiving funds under CAPTA must disclose to the public findings and information about child abuse and neglect cases that result in fatalities or near fatalities. On December 8, 2015, the federal Administration for Children, Youth, and Families (ACYF) notified DSS of non-compliance with federal guidelines regarding public disclosure procedures in cases where a child dies or nearly dies as the result of abuse or neglect.

Last year, the department proposed language to bring state law in to compliance with federal requirements. However, there was no consensus among stakeholders regarding whether it would be most appropriate for the state to model its disclosures in the cases of near-fatalities after the requirements established by SB 39 (Migden), Chapter 468, Statutes of 2007, or to create different procedures. Ultimately, no action was taken by the Legislature.

The department notes that it is currently working on a new proposal that should be forthcoming within the current legislative session. If the state is unable to comply with federal reporting requirements, California could lose up to a total of $4.8 million.

Recent policy and budget actions. Several policies and budget actions lay the groundwork for child welfare reform, including:

- **Extended foster care.** AB 12 (Beall), Chapter 559, Statutes of 2010, enacted the "California Fostering Connections to Success Act of 2010," which provides an extension for foster youth, under specified circumstance, to remain in care until age 21; increases support for kinship care (opportunities for youth to live with family members); improves education stability; coordinated health care services; provides direct child welfare; and, expands federal resources to train caregivers, child welfare staff, attorneys, and more.

- **Title IV-E Waiver.** Title IV-E is the major federal funding source for child welfare and related probation services. These funds, which were previously restricted to pay for board-and-care costs and child welfare administration, can be used to provide direct services and supports under the waiver extension. Since Title IV-E funding is based solely on actual cost of care, if a county's preventative services are effective and fewer children enter or stay in the foster care system, the county's Title IV-E funding is reduced. Thus, the county is penalized for reducing foster care placements, even though such a reduction is the most desirable outcome. The 2014-

15 budget authorized the waiver extension for five years, beginning October 1, 2014. The seven participating counties include: Alameda, Butte, Lake, Los Angeles, Sacramento, San Diego, San Francisco, Santa Clara, and Sonoma.

- **Commercial Sexual Exploitation of Children (CSEC) Program.** SB 855 (Budget and Fiscal Review Committee), Chapter 29, Statutes of 2014, established the state CSEC program to enable county child welfare agencies to provide services to child victims of commercial sexual exploitation. The CSEC program was established as a county opt-in program, and the 35 counties who opted in were separated into two tiers: 13 Tier I counties received $25,000 to develop Interagency Protocols and 22 Tier II counties received enhanced funding based on their prevalence of CSEC youth, completion of a CSEC protocol, and the county's readiness to serve. Shortly after the state program was enacted, federal CSEC legislation was enacted with statewide requirements.

  Proposed funding levels for 2015-16 and 2016-17 remain the since the program was implemented at $14 million General Fund. Coordination efforts with county child welfare departments, training entities, and the Child Welfare Council's CSEC Action Team are ongoing. Letters will go out to counties in the spring providing them with updated sample protocol tools to comply with the federal CSEC Program, instructions on how to opt into the FY 2016-17 state CSEC Program, how to report data, and guidance on the many policy changes that social workers and providers are experiencing.

- **Relative Caregiver Funding.** Effective January 1, 2015, counties, who opt-in to the Approved Relative Caregiver Funding Program, must pay an approved relative caregiver a per child, per month rate, in return for the care and supervision of a federally ineligible Aid to Families with Dependent Children-Foster Care (AFDC-FC) child placed with the relative caregiver, equal to the base rate paid to foster care providers for a federally-eligible AFDC-FC child.

  To date, a total of 49 counties have opted in. Eleven counties opted to make payments retroactive to January 1, 2015.

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

Questions.

1. Please provide an overview of the program, services, caseload trends, and proposed budget.

2. Please provide a brief update on reports of child near-fatalities. When can the Legislature expect to see language?

3. Please include an update on CSEC and ARC programs.

Issue 2: Budget Change Proposal: Child Welfare Services Case Reviews

Governor's Proposal. The Administration requests resources to establish a Child Welfare Services Case Reviews unit in response to the federal Administration for Children and Families (ACF) notification that the Department of Social Services oversight of Child Welfare Services is inadequate and needs a quality assurance program as required in the Child and Family Services Review (CFSR).

Specifically, the department is requesting the below positions in the Children and Family Services Divison, Outcomes and Accountability Bureau to conduct oversight and quality assurance activities:

- 5.0 Associate Governmental Program Analysts (AGPA)
- 1.0 Staff Services Manager (SSM I)
- 1.0 Office Technician – Typing (OT)

Background. The federal ACF expressed their concern in a letter dated May 12, 2015, and concluded that the state had insufficient resources to provide the necessary oversight and effective quality assurance management principles to obtain federal approval of the case review process that is required. Last year, ACF had completed the rule-making process to modify the existing CFSR, including that all states must use a comprehensive review process in place of the current traditional case review methodology.

The department notes that these new resources will ensure compliance with the continued receipt of federal Title IV-B and Title IV-E funds. The new activities required by ACF cannot be absorbed by current staffing resources.

Staff Comment. Staff notes that the concerns of the ACF as well as new requirements must be addressed in order to maintain federal funding and reduce the risk of future fiscal penalties.

Questions.

1. DSS: Please provide an overview of the proposal.

Staff Recommendation. Hold open.

Issue 3: Proposals for Investment

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

- Child Care for Foster Children

Budget Issue. There are currently two related proposals to ensure that the ability to obtain child care for foster youth is more available and accessible. Advocates cite the inability to access child care as a top barrier to finding placement for children removed from their parents.

Los Angeles County requests $31 million to increase access to child care and enable a larger pool of families to become foster parents. This proposal includes three pieces: (1) Any resource family needing child care for children ages 0 through 3, as well as parenting foster youth, would receive an immediate, time-limited voucher to pay for child care for up to six months following a child's placement. This voucher would ensure care while the caregiver is at work, school, or fulfilling training and home approval requirements, at a cost of $22 million. (2) Funding of $4 million to support child care navigators through the county Resource and Referral agencies who work with the resource family to facilitate the use of the emergency voucher to ensure a foster child's immediate access to child care and continue to work with the family to facilitate placement. (3) Inclusion of $5 million to provide appropriate trauma-informed training for child care providers, with a trainer to cover every county.

The County Welfare Directors Association of California (CWDA) proposes Trailer Bill Language to clarify statues governing the child care system for foster youth. Specifically, the language (1) would ensure continuity of care for children already receiving child care services who are removed from their families by enabling child care services to be maintained for foster youth when placed with a foster family, and (2) would clarify the income-eligibility priorities for foster youth by excluding foster care payments from being counted as income, which would ensure that foster youth receive priority for child care services under the income-eligibility provisions. CWDA notes that this language is meant to assist counties in implementing AB 403 (Stone), Chapter 773, Statutes of 2015.

Staff Comment and Recommendation. Hold open.

- Meeting the Requirements of CSEC Mandates

Budget Issue. The County Welfare Directors Association of California (CWDA) requests a total of $19.7 million GF increase for the CSEC program to aid child welfare agencies in meeting their mandate to serve children who are commercially sexually exploited. Specifically, CWDA requests $16.2 million GF to bring Tier I counties up to Tier II level funding, and to fully fund all Tier II counties. CWDA also requests $3.5 million GF for on-going training of child welfare staff to help CSEC youth.

Background. In 2014, SB 855 clarified that children who are commercially sexually exploited must be served as dependents under the child welfare system. Shortly after SB 855 was signed into law, federal mandates created additional imperative for child welfare agencies to serve this population. In 2015-16, $10.75 million GF was made available for counties. Eighteen counties received Tier I funding to support local protocol development and twenty-two counties with established protocols received Tier II funding to implement those protocols.

Staff Comment and Recommendation. Hold open.

- Housing Child-Welfare Involved Families Experiencing Homelessness

Budget Issue. The Corporation for Supportive Housing (CSH) and various other organizations request $10 million GF to fund the Bringing Families Home proposal, which would create a state grant program to house child-welfare-involved families experiencing homelessness. CSH estimates this program could reach approximately 135 to 350 families.

Background. In FY 2014-15, CSH requested $3 million for this item, and in FY 2015-16 they requested $10 million. It was initially included in the Assembly budget, but it was not included in the final budget

Staff Comment and Recommendation. Hold open. An unspecified amount for the Bringing Families Home Program is also included in the Senate "No Place Like Home" proposal.

- Chafee Education and Training Voucher (ETV) Grants to All Eligible Foster Youth

Budget Issue. The John Burton Foundation and various other organizations request $3.63 million GF to provide Chafee Education and Training Voucher (ETV) grants to all eligible foster youth who apply. The proposal would also align the institutional eligibility to receive the Chafee ETV with the criteria applied to institutions who receive the Cal Grant, which would prohibit the use of Chafee funds at post-secondary institutions that do not meet specified graduation and loan default requirements.

Background. According to the California Student Aid Commission (CSAC), a total of 4,609 students applied for the Chafee ETV and were determined eligible in 2014-15. However, due to insufficient funds, one in four of those who applied and were eligible received a grant.

Staff Comment and Recommendation. Hold open.

- Pregnancy Prevention Among Foster Youth

Budget Issue. The John Burton Foundation and various other organizations request $10 million GF to create a county opt-in program to prevent pregnancy among foster youth. The sponsors note that six counties in California have been testing a series of strategies to reverse the trend of pregnancy among foster youth, and this proposal would support those activities. The program would be voluntary and funds would be disbursed by DSS through an application process.

Staff Comment and Recommendation. Hold open.

- Transitional Housing Program (THP-Plus) for Former Foster Youth

Budget Issue. The John Burton Foundation and various other organizations request $5 million GF to make the THP-Plus program available to youth who would be eligible if they were in foster care on or after age 16. Currently this group is not eligible for the program.

Background. THP-Plus was established by the Legislature in 2001 and provides affordable housing and supportive services to youth who turned age 18 while in the foster care or juvenile probation

systems. THP-Plus is administered by child county welfare agencies operated by non-profit organizations. Current eligibility extends to youth if they were in foster care on or after their 18th birthday; however, a number of youth exit between the ages of 16 and 18.

Staff Comment and Recommendation. Hold open.

- Child-Centered Specialized Permanency Services Training

Budget Issue. Families Now requests $1.1 million GF to sponsor a series of introductory training sessions and build a cohort of implementation pilot counties using a shared learning model to implement specialized permanency services.

Staff Comment and Recommendation. Hold open.

- Public Health Nursing and Monitoring of Psychotropic Medication

Budget Issue. The National Center for Youth Law and various other organizations request $1.65 million GF (with an assumed federal match of $4.95 million) to provide additional staffing to ensure that there is appropriate medication case management within the Health Care Program for Children in Foster Care (HCPCFC) and to meet the requirements of recently passed legislation. This funding would enable the hiring of additional Public Health Nurses (PHNs) to review and monitor psychotropic medication and treatment, assist in scheduling and monitoring appointments, and support court review of treatments.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)

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

Governor's Proposal. The budget includes approximately $61 million General Fund to implement various components of the Continuum of Care Reform (CCR) enacted by AB 403 (Stone), Chapter 773, Statutes of 2015.

Background. Most children served by a child welfare agency are placed with families. However, several thousand children and youth are placed in group homes for more than one year, and probation departments often use group home settings in lieu of locked settings. Significant research documents the poor outcomes of children and youth in group homes, such as higher re-entry rates into foster care, low graduation rates, and increased risk of arrest. These group homes are also much more expensive than family placements and can cost up to $10,000 a month per child depending on the level of care provided, whereas foster care payments for home-based family settings generally range from $700 to $2,000 per child per month, although some home-based family placements have higher costs due to the intensive services they also provide.

In an effort to reduce the reliance on group home placements, and to develop strategies to cultivate an adequate supply of home-based family settings, the Legislature passed SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, which authorized the CCR effort to develop recommendations related to the state's current rate setting system, and to services and programs that serve children and families in the continuum of Aid to Families with Dependent Children-Foster Care (AFDC-FC) eligible placement settings. In particular, the Legislature expressed its intent for recommended reforms, including reforms related to the use of group homes, changes to the rate systems, and changes to the assessment of children's needs, and to outcome measurement, to promote positive outcomes for children and families. In January 2015, the department released the report "California's Child Welfare Continuum of Care Reform". This report provided 19 specific recommendations with the expressed goal to:

Reduce reliance on group homes as a long-term placement setting by narrowly defining the purpose of group care, and by increasing the capacity of home-based family care to better address the individual needs of all children, youth, and caregivers.

According to the department, the recommendations "represent a paradigm shift from traditional group homes as a long-term placement to Short-Term Residential Treatment Centers (STRTC) as an intervention." The list of 19 recommendations seek to improvement assessment of child and families to make more appropriate initial placement decisions; emphasize home-based family care; support placement with available services; change the goals for group home care placement; and, increase transparency for child outcomes.

The Legislature subsequently passed AB 403 (Stone), Chapter 773, Statutes of 2015 to implement the CCR, which codified the recommendations. Various components of the statute have already begun to implement, such as the foster family agency social worker rate increase and training, recruitment, retention and support activities for resource families and foster parents. However, many key changes such as the establishment of new rates and of short-term residential treatment centers (STRTCs), will implement at later dates. Some of the main components of AB 403 include:

- Short-Term Residential Treatment Centers (STRTCs). This new placement type will begin on January 1, 2017, at which time group homes will no longer be a placement option (subject to case-by-case exceptions that may allow them to continue to operate for a period of time). STRTCs will provide care, supervision, and expanded services and supports. Children whose level of need would qualify them for the STRTC placement include those assessed as seriously emotionally disturbed or victims of commercial sexual exploitation. Children's case plans will be subject to review every six months.

- Efforts to increase access to services and supports. FFAs and STRTCs will be required to ensure access to specialty mental health services and strengthen their permanency placement services by approving families for adoption, providing services to help families reunify, and give follow-up support to families after a child has transitioned to a less restrictive placement. AB 403 also requires FFAs and STRTCs to make educational, health, and social supports available.

- Additional integration between child welfare and mental health services. AB 403 requires all FFAs and STRTCs to either obtain certification from the Department of Health Care Services (DHCS) or county Mental Health Plans (MHPs) to provide mental health services directly, or contract with mental health providers to serve children in their care.

- Efforts to improve quality and oversight. Under CCR, FFAs and STRTCs are required to obtain and maintain accreditation from a nationally-recognized body. CCR also calls for the development of publicly available FFA and STRTC performance measures, such as rates of successful family reunifications, placement stability, client satisfaction, and health and safety standards.

- Resource Family Approval (RFA). RFA replaces the existing multiple approval, licensing, and certification processes for home-based family caregivers. This streamlined assessment includes a psychosocial evaluation, risk assessment, and permanency assessment, and will automatically qualify a foster family for guardianship and adoption. This process is underway in five early-implementer counties, and the rest of the state will transition to the RFA process by January 1, 2017.

- Child and family teams. CCR also mandates the use of child and family teams in decision-making, which can include the child, his or her custodial or noncustodial parents, representatives from the child's out-of-home placement, the child's mental health clinician, and other persons with a connection to the child.

- New assessment tool. CCR calls for the creation of a new, comprehensive strengths and needs assessment upon entering the child welfare system in order to improve placement decisions and ensure prompt access to supportive services.

- New STRTC and FFA payment rates. Reimbursement rates for 14 separate group home levels will be replaced by a new set of rates, beginning January 1, 2017. These new rates are expected to reflect the expanded set of responsibilities of STRTCs and FFAs under CCR. A DSS and stakeholder workgroup is considering a system where the child's needs assessment partly determines the rate paid to a child's caregiver and supportive service providers, which could

allow a county to contract or provide supportive services for children in home-based family placements other than FFA-certified homes, as opposed to current practice where a child's placement generally determines the foster care payment rate and services the child receives.

Implementation Update.

The Governor's 2016-17 proposed budget recognizes new state General Fund costs associated with CCR implementation and also county savings from the elimination of duplicative foster caregiver approval processes and the transition of children out of group homes.

Figure 11

2016-17 Proposed Continuum of Care Reform State Spending

(In Millions)

General Fund	2015-16 Estimated	2016-17 Proposed	Change
Local assistance to county welfare and probation departments	$21.5	$57.5	$36.0
Department of Social Services—state support	0.5	3.0	2.5
Department of Health Care Services and local assistance to county mental health plans	—	0.4	0.4
Totals	**$22.0**	**$60.8**	**$38.8**

Below is a breakdown of the total approximately $61 million General Fund:

Figure 12

Proposed CCR State Spending for County Child Welfare and Probation Department Implementation

(In Millions)

Activity	2015-16 General Fund	2015-16 Total Funds	2016-17 General Fund	2016-17 Total Funds	Change From 2015-16 General Fund	Change From 2015-16 Total Funds
Foster parent training, recruitment, retention, and support	$17.2	$25.8	$32.2	$47.4	$15.0	$21.6
Resource Family Approval[a]	—	—	11.2	16.2	11.2	16.2
Child and family teaming	—	—	9.7	14.4	9.7	14.4
2015-16 FFA rate increase	4.3	7.3	4.5	7.6	0.2	0.3
Case planning assessment, reviews, and training	—	—	4.4	6.6	4.4	6.6
Accreditation	—	—	1.4	2.8	1.4	2.8
Automation and performance measure development	—	—	0.5	0.8	0.5	0.8
Assumed foster care payment savings at the county level[b]	—	—	-6.4	-7.3	-6.4	-7.3
Totals[c]	**$21.5**	**$33.1**	**$57.5**	**$88.6**	**$36.0**	**$55.5**

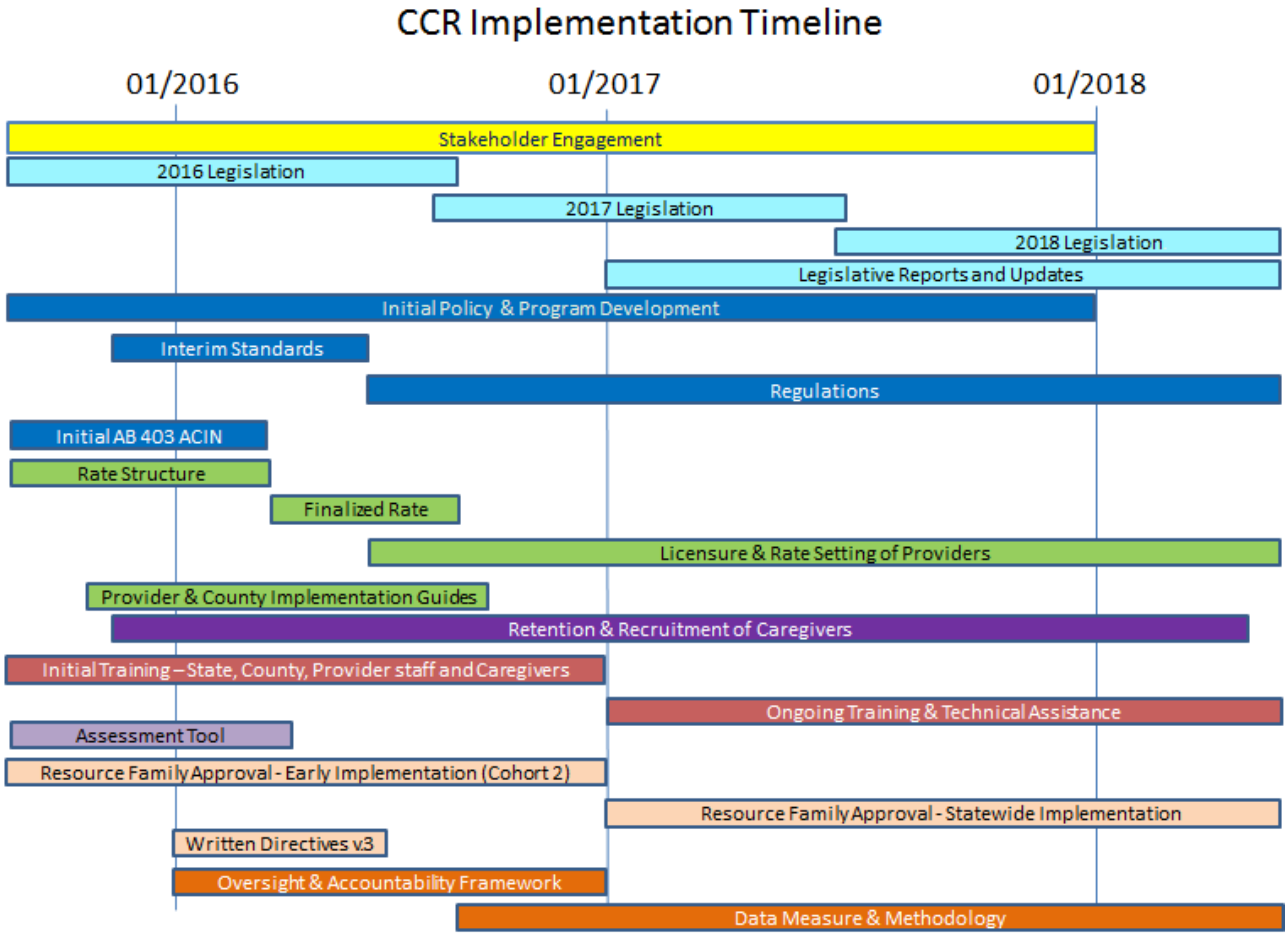
[a] Estimated total spending for Resource Family Approval is net of estimated county savings, which are estimated at approximately $19 million in total funds.

[b] Assumed foster care payment savings offset the costs of the other proposed CCR activities, reducing the total estimated state funding for CCR implementation.

[c] This figure does not include the approximately $3.4 million General Fund ($6.4 million total funds) in the Governor's proposed budget to support DSS state operations, DHCS state operations, and county Mental Health Plans' CCR implementation efforts.

CCR = Continuum of Care Reform; FFA = Foster Family Agency; DSS = Department of Social Services; and DHCS = Department of Health Care Services.

The department has provided the following timeline of implementation activities:



The main activities that the Governor's budget provides funding for are:

- Foster Parent Recruitment and Support. Over half of the Governor's proposed spending is to help counties increase the supply of high-quality, home-based family placements. About half of this proposed spending is intended for county probation departments. In 2015-16, allowable uses of the funding provided to counties included: (1) staffing to provide direct services and supports to foster caregivers, (2) foster care payment supplements to support caregivers of children with exceptional needs, and (3) intensive relative finding and engagement. It is unclear whether the 2016-17 proposed funds will be allocated to counties using the same criteria.

- RFA implementation. Although meant to save money in the long-run by eliminating duplicative processes, RFA imposes additional training requirements on home-based family caregivers and expands the assessment criteria that child welfare workers have to apply before approving a caregiver as a qualified placement.

- Other CCR-related activities. Various other activities are funded in the Governor's budget, including (1) maintaining the FFA rate increase enacted in 2015-16, (2) implementing needs assessments and

STRTC case reviews, (3) helping cover a portion of initial FFA and STRTC accreditation costs, (4) updating child welfare workers' case management system, (5) developing the provider performance indicator dashboard, and (6) aiding county MHPs in ensuring children in STRTCs are appropriately placed.

The department notes the following implementation activities that are underway:

- DSS hosts State/County and Stakeholder Implementation committees, a workgroup for FFAs, STRTCs, and other stakeholder meetings to provide policy recommendations for the implementation of CCR, and training workgroups.

- Additional workgroups for probation, performance and outcomes, and mental health will convene in spring 2016, and an All County Information Notice outlining the requirements of AB 403 is scheduled to be released in late spring 2016.

- Implementation Guides for county agencies, FFAs and STRTCs are currently being developed and will be available in April 2016.

- The policy development for Core Services to be provided by FFAs and STRTCs, is currently being drafted.

- A proposed rate structure for FFAs and STRTCs will be released by spring 2016. Interim licensing standards are anticipated to be available by July 1, 2016.

The department has also provided the following timeline of important implementation milestones leading up to the January 1, 2017 implementation date:

1. Identify an Assessment Tool/s and Provide Instruction to Counties		
Selection of child welfare assessment tool/s to be tested by the state pursuant to CCR assessment provisions	CDSS	Mar-16
Develop agreement with tool developer for pilot	CDSS	Mar-16
Develop procedures and training for county pilots	CDSS	Mar-16
Outline expectations for use of tool (ACIN/ACL) statewide	CDSS	Mar-16
Develop and inform counties of accountability expectations such as reporting, integration into CQI etc.	CDSS	Apr-16
Develop direction for how counties will use assessment information to inform rate.	CDSS	
Identify training resources available to counties to ensure fidelity and consistent training plans for using new tool	CDSS	Apr-16
2. Budgeting and County Resources for Implementation		
Determine costs and standards for consistent application of CFT process	CDSS, DHCS	Apr-16
Identify costs for RFA implementation	CDSS	Apr-16
Determine resources for Foster Parent Recruitment, Retention & Support	CDSS	Apr-16
Determine other resource needs	CDSS	Apr-16
Complete assessment for anticipated resource needs for FY 16-17	CDSS	Apr-16
Budget-allocation and instructions for claiming	CDSS	Sep-16

3. Rates		
Determine rate structure for FFAs and STRTPs	CDSS	Apr-16
Identify process and tools to be used for level of care determinations within the CFT	CDSS, counties	Jul-16
Issue instructions to providers and counties	CDSS	Jul-16
4. RFA		
Implement survey of Resource Families	CDSS	Jan-16
Determine staff qualifications for counties	CDSS	Jul-16
Written Directives on new RFA requirements (including Due Process)	CDSS	Jul-16
Determine Staff Qualifications for FFA's	CDSS	Jul-16
Emergency Relative Approval - Variance determination/approval	CDSS, Fed CMS	Aug-16
Identify Early implementing FFA's for RFA	CDSS	Aug-16
Review county implementation plans for RFA implementation	CDSS, CWDA	Jan-17
5. CFT		
Reporting/Accountability/Evaluation Design (engage with counties and stakeholders)	CDSS	Jan-16
Clarify and align expectations about MHP participation	CDSS, DHCS	Jul-16
Confidentiality and Information Sharing - Identify barriers and resolutions per AB 403	CDSS	Jul-16
Clarify expectations for Regional Center participation in CFT's (coordinate with DDS & DHCS)	CDSS, DHCS	Jul-16
ACL on CFT process and CCR requirements	CDSS	Jul-16
Training Plan in CFT process for Social Workers and additional CFT Facilitators		
6. Mental Health Coordination		
Development of Core Services Guide	CDSS, DHCS	Jul-16
Mental Health Certification Instructions Issued	CDSS, DHCS	Jul-16
Revise statutory provisions for Mental Health certification/contract provisions	CDSS, DHCS	May-16
Align definitions between DHCS and CDSS for terms: assessment, certification and outcomes	CDSS, DHCS	May-16
Align/clarify language to address SED determinations between CW and Probation populations	CDSS, DHCS	May-16
Clarify "medical necessity" determinations for youth requiring STRTP placement that do not currently meet MN standard	CDSS, DHCS	May-16
Analyses certification, accreditation, licensure processes to identify overlap, duplication and streamlining opportunities	CDSS, DHCS	May-16
Develop System for updated list of approved mental health services in STRTPs and FFAs	CDSS, DHCS	Aug-16
7. STRTP & FFAs		
Develop STRTP classifications for STRTP 'peer support' and 'volunteer classifications' per CCR report	CDSS	Jan-16
Interim Standards for FFA's and GH's to transition (including program statement and core services)	CDSS	Jul-16
Transition process - DSS staffing in place/trained	CDSS	ongoing

Instructions to counties on approving program statements	CDSS	Jul-16
Instructions to providers and counties regarding rate extensions	CDSS	Jul-16
Update Placement Agreement for services to be delivered	CDSS	Jul-16
8. Accreditation		
Timeline for agencies to transition	CDSS	May-16
Exemption process finalized and instructions issued	CDSS	Jul-16
Instructions for agencies to receive reimbursement for accreditation costs (pending budget approval)	CDSS	Aug-16
9. Performance Outcomes		
Define performance outcomes for providers	CDSS, DHCS	Jan-16
Determine process for Client Satisfaction survey	CDSS	Jan-16
Post data twice per year per AB 403 regarding provider performance	CDSS	Jan-16
ACL on Performance Outcomes and Client Satisfaction Survey	CDSS	Jan-16
10. Other - Policy		
ACIN on CCR	CDSS	Mid-Mar-16
Implementation Guides for Counties and FFA's	CDSS	Apr-16
Data reports to counties with child count for children/youth in GH care level 1-9 and 10-13	CDSS	Early April
ACL or ACIN on county extension process for providers who may not be able to meet 1/17 timeline	CDSS	Jul-16
ACL to counties to meet new requirements under WIC 361.2	CDSS	Jul-16
Changes in licensing regulations to conform to CCR	CDSS	Jul-16
Process for counties to operate an FFA or STRTC	CDSS	Jul-16
11. County Shelters		
Consult with counties in development of transition plans for County shelters	CDSS	May-16
ACL or ACIN on new Shelter facility requirements	CDSS	Aug-16
12. Youth in GH - Transition		
Develop transition strategies for foster youth in group homes who do not want to be transitioned to family-based care (Rec #3 CCR Report)	CDSS	Sep-16

Also of note, the Administration has reversed its estimate on county savings since January and no longer presumes them, so the previous charts no longer accurately reflect what the Governor's proposed spending on CCR will look like. Funding updates to this and other components of the CCR are expected in the May Revision.

Advocate Concerns. The counties and other stakeholders have raised significant concerns about the possible lack of adequate funding in the Governor's proposal. The counties are working closely with the department, and an update is expected in this hearing regarding the status of those conversations.

LAO Comments. In the "2016-17: Analysis of the Human Services Budget," the LAO notes that the Governor's proposal is a logical next step in the implementation of CCR, but that many uncertainties still surround CCR implementation, including:

- Future costs or savings from CCR are contingent on a host of interconnected factors, including the new STRTC and FFA foster care payment rates, the rate at which children exit group homes to

home-based family care, and which home-based settings are most heavily utilized following the closure of group homes.

- Without a considerable increase in the number of home-based family placements, CCR's goal of reducing the state's reliance on long-term group home placements cannot be met.

- Realignment may complicate budgeting for CCR implementation. The Governor's budget attempts to compensate counties for the increased net costs associated with CCR, but current estimates are based on a number of assumptions.

- There are still uncertainties surrounding mental health services and certification.

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

- Frank Mecca, County Welfare Directors Association of California
- Ben Johnson, Legislative Analyst's Office
- Chi Lee, Department of Finance

Staff Comment. AB 403 enacted major policy shifts in the child welfare system that the Legislature has long been invested in seeing come to fruition for the well-being of children and cost-effectiveness of the system. Given the complexities and uncertainties surrounding the implementation of CCR, a refinement of the Governor's proposal is expected at May Revision that will incorporate feedback from the counties and other stakeholders. In particular, the development of rates is critical and will be the driving force behind a number of costs in CCR.

Questions.

1. Please provide an overview of CCR and current implementation.

2. Please explain what activities are the most critical to fund this year in order to meet the January 1, 2017 deadline.

3. Does the department expect to be able to implement all necessary activities by January 1, 2017?

4. When will a rates package be released in order to provide adequate time for legislative and stakeholder review?

5. How does the department intend to report on CCR outcomes? What can the Legislature expect for CCR progress reporting before the January 1, 2017 implementation date, and after?

6. Please provide an update on conversations with counties and stakeholders.

Staff Recommendation. Hold open.

Issue 2: Budget Change Proposal: Funding Continuum of Care Reform Implementation (AB 403)

Governor's Proposal. The Administration requests $5 million ($2.5 million General Fund) on a three-year limited term basis to support approximately 34 positions to implement AB 403. The requested positions are as follows:

CCR - AB 403 BCP

POSITIONS	CFSD*	CCLD*	Legal	ISD*	Admin	Total
CEA	1.0	-	-	-	-	1.0
SSMI	5.0	-	-	-	-	5.0
SSMII	1.0	-	-	-	-	1.0
AGPA	10.0	1.0	-	-	-	11.0
RPS II	1.0	-	-	-	-	1.0
ATTY III	-	-	4.0	-	-	4.0
OT	1.0	1.5	-	-	-	2.5
Sr Programmer Analyst	-	-	-	3.0	-	3.0
SSA	-	4.5	-	-	-	4.5
Accounting Admin I - Specialist		-	-	-	1.0	1.0
Total Positions	**19.0**	**7.0**	**4.0**	**3.0**	**1.0**	**34.0**

* *CFSD- Children and Family Services Division*
CCLD- Community Care Licensing Division
ISD- Information Systems Division

Background. AB 403 seeks to achieve the goal that all children as members of committed, nurturing, and permanent families, and that these children and their families must have local access to a broad continuum of services and supports. This legislation fundamentally changed the manner in which foster care and other entities coordinate and deliver services to foster children. Workload includes the development of 228 new procedures, processses, or protocols; 26 consultations with varying combinations of 18 specified or open-ended stakeholder groups; development of 19 sections of regulations; development of eight new training programs or new curriculum for existing programs; and reports to the Legislature or to publicly publish information.

The department asserts that a group of dedicated personnel is required to carry out AB 403 activities, particularly to meet the January 1, 2017 implementation deadline. The requested staff will be used to achieve the following goals: limit reliance on congregate care; increase capacity for home-based family care; increase engagement with foster children/youth and families; revise the foster care rate structure; increase accountability and performance; reporting; and legal support.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

April 21, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

OUTCOMES

Item	Department	Action
0530	**Health and Human Services Agency/Office of Systems Integration**	
5180	**Department of Social Services – Child Welfare Services**	
Issue 1	Overview: Child Welfare Services: New System (CWS-NS)	Hold Open
Issue 2	BCP: Child Welfare Services: New System Project	Hold Open
Issue 3	SFL: Child Welfare Services: New System Project	Hold Open
Issue 4	Proposals for Investment	Hold Open
5180	**Department of Social Services – Child Welfare Services**	
Issue 1	Overview	Informational
Issue 2	BCP: Child Welfare Services Case Reviews	Hold Open
Issue 3	Proposals for Investment	Hold Open
5180	**Department of Social Services – Child Welfare Services**	
Issue 1	Oversight: Continuum of Care Reform Implementation	Informational
Issue 2	BCP: Funding Continuum of Care Reform Implementation	Hold Open

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, April 21, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Part B

Consultant: Michelle Baass

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Continuum of Care Reform: Short-Term Residential Treatment Center Licensing (AB 403, 2015)

Budget Issue. DHCS requests the following resources to implement AB 403 (Stone), Chapter 773, Statutes of 2015:

- One permanent position and expenditure authority of $118,000 for one associate governmental program analyst (AGPA).
- Three-year funding (phased-in) of $251,000 for staffing resources equivalent to one staff services manager I and one AGPA.
- $416,000 ($208,000 General Fund) to reimburse counties for participating in a child and family team and providing assessments for seriously emotionally disturbed children.

Background. AB 403 decreases the usage of group homes and establishes short-term residential treatment centers (STRTCs) as a new type of a community care facility licensed and regulated by the California Department of Social Services (CDSS). The services provided through STRTCs include mental health treatment for children assessed as seriously emotionally disturbed (SED) or that meet the medical necessity criteria for Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

AB 403 requires DHCS or its mental health plans (MHPs) to certify mental health programs for STRTCs. This process includes an on-site review of operations, clinical practice standards, policies and procedures, and treatment modalities. Currently, DHCS is responsible for the certification of rate classification level (RCL) 13 and 14 group homes under the county MHPs. (RCL 13 and 14 group homes can only take seriously emotionally disturbed children.) Under AB 403, the STRTCs will replace the RCL scheme and it is anticipated that a portion of the currently identified 679 RCL group homes will transition to STRTCs. Prior to AB 403, DHCS and MHPs were responsible for certification of 54 RCL 13/14 group homes. Therefore, AB 403 is projected to result in an initial increase in the volume of mental health service centers that must be certified as STRTCs.

In addition to the increased certifications, AB 403 requires DHCS to develop program standards so that intensive mental health treatment services are provided to children housed in STRTCs. Therefore, DHCS will need to promulgate regulations, provide legal consultation and opinion, and develop clear policies and procedures to implement these requirements.

DHCS, or a delegated MHP, certifies the mental health program for RCL 13/14 group homes, pursuant to Welfare and Institutions Code (WIC) Section 11462.01(a). DHCS, or a delegated MHP, uses the criteria for certification to evaluate whether or not the program meets the needs of SED youth. Presently, RCL 13/14 group homes are not required to provide intensive treatment services, as is required for STRTCs. The intensive treatment services that foster children and youth would have access to in STRTCs include, but are not limited to clinical treatment such as psychiatric and psychological services, which could include specialty mental health services; learning disability

assessment and educational services; pre-vocational and vocational counseling; development of independent living, self-help and social skills; and community outreach to develop linkages with other local support and service systems.

DHCS, or a delegated MHP, will continue to conduct annual onsite reviews to ensure compliance with program standards; however, it is anticipated that there will be an increase in the number of onsite reviews. These reviews will continue to include, but are not limited to, a review of client charts, staff in-service training records, program staff resumes, groups/activities, outside resource contracts, program logs and documents, financial records, and policies regarding the operation of the program.

Oversight activities also will continue to include interviews with clients and clinical staff and a review of staff qualifications, as well as any complaint files. When applicable, DHCS will continue to take administrative actions against programs, including the denial, suspension, or revocation of program certifications, or imposition of sanctions and/or plans of correction. DHCS will need to develop a tracking system for initial and annual certifications of STRTCs completed by counties. DHCS will need to coordinate program, fiscal, and health and safety reviews jointly with CDSS' Children and Family Services Division and Community Care Licensing Division.

Previously all of the RCL 13/14 group homes were certified by delegated MHPs. With the new requirements of AB 403, the number of group homes to certify is expected to increase. There are currently 54 RCL 13/14 group homes certified by the MHP delegates, for which DHCS maintains overall responsibility and oversight. Prior to the transition of group homes to STRTCs, DHCS will develop and implement policies and regulations. During the transition and post-transition, DHCS will be responsible for reviewing appeals and waiver requests, providing specialized training to staff, and providing technical assistance to improve the quality and effectiveness of treatment in the STRTCs. This proposal requests resources to address the initial workload anticipated during the transition of RCLs to STRTCs.

Under AB 403, an STRTC becomes a "blended" facility; both a community residential treatment facility, falling under the regulatory authority of CDSS, and an intensive mental health treatment program, under the auspices of DHCS or a delegated MHP. DHCS, or its MHP delegate, currently certifies and oversees all aspects of the residents' mental health treatment program. AB 403 requires DHCS or its MHP delegate and CDSS to conduct joint annual onsite reviews. This approach should improve the oversight and monitoring of the foster care system, since the majority of the youth who will live in these facilities need services delivered by both the mental health and the social service systems.

The Legislative Analyst's Office (LAO). The LAO finds that there is some uncertainty around what certification will require and who will be the certifying entity or entities. The Governor proposes funding for DHCS and MHPs to carry out CCR–related workload, but the augmentation is limited to what is needed to serve STRTCs. Foster Family Agencies (FFAs) facing the same rules as STRTCs do not appear to be accounted for in the Governor's mental health–related budget augmentations. It is unclear whether there may be additional General Fund cost pressures associated with the mental health certification of FFAs. The LAO also notes that more clarity is needed in regard to the role of mental health in CCR.

Subcommittee Staff Comment and Recommendation—Hold Open. The following concerns should be considered when evaluating these proposals:

1. **Short Timeframe to Develop Mental Health Program Approval Standards.** DSS indicates that it plans to have its licensing policies and processes in place for the new STRTCs in July of 2016, so that this placement type can begin on January 1, 2017. DHCS also indicates that it will issue the mental health certification guidelines for STRTCs in July 2016. However, DHCS has just begun meeting with non-county stakeholders this week to discuss mental health issues related to CCR. Consequently, it is unclear how DHCS will be able to issue policies outlining the certification/program approval process and standards for STRTCs by the targeted date of July 2016. Key issues, such as statutory changes; contract amendments; alignment of definitions of assessment, certification, and outcomes; and clarification of "medical necessity" for youth in STRTP placement, still need to be discussed and resolved.

2. **Role of County Mental Health in AB 403 Implementation is Still Unclear.** It is critical for the Administration to clarify the role of county mental health in the implementation of CCR. For example, it is still unknown if the state or county mental health will be conducting the mental health program certification/approval for the STRTCs and FFAs. Similarly, clarity is needed in regard to county mental health's role in child and family teams and the new comprehensive assessment tool (for children entering into the child welfare system).

3. **Budget Estimate Does Not Address FFA.** As noted by the LAO, the Governor's budget does not include funding for the mental health program certification/approval for FFAs. DHCS indicates that it is still working through this issue.

Questions.

1. Please provide an overview of these proposals and the overlap between mental health and CCR.

2. DHCS: Please explain how DHCS will monitor STRTCs and FFAs to ensure that children receive access to specialty mental health services?

3. DHCS: What is the timeline for DHCS to develop the "mental health program" approval standards for STRTCs and FFA? How is DHCS working to meet this timeline?

4. DSS: How does DHCS's timeline to develop standards impact DSS's ability to implement CCR?

5. DHCS: How is DHCS involved in the discussion on reporting CCR outcomes?

Issue 2: Foster Care: Psychotropic Medications (SB 238, 2015)

Budget Issue. The budget includes the following requests:

1. DHCS requests one full-time permanent research program specialist II (RPS II) and $134,000 ($67,000 General Fund) in 2016-17 and $125,000 ($63,000 GF) ongoing, to implement the requirements of SB 238 (Mitchell) Chapter 534, Statutes of 2015.

2. DSS requests resources to meet the requirements of SB 238 and SB 484 (Beall), Chapter 540, Statutes of 2015. Specifically, to meet the requirements of SB 238, DSS is requesting $149,000 ($100,000 General Fund) in contract funding to develop monthly, county-specific reports for children in foster care who are prescribed psychotropic medications through Medi-Cal. To meet the requirements of SB 484, DDS is requesting two-year limited-term funding of $833,000 ($684,000 General Fund) to support approximately five positions (three licensing program analysts (LPA), 0.5 licensing program manager I, 0.5 office assistant, one associate governmental program analyst), effective July 1, 2016.

Background. SB 238 requires data sharing agreements between DHCS and the Department of Social Services (DSS) as well as between DHCS, DSS and county placing agencies regarding children and foster youth taking psychotropic medication. It also requires DSS, in consultation with DHCS and stakeholders, to develop and distribute a monthly report to each county placing agency, and would require this report to include specified information regarding foster youth taking psychotropic medications that have been paid for under Medi-Cal. The monthly report must, at a minimum, include the following information:

- Psychotropic medications that have been authorized for the child.
- Pharmacy data based on paid claims and managed care encounters, including the name of the psychotropic medication, quantity, and dose prescribed for the child.
- Other available data, including, but not limited to, information regarding psychosocial interventions and incidents of polypharmacy.
- One or more indicators that note children for whom additional follow-up may be appropriate. The indicators may include, but need not be limited to, an indicator that identifies each child under five years of age for whom one or more psychotropic medications is prescribed and an indicator that identifies each child of any age for whom three or more psychotropic medications are prescribed.

The federal Child and Family Services Improvement and Innovation Act of 2011 requires states to develop protocols regarding the appropriate use and monitoring of psychotropic medications and how the state will address emotional trauma associated with being a child that is maltreated and removed from their home through placement in foster care.

In October 2012, DHCS and DSS undertook a quality improvement project titled "Improving Psychotropic Medication Use in Children and Youth in Foster Care" in order to explore, identify, and support effective strategies in overseeing and monitoring the use of psychotropic medications of children and youth in the foster care system. This topic and project has received significant interest from, and heightened the awareness of stakeholders, the media, government oversight entities like the Child Welfare Council, as well as the Legislature.

State Agencies Data Sharing Agreements. DHCS currently has an interagency agreement (IA) with DSS, effective April 2015, to share information regarding the oversight and monitoring of psychotropic medication prescribing within the child foster care population. In an effort to address foster youth psychotropic medication prescribing from the provider perspective, the Medical Board of California (MBC) also entered into a data use agreement (DUA) with DHCS in April 2015.

State and County Data Sharing Agreements. Additionally, DHCS has encouraged and signed DUAs with individual counties who want to monitor psychotropic medication use in their specific foster care population. In addition to these currently established DUAs, SB 238 requires more robust data sharing agreements between DHCS and DSS and county placing agencies in a three-way arrangement known as the Global Interagency Agreement (GIA). Under the GIA, DHCS will provide DSS with both medical and pharmacy claims level detail, with which DSS will match with their foster care specific data. This combined, matched data will then be provided to each county's foster care placing agency. Over time, the parameters of the data sharing under the GIA are expected to change as counties develop ways to analyze the data. Such changes will necessitate changes in how the data is pulled and compiled by both DHCS and DSS.

SB 238 creates a mandate for DHCS and DSS to ensure foster care data is shared with all 58 county placing agencies. According to DHCS, this mandate eliminates the existing voluntary nature of the DUAs and will result in increased research and data programming to ensure all 58 counties of California are represented and receiving the required foster care data. See below for information on which counties have DUAs and GIAs.

Individual County DUAs	**Global DUAs (GIA)**
Alameda	Contra Costa
Los Angeles	Santa Clara
Ventura	San Louis Obispo
Riverside	Yuba
	San Francisco
	Butte
	San Mateo
	Madera
	Mendocino
	Modoc
	Placer
	Humboldt
	Kern
	Lake
	Sacramento
	San Diego
	Sonoma
	Yolo

SB 484 mandates additional review and increased standards regarding psychotropic medication usage in group homes, and creates new data collection and notification requirements for the Community Care Licensing Division (CCLD) within DSS in order to identify and mitigate inappropriate levels of psychotropic medication use by children in foster care residing in group homes.

Quality Improvement Project: Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. DHCS and DSS have convened a statewide quality improvement project to design, pilot, and evaluate effective practices to improve psychotropic medication use among children and youth in foster care. In order to meet the goals of the quality improvement project, three workgroups have been created. These include the Clinical Workgroup, the Data and Technology Workgroup, and the Youth, Family, and Education Workgroup.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. DHCS and DSS: Please provide an overview of these proposals.

2. DHCS and DSS: Why don't all counties have DUAs or GIAs? How are DHCS and DSS working with counties to get these established? How are DHCS and DSS meeting the SB 238 mandate to share foster care data with all 58 county placing agencies?

3. DHCS and DSS: Please describe how these reports and data provide oversight at the county level and state level?

4. DHCS and DSS: How will this information be used to reduce the use of psychotropic medications and increase access to mental health, psychosocial, and other support services?

5. DHCS and DSS: Please provide an update on the "Quality Improvement Project: Improving the Use of Psychotropic Medication among Children and Youth in Foster Care."

Issue 3: Oversight: Out-of-County Placements

Oversight Issue. Concerns have been raised regarding a longstanding issue of access to mental health services for foster children and youth placed out of county. When these children are placed out of county, they are at risk of experiencing prolonged delays or denials in accessing mental health services as counties dispute the authorization of, and payment for, services and the responsibility for coordinating these services.

In 2010, the Child Welfare Council approved an action plan to resolve this problem. However, this action plan was not implemented. In early 2015, the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) released a "concept paper" outlining a solution to this longstanding problem. DHCS and DSS indicate that they are close to finalizing guidance to counties on this issue and are awaiting the outcome of AB 1299 (Ridley-Thomas), which was placed on the Senate Appropriations Committee Suspense File in August 2015. This bill would require DHCS to issue policy guidance that establishes conditions for the presumptive transfer of responsibility for providing mental health services to foster youth, from the county of original jurisdiction to the county of residence.

Background. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is an entitlement under federal law for all Medi-Cal-eligible children including children placed into foster care. Specialty mental health is a covered EPSDT benefit for children who meet "medical necessity" criteria for such care.

County mental health plans are the responsible entity that ensures Medi-Cal specialty mental health services are provided. Each county mental health plan contracts with local private mental health service providers or uses county mental health staff to deliver services.

It is estimated that 20 percent of foster children and youth are placed out of county. They are placed out of county for various reasons, such as placement with a relative that may live in another county or placement in a short-term residential placement. In these situations, counties can (1) keep the child enrolled in Medi-Cal in the home county or (2) transfer the child's Medi-Cal case to the host county. There is no statewide policy regarding this choice as each child's situation may be different (and each county may have a different policy).

Staff Comment & Recommendation—Hold Open. Very little progress (since last year's subcommittee hearing on this topic) has been made by the state in providing formal guidance to counties on this topic. While the departments cite AB 1299 as the reason it has not taken any action on this issue, the status of negotiations on AB 1299 remain unclear. DHCS and DSS should determine at what point it will decide to issue its formal guidance and resolve this longstanding issue.

Questions.

1. Please provide an overview of this issue. How are access to care problems that are caused by this uncertainty resolved now?

2. Please provide a brief overview of the policies contained in the draft guidance the state is preparing to release.

3. Given the status of AB 1299, at what point, will the departments determine that it should release its guidance?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Community Mental Health Overview

Background. California has a decentralized public mental health system with most direct services provided through the county mental health system. Counties (i.e., county mental health plans) have the primary funding and programmatic responsibility for the majority of local mental health programs. See table below for a summary of county community mental health funding.

Table: Estimated Community Mental Health Funding Summary

Fund Source	2014-15	2015-16	2016-17
	Total	Total	Total
1991 Realignment			
Mental Health Subaccount (base and growth)*	$82,721,000	$122,920,000	$172,928,000
2011 Realignment			
Mental Subaccount Health Account (base and growth)*	$1,121,940,000	$1,132,600,000	$1,121,880,000
Behavioral Health Subaccount (base)**	$1,051,400,000	$1,168,400,000	$1,288,200,000
Behavioral Health Growth Account	$117,000,000	$119,800,000	$128,000,000
Realignment Total	**$2,373,061,000**	**$2,543,720,000**	**$2,711,008,000**
Medi-Cal Specialty Mental Health Federal Funds	**$2,153,244,000**	**$2,279,073,000**	**$2,252,897,000**
Medi-Cal Specialty Mental Health General Fund	**$117,209,000**	**$151,199,000**	**$139,760,000**
Mental Health Services Act Local Expenditures	**$1,730,050,000**	**$1,340,000,000**	**$1,340,000,000**
Total Funds	**$6,373,564,000**	**$6,313,992,000**	**$6,443,665,000**

*2011 Realignment changed the distribution of 1991 Realignment funds in that the funds that would have been deposited into the 1991 Realignment Mental Health Subaccount, a maximum of $1.12 billion, is now deposited into the 1991 Realignment CalWORKs MOE Subaccount. Consequently, 2011 Realignment deposits $1.12 billion into the 2011 Realignment Mental Health Account.
**Reflects $5.1 million allocation to Women and Children's Residential Treatment Services. Includes Drug Medi-Cal.

Medi-Cal Mental Health. As of January 1, 2014, there are three systems that provide mental health services to Medi-Cal beneficiaries:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal "specialty" mental health services under a waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment

(EPSDT) benefit for persons under age 21. County mental health plans are the responsible entity that ensures specialty mental health services are provided. Medi-Cal enrollees must obtain their specialty mental health services through the county.

California's Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2015. See issue two of this agenda for discussion of the renewal of this waiver.

2. **Managed Care Plans (MCPs) -** Effective January 1, 2014, SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session expanded the scope of Medi-Cal mental health benefits and required these services to be provided by the Medi-Cal Managed Care Plans (MCP) excluding those benefits provided by county mental health plans under the SMHS Waiver. Generally these are mental health services to those with mild to moderate levels of impairment. The mental health services provided by the MCPs include:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

3. **Fee-For-Service Provider System (FFS system) -** Effective January 1, 2014 the mental health services listed below are also available through the Fee-For-Service/Medi-Cal provider system:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

Mental Health Services Act (Proposition 63, Statutes of 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. These tax receipts are reconciled and deposited into the MHSA Fund on a "cash basis" (cash transfers) to reflect funds actually received in the fiscal year. The MHSA provides for a continuous appropriation of funds for local assistance.

The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Most of the act's funding is to be expended by county mental health departments for mental health services consistent with their approved local plans (three-year plans with annual updates) and the required five components, as contained in the MHSA. The following is a brief description of the five components:

- **Community Services and Supports for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through its

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

- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.

- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded from five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.

- **Workforce Education and Training.** The component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

Counties are required to submit annual expenditure and revenue reports to the DHCS (and the MHSOAC). DHCS monitors county's use of MHS funds to ensure that the county meets the MHSA and MHS Fund requirements.

Mental Health Services Act Projected Revenue Summary

MHSA Revenues (in millions)							
	actuals	actuals					
	2012-13	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**
Distribution to counties*	$1,590	$1,236	$1,730	TBD	TBD	TBD	TBD
State Administration**	32	39	79	134	83	105	106
Total MHSA Revenues	**$1,684**	**$1,281**	**$1,851**	**$2,028**	**$2,051**	**$2,093**	**$2,123**

*Source: State Controller's Office Year-to-Date Reports for Monthly Mental Health Services Fund distributions for 2012-13 through 2014-15. For remaining fiscal years, 2016-17 Governor's Budget estimates.
**Source: Department of Finance MHSA Admin Chart.

Subcommittee Staff Comments—Informational Item.

Questions.

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

Issue 2: 2011 Realignment Behavioral Health Subaccount

Oversight Issue. The budget projects $117 million in the Behavioral Health Subaccount Growth for 2014-15, $119.8 million for 2015-16, and $128 million in 2016-17.

SB 1020 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2012, created the permanent structure for 2011 Realignment. SB 1020 codified the Behavioral Health Subaccount which funds Medi-Cal Specialty Mental Health Services (for children and adults), Drug Medi-Cal, residential perinatal drug services and treatment, drug court operations, and other non-Drug Medi-Cal programs. Medi-Cal Specialty Mental Health and Drug Medi-Cal are entitlement programs and counties have a responsibility to provide for these entitlement programs.

Government Code Section 30026.5(k) specifies that Medi-Cal Specialty Mental Health Services shall be funded from the Behavioral Health Subaccount, the Behavioral Health Growth Special Account, the Mental Health Subaccount (1991 Realignment), the Mental Health Account (1991 Realignment), and to the extent permissible under the Mental Health Services Act, the Mental Health Services Fund. Government Code Section 30026.5(g) requires counties to exhaust both 2011 and 1991 Realignment funds before county General Fund is used for entitlements. A county board of supervisors also has the ability to establish a reserve using five percent of the yearly allocation to the Behavioral Health Subaccount that can be used in the same manner as their yearly Behavioral Health allocation, pursuant Government Code Section 30025(f).

Consistent with practices established in 1991 Realignment, up to 10 percent of the amount deposited in the fund from the immediately preceding fiscal year can be shifted between subaccounts in the Support Services Account with notice to the Board of Supervisors, pursuant to Government Code Section 30025(f). This shift can be done on a one-time basis and does not change base funding. In addition, there is no restriction for the shifting of funds within a subaccount, but any elimination of a program, or reduction of 10 percent in one year or 25 percent over three years, must be duly noticed in an open session as an action item by the Board of Supervisors, pursuant to Government Code Section 30026.5(f). Government Code Section 30026.5(e) also requires 2011 Realignment funds to be used in a manner to maintain eligibility for federal matching funds.

DHCS issued Mental Health Services Division Information Notice 13-01 on January 30, 2013, to inform counties that 2011 Realignment did not abrogate or diminish the responsibility that, "they must provide, or arrange for the provision of, Medi-Cal specialty mental health services, including specialty mental health services under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit." As noted above, Government Code Section 30026.5(k) specifies fund sources for Medi-Cal Specialty Mental Health Services. The Administration continues to work with the California State Association of Counties and the California Behavioral Health Directors Association to ensure all counties are aware of these entitlement programs and clients cannot be denied services.

For the 2012-13, DHCS gave first priority to Behavioral Health Growth Account funding to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health EPSDT and Drug Medi-Cal. Specifically, this allocation provided additional funding to counties in which the approved claims for EPSDT and Drug Medi-Cal services in each fiscal year were greater than the funding they received in the respective fiscal year from the Behavioral Health Subaccount. The remaining balance of this growth account was then distributed using the same percentage schedule used to distribute the funds allocated to the Behavioral Health Subaccount.

For 2013-14, DHCS gave first priority to Behavioral Health Growth Account funding to reimburse counties for the two entitlement programs, Medi-Cal Specialty Mental Health EPSDT and Drug Medi-Cal, and then distributed the remaining funds based on Medi-Cal enrollment (per county).

The Administration indicates that it anticipates using the same allocation formula for the $117 million in 2014-15 Behavioral Health Growth Account funds that it used in 2013-14.

Base. Revenues deposited into the Behavioral Health Subaccount are distributed based on a schedule created by the Department of Finance in consultation with state agencies and the California State Association of Counties. The Administration and counties are working to develop a formula to distribute the base allocation from the Behavioral Health Subaccount and are targeting to set the base for 2016-17.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised by stakeholders that the state should develop mechanisms to distribute the growth funding upfront to incentivize counties to address unmet needs.

Questions.

1. Please provide an overview of this issue.

2. When does DHCS plan to distribute the $117 million in 2014-15 growth funds?

3. What is DHCS's view on how this growth account funding could be used to incentivize counties to increase utilization of specialty mental health and Drug Medi-Cal services?

4. Have counties fully utilized their Behavioral Health Subaccount funds? What happens if counties do not fully utilize these funds in a fiscal year?

Issue 3: Specialty Mental Health Services Oversight and Monitoring

Budget Issue. DHCS requests 13 full-time, permanent positions and expenditure authority of $1,925,000 ($866,000 General Fund) for 2016-17 and $2,128,000 ($972,000 General Fund) on-going. The permanent resources requested, included $400,000 for contracted clinicians, who will work to meet the Special Terms and Conditions (STCs) required by the Centers for Medicare and Medicaid Services (CMS). CMS placed this as a condition of the renewal of DHCS Medi-Cal Specialty Mental Health Services (SMHS) Waiver authorized under Section 1915(b) of the Social Security Act.

The following positions are requested:

Classification	Effective Date
1.0 Nurse Consultant II	7/1/16
2.0 Health Program Spec II 2.0 Health Program Spec I	9/1/16
1.0 Office Technician	1/1/17
1.0 Nurse Consultant II 1.0 Health Program Spec II 1.0 AGPA	7/1/16
1.0 Health Program Spec II 2.0 AGPA 1.0 Staff Services Manager I	1/1/17

Background. On June 24, 2015, CMS issued an approval of the five-year SMHS Waiver and indicated their concerns continue to be program integrity monitoring and compliance of this waiver. This renewal is effective July 1, 2015 through June 30, 2020**.** The STCs will require a substantial increase in workload. As in prior years, ongoing non-compliance issues and chart review disallowances by the County MHPs remain; these issues have recently triggered an audit by the Office of the Inspector General (OIG), which is currently underway. In the renewal, CMS set out specific conditions in order for DHCS to attain compliance with federal and state regulatory requirements as well as the MHP contract requirements, including requiring a process for levying fines, sanctions, and penalties on MHPs that have continued, significant non-compliance issues. While meeting the STCs involves current functions and workload for which resources are needed, it also involves completely new functions and a substantial increase in workload that requires additional resources.

One new function is development and ongoing reporting on a mental health dashboard, using data from External Quality Review Organization (EQRO) and other relevant sources. This is an entirely new function for MHSD, and requires additional resources to design, develop, and post the first mental health dashboard and regular updates. The first dashboard is due by September 1, 2016. During this time, DHCS will also be working with CMS each month to discuss the identified action plans and milestones to ensure they meet CMS' expectations prior to implementation.

According to DHCS, it performs a number of different reviews to determine compliance with state and federal policies, regulations and statutes, as well as the MHP contract. These reviews include, but are not limited to the following:

- Triennial system reviews of MHPs to determine whether they are operating in accordance with all applicable policies, regulations, and statutes.

- Medi-Cal provider certifications and re-certifications for SMHS.

- Triennial outpatient medical record reviews to ensure compliance with medical necessity criteria (per Sections 1830.205 and 1830.210 of Title 9 of the California Code of Regulations (CCR)).

- Triennial inpatient medical record reviews to ensure compliance with medical necessity criteria for hospital days (per Section 1820.205 of Title 9 of the CCR), or, where applicable, for administrative day services (per Section 1820.230 of Title 9 of the CCR).

- Targeted reviews (on a single MHP or a single Medi-Cal provider) as needed, when indicated by a pattern of improper claiming or violations of regulations or statutes.

These reviews have reflected elevated rates of disallowance and/or non-compliance:

- The average non-compliance rate for system reviews of MHPs for 2011-2012, 2012-2013, and 2013-2014 was 17 percent.

- The average disallowance rate for outpatient medical record reviews for 2011-2012, 2012-2013, and 2013-2014 was 38 percent.

- The average 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.

Generally, CMS finds that a disallowance rate above three to five percent is noteworthy.

Based on a review of the triennial monitoring reports, CMS has identified three major concerns with DHCS' ability to assure that MHPs comply with the waiver requirements. First, DHCS currently only requires MHPs to repay funds back to the state for compliance issues associated with a beneficiary's clinical chart. Thus, MHPs do not face fiscal repercussions for other types of violations that may significantly impede beneficiaries' access to care, such as the required statewide, toll-free 24/7 telephone access line, available in all languages spoken by beneficiaries of the county. Though there is a history of high rates of non-compliance with this regulatory requirement, there are no sanctions, fines, or penalties for these or other violations not associated with beneficiary clinical carts.

Second, in cases where DHCS recoups the reimbursement from MHPs for claims associated with a beneficiary's clinical chart, many of the same compliance issues repeat throughout the triennial reviews. The department's approach (i.e. recoupment for chart disallowances) has not adequately addressed the consistently high error and disallowance rates. While there is existing authority for sanctions, there is not enough analytical and clinical staff to develop and implement sanctions.

Third, the error rates found in chart reviews are not currently extrapolated to the MHPs entire population, in contravention to general auditing principles. DHCS does not extrapolate error rates to the Specialty Mental Health population for the county, and thus MHPs are only required to recompense the state for compliance issues that are identified for specific charts included in the audit sample during triennial reviews.

CMS is concerned about the continued and long-standing MHP noncompliance issues and the consistently elevated rates of disallowance resulting from inpatient and outpatient medical record

reviews. As such, CMS will be carefully analyzing the state's monitoring activities and corrective action plans to ensure all necessary actions are implemented and improvement occurs. Furthermore, these error rates triggered CMS to notify the Office of the Inspector General (OIG), which has begun a review.

Expected outcomes of the approval of these positions would include the following:

- Retention of a five-year Medi-Cal SMHS Waiver by providing the staff resources needed to meet the STCs and implement program improvements required by CMS.
- Increased intensity of primary oversight functions, including more frequent MHP system reviews and outpatient medical record reviews.
- Reduction in the average non-compliance rate for system reviews of MHPs and decreased number of MHPs with low compliance levels.
- Reduction in the average disallowance rate for outpatient medical record reviews and the 18 Short-Doyle/Medi-Cal acute psychiatric inpatient hospitals resulting from inpatient medical record reviews.
- Improved tracking, monitoring and improvement of timeliness of care, access to care, and MHP and subcontractor grievances and appeals.
- Improved transparency of communication with CMS and stakeholders through availability of dashboard MHP performance and subcontractor information.
- Establishment of a system for the levying of sanctions, fines, and penalties for identified levels of continued non-compliance.

Caseload. See table below for projected specialty mental health unduplicated caseload.

Specialty Mental Health Unduplicated Caseload Growth

Year	Unduplicated Adults*	Percent Growth	Unduplicated Children	Percent Growth
2012-13	232,973	0.54%	245215	7.57%
2013-14	234,770	0.77%	261,401	6.60%
2014-15	236,608	0.78%	266,717	2.91%
2015-16	238,000	0.59%	280,569	4.36%
2016-17	239,393	0.59%	292,284	4.18%

*Excludes adults eligible for Medi-Cal as a result of federal health care reform optional Medi-Cal expansion.

Timely Access to Specialty Mental Health Services. At the DHCS Behavioral Health Forum on April 6, 2015, DHCS discussed establishing statewide timely access standards for mental health services provided by county mental health plans. DHCS indicates that discussions with the counties have continued on this topic and that it is close to releasing an information notice regarding these standards. It should be noted that on the physical health care side, managed care plans are required to

meet Knox-Keene statewide standards for timely access to services, for example, for non-urgent and primary care appointments within 10 days of the request.

Medi-Cal Mental Health Ombudsman. The table below summarizes call volume at the Medi-Cal Mental Health Ombudsman Office. This ombudsman is to serve as a bridge between the county mental health plan system and individuals, family members and friends of individuals, in need of mental health services by providing information and assistance in navigating through the system

Table: Summary of Office of the Mental Health Ombudsman Calls (2010 - 2015)

Month	Total	SMHS	Unknown/ Other[i]	Non-MH[ii]	SUD[iii]	LPS[iv]	MCP-MH[v]
2010	4869	1927	N/A	N/A	N/A	N/A	N/A
2011	2121	1011	N/A	N/A	N/A	N/A	N/A
2012	586	366	N/A	N/A	N/A	N/A	N/A
2013	1806	1278	N/A	N/A	N/A	N/A	N/A
2014	5481	3035	N/A	N/A	N/A	N/A	N/A
2015	7509	1213	1182	3020	937	N/A	1157

[i] Unknown/Other category = calls that do not fit within other categories.
[ii] Non-MH = all inquiries regarding non-mental health services (e.g., Medi-Cal enrollment and removing holds).
[iii] SUD = Substance Use Disorders. MHSD began tracking this in 2015 once calls were re-routed to MHSD.
[iv] LPS = Lanterman-Petris-Short (LPS) facilities- calls from conserved individuals or callers seeking information on conservatorships.
[v] MCP-MH = calls related to mental health services delivered by Medi-Cal Managed Care Plans.
Note: This table includes information regarding the number and types of calls received by the Mental Health Ombudsman. This information is based on calls received by the ombudsman. In addition, this information is not reflective of actual call volume as this information has not been consistently tracked due to the factors listed below. As a result, DHCS does not have the ability to provide a true comparison of types of calls for this time period.

- The 2010 and 2011 data is inclusive of inquiries for California State Hospitals. In 2011 – 2012 the Department of State Hospitals became its own entity which resulted in the mental health Ombudsman no longer capturing this information.
- From August 2011 to June 2013, the database was only sporadically used as the former Department of Mental Health was transitioned to the Department of Health Care Services. The data during this period is not reflective of actual call volume.
- 2013-14 numbers are reflective of the Healthy Families transition, and the Affordable Care Act implementation.
- In 2015 the Ombudsman began capturing Substance Use Disorder calls

Subcommittee Staff Comment and Recommendation—Hold Open. The following concerns should be noted:

1. **Broader Engagement of Stakeholder Community is Critical.** Concerns have been raised that DHCS has primarily been working with counties on implementation of the STCs and efforts to improve oversight of county mental health plans. While counties are key partners and deliver specialty mental health services on behalf of the state, other stakeholders, including consumer advocates and providers, have a meaningful perspective in regard to how counties implement and deliver these services.

2. **Limited Caseload Growth.** As noted in the table above, the count of unduplicated adults receiving specialty mental health services is expected to grow less than one percent from the current year to the budget year. This less than one percent growth has occurred or is expected to occur for the last few years. DHCS not been able to provide information explaining this, what appears to be low, growth rate. This same population in Medi-Cal grew an average of six percent for the same time period. The inability of DHCS to understand these caseload numbers

is concerning. A comprehensive understanding of caseload, service utilization, and expenditures is critical in maintaining oversight of county mental health plans and the requirement that individuals have access to these services.

3. **Information Requested by Subcommittee Still Outstanding.** In January, subcommittee staff requested information related to the waiver STCs, such as the recommended indicators for quality and access due to CMS on January 31, 2016, the annual grievance and appeal report due to CMS on January 31, 2016, and the External Quality Review Organization's mental health plan timeliness self-assessment findings presented on December 3, 2015. This information has not been received.

Questions.

1. Please provide an overview of this proposal.

2. How is DHCS working with stakeholders on implementation of the STCs? Who is DHCS working with?

3. As required by the STCs, when does DHCS anticipate posting county mental health plans' plan of corrective action and quality improvement plan as a result of the state compliance reviews?

4. How is DHCS working with stakeholders on the development of dashboard required by the STCs? Will the dashboard be a tool to identify disparities in treatment, access and outcomes?

5. What is DHCS's assessment of the slow rate of growth of unduplicated adults receiving specialty mental health? How does DHCS monitor this?

6. How does DHCS monitor if a county mental health plan fails to authorize all medically-necessary services requested to meet the needs of children?

7. How does DHCS monitor referrals and whether there is a follow-up by the county mental health plan or a provider?

8. What is DHCS's timeline for releasing the information notice regarding timely access standards for mental health services provided by county mental health plans? Do these standards include standards for follow-up appointments?

9. How does DHCS monitor and assess trends in Mental Health Ombudsman call data? What actions has DHCS taken as a result of this assessment? How is DHCS managing resources for this office given the growth in call volume?

10. When will DHCS provide the subcommittee the requested information regarding the STCs?

Issue 4: Performance Outcomes System for Medi-Cal Specialty Mental Health Services

Budget Issue. The budget includes $23.7 million ($11.9 million General Fund) for implementation of the performance outcomes system (POS) for Medi-Cal specialty 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.

These funds would be used to fund county personnel costs and for training for county clinicians on how to use the tools for data collection. County mental health plans will collect, manage, use, and report additional functional assessment data as part of the POS.

Background. SB 1009 requires DHCS to develop a Performance Outcomes System for Medi-Cal Specialty Mental Health Services for children and youth. Consistent with statute, DHCS has produced a Performance Outcomes System Implementation Plan. DHCS released the Performance Outcomes System Implementation Plan with the 2014-15 Governor's budget, and a budget change proposal with initial resources (four staff) to begin to implement and operate this system.

In 2013, SB 1009 was amended through AB 82, to add the requirement for mental health screening of children/youth as part of Medi-Cal managed care. The legislation also required the development of measures for screening and referring Medi-Cal beneficiaries to mental health services and supports, making recommendations regarding performance and outcome measures, and providing an updated Performance Outcomes System plan to the fiscal and appropriate policy committees of the Legislature by October 1, 2014. The amendment also requires the department to propose how to implement the updated Performance Outcomes System plan by January 10, 2015. The Legislature has not yet received this updated system plan.

The purpose of the Performance Outcome System is to provide the capability to understand the statewide outcomes of specialty mental health services provided, in order to best ensure compliance with the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirement. Although the non-federal share-of-funding for the Medi-Cal Specialty Mental Health program has been realigned to the counties, the state maintains a responsibility for ensuring access to the federal entitlement for the Medi-Cal Specialty Mental Health program. For children and youth up to age 21 in this program, federal law further requires EPSDT to ensure access to medically-necessary specialty mental health services. The Performance Outcomes System will measure individual outcomes as clients receive managed care or specialty mental health services.

Through implementation of the POS, California will have a coordinated method for data collection, be able to evaluate specific measures of mental health services, and establish an ongoing process for quality improvement. According to DHCS, in order to meet the POS project milestones, a Quality Assurance/Improvement team will be needed at the county level to collect, manage, use, and report information obtained from the additional functional assessment data. This require modifying existing data systems and increasing staff time or enhancing current staffing levels to implement the plan.

The responsibility for specialty mental health was realigned to the counties in 2011 (2011 Realignment). Pursuant to Proposition 30 (of 2012), legislation enacted after September 30, 2012, that has an overall effect of increasing the costs already borne by a local agency for programs or levels of service mandated by 2011 Realignment shall apply to local agencies only to the extent that the state provides annual funding for the cost increase. Local agencies are not obligated to provide programs or

levels of service required by legislation, above the level for which funding has been provided. Therefore, funding for the remaining non-federal costs for counties is 100 percent General Fund.

The last POS report can be found at:
http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/20160111POSStatewide-Final.pdf

Table: Performance Outcomes System Timeline, April 2016

Milestones	Date
System Implementation Plan	
Draft System Implementation Plan	November 2013
Obtain input on the final draft Implementation Plan from the Performance Outcomes System Stakeholder Advisory Committee	December 2013
Deliverable: System Implementation Plan	**January 2014**
Establish Performance Outcomes System Methodology	
Facilitate stakeholder input on a performance outcomes system evaluation methodology (including standardized data sources and data collection tools used for the system, frequency of administration, etc.)	December 2014
Obtain Input on the Performance Outcomes System methodology protocol from the Performance Outcomes System Stakeholder Advisory Committee	February 2015
Deliverable: Performance Outcomes System Protocol	**January 2017**
Initial Performance Outcomes Reporting: Existing DHCS Databases	
Identify performance outcomes data elements in existing DHCS databases	May 2014
Assess data integrity	July 2014
Develop county data quality improvement reports	December 2014
Counties remedy data quality issues	Ongoing
Develop performance outcomes report templates	December 2014
Obtain input on the report templates from the Performance Outcomes System Stakeholder Advisory Committee	February 2015
Deliverable: Statewide and County Reports on Initial Performance Outcomes Using Data from Existing DHCS Databases	**State Reports: Starting February 2015 County Reports: Starting May 2016**
Continuum of Care: Screenings and Referrals	
Convene Performance Outcomes System Stakeholder Advisory Committee to discuss Continuum of Care	December 2013
Obtain input on screening and referral information needed for the Performance Outcomes System from the Stakeholder Advisory Committee	April 2014
Deliverable: Performance Outcomes System Plan Update	**January 2015**
Deliverable: Performance Outcomes System Implementation Plan Update	**On Hold**[1]

1 There have been no changes to the Implementation Plan, so DHCS has focused resources on implementing the other deliverables in the timeline.

Milestones	Date
Comprehensive Performance Outcomes Reporting: Expanded Data Collection	
The activities associated with this task are dependent on the number and scope of additional data elements adopted as part of the Performance Outcomes System methodology.	2014-15
Obtain input on the report templates from the Performance Outcomes System Stakeholder Advisory Committee	Fall 2015
Deliverable: Statewide and County Reports on Comprehensive Performance Outcomes Using Existing and Expanded Data	**2016-2017**
Continuous Quality Improvement Using Performance Outcomes Reports	
Develop trainings to support interpretation of the performance outcomes reports (initial and comprehensive)	Ongoing Beginning in June 2016
Develop quality improvement plan process	Ongoing Beginning in March 2016
Obtain input on the quality improvement plan process from the Performance Outcomes System Stakeholder Advisory Committee	Spring 2016
Deliverable: Quality Improvement Plan Process	**Summer 2016**
Support and monitoring of quality improvement	Ongoing

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

2. When will county specific data be reported? (It was previously reported to this committee that these reports would be posted in February 2016.)

3. When does DHCS plan to delineate foster care information in these reports?

4. What are some findings from the September 2015 report that DHCS has taken action on?

5. Why was development of the implementation plan update related to screenings and referrals put on hold?

6. When does DHCS plan to incorporate Medi-Cal managed care plan mental health screenings and referrals into the POS?

Issue 5: Mental Health Services Act (Proposition 63) Reappropriation

Budget Issue. Through a Spring Finance Letter, DHCS requests reappropriation of $1.9 million in unexpended Mental Health Services Act (MHSA) funding from 2013-14, 2014-15, and 2015-16. The reappropriated funds will support costs to procure contracts for 1) MHSA data quality assurance, 2) MHSA data collection, and 3) MHSD Web re-design. Currently, the department indicates it is unable to provide timely and accurate information for data queries from stakeholders or legislative staff. This proposal requests the following budget bill language to reappropriate unexpended prior year funding:

> **4260-490—Reappropriation, Department of Health Care Services. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2018:**
> **3085—Mental Health Services Fund**
> **(1) Item 4260-001-3085, Budget Act of 2013 (Chs. 20 and 354, Stats. of 2013),**
> **(2) Item 4260-001-3085, Budget Act of 2014 (Ch. 25, Stats. of 2014),**
> **(3) Item 4260-001-3085, Budget Act of 2015 (Ch. 10, Stats. of 2015)**

Of the $1.9 million in funds to be reappropriated, $250,000 per year for 2013-14, 2014-15, and 2015-16 is from unused contract funds and the remaining unexpended funds are due to salary savings in 2013-14, 2014/-5, and 2015-16.

Background. Senate Bill 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012, transferred functions from the former Department of Mental Health (DMH), including functions related to administration of the MHSA program, to DHCS. As part of this transfer, a number of information technology (IT) systems, including the Data Collection and Reporting (DCR) system, were migrated from the former DMH to DHCS. DHCS planned to migrate these systems in two phases. Phase 1 was the transfer of the IT systems from DMH to DHCS. Phase 2 involves a business process reengineering effort to capture system and process efficiencies. Phase I was successfully completed on July 2013.

According to DHCS, by reappropriating the unexpended funds for these contract services, DHCS will be able to:

- Rewrite the DCR system to meet current security and architecture standards.
- Align the DCR system with DHCS' architectural and programming standards in order to more efficiently maintain and adapt the system to changing needs. Currently, the department is not able to modify the system to capture additional data elements without updating the architectural and programming standards.
- Streamline the process of publishing information in an accessible format through a contract for Web re-design.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal and how these reappropriated funds would be used.

2. What was the original intended use of these funds? Why were the contract funds not used?

Issue 6: Drug Medi-Cal

Oversight and Budget Issue. Through a Spring Finance Letter, the Administration requests eight permanent full-time positions to support fiscal oversight and programmatic monitoring requirements 1115 Demonstration Waiver Amendment for the Drug Medi-Cal Organized Delivery System (DMC-ODS).

These resources would be phased in over two years, five positions in 2016-17, for a cost of $624,000 ($312,000 General Fund), and three more positions in 2017-18 for a cost of $322,000 ($161,000 General Fund) given the uncertainty related to how many counties will be ready to file implementation plans and how many will be approved by the federal Centers for Medicare and Medicaid Services (CMS).

Background. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. See table below for Drug Medi-Cal funding summary.

Table: Drug Medi-Cal Program Funding Summary (dollars in thousands)

	2015-16				2016-17			
Service Description	**GF**	**County Funds**	**FF**	**TF**	**GF**	**County Funds**	**FF**	**TF**
Narcotic Treatment Program	$0	$76,438	$93,397	$169,835	$421	$78,896	$96,209	$175,526
Residential Substance Use Services*	$0	$5,088	$5,162	$10,250	$0	$5,650	$5,745	$11,395
Residential Treatment Expansion	$5,096	$0	$9,464	$14,561	$32,494	$0	$58,398	$90,892
Outpatient Drug Free Treatment Services	$0	$13,228	$14,495	$27,723	$121	$10,648	$14,496	$25,265
Intensive Outpatient Services**	$12,293	$1,708	$20,339	$34,340	$12,644	$2,094	$16,550	$31,288
County Administration	$1,287	$9,339	$14,564	$25,190	$1,864	$10,376	$16,710	$28,950

*Previously named "Perinatal Residential Substance Abuse Services"
**Previously name "Day Care Rehabilitative Services"

In 2011, funding for the DMC program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS as part of the Public Safety Realignment initiated by AB 109 (Committee on Budget), Chapter 15, Statutes of 2011. Prior to the realignment of the DMC program, DMC was funded with General Fund and federal funds. Enactment of the 2011 Public Safety Realignment marked a significant shift in the state's role in administering programs and functions related to substance use disorder (SUD). Realignment also redirected funding for DMC and discretionary substance use disorder programs to the counties. Consequently, counties are responsible for providing the non-federal match used to draw down federal Medicaid funds for DMC services as they existed in

2011 and for individuals eligible for DMC under 2011 Medi-Cal eligibility rules (pre-health care reform). Additionally, the enactment of 2012-13 and 2013-14 state budgets transferred the responsibility for the SUD programs including DMC, from the former DADP to DHCS.

Drug Medi-Cal Organized Delivery System. At the beginning of 2014, DHCS began a stakeholder engagement process to solicit input to improve the DMC system and purse a DMC-ODS federal waiver to provide an organized delivery system of substance use disorder services and demonstrate how this organized system of care would increase successful outcomes for DMC beneficiaries. The DMC-ODS waiver, an amendment to DHCS' Bridge to Reform Waiver, was approved by CMS on August 13, 2015 for five and a half years.

According to DHCS, the continuum of care model enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance use disorder treatment, and coordinates with other systems of health care.

The implementation of the DMC-ODS is occurring in regional phases modeled after the California Behavioral Health Director's Association boundaries for each region. Additionally, this approach gives DHCS and counties the opportunity to learn from each implementation phase and improve their submission for the next. See charts below for more information on the proposed implementation timeline and participating counties.

Proposed Counties and Implementation Phase Timeline

Description	Phase One (21.3% of population)	Phase Two (60.8% of population)	Phase Three (13.8% of population)	Phase Four (2.7% of population)	Phase Five
Counties completed an Expression of Interest Survey regarding their interest to opt-in to the four phases of implementation. County participation in the Waiver is voluntary. Fifty-three counties expressed interest in participating in the Waiver.	Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma	Kern, Los Angeles, Ventura, San Diego, Imperial, San Luis Obispo, Orange, Santa Barbara, Riverside, San Bernardino	Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Merced, Mono, Placer, Sacramento, Stanislaus, Yolo, San Joaquin, Sutter, Tuolumne, Yuba	Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Siskiyou, Tehama, Trinity	Tribal Partners
Proposed Timeline for Implementation	July 2016	January 2017	July 2017	January 2018	2018

As of March 2016, seven counties have submitted their implementation plans (IPs) for DHCS and CMS review and approval, see table below. On April 8, 2016, San Mateo's implementation plan was approved. DHCS anticipates the experience gained from the initial IP reviews will improve subsequent phase implementations.

Counties Who Have Submitted Their Implementation Plans

County	Date Submitted Implementation Plan to DHCS	Date Implementation Plan Approved
San Francisco	11/20/2015	
San Mateo	11/21/2015	4/8/2016
Riverside	12/07/2015	
Santa Cruz	12/09/2015	
Santa Clara	02/03/2016	
Marin	02/05/2016	
Los Angeles	02/11/2016	

Counties must submit to DHCS a plan on their implementation of the DMC-ODS. DHCS and CMS are reviewing IPs concurrently with a target of 60 days to approve or send back for adjustments. County IPs will ensure providers are appropriately certified for the contracted services, implementing

at least two evidenced-based practices, trained in ASAM criteria, and participating in efforts to promote culturally competent service delivery.

Simultaneously or after plan review, counties must submit proposed interim rates to DHCS for review and approval. DHCS has been providing technical assistance to counties regarding rate development. DHCS is awaiting approval from CMS regarding the certified public expenditure (CPE) protocol. The CPE protocol is the process by which counties certify they have paid providers for services when submitting claims to the state for reimbursement. The state then makes interim payments to counties based on submitted expenditures. CMS must approve the CPE protocol before any DMC claims will be reimbursed for the federal financial participation. DHCS expects approval of the CPE protocol in the next month.

Upon receipt of rate approval, counties submit their state/county contact to their Board of Supervisors. After approvals are received from the Board of Supervisors, CMS will give the final approval of the DMC-ODS plan. In addition, before providing services, counties must ensure that all providers are trained in the ASAM criteria. DHCS estimates that as long as a county has passed through the CMS, DHCS and county approval processes, it may begin providing DMC services under the waiver in summer 2016.

Counties are not eligible for reimbursement of services without approval of the implementation plan, state contract, and reimbursement rates by CMS and DHCS. Currently for non-waiver counties, the standard statewide DMC service rates are developed by DHCS in accordance with the Welfare and Institutions Code, Sections 14021.51, 14021.6 and 14021.9. Once established, the statewide DMC reimbursement rates are coded into the DMC billing and payment systems (Short-Doyle and SMART) so that services provided to beneficiaries in all counties are reimbursed at the same rate. However, participating waiver counties will propose their own county-specific rates, with subsequent DHCS and CMS approval.

The waiver's STCs include many quality assurance, monitoring, and reporting requirements for participating providers, counties and the state. These activities are to ensure accountability to CMS, as well as, continued program integrity monitoring efforts to prevent waste, abuse and fraud within the DMC services. Quality assurance activities are modeled after Specialty Mental Health requirements and ensure the federal and state provisions of the waiver are properly implemented and oversight is maintained by DHCS. For example, it will remain the state's responsibility to monitor DMC treatment providers and county adherence to the state-county contract through fiscal and cost reporting, collecting beneficiary treatment data, and on-site compliance reviews and licensure renewal.

Existing staff at DHCS have initiated the following activities in preparation for the waiver implementation:

- Participating in weekly workgroups related to new and expanded waiver services, rate setting, IT requirements, cost report requirements, and provider database requirements;
- Conducting preliminary research and work with the Office of Legal Services on waiver contract requirements and developing draft contract documents;
- Identifying global claim adjudication rules which need to be established for the development into the Short Doyle Medi-Cal (SDMC) system to clearly identify waiver claims and differentiate from current regular DMC claims;
- Identifying system changes needed to capture the requirement that every county participating in the waiver will be reimbursed at individually-approved interim rates;
- Developing preliminary modalities, program codes, and service codes for cost reporting purposes;

- Analyzing and developing the different processes needed for cost settlement of waiver counties using an interim rate methodology as opposed to the established methodology of settling at the lower of the provider's allowable cost of rendering the services, the provider's usual and customary charge to the general public for similar services, or the state maximum allowance for the services provided;
- Developing policy documents for new waiver services and additional treatment modalities;
- Developing county monitoring instrument for waiver contracts and annual review protocols;
- Developing program integrity training for county personnel; and
- Reviewing protocols for quality assurance reports from counties and EQRO reports.

According to DHCS, many additional tasks must be accomplished prior to implementation of waiver services and then there will be ongoing functions required to maintain the waiver program and services, separate from non-waiver program activities.

Subcommittee Staff Comment and Recommendation—Hold Open. DHCS indicates that there is backlog in licensing Drug Medi-Cal providers, residential treatment providers in particular. Subcommittee staff has requested information on this backlog. It is unclear how this backlog will impact implementation of DMC-ODS.

Questions.

1. Please provide an overview of this proposal and the status of the waiver implementation.

2. How is DHCS addressing the backlog of residential treatment providers requesting a license? Will this backlog impact timely implementation of DMC-ODS?

3. Please provide an update on how DHCS is meeting the waiver requirement to integrate SUD and primary care services. Has DHCS completed its integration approach due April 1, 2016? How is DHCS working with stakeholders to develop this model?

4. How does DHCS monitor utilization of Drug Medi-Cal services? Why are caseloads and spending for intensive outpatient treatment services and outpatient drug free treatment services going down?

Issue 7: Substance Use Disorders Health Care Reform Implementation

Budget Issue. DHCS requests $1,456,000 ($729,000 General Fund) to convert ten limited-term positions to permanent full-time positions and add one new permanent legal position. The ten two-year limited-term positions are set to expire on June 30, 2016. According to DHCS, the conversion of the positions to permanent full-time positions is necessary to continue to support the requirements set forth in the Affordable Care Act (ACA) and enacted in SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, which enhanced Medi-Cal substance use disorder services. The additional legal position will address litigation workload associated with both SB 1 X1 and AB 848 (Stone), Chapter 744, Statutes of 2015, discussed later in this agenda. The legal position will be phased-in effective January 1, 2017.

Background. The ACA required 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, in accord with the federal requirements. The ACA regulations delineated mental health and substance use disorder services as part of the EHB standard and required all alternative benefit plans under Section 1937 of Title XIX of the Social Security Act to cover such services.

To comply with ACA, substance use disorder services under the Drug Medi-Cal (DMC) program were expanded and made available to additional beneficiaries. Treatment planning was added as a component to narcotic treatment, naltrexone treatment, and outpatient drug free treatment services. Intensive outpatient treatment services (previously available only to those who are pregnant, postpartum, or youth eligible for Early and Periodic Screening, Diagnosis and Treatment) was made available to all beneficiaries who meet the requirement for medical necessity. Counseling time limits in narcotic treatment settings were eliminated.

The requirement to expand substance use disorder services and include additional beneficiaries has led to an increase in new providers as well as existing providers expanding their available services. This in turn has increased the baseline workload at DHCS, necessitating additional permanent positions to meet the ongoing demands of updating and maintaining certified provider information databases, processing claims and payments, conducting onsite provider post-service, post-payment reviews, developing and monitoring county and direct provider contracts, and analyzing and settling county and provider cost reports.

According to DHCS, these positions have accomplished the following and are still needed due to the ongoing nature of this workload:

- Participated in the strike teams led by Audits & Investigations (A&I) Division to rid the DMC program of fraudulent providers, as well as, efforts to address the California State Auditor's (CSA) program-related recommendations. Further, these staff assisted with strengthening Title 22 regulations, improved internal controls and program procedures, and conducted DMC trainings to providers to ensure compliance. Additionally, A&I staff conducted a limited-scope review of the DMC program identifying 32 recommendations to improve program integrity. The requested staff would prioritize and implement these recommendations.

- Developed business rules for cost reports, including aid code sources for more than 50 new funding lines and fund combinations resulting from new eligibility aid codes required for the ACA.

- Worked on the electronic funds transfer (EFT) project to enable counties and direct contract providers to receive EFT payment rather than paper warrants.

- Developed new DMC claim reconciliation reports for counties.

- Assisted in the development and implementation of expanded populations into the related DMC billing and payment systems for proper adjudication and payment and provided technical assistance on the necessary changes to ensure there was no break in DMC billing and claims payment.

- Researched all recoupments identified by the CSA and A&I limited scope to recover over $200,000 FFP in DMC funds owed to the state.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

Issue 8: Residential Treatment Facilities (AB 848, 2015)

Budget Issue. DHCS requests four permanent positons and expenditure authority of $478,000, from the Residential and Outpatient Program Licensing Fund (ROLF), to implement AB 848 (Stone), Chapter 744, Statutes of 2015. Of the four positions, one nurse consultant II position will be phased-in effective January 1, 2017, while the rest will be effective July 1, 2016.

Background. Prior to July 1, 2013, the Department of Alcohol and Drug Programs (DADP) was responsible for oversight of residential treatment facilities (RTFs). Effective with the passage of the 2013-2014 budget and associated legislation, all DADP programs and staff, except the Office of Problem Gambling, transferred to the DHCS. Under Health and Safety Code (HSC) Section 11834.01, DHCS has sole authority in state government to license adult alcoholism or drug abuse recovery or treatment facilities. Prior to the enactment of AB 848, HSC Section 11834.02 defined residential alcohol and other drug facilities as any premises, place or building that provides 24-hour residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, that includes at least one of the following: recovery services, treatment services or detoxification services, but prohibited incidental medical services from being provided onsite.

AB 848 permits medical care in a residential treatment facility, and requires specific oversight activities. AB 848 is a direct result of concerns raised, in the September 12, 2012 report by the California Senate Office of Oversight and Outcomes, regarding state oversight of drug and alcohol homes and the potential benefits of limited onsite medical care.

AB 848 amends the HSC to add Section 11834.026 to allow a licensed alcoholism or drug abuse recovery or treatment facility to provide incidental medical services to a resident at the facility premises through or under the supervision of one or more physicians or surgeons licensed by the Medical Board of California or the Osteopathic Medical Board who are knowledgeable about addiction medicine. Incidental medical services at RTFs may also be provided by one or more other health care practitioners acting within the scope of practice of his or her license and under the direction of a physician or surgeon, and who are also knowledgeable about addiction medicine, when specified legislative requirements are met.

According to DHCS, the enactment of AB 848 requires DHCS to assume an additional workload. The bill requires DHCS to develop, adopt and implement regulations on or before July 1, 2018. In addition, staff will establish in-house policies and procedures related to the enforcement of regulations and will provide oversight of RTFs providing incidental medical services in accordance with the regulations. DHCS is also required to review applications from facilities requesting to amend their licenses to include incidental medical services, and establish and collect an additional fee from participating facilities, in an amount sufficient to cover the department's reasonable costs of regulating the provision of those services. As required by statute, any fee that is established is required to be discussed and vetted with stakeholders before being determined. The Legislature must also review and approve the fee.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES (DHCS)

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION (OAC)

Issue 1: Oversight of Mental Health Services Act Funds and Outcome Evaluation

Oversight Issue. Numerous concerns have been raised that the state maintains limited oversight of the approximately $2 billion in Mental Health Services Act (MHSA) (Proposition 63) funds distributed to counties. Fundamental questions about county spending on the components of MHSA and outcomes from these expenditures are not easily available or publically reported.

State Positions for MHSA Oversight. According to the January 2016 Mental Health Services Act Expenditure Report, 19 positions at DHCS are funded with MHSA State Administrative Cap funding to provide fiscal and program oversight of the MHSA. According to the report, these positions are used "to develop the county performance contracts, review the current allocation methodology for monthly distribution of MHSA funds, develop annual revenue and expenditure report (RER) forms and review county RER submissions, conduct fiscal audits of county MHSA funds, review issues submitted through the issue resolution process, and review and amend MHSA regulations."

At the OAC, 30 positions support the OAC's statutory oversight and accountability for the MHSA. The primary roles of these functions include "ensuring MHSA funds are expended in the most cost-effective manner and services are provided in accordance with recommended best practices, providing oversight, review, training and technical assistance, for accountability and evaluation of local and statewide projects supported by MHSA funds, ensuring adequate research and evaluation regarding the effectiveness of services being provided and achievement of outcome measures, approving county innovation plans, receiving and reviewing county three-year program and expenditure plan, annual updates and annual revenue and expenditure reports, and implementing and managing the SB 82 Triage Program."

Revenue and Expenditure Reports. Counties are required to submit to DHCS an annual RER. These reports contain information regarding county expenditures for each component of the MHSA. Generally, a fiscal year's information is compiled and posted approximately three years later. For example, in March 2016, the 2012-13 county expenditure report was made available by DHCS. The delay in compiling and posting this information, according to DHCS, is for a number of reasons, including counties not submitting their data timely. Counties note that the template to submit this information is flawed and that it is awaiting revisions to the template.

Performance Contracts. As required by state law, counties must enter into performance contracts with DHCS in order to receive MHSA funds. As part of this agreement, counties must provide all application data and information required by the state to receive this funding, including the RER. Pursuant to this contract, DHCS can withhold payments to counties from the MHS fund.

Reversion and Pending MHSA Related Regulations. DHCS is in the process of developing regulations related the reversion of MHSA funds (unspent funds have not reverted since 2008), regulations for the Local Mental Health Services Fund, investment income, local prudent reserve, and the Annual MHSA Revenue and Expenditure Report. DHCS expects to complete the initial draft of the regulations by mid-April 2016. DHCS indicates it will solicit input from the OAC and County

Behavioral Health Directors Association of California (CBHDA) after the draft regulations have been approved by its Office of Legal Services. DHCS will begin the formal rulemaking process after consulting with MHSOAC and CBHDA. The final regulations package is expected to be sent to the Office of Administrative Law in February 2018.

According to DHCS, the absence of regulations is the reason that DHCS has not reverted any MHSA funds. The former Department of Mental Health determined reversion according to whether a county requested all funds available from a particular fiscal year, within a three year period. The former DMH reverted funds that had not been requested within three years and redistributed those funds. The State Controller's Office distributed to counties all funds that had not been distributed in 2011-12 pursuant to AB 100 (Committee on Budget), Chapter 5, Statutes of 2011. The State Controller now distributes all unreserved funds to counties on a monthly basis. As a result, DHCS is not able to revert funds that have not been requested within a three year period. DHCS is considering prior information notices and stakeholder input as it develops the process for calculating and collecting reversion. While statute is clear that MHSA funds are subject to reversion (see W&I Code Section 5892(h)), according to DHCS, the process for calculating and collecting reversion is not well defined. As such, DHCS indicates that without regulations it would be very difficult for the department to collect any funds from counties.

Fiscal Transparency and Data Efforts. The OAC has entered into contracts with a vendor to improve the fiscal transparency of local MHSA funds. As part of these contracts, a publically-accessible tool is being developed to allow public reporting of Innovation funding (a component of MHSA funding), expenditures, and balances statewide and by county over time. This tool would be dependent on data collected by the RERs.

Additionally, DHCS and OAC have entered into a contract with a vendor to provide a secure environment for viewing confidential health information and analytic software to access data and conduct research and evaluations.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. DHCS: Please explain DHCS's activities related to oversight and monitoring of the Proposition 63 funds distributed to counties (e.g., audits, cost reporting analysis). If deficiencies are found, that tools does DHCS have to remediate the problems?

2. DHCS: Please provide an update on counties reporting Proposition 63 revenues and expenditures for 2013-14. When was this information due? How many counties have reported this information? How does DHCS work with counties that have not submitted this information? What is the status of discussions on the template to report this information?

3. DHCS: Why does it take close to three years for Proposition 63 revenues and expenditures to be reported publically?

4. DHCS: Please describe how DHCS enforces the provisions of the MHSA performance contract.

5. DHCS: Please provide an update on the MHSA financial regulation package. Has it been submitted to DHCS's Office of Legal Services?

6. DHCS: Annually, how many issues are raised through the Issue Resolution Process? Please explain what types of issues are raised through this process?

7. OAC: Please explain OAC's activities related to oversight and monitoring of the Proposition 63 funds distributed to counties.

Issue 2: Children's Crisis Services Capacity Development Grant Program

As noted in the table below, approximately $52 million in MHSA State Administrative Cap is available (unspent) in 2016-17. The Legislature may want to consider using this available funding to establish a one-time grant program to build capacity for the continuum of children's crisis services. This continuum of services includes, but is not limited to, crisis residential programs, crisis stabilization services, mobile crisis support teams, family support services, and training.

Table: 2016-17 Governor's Budget and March Annual Accrual Adjustment Mental Health Services Fund Administrative Cap (dollars in thousands)

Fiscal Year	Monthly Cash Transfers	Accruals	Interest	Total Revenue	Admin Cap	Expenditures/ Approps**	Available Cap	Comments
	A	B	C	D	E	F	G	
				(A+B+C)	(D[.035 or .05])		(E-F)	
2012-13*	$1,204,000	$480,000	$721	$1,684,721	$58,965	$31,572	$27,393	Item 4265-001-3085 ($15m appropriated without regard to fiscal year in 2012 Budget Act). Item 6440-001-3085 ($12.3m appropriated in 2014 Budget Act).
2013-14	$1,187,000	$94,000	$548	$1,281,548	$64,077	$39,474	$24,603	Item 4265-001-3085 ($15m appropriated without regard to fiscal year in 2013 Budget Act).
2014-15 /e	$1,367,000	$484,000	$844	$1,851,844	$92,592	$78,989	$13,603	2014 Budget Act appropriations: Item 4265-001-3085 ($15m appropriated without regard to fiscal year), and Items 4560-491 and 6440-001-3085 (subject to available funds through June 30, 2017).
2015-16 /e	$1,462,000	$566,000	$844	$2,028,844	$101,442	$134,406	($32,964)	2015 Governor's Budget: Item 4265-001-3085 ($15m appropriated without regard to fiscal year). The expenditures include $45m for the California Reducing Disparities Project (DPH).
2016-17/e	$1,515,000	$536,000	$844	$2,051,844	$102,592	$83,286	$19,306	2016 Governor's Budget: Reflects $15 million appropriated without regard to fiscal for the California Reducing Disparities Project (DPH).
TOTALS:					$419,669	$367,727	**$51,942**	
*The administrative cap applicable in 2011-12 and 2012-13 was 3.5 percent. The cap was restored to 5 percent in 2013-14.								
**Expenditures in 2014-15, 2015-16, and 2016-17 are displayed in the 2016 Governor's Budget.								
e/ = estimate								
Departments Funded in 2016-17: Judicial Branch (0250), State Treasurer-California Health Facilities Financing Authority (0977), Office of Statewide Health Planning & Development (4140), Department of Health Care Services (4260), Department of Public Health (4265), Department of Developmental Services (4300), Mental Health Oversight and Accountability Commission (4560), Department of Education (6110), University of California (6440), Financial Information Systems for California (8880), Department of the Military (8940), Department of Veterans Affairs (8955) and Statewide General Administrative Expenses (9900).								

As noted in the chart above, about $52 million in State Administrative Cap funding is available.

Background. Reports have called to attention a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited mental health services for individuals, children in particular, in psychological distress and acute psychiatric crisis. Nearly 40,000 California children ages 5-19 (or five of every 1,000) were hospitalized for mental health issues in 2014.

In 2015, the Mental Health Services Oversight and Accountability Commission initiated a project to understand the state of children's mental health crisis services, document challenges, identify effective

service delivery models, and advance specific policy, funding, and regulatory changes to improve service quality and outcomes. According to draft OAC report, "no county has successfully built out the full continuum of services required to fully meet the needs of children and families in crisis." The OAC has issued draft recommendations to "support the continued buildout" of a comprehensive continuum of crisis services and ensure access for all children and youth.

Research indicates that crisis residential and stabilization programs reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of emergency room visits, and divert inappropriate incarcerations while producing the same or superior outcomes to those of institutional care. Furthermore, these types of services, according to a California Mental Health Planning Council report, exemplify "the spirit, intent, and guidelines of the Mental Health Services Act" in that it "is a recovery-oriented, client-driven system that modifies to the needs of the client for optimal outcomes."

The continuum of children's crisis services includes:

- Crisis Residential – Crisis residential programs are a community-based treatment option in home-like settings that offer safe, trauma informed alternatives to psychiatric emergency units or other locked facilities.
- Crisis Stabilization – Crisis stabilization services are those lasting less than 24 hours for individuals who are in psychiatric crisis. The goal of crisis stabilization is to avoid the need for inpatient services. These services must be provided on a site at licensed 24-hour health care facility.
- Mobile Crisis Support Teams – Mobile crisis support teams can provide crisis intervention and family support.
- Family Support Services – Family support services help families participate in the planning process, access services, and navigate programs.

Subcommittee Staff Comment and Recommendations—Hold Open. It is recommended to hold this item open as discussions continue on this topic, feedback is received from stakeholders, and MHSA State Administrative Cap updates are provided in the May Revision.

Additionally, it should be noted that AB 741 (Williams) proposes to expand the definition of "social rehabilitation facility" to include residential facilities that provide social rehabilitation services in a group setting to children and adolescents recovering from mental illness or in a mental health crisis. Current law only defines these facilities for adults. Creating this licensure category for children's crisis residential programs would be necessary in order to be eligible for federal Medicaid funding for these crisis services.

Questions.

1. OAC: Please provide an overview of this issue proposed by the Subcommittee.

2. OAC: Please provide an overview of the OAC's project on children's mental health crisis services.

3. OAC and DHCS: Do you have any feedback or comments on this proposal?

Issue 3: Suicide Hotlines

Oversight Issue. The Supplemental Report of the 2015 Budget Act requires DHCS to provide to the fiscal and policy committees of the Legislature and to the Legislative Analyst's Office a report on the status of suicide hotlines in the state of California no later than January 10, 2016. The report shall include: (a) a comprehensive assessment of the accessibility of suicide hotlines throughout the state, (b) a cost estimate of ensuring access to suicide hotlines in all parts of the state, (c) a description of how suicide hotlines have been funded over the time period beginning January 1, 2005, and ending January 1, 2016, (d) an explanation of the role of national suicide hotlines in terms of what value is added, and needed, by having separate, state-based suicide hotlines, and (e) an analysis and description of funding strategies to fund suicide hotlines in the future. In developing the report, the department shall confer with the Mental Health Services Oversight and Accountability Commission, the California Mental Health Services Authority, the Office of Emergency Services, County Behavioral Health Directors Association of California, and other key stakeholders.

This report has not yet been received. The Legislature requested this report last year given community mental health advocates requests that the Legislature identify a long-term stable funding source for suicide hotlines as an agreement to use county MHSA funds for this purpose was expiring.

Subcommittee Staff Comment and Recommendation—Hold Open. DHCS indicates that it is in the finalize stages of review for this report; however, it is unknown when it will be released. Community mental health advocates indicate that they are continuing to work with counties and the state to identify a long-term solution.

Questions.

1. Please provide an overview of this issue and findings DHCS has learned in the process of completing this report. What recommendations does DHCS have on this topic?

2. Does anything preclude counties from using MHSA funds to continue to fund suicide hotlines?

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Overview

Mental Health Services Act (Proposition 63, Statutes of 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Mental Health Services Oversight and Accountability Commission. The Mental Health Services Oversight and Accountability Commission (OAC) was established in 2005 and is composed of 16 voting members. Among other things, the role of the MHSOAC is to:

- Ensure that services provided, pursuant to the MHSA, are cost effective and provided in accordance with best practices;
- Ensure that the perspective and participation of members and others with severe mental illness and their family members are significant factors in all of its decisions and recommendations; and,
- Recommend policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the MHSA.

Subcommittee Staff Comment—Informational Item.

Questions.

1. Please provide a brief overview of the OAC.

2. Please explain how the OAC ensures that services provided, pursuant to the MHSA, are cost effective and consistent with the MHSA. Does it make the findings from these reviews public?

Issue 2: Investment in Mental Health Wellness Act of 2013 – Triage Personnel Grants

Budget Issue. The commission requests reappropriation of $3.8 million in funds from 2013-14 ($2.2 million), 2014-15 ($939,276), and 2015-16 ($585,214), to support triage personnel grants until 2017-18, allowing counties to spend the Triage Grant funding until the end of the current grant cycle.

According to the commission, allowing counties to continue to use the funds awarded to them for the triage personnel grant programs for an additional year would provide more complete information to evaluate the program's effectiveness and further assist thousands of high-need individuals in accessing crisis services including; mental health care, medical care, alcohol and drug treatment, social services, and educational services, as well as reduce unnecessary hospitalizations and inpatient days. Positions funded with these grants are mobile and able to travel to respond to mental health crises, including crisis involving law enforcement. These personnel cab 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. Providing crisis intervention services reduces recidivism and mitigates unnecessary expenditures for local law enforcement. Additionally, the commission will better understand the outcomes of these services now that programs are in place and triage staff has been hired. The required evaluation reports over the next few years will assist the commission with the next cycle of grants by using lessons learned from the current triage personnel grants.

Background. 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

These grants cover four fiscal years, with grant funds allocated annually for 2013-14 (for five months), 2014-15, 2015-16, and 2016-17. See table below for award details.

Table: Investment in Mental Health Wellness – Triage Personnel Grant Awards

Mental Health Wellness Act of 2013
Approved Triage Grants FY 2013-2017

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17		
Amount Allocated	**$32,000,000**	**$32,000,000**	**$32,000,000**	**$32,000,000**		
	Approved	Approved	Approved	Approved	County Anticipated FTE's	FTE's as of 3/30/16
Southern Region	**$10,848,000**	**$10,848,000**	**$10,848,000**	**$10,848,000**		
Ventura	$840,259	$2,126,827	$2,242,542	$2,364,043	23.0	20.5
Riverside	$488,257	$2,134,233	$2,307,808	$2,510,844	32.3	23.0
Santa Barbara	$933,135	$2,352,536	$2,468,608	$2,594,250	23.5	20.0
Orange	$1,250,000	$3,000,000	$3,000,000	$3,000,000	28.0	8.0
San Bernardino*	$7,174,512	$938,985	$0	$0	25.0	19.0
Region Total	**$10,686,163**	**$10,552,581**	**$10,018,958**	**$10,469,137**	**131.8**	**90.5**
Los Angeles	**$9,152,000**	**$9,152,000**	**$9,152,000**	**$9,152,000**		
Los Angeles	$3,802,000	$9,125,000	$9,125,000	$9,125,000	183.0	97.0
Region Total	**$3,802,000**	**$9,125,000**	**$9,125,000**	**$9,125,000**	**183.0**	**97.0**
Central	**$4,576,000**	**$4,576,000**	**$4,576,000**	**$4,576,000**		
Yolo	$221,736	$505,786	$496,247	$504,465	8.3	6.8
Calaveras	$41,982	$73,568	$73,568	$73,568	1.0	1.0
Tuolumne	$74,886	$132,705	$135,394	$135,518	3.0	3.0
Sacramento	$545,721	$1,309,729	$1,309,729	$1,309,729	20.8	16.0
Mariposa	$88,972	$196,336	$203,327	$210,793	4.3	4.3
Placer	$402,798	$750,304	$667,827	$688,417	13.6	12.8
Madera	$163,951	$389,823	$410,792	$396,030	4.2	4.2
Fresno*	$2,953,099	$120,001	$0	$0	11.5	9.3
Merced	$359,066	$868,427	$882,550	$893,026	8.0	3.0
Region Total	**$4,852,211**	**$4,346,679**	**$4,179,434**	**$4,211,546**	**74.7**	**60.4**
Bay Area	**$6,208,000**	**$6,208,000**	**$6,208,000**	**$6,208,000**		
Sonoma	$351,672	$871,522	$897,281	$923,888	8.0	8.0
Napa	$126,102	$411,555	$403,665	$382,313	6.0	6.0
San Francisco	$1,751,827	$4,204,394	$4,204,394	$4,204,394	61.5	40.2
Marin	$137,065	$315,738	$320,373	$326,746	3.0	3.0
Alameda	$311,220	$765,811	$785,074	$804,692	11.6	12.0
Region Total	**$2,677,886**	**$6,569,020**	**$6,610,787**	**$6,642,033**	**90.1**	**69.2**
Superior	**$1,216,000**	**$1,216,000**	**$1,216,000**	**$1,216,000**		
Butte	$358,519	$514,079	$199,195	$3,277	18.0	14.0
Lake	$26,394	$52,800	$52,800	$52,800	1.0	1.0
Trinity	$60,697	$145,672	$145,672	$145,672	2.5	3.0
Nevada	$289,260	$694,169	$728,878	$765,321	11.8	11.8
Region Total	**$734,870**	**$1,406,720**	**$1,126,545**	**$967,070**	**33.3**	**29.8**
Suicide Prevention	**$7,000,000**					
Golden Gate Nets**	**$7,000,000**					
Project Total	**$7,000,000**					
Total All Regions	**$29,753,130**	**$32,000,000**	**$31,060,724**	**$31,414,786**	**512.9**	**346.9**
Total Vacant Positions						**166.0**
Unencumbered Funds	**$2,246,870**	**$0.00**	**$939,276**	**$585,214**	**Total**	**$3,771,360**

*Reappropriated $19.3 million of the Fiscal Year 2013-14 funds. The OAC funded two additional county Triage programs (San Bernardino and Fresno).

**Redirected $7 million of the reappropriation for suicide prevention efforts.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this item.

2. How does the OAC monitor the progress of and outcomes from these grants? Why are 166 of the 346.9 positions established with these funds vacant?

3. How many individuals have been served with these funds?

Issue 3: Innovation Plan Reviews

Budget Issue. The OAC requests three permanent, full-time positions, for $396,000 from the Mental Health Services Fund (MHSF), to support administration of regulatory authority to perform a review of innovation plans under AB 82 (Committee on Budget), Chapter 23, Statutes of 2013.

Background. In June of 2013, the Governor signed AB 82, a budget trailer bill that modified the Mental Health Services Act and directed the OAC to issue regulations for prevention and early intervention (PEI) programs and innovation programs that were initially authorized under Proposition 63. Innovation is a strategic component of the MHSA, which includes specific goals for reducing homelessness, incarceration, suicide, unemployment and related challenges.

In the summer of 2015, the OAC adopted regulations governing county implementation of prevention and early intervention programs and innovation programs. For this first phase of regulatory work, the OAC redirected administrative, program and legal staff for the development, review and adoption of regulations. The OAC absorbed this workload by delaying other work, reducing its short-term commitments in some areas, such as plan review, contract monitoring and recruitment.

For the second phase of its obligations under AB 82, the OAC is directed to monitor implementation of the regulations and to provide technical assistance to counties under both prevention and early intervention programs and innovation programs. The OAC is proposing to deploy two existing positions for this work – a consulting psychologist and a staff mental health specialist – and is requesting three additional positions – two health program specialist I/II positions, and one research program specialist I/II position. The OAC indicates it also will dedicate, on a temporary basis, a second staff mental health specialist to support initial implementation of PEI regulations.

In 2014-15, the OAC approved 27 innovation plans totaling $129 million in spending. During the first two months of 2015-16, the OAC has reviewed and approved five innovation plans, totaling $24 million in spending. The OAC anticipates an increase in requests for innovation spending, in part because the OAC is working to improve awareness of the availability of innovation funding through the use of an "Innovation Balance Calculator" on its website, which will allow the public, policymakers and mental health advocates to determine the availability of unallocated innovation funds. In 2016-17, it is projected that Innovation component of the MHSA will be $67 million.

Successful innovations in one county can inform and guide investments across all counties. To capture the benefits of innovation, California must improve its ability to recognize and learn from the lessons of innovation, both successes and setbacks. There currently are no efforts to disseminate information on best practices developed and evaluated through an innovation agenda. The OAC, because of its regulatory oversight and the current approval process, finds that it is the appropriate entity to gather and report information on innovations and lessons learned. The OAC believes that this proposal will better equip the OAC to pursue that opportunity.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

Issue 4: Advocacy Contracts

Budget Issue. Through a Spring Finance Letter, the OAC requests $200,000 Mental Health Services Fund (MHSF) ongoing funds beginning in 2016-17 to support mental health advocacy for lesbian, gay, bisexual, transgender, questioning (LGBT) populations, and $1 million MHSF ongoing to support advocacy contracts for youth, veterans, and racial and ethnic minorities.

Background. The Mental Health Services Oversight and Accountability Commission oversees the activities of statewide stakeholder advocacy contracts funded under Welfare and Institution Code Section 5892(d). These contracts, currently held by NAMI California, United Advocates for Children and Families (UACF), California Youth Empowerment Network (CAYEN), and California Association of Mental Health Peer Run Organizations (CAMHPRO) are focused on supporting the mental health needs of clients, consumers, children and youth, and transition aged youth and their families through education, advocacy, and outreach efforts.

These contracts, originally awarded on a sole source basis, were transferred to the OAC after the dissolution of the Department of Mental Health in 2011. Historically, the amount allocated for stakeholder contracts has been a total of $1,954,000 per year, distributed between the following four populations; clients/consumers, children and youth, transition aged youth, and families of clients/consumers.

The Budget Act of 2015 included an additional $1 million MHSF, subject to availability of funds within the five percent administrative cap, to support mental health advocacy on behalf of youth, veterans, and racial and ethnic minorities to be awarded through a competitive process. On January 28, 2016, the OAC adopted language for an additional contract to support mental health advocacy on behalf of LGBTQ. The OAC is requesting an additional $200,000 per year ongoing funds to support this effort.

Advocacy contracts increase participation by underserved populations in discussions to address the mental health needs of consumers and their families through education, advocacy, and outreach efforts. The OAC will release a request for proposal in July 2016 with a focus on supporting the mental health needs of the LGBTQ communities, as well as youth, veterans, and racial and ethnic minorities through education, advocacy, and outreach efforts.

Proposed Allocations for Contracts*	**2016-17**
Clients/Consumers	**$548,000**
Families of Clients/Consumers	**$669,000**
Children and Youth and their Parents/Caregivers	**$437,000**
Transition Age Youth (TAY)	**$500,000**
Veterans	**$400,000**
Racial/Ethnic Minorities	**$400,000**
Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)*	**$200,000**
Total	**$3,154,000**

*Includes funding requested via Spring Finance Letter.

Subcommittee Staff Comment and Recommendation—Hold Open. The Subcommittee is in receipt of a request from Mental Health America of California for an additional $1.536 million augmentation to bring all consumer advocacy contracts to roughly same level as the families of clients/consumers contract (the request is for $670,000 for all contracts).

Questions.

1. Please provide an overview of this proposal.

2. When does the OAC plan to issue the RFP for these contracts? What will be the terms of these contracts?

3. How is the OAC encouraging and requiring these advocates to work at the local level and with boards of supervisors on mental health policy decisions given that most MHSA funds and realigned specialty mental health funds are allocated directly to counties?

Issue 5: Reappropriation of Mental Health Services Fund

Budget Issue. Through a Spring Finance Letter, the OAC requests a reappropriation of $2.5 million Mental Health Services Fund (MHSF) from 2015-16 to continue support of the Evaluation Master Plan and $315,000 MHSF from 2013-14 to permit the completion of consensus guidelines and best practices for involuntary commitment care and provide applicable training. In addition, the Administration proposes amending the budget bill, as specified below:

> "4560-491—Reappropriation, Mental Health Services Oversight and Accountability Commission. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2018:
> 3085—Mental Health Services Fund
> (1) Item 4560-001-3085, Budget Act of 2013 (Chs. 20 and 354, Stats. 2013), as reappropriated by Item 4560-491, Budget Act of 2014 (Ch. 25, Stats. 2014)
> (2) Item 4560-001-3085, Budget Act of 2014 (Ch. 25, Stats. 2014)
> (3) Item 4560-001-3085, Budget Act of 2015 (Ch. 10, Stats. 2015)
> ~~Provisions:~~
> ~~1. T~~
> ~~he funds reappropriated in this item are available to continue funding triage personnel grants approved by the Mental Health Services Oversight and Accountability Commission.~~"

Background. The Budget Act of 2013 included an additional $400,000 one-time MHSF to develop consensus guidelines and best practices for involuntary commitment care and to provide applicable training. The budget further directed that the funds be provided to a statewide and technical assistance entity as contained in Welfare and Institutions Code Section 4061(a)(5). Consistent with that provision, the OAC contracted with the California Institute for Behavioral Health Solutions (CIBHS) to develop the guidelines and implement appropriate training. According to the OAC, unforeseen circumstances have delayed completion of that contract.

State law specifies that, subject to the availability of funds, the OAC shall engage in evaluation activities to help the counties and the Department of Health Care Services ensure that county-level systems of care are serving their target populations; that timely performance data related to client outcome and cost avoidance are being collected, analyzed, and reported; that system of care components are implemented as intended; and to provide information documenting needs for future planning. In recognition of these goals the 2013-14 budget included approval of additional resources for the OAC to implement a broad strategy of ongoing research and evaluation (the Evaluation Master Plan). These resources included ongoing approval for additional permanent staff positions to conduct evaluation activities and monitor contracts. The Evaluation Master Plan identified an initial, five-year strategy to utilize new staffing and contracting resources to improve the state's technical capacity to evaluate mental health program outcomes and to support statewide and county-level goals to assess and improve mental health program performance.

The Budget Act of 2015 included $2.7 million to support new research and evaluation activities, primarily through contracts with external entities. During the past year, the OAC has experienced significant turnover in key staff leadership positions, which has delayed development and

implementation of new research and evaluation contracts. Consequently, the OAC is requesting reappropriation of $2.5 million MHSF to continue implementation of the goals of the Evaluation Master Plan. This reappropriation authority would provide the OAC with additional time to meet the 2015-16 goals of the Evaluation Master Plan in consultation with state and local agencies and mental health providers.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this proposal.

2. What implementation goals of the Evaluation Master Plan will be continued with these funds?

3. What are the "unforeseen circumstances" that have delayed the contract regarding the development of consensus guidelines and best practices for involuntary commitment care?

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY (CHFFA)

Issue 1: Investment in Mental Health Wellness Act of 2013

Oversight Issue. SB 82 (Committee of Budget and Fiscal Review), Chapter 34, Statutes of 2013, enacted the Investment in Mental Health Wellness Act of 2013 that appropriated $149.8 million to CHFFA as follows:

- Crisis Residential Treatment Beds – $125 million one-time General Fund to provide grants to expand existing capacity by at least 2,000 crisis residential treatment beds over two years. These funds are to be used to leverage other private and public funds.

- Mobile Crisis Teams - $2.5 million one-time ($2 million General Fund and $500,000 Mental Health Services Act Fund State Administration) to purchase vehicles to be used for mobile crisis teams and $6.8 million ongoing ($4 million Mental Health Services Act Fund State Administration and $2.8 million federal funds) to support mobile crisis support team personnel.

- Crisis Stabilization Units - $15 million one-time General Fund to provide grants to increase the number of crisis stabilization units.

- $500,000 in one-time General Fund for CHFFA to develop the above-specified grant programs.

Additionally, SB 82 required CHFFA to submit to the Legislature, on or before May 1, 2015, a report on the progress of the implementation of these grant programs.

Implementation Status. To date, CHFFA completed and approved four funding rounds; resulting in 38 grants for the benefit of 35 counties totaling $114,777,577.51. These grants are expected to add 61 mobile crisis vehicles, 58.25 mobile crisis staff, and 1,053 crisis residential treatment and crisis stabilization beds.

All projects are in various stages of completion. As of April 2016, approximately $25.2 million has been disbursed.

As of February 2016, for mobile crisis support teams, counties have purchased 60 of 61 approved vehicles and hired 50.35 of the 58.25 approved mobile crisis staff. For crisis residential treatment programs, Alameda (16) and Santa Barbara (8) counties have completed their projects adding 24 new beds. As for crisis stabilization programs, Fresno (16), Santa Barbara (8) and Nevada (4) counties have completed their projects adding 28 new beds, eight of which are dedicated to children. Sonoma County is expected to open its Crisis Stabilization at the end of February 2016 to add 18 new beds.

See table below for summary of awards and disbursements.

County	Program	Approved Amounts	Disbursements
Alameda	Crisis Residential	$ 6,536,507.37	$ 4,458,330.74
Alameda	Crisis Stabilization	$ 2,183,118.00	$ -
Butte	Crisis Residential	$ 867,425.00	$ 417,050.59
Contra Costa	Mobile Crisis Support	$ 551,511.24	$ 500,086.96
Fresno	Crisis Stabilization	$ 794,795.45	$ 794,795.45
Fresno	Crisis Residential	$ 3,100,714.60	$ -
Kings	Crisis Residential	$ 995,903.84	$ -
Kern	Crisis Stabilization	$ 1,701,924.00	$ -
Lake	Mobile Crisis Support	$ 256,263.09	$ 108,458.88
Los Angeles	Crisis Residential	$ 35,000,000.00	$ -
Los Angeles	Crisis Stabilization	$ 4,210,526.31	$ -
Los Angeles	Mobile Crisis Support	$ 1,817,174.18	$ 627,623.63
Marin	Mobile Crisis Support	$ 439,368.05	$ 77,048.00
Mendocino[1]	Mobile Crisis Support	$ 40,713.18	$ 81,426.36
Mendocino	Crisis Residential	$ 500,000.00	$ -
Merced	Crisis Residential	$ 3,546,999.00	$ 1,536,372.00
Monterey	Mobile Crisis Support	$ 193,615.80	$ 193,615.80
Napa	Crisis Stabilization	$ 1,998,183.38	$ -
Nevada	Crisis Stabilization	$ 500,000.00	$ -
Riverside	Crisis Residential	$ 3,778,935.00	$ -
Riverside	Crisis Stabilization	$ 2,102,065.00	$ -
Riverside	Mobile Crisis Support	$ 775,415.22	$ 492,303.94
Sacramento	Mobile Crisis Support	$ 266,287.01	$ 251,517.03
Sacramento	Crisis Residential	$ 6,945,303.00	$ 755,851.34
San Bernardino	Crisis Residential	$ 11,886,185.00	$ 3,945,906.00
San Bernardino	Crisis Stabilization	$ 2,700,000.00	$ -
San Diego	Crisis Residential	$ 3,688,468.00	$ 2,926,512.00
San Joaquin	Crisis Stabilization	$ 1,836,783.50	$ 137,454.97
San Joaquin	Mobile Crisis Support	$ 696,574.18	$ 270,828.28
San Luis Obispo	Crisis Stabilization	$ 971,070.00	$ -
San Luis Obispo	Mobile Crisis Support	$ 67,377.00	$ 67,377.00
Santa Barbara	Crisis Residential	$ 450,000.00	$ -
Santa Barbara	Crisis Stabilization	$ 1,500,000.00	$ -
Santa Barbara[1]	Mobile Crisis Support	$ 713,525.96	$ 1,375,488.09
Santa Clara	Crisis Residential	$ 3,963,106.00	$ 3,258,666.00
Santa Clara	Crisis Stabilization	$ 736,842.11	$ 418,846.11
Solano	Crisis Residential	$ 2,000,000.00	$ -
Sonoma	Crisis Residential	$ 870,343.00	$ -
Sonoma	Crisis Stabilization	$ 2,000,000.00	$ 2,000,000.00
Ventura	Crisis Stabilization	$ 1,134,777.11	$ 109,875.29
Ventura	Mobile Crisis Support	$ 282,277.93	$ 244,905.36
Yolo	Mobile Crisis Support	$ 177,500.00	$ 160,854.42
	Totals	**$ 114,777,577.51**	**$ 25,211,194.24**

Program	Approved Amount	Disbursement
Crisis Residential	$ 84,129,889.81	$ 17,298,688.67
Crisis Stabilization	$ 24,370,084.86	$ 3,460,971.82
Mobile Crisis Support	$ 6,277,602.84	$ 4,451,533.75
Total	**$ 114,777,577.51**	**$ 25,211,194.24**

1 - Includes a 2nd year of personnel funding allocation disbursement.

[1] - Includes a second year of personnel funding allocation disbursement.

Fifth and Final Funding Round. On March 8th, the application period for the final round of funding closed. CHFFA received 20 applications totaling approximately $27.5 million; approximately $31.7 million is available to be awarded. The Peer Respite program was the only program that was oversubscribed, it received six applications totaling over $4.5 million (maximum award amount, by statute, is $3 million). CHFFA indicates it plans to bring forward funding recommendations to the board at the May 26 meeting. See table below for summary of 5th funding round grant applications.

SB 82 Grant Application - 5th Funding Round

County	Crisis Residential Treatment	Crisis Stabilization	Mobile Crisis Support Teams	Peer Respite Care
Alameda	X	X		X
Imperial		X	X	
Kern			X	
Marin		X		
Mendocino				X
Merced		X		X
Napa	X			
Orange		X		
Sacramento				X
San Bernardino	X	X	X	
San Diego		X		
San Mateo	X			
Santa Barbara	X			
Santa Cruz		X	X	X
Shasta		X		
Sonoma				X
Trinity				X
Program Amounts Requested				
Crisis Residential Treatment	$ 8,965,362			
Crisis Stabilization	$ 13,187,659			
Mobile Crisis Support	$ 750,357			
Peer Respite Care	$ 4,581,538			
Total	**$ 27,484,916**			

CHFFA also notes that it is seeing funds awarded from earlier funding rounds go unclaimed and returned. The most common reason for this seems to be vehicles purchased for mobile crisis programs are less expensive than originally estimated in the grant application.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview and update on this item.

2. Are counties experiencing difficulties in getting their crisis residential and crisis stabilization programs implemented? Why? Are regulatory or legislative changes needed to address these difficulties?

3. Given that only $27.5 million in funding was requested and $31.7 million is available, what does CHFFA plan to do with this balance? Will these funds revert to the General Fund in 2016-17?

4. How much from earlier funding rounds is expected to go unclaimed and returned to CHFFA? What does CHFFA plan to do with this money?

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

April 28, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

Consultant: Theresa Pena

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

5180 – DEPARTMENT OF SOCIAL SERVICES – IMMIGRATIONS BRANCH

Issue 1: Update – Immigration Services Programs

Background. The 2015 Budget Act included $15 million General Fund for the Immigration Services Program. Through this program, qualified nonprofits who meet specific criteria and guidelines may apply for grants to provide education, outreach, and application assistance to immigrant community members eligible for either deferred action programs or naturalized citizenship.

DSS has awarded 61 contracts to qualified nonprofit organizations that will provide services under one or more of the following service categories: (1) Services to Assist Applicants seeking Deferred Action for Childhood Arrivals (DACA) or other immigration remedies; (2) Services to Assist Applicants seeking Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) or other immigration remedies; (3) Services to Assist Applicants seeking Naturalization; (4) Legal Training and Technical Assistance Services; and (5) Education and Outreach Activities. Services began under an 18-month contract on January 1, 2016.

Below is an implementation timeline provided by the department:

ACTIVITY	DATE		
Request for Applications (RFA) Overview Conference Call	October 09, 2015		
Application Due Date	October 30, 2015,		
Application Review Period	November 02 - 17, 2015		
Tentative Award Notification	November 18, 2015		
Standard Agreements Released	December 14, 2015		
Service Implementation	January 01, 2016		
Invoices Due	Period Covered	Due to CDSS	Funding
	01/01/2016 – 06/30/2016	01/29/2016	40%
	07/01/2016 – 12/31/2016	07/29/2016	25%
	01/01/2017 – 06/30/2017	01/31/2017	25%
	06/2017- Closeout	07/31/2017	10%
Reports Due	Period Covered	Due to CDSS	
	01/01/2016 – 03/30/2016	04/15/2016	
	04/01/2016 – 06/30/2016	07/15/2016	
	07/01/2016 – 09/30/2016	10/14/2016	
	10/01/2016 – 12/31/2016	01/13/2017	
	01/01/2017 – 03/30/2017	04/14/2017	
	04/01/2017 – 06/30/2017	07/14/2017	
End of Contract	June 30, 2017		

Regions served include: Statewide (serving multiple regions), Central Valley (Butte, Colusa, Fresno, Glenn, Kern, Kings, Madera, Merced, Placer, San Joaquin, Sacramento, Shasta, Stanislaus, Sutter, Tehama, Tulare, Yolo, Yuba), Bay Area (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma), Central Coast (Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz), Inland Empire (Riverside, San Bernardino, Inyo), Los Angeles (Los Angeles), Orange County (Orange, Ventura), and San Diego (Imperial, San Diego).

Below is a chart that shows what activities were funded and at what level:

TOTAL FUNDING PER SERVICE CATEGORY

SERVICE CATEGORY	REQUESTED	AWARDED
Application Assistance - DACA	$7,327,600	$5,762,400
(Other Immigration Remedies)	*$4,754,000*	*$2,804,000*
Application Assistance - DAPA	$2,230,500	$255,150
(Other Immigration Remedies)	*$6,872,000*	*$522,000*
Application Assistance - Naturalization	$9,321,900	$2,434,500
Legal Training and Technical Assistance	$1,823,000	$443,450
Education and Outreach	$8,632,480	$2,238,500
TOTAL	$40,961,480	$14,460,000

Total amount requested from awarded organizations is $40,961,480.
Total amount requested from all organizations, including denied organizations, is $47,453,496.

Immigration Services Clients Served and Cost.

Application Assistance – DACA
16,438 individuals to be served
Workshops: 11,704 individuals to be served at @$350 per case
Direct Representation: 3,332 individuals to be served @$500 per case
Other Immigration Remedies: 1,402 individuals to be served @$2,000 per case

Application Assistance – DAPA
1,962 individuals to be served
Workshops: 1,701 individuals to be served at @$150 per case
Other Immigration Remedies: 261 individuals to be served @$2,000 per case

Application Assistance – Naturalization
7,254 individuals to be served
Workshops: 5,532 individuals to be served at @$300 per case
Direct Representation: 1,722 individuals to be served @$450 per case

Legal Training and Technical Assistance
472 activities to be delivered
In-Person Community Trainings: 31 activities to be delivered @$5,000 per activity
Webinar Activities: 43 activities to be delivered @$2,500 per activity
Consultation from Contractor (in hours): 373 hours to be provided @$150 per hour
Practice Advisories: 25 practice advisories to be created @$20 per person reached

Reporting Outcomes. The first reporting period ends on March 31, 2016 and reports are due on April 15, 2016. On-site monitoring visits will begin in the spring of 2016 and continue throughout the contract period. Quarterly conference calls, regional meetings, and ongoing technical assistance have been occurring, and will continue, since program implementation and throughout the contract period.

Unaccompanied Undocumented Minors (UUM). DSS oversees $3 million legal services funding for the UUM program. The department awarded contracts to 21 qualified nonprofit legal services organizations that will provide legal representation for UUMs in the filing of, preparation for and representation in administrative and/or judicial proceedings for the following immigration statuses: asylum, T-Visa, U-Visa, and/or Special Immigrant Juvenile Status (SIJS). The legal services include culturally and linguistically appropriate services provided by attorneys, paralegals, interpreters and other support staff for state court proceedings, federal immigration proceedings, and any appeals arising from those proceedings. Services began on December 19, 2014.

The UUM fee-per-case was increased in FY 2015/16 from $4,000 per case to $5,000 per case to adequately compensate legal services organizations for the contracted UUM services. A departmental survey and research of costs associated with providing UUM legal services ranged from $2,000 to $12,000, depending on the case type. Invoicing records show that the majority of cases that contractors are handling involve Asylum and Special Immigrant Juvenile Status, which have the greatest expense.

The average wait time to secure a court decision for a UUM client is 1,071 days (2.9 years). All UUM contractors have until June 30, 2021 to close out all active cases and submit final invoices.

There have been a total of 155 adjudicated cases. Below are outcomes for 125 of those cases, which successfully resulted in the following immigration remedies. The remaining 30 cases, not reported below, are awaiting outcome details from the reporting contractors:

Fiscal Year	2014/15	2015/16
Clients Completed (Adjudicated)	117	8
Final Case Outcomes:		
Asylum	83	7
T-Visa	0	0
U-Visa	0	0
SIJS	32	1
Other (Citizenship)	2	0

Staff Comment. No action. Item included for information and discussion purposes.

Question.

1. Please briefly summarize the program and services.

2. Please provide an update on the reports that were due on April 15, 2016.

3. Please provide an update on UUM.

Staff Recommendation. No action required.

Issue 2: Proposal for Investment

The subcommittee has received the following proposal for investment.

- Increase in funding for the Immigration Services Program

Budget Issue. The One California coalition, joined by the Latino Legislative Caucus and the Asian Pacific Islander Legislative Caucus, request an increase of $25 million to the Immigration Services Program for a total of $40 million in FY 2016-17. They state that the current level of investment does not reflect the need for services in the state or the demonstrated capacity to meet those needs.

Background. The Immigration Services Program was established in the 2015-16 budget to provide services for California's immigrant communities that may be eligible for deferred action protection programs or citizenship. Advocates claim that under the current $15 million investment, less than 1 percent of the immigrant community that is eligible to apply for naturalized citizenship is being reached. They also point out that despite the emphasis on DACA, the funding will only reach 2.8 percent of the total eligible population in the state.

Staff Comment and Recommendation. Hold open.

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

Issue 3: Overview – SSI/SSP

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

Funding. The budget proposes $10.3 billion total funds ($2.9 billion General Fund) for SSI/SSP. The state pays administration costs for SSP, around $189 million for the budget year. From 2015-16 to budget year, the budget is projected to increase by $23.5 million General Fund due to a projected average monthly caseload growth.

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

Cash Assistance Program for Immigrants (CAPI). In 1998, the Cash Assistance Program for Immigrants (CAPI) was established as a state-only program to serve some legal non-citizens who were aged, blind, or had disabilities. After 1996 federal law changes, most entering immigrants were ineligible for SSI, although those with refugee status are allowed seven years of SSI. CAPI benefits are equivalent to SSI/SSP program benefits, less $10 per individual and $20 per couple. The CAPI recipients in the base program include 1) immigrants who entered the United States prior to August 22, 1996, and are not eligible for SSI/SSP benefits solely due to their immigration status; and 2) those who entered the U.S. on or after August 22, 1996, but meet special sponsor restrictions (have a sponsor who is disabled, deceased, or abusive). The extended CAPI caseload, which is separate from the base CAPI caseload, includes immigrants who entered the U.S. on or after August 22, 1996, who do not have a sponsor or have a sponsor who does not meet the sponsor restrictions of the base program. In 2016-17, the estimated monthly average caseload is 15,099 cases for both CAPI and extended CAPI.

California Veterans Cash Benefit Program (CVCB) Program. The California Veterans Cash Benefit Program (CVCB) program is linked to the federal Special Veterans Benefit (SVB) Program, which was signed into law in 1999 and provides benefits for certain World War II veterans. The SVB application also serves as the CVCB application, and payments for both programs are combined and issued by the SSA. CVCB program benefits are specifically for certain Filipino veterans of World War II who were eligible for CA SSP in 1999, who are eligible for the SVB program, and who have returned to live in the Republic of the Philippines. The department estimates that the caseload is around 375 cases. Grant levels are identical to the SSP portion for individuals.

Caseload. The SSI/SSP caseload has experienced slow and steady growth over the last decade at an average of approximately 0.9 percent annually. The caseload growth for 2016-17 continues this trend, growing from 1,307,789 in 2015-16 to 1,311,082 individuals, or an increase of 0.8 percent.

Cost-of-Living Adjustment (COLA). Under current law, the federal SSI and grant payments for SSI/SSP recipients are adjusted for inflation each January through Cost-of-Living Adjustments (COLAs). The state COLA for the SSP grant was suspended periodically throughout the 1990s and into the 2000s, with the last increase in 2005. The SSP COLA was permanently repealed in 2011 through statute.

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

Grant Levels. The chart below displays the maximum monthly SSI/SSP grant for individuals and couples in 2007–08, as compared to grant levels for 2015–16. Reflecting SSP grant reductions and the suspension of the state COLA, the combined SSI/SSP maximum monthly grant for individuals and couples has declined as a percentage of federal poverty level (FPL) over the nine–year period.

	2007-08	**2015-16**
Maximum Grant—Individuals		
SSI	$637	$733
SSP	233	156
Totals	**$870**	**$889**
Percent of FPL	102.3%	90.6%
Maximum Grant—Couples		
SSI	$956	$1,100
SSP	568	396
Totals	**$1,524**	**$1,496**
Percent of FPL[1]	133.6%	112.7%

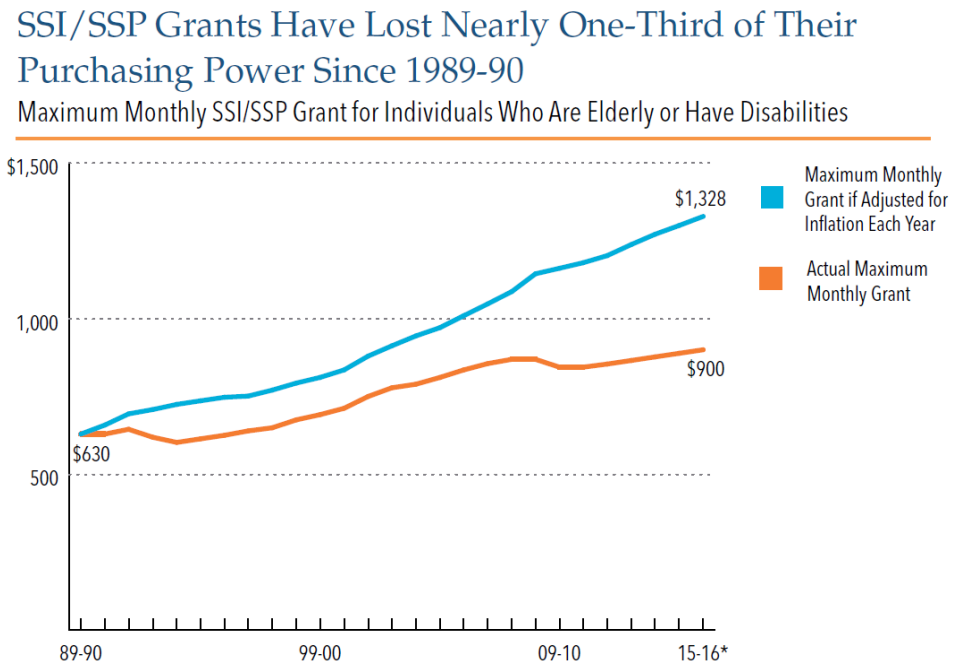
If the SSP COLA had been applied annually since 2005, when the last COLA was given to the SSP grant, the maximum grant for individuals would be $1,052 and the maximum grant for couples would be $1,868 in 2015-16.

According to the Legislative Analyst's Office (LAO), after adjusting for inflation, the maximum combined SSI/SSP grant for 2015-16 has declined significantly in purchasing power since 2007-08:

[1] FPL = federal poverty level

- Represents roughly $76 (8.7 percent) less purchasing power for individuals.
- Represents roughly $190 (12.4 percent) less purchasing power for couples.

According to the California Budget and Policy Center, fair market rent for a studio apartment exceeds one-half of the SSI/SSP grant for an individual in all 58 counties and is actually higher than the entire grant for 15 counties.[2] The chart below compares an individual's SSI maximum grant amount as a percentage of the federal poverty level and demonstrates its loss of purchasing power since 1989.



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

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

Some counties are currently investing in SSI advocacy programs to proactively assist applicants with the application process and helping them stabilize in the interim. Best practices include providing modest

[2] http://calbudgetcenter.org/wp-content/uploads/Fact-Sheet-_3.11.15_Due-to-State-Cuts-SSI_SSP-Grants-Lose-Ground-to-Housing-Costs.pdf
[3] http://economicrt.org/publication/all-alone/

housing subsidies, transportation and other supportive services, case management, outreach to participants, and collaboration with medical providers.[4] In particular, for individuals approved for SSI, housing subsidies can be recouped through the Interim Assistance Reimbursement (IAR), and these funds can then be applied toward another applicant in need of a housing subsidy.

The Senate "No Place Like Home" proposal includes a one-time investment to incentivize local governments to boost outreach efforts and advocacy to get more eligible poor people enrolled in the SSI/SSP program. The federal government covers 72% of the total costs of the SSI/SSP program.

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

- San Mateo County representative
- Los Angeles County representative

Staff Comment and 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.

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

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

Issue 4: Trailer Bill Language: Governor's Proposal to Increase SSP Portion of Grant

Governor's Proposal. The Administration proposes to provide a COLA to the SSP portion of the grant. A COLA using the California Necessities Index (CNI) of 2.96 will be applied to the SSP portion of the grant beginning January 1, 2017. Half-year costs are $40.7 million General Fund (GF).

Background. As highlighted in the table below, the proposed state COLA would increase the SSP portion of the maximum grant by $4.63 per month for individuals and $11.73 per month for couples. Together with the estimated federal COLA, this proposal would raise individual grants by $17.09 per month, and couples' grants by $30.43 per month.

The combined state and federal COLAs would raise the individual maximum SSI/SSP grant to 92 percent of the 2015 federal poverty level, and the couples' maximum SSI/SSP grant to 115 percent of the 2015 federal poverty level. The federal poverty level for 2016 and 2017 has not yet been released, but it typically increases annually.

SSI/SSP Maximum Monthly Grants

	2016 Current Law Grant Levels	2017 Governor's Proposal	Difference
Individuals a>			
SSI	$733.00	$745.46	$12.46
SSP	$156.40	$161.03	$4.63
Totals	**$889.40**	**$906.49**	**$17.09**
Federal Poverty Level	*$980.83*	*$980.83*	
Percent of Poverty b>	**91%**	**92%**	
Couples c>			
SSI	$1,100.00	$1,118.70	$18.70
SSP	$396.20	$407.93	$11.73
Totals	**$1,496.20**	**$1,526.63**	**$30.43**
Federal Poverty Level	*$1,327.50*	*$1,327.50*	
Percent of Poverty b>	**113%**	**115%**	

a> Individuals category refers to aged or disabled individuals living independently in his/her own household.
b> Compares grant level to federal poverty guideline from the U.S. Department of Health and Human Services in 2015.
c> Couples category refers to aged or disabled couples living in their own household.

Source: Legislative Analyst's Office. January 2016.

The Legislative Analyst's Office expects the January CNI to be closer to 2.76 percent, which would decrease the cost for the proposed increase by approximately $3 million GF. They also estimate the CPI used by the federal government to adjust the SSI portion of the grant will be closer to 1.4 percent, as opposed to the 1.7 percent used in the Governor's proposal. The estimates for grant increases using the lower CNI and CPI are $14.51 for individuals and $26.23 for couples.

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

Subcommittee staff has requested the Legislative Analyst's Office to provide estimates for several different scenarios to provide a better fiscal picture of what other options might cost. The scenarios and their estimated costs are as follows:

- Whole-grant COLA. Using the updated CNI of 2.76 percent and the updated CPI of 1.39 percent, applying a whole-grant COLA using the historical statutory formula would cost the General Fund about $115 million for six months, and about $232 million for a full-year.

- Increasing individuals' grants to the Federal Poverty Level (FPL). This would bring the maximum monthly grant for individuals to the 2016 FPL. The estimated cost for this scenario is $620 million for six months in 2016-17 and over $1.25 billion for the full year in 2017-18.

- Increasing all SSP grants by $10. Raising monthly grants by $10 for all recipients would result in General Fund costs of approximately $80 million for 6 months in 2016-17 and $162 million for the full year in 2017-18.

Staff Comment. The Legislature should carefully consider the implications of the proposed grant increase, particularly how the amount will impact recipients and how it fits into the overall larger picture of reducing poverty, and explore different options of how to apply the COLA to the SSI/SSP grant or otherwise increase the SSI/SSP grant. Staff also notes that the Senate Pro Tem and several other Senators have proposed a "No Place Like Home" initiative that includes state-level policy changes and investments intended to assist local governments in tackling the homelessness problem. The plan includes an augmentation to SSI/SSP grants and SSI advocacy, although the details are not yet specified.

Questions.

1. DSS: Please summarize the proposal.

2. LAO: Please discuss estimates for the following options for increasing the SSI/SSP grant amounts: (1) Whole grant COLA, (2) Increasing individuals' grants to the Federal Poverty Level, and (3) Increasing all SSP grants by $10.

Staff Recommendation. Hold Open.

Issue 5: Proposals for Investment

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

- Restore the SSI/SSP Grant Cuts and the COLA

Budget Issue. The Western Center on Law and Poverty and other advocates request restoration on the SSP grant cuts and the cost-of-living adjustment (COLA) to bring individuals to at or above the FPL.

Background. Currently, the individual SSI/SSP grant is worth 90.2 percent of the FPL. If grant cuts had not occurred, and the COLA were applied annually, the SSI/SSP grant level for individuals would be 106.7 percent of the FPL.

Staff Comment and Recommendation. Hold open. The Senate "No Place Like Home" proposal also includes an undetermined augmentation to increase SSI/SSP grants.

- Expand SSI Advocacy for GA/GR Recipients

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

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

Staff Comment and Recommendation. Hold open. The Senate "No Place Like Home" proposal also includes a one-time investment to incentivize local governments to boost outreach efforts and advocacy to get more eligible people enrolled in the SSI/SSP program.

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

Issue 6: Overview - IHSS

The In-Home Supportive Services (IHSS) program provides personal care services to approximately 490,000 qualified low-income individuals who are blind, aged (over 65), or who have disabilities. Services include feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services help program recipients avoid or delay more expensive and less desirable institutional care settings.

Budget Issue. The budget proposes $10.2 billion ($3.2 billion General Fund) for services and administration and includes funding for compliance with federal overtime regulations. Of that amount, $3.1 billion ($1.6 billion General Fund) is for IHSS Basic Services, an overall increase due to growth in caseload of 5.7 percent, and higher cost per hour, due to the increase in the hourly minimum wage from $9 to $10, effective January 1, 2016, and county wage increases. In addition, the budget includes a net increase of $186.4 million ($82.8 million GF) from 2015-16 to reflect the annualized cost of complying with federal labor regulations and making system changes in CMIPS. Caseload growth and wage increases for IHSS Providers continue to be two primary drivers of increasing IHSS service costs.

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

In the current year, IHSS providers' combined hourly wages and health benefits vary by county, and range from approximately $9.00 to $18.00 per hour. Prior to July 1, 2012, county public authorities or nonprofit consortia were designated as "employers of record" for collective bargaining purposes on a statewide basis, while the state administered payroll and benefits. Pursuant to 2012-13 trailer bill language, however, collective bargaining responsibilities in seven counties – Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara – participating in Coordinate Care Initiative (CCI) shifted to an IHSS Authority administered by the state.

Coordinated Care Initiative. CCI requires Cal Medi-Connect to coordinate medical, behavioral health, long-term institutional, and home and community-based services, and to administer IHSS according to current program standards and requirements. The intent of CCI is to improve integration of medical and long-term care services through the use of managed health care plans and to realize accompanying fiscal savings. As IHSS becomes a Medi-Cal managed care benefit in the seven counties, each county is responsible for paying a MOE amount, not a percentage of program costs.

The department indicates that it continues integration and monitoring of CCI requirements. DSS collects monthly and quarterly statistics from the CCI counties regarding integration of IHSS into managed health care plan (MHCP) operating procedures and monitors effectiveness of MHCP Care Coordination Teams The Governor's budget extends CCI funding into FY 2016-17.

Universal Assessment Tool. Under CCI, IHSS will continue to be the major home and community-based services for seniors and persons with disabilities. In 2012, the Legislature authorized the development and pilot implementation of a universal assessment tool (UAT). DHCS, DSS, and CDA must develop a UAT to assess a Medi-Cal beneficiary's need for Home and Community-Based Services. The goal is to enhance personalized care planning under CCI, and create a common tool that can be used by all involved in the care of beneficiaries who need home and community based long-term care services.

CDSS, DHCS and CDA continue to work with the Design Team from the UCLA Boren School of Gerontology to prepare draft UAT for focus group, pre-pilot and pilot testing. It is expected that UAT focus group testing will begin in May 2016 and pre-pilot testing in early 2017. Below is a timeline for the UAT provided by the department:

UNIVERSAL ASSESSMENT TOOL (UAT)
FY 2015-16 and FY 2016-17 Estimated Timeline

ESTIMATED DATES*	ACTION	DESCRIPTION
May/June 2016	Focus groups	▪ Submit focus group protocols to UCLA Institutional Review Board, review recommendations with Advisory Team, update. ▪ Recruit focus group participants, report to Advisory Team on challenges. ▪ Conduct focus groups.
	Stakeholder participation	▪ Identify stakeholders to be included in reconstituted stakeholder group, ▪ draft materials and agenda, ▪ conduct stakeholder meeting w/public comment period, and ▪ update UAT based on stakeholder participation.
	UAT Version 1.0	▪ Provide draft of Pre-Assessment Telephone Interview. ▪ Provide item list for Advisory Team review. ▪ Create first complete version of tool.
July/August 2016	Draft pilot design parameters	▪ Describe procedures to be followed in pilot testing UAT. ▪ Obtain approval from UCLA Institutional Review Board.
September/October 2016	UAT Version 2.0 Final	▪ Finalize the UAT version to be used for pilot testing.
November 2016	Stakeholders' meeting	▪ Public comment period. ▪ Review pilot testing version of UAT with stakeholders. ▪ Incorporate feedback.
December	Prepare for pilot testing	▪ Identify counties to participate in pilot testing.

ESTIMATED DATES*	ACTION	DESCRIPTION
2016/January 2017		▪ Meet with those counties to discuss pilot procedures and monitoring of pilot progress.
February/March 2017	Conduct pilot testing	▪ Participating counties will use the UAT for IHSS assessments and reassessments. ▪ UAT team will observe during "ride-alongs."
April/May 2017	Pilot debriefing	▪ Meet with participating counties for feedback on experience with UAT pilot.
May/June 2017	UAT revisions	▪ Revise UAT, incorporating feedback from counties, with the goals of improving validity and reliability, adjusting and clarifying language, and improving the experience for the assessor and applicant. ▪ Begin review analysis of impact to CMIPS.

*Note that these timelines are contingent on work with the vendor and are subject to change.

Program Funding. The program is funded with federal, state, and county resources. Federal funding is provided by Title XIX of the Social Security Act. Prior to July 1, 2012, the state and counties split the non-federal share of IHSS funding at 65 and 35 percent, respectively. A 2012-13 budget trailer bill changed this structure as of July 1, 2012, to base county IHSS costs on a maintenance-of-effort (MOE) requirement. The change was related to enactment of the CCI, also called the Duals Demonstration project.

Recent policies. Several recent policies have impacted the IHSS program[5], including:

- Reduction of IHSS recipient hours. A legal settlement related to *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*, resulted in an eight percent reduction to authorized IHSS hours, effective July 1, 2013. Beginning in July 1, 2014, the reduction in authorized service hours was changed to seven percent. The 2015 Budget Act approved $225.9 million in one-time General Fund resources, and related budget bill language, to offset the seven-percent across-the-board reduction in service hours.

  The 2016-17 Governor's budget proposed to use a portion of the revenues from a restructuring of the existing Managed Care Organization (MCO) tax to restore the seven percent across-the-board reduction, beginning July 1, 2016. The cost for the seven percent restoration is estimated at $236 million General Fund in 2016-17. However, the MCO tax, as passed on February 29, 2016, does not include the seven percent restoration on an ongoing basis. Details of the Administration's proposal to restore the IHSS service hours for the budget year will be provided at May Revision. The Administration believes the restoration should remain in effect as long as the MCO tax is operational.

3. Some policies, including the "share-of-cost," remain in effect. An individual pays a share-of-cost for IHSS services,if they have income above SSI/SSP grant level.

- Minimum wage increases. Assembly Bill 10 (Alejo), Chapter 351, Statutes of 2013, increased the minimum wage from $8 per hour to $9 per hour in July 2014, with gradual increases until the minimum wage meets $10 per hour by January 2016. 29 counties will be impacted by the minimum wage increase in 2016-17. All non-federal IHSS provider wage costs will be funded by the General Fund, around $33 million for 2015-16 and $69.7 million for 2016-17.

  In addition, SB 3 (Leno) was signed by the Governor on April 4, 2016 which will move the state's current $10 per month for minimum wage to $10.50 at the beginning of 2017, and schedules annual increases to $15 for most employers by 2022. SB 3 also provides three paid sick leave days to IHSS workers beginning July 2018, and requires DSS, in conjunction with stakeholders, to convene a workgroup to implement paid sick leave for IHSS providers and issue guidance by December 1, 2017. The department estimates costs arising from this bill will be $21 million General Fund in the first year of implementation, with cumulative costs of $1.8 billion General Fund at full implementation for IHSS providers. (Approximately $228 million of this total at full implementation is attributable to IHSS sick leave).

- Fair Labor Standards Act (FLSA)—Final Rule. 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, clothes washing, 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 redefined "companionship services;" limited exemptions for "companionship services" and "live-in domestic service employees" to the individual, family, or household using the services (not a third party employer). The rule also required 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 more than 40 hours per work week. However, due to various court actions, the final rule was implemented in California effective February 1, 2016.

  SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014, established a limit of 66 hours per week for IHSS providers based on the statutory maximum of 283 hours a month for IHSS recipients, and limited travel time for providers to seven hours a week. DSS or counties may terminate a provider in the event of persistent violations of overtime or travel

limitations. There is a three month hold-harmless period for IHSS providers as overtime changes take effect. More information on FLSA and implementation is included later on in this agenda.

Staff Comment and Recommendation. Hold open. In regards to the restoration of the seven percent reduction in service hours for IHSS recipients, it appears that the Administration views the restoration as tied to the MCO tax. The Legislature may wish to consider if it makes sense to continue to tie the restoration to the MCO tax or to separate it and have it included as ongoing.

Questions.

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

2. Please provide an update on CCI and the UAT.

3. What is the implementation date for the UAT now?

4. Please describe the current thinking around the restoration of the seven percent for IHSS recipients.

Issue 7: Oversight – Fair Labor Standards Act (FLSA) Overtime Implementation

Governor's Proposal. The budget assumes FLSA regulations, as set forth under SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014, will begin on February 1, 2016, and provides $580 million ($270 million General Fund) in 2015-16, and $850 million ($393 million General Fund) in 2016-17, for the implementation of the federal requirements. The $850 million is allocated as follows:

- $475 million for FLSA regulations
- $366 million for FLSA compliance (medical accompaniment wait time, travel time, and mandatory provider training)
- $5 million for FLSA administration
- $4 million for the Case Management, Information and Payrolling System (CMIPS)

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

SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014, established a limit of 66 hours per week for IHSS providers based on the statutory maximum of 283 hours a month for IHSS recipients, and limited travel time for providers to seven hours a week. DSS or counties may terminate a provider in the event of persistent violations of overtime or travel limitations. The final rule was implemented in California effective February 1, 2016. There is a three month hold-harmless period until May 1, 2016, for IHSS providers as overtime changes take effect. During this period, providers will not accrue penalties if they violate the overtime and travel time limits, and county social workers can work with IHSS providers found violating the limits to ensure that they won't make the same mistakes when the grace period is over.

The Governor's budget estimates that 28 percent of providers typically work more than 40 hours per week, and that most of these providers generally work less than the new 66 hour per week cap.

Recently enacted policies. After the release of the 2016-17 budget, the department issued guidance to counties establishing two exemptions to the overtime cap to ensure continuity of care and allow IHSS recipients to remain safely in their own homes:

- **Exemption 1: Live-In Family Care Providers**. An exemption for providers with multiple live-in recipients includes providers who, as of January 31, 2016 are live-in family care providers (including, parent, grandparent, adoptive parent, step-parent or legal guardian), residing in the home for two or more disabled minor or adult children or grandchildren for whom they provide IHSS. The IHSS providers who meet these requirements will be able to work up to 90 hours per

work week, not to exceed 360 hours per month. This exemption is expected to apply to approximately 1,200 IHSS providers.

- **Exemption 2: Extraordinary Circumstances**. An exemption to the hour limitations is also available for providers who have extraordinary incurable circumstances who will be allowed to work beyond the recipient's maximum weekly hours or beyond the 66 hour limitation for two or more IHSS recipients. To be considered for Exemption 2, the provider must work for two or more IHSS recipients whose circumstances put them at serious risk of placement in out-of-home care. In order to qualify for Exemption 2, all recipients the provider works for must meet at least one of the following conditions:

    - Have complex medical and/or behavioral needs that must be met by a provider who lives in the same home as the recipient.
    - Live in a rural or remote area where available providers are limited and as a result the recipient is unable to hire another provider.
    - Be unable to hire a provider who speaks his/her same language in order to direct his/her own care.
    - The provider need not live in same home as the recipient(s) to qualify for Exemption 2 if the recipients meet conditions B and/or C above. Evaluation of cases to determine whether an exemption will be granted or denied will be conducted by CDSS and counties.

Recently, on April 8, 2016, the department issued a decision that the State will not terminate IHSS providers from the program if they fail to return the "IHSS Provider Enrollment Agreement" form by the April 15th deadline. However, this does not affect the notice and penalty procedures for IHSS program violations related to implementation of the FLSA regulations, which will still go into effect beginning May 1, 2016.

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

CDSS ADULT PROGRAMS DIVISION
OVERTIME (FLSA IMPLEMENTATION) TIMELINE

Completion Date	Milestone	State/County Activities
February 1, 2016	Implementation of overtime	**Implementation of FLSA requirements – SB 855 and SB 873 workweek and overtime provisions.** • CDSS released ACL 16-01 to provide counties with instructions, including the policies and procedures for implementation of the overtime, workweek requirements, (pursuant to SB 855 and SB 873). These included the revised forms and notices (including the workweek agreements for providers and recipients).
		Timesheets and Travel Claim Form - Timesheet (SOC 2261) and CMIPS modifications were made to accommodate the payment of overtime implemented on February 1, 2016 as well as claiming of travel time.
Feb 9, - Feb 26, 2016	Training Sessions	**Training-for-Trainer (T4T) sessions commenced February 9, 2016, and concluded February 26, 2016.** • CDSS conducted the training sessions statewide to approximately 320 trainers at the counties, Public Authorities (PAs), and labor organizations.
February 21, 2016	Overtime Exemption 1	**Overtime Exemption 1: Live-In Family Care Provider Overtime Exemption.** • CDSS released ACL 16-07 to provide counties with information for implementing Overtime Exemption 1. IHSS providers who want to qualify for Overtime Exemption 1 must submit the completed SOC 2279 to CDSS by April 1.
Currently in process	Overtime Exemption 2	**Overtime Exemption 2: Extraordinary Circumstances.** • CDSS is developing a second exemption to allow IHSS providers to work beyond a recipient's maximum weekly hours or beyond the 66-hour workweek limitation.
April 15, 2016	Forms and Workweek Agreements	**Deadline for completed forms SOC 846, SOC 2256 and SOC 2255 to be returned (completed) to counties for processing**
May 1, 2016	Violations	**Violations (Non-Compliance with Workweek and Overtime Requirements) -** Grace period ends. Violations for non-compliance with workweek and overtime requirements will be formally enforced beginning May 1, 2016.

Ongoing Implementation Monitoring. The department states that it will continue to provide training sessions and monthly data, and counties will provide technical assistance and coaching to providers on how to fill out time sheets properly. In addition, the department will provide data in quarterly reports starting six months after implementing the FLSA that will include data on the number of timesheets with overtime, the number of exemptions, payroll stats, etc. This is in addition to the requirement for a study that was included in SB 855.

Advocate Concerns. The IHSS Coalition is made up of 50 advocacy organizations, including the County Welfare Directors Association, California Association of Public Authorities, Disability Rights California, Service Employees International Union, and UDW/AFSCME. The Coalition has expressed that they have serious concerns over current FLSA implementation, and they have identified various concerns with the roll out of the FLSA provisions, including:

- Late and incomplete All County Letters/instructions make it extremely difficult for counties to implement FLSA. Without adequate instructions, counties and public authorities cannot plan for adequate staffing. Additionally, stakeholders note that they generally have little time to review or provide input on draft versions of All County Letters.

- Advocates are concerned that the violations policy doesn't appear to allow counties to reverse or rescind violations based on simple timesheet errors.

- The exemptions policy is late and falls short of meeting critical client needs. Specifically, the latest Exemption 2 policy was just recently issued on April 1st without stakeholder review. Advocates feel that the policy misses critical populations – those that are not living together but have a provider who is critical to providing that care.

- For Exemption 1, the Coalition is disappointed in the direction that DSS has opted to take to exclude providers who completed all enrollment requirements except that his or her CORI results were not received.

- The Coalition has further concerns on the implementation of the exemptions policy. For Exemption 1, counties discovered that not all of the potentially eligible Exemption 1 groups were properly noticed by DSS. This is because of how CMIPS identified providers. Counties will notice and reach out to those who were left out, but in the meantime DSS has given those parents to April 1st to apply. Advocates are concerned that this is too short of a timeline, and although DSS staff say they will continue to accept requests after April 1st, advocates do not know for how long.

- For Exemption 2, the biggest concern is that DSS refused to notice the potential eligible population, which leaves this responsibility to the counties and leaves eligible consumers and providers with no chance to get this exemption before violations start.

- The Waiver of Personal Care Services (WPCS) clients are also eligible for exemptions, but this is administered by DHCS which has yet to provide specific information on how to apply for an exemption. Those providers who provide WPCS and IHSS, with hours over 283 per month, will start receiving violation notices on May, and advocates do not know who will be able to remove violations from the CMIPS record.

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

- Cathy Senderling, CWDA
- Deborah Doctor, Disability Rights California
- SEIU Representative

Staff Comment. In considering implementation of overtime regulations, the Legislature may wish to consider the following:

- **Exemptions.** The Legislature may want to consider whether current exemptions policies are sufficient to ensure that these vulnerable populations are not negatively impacted by the caps, and decide whether the Governor's administrative approach is sufficient, or if a statutory change is needed.

- **Continued Monitoring of Implementation.** As implementation of FLSA goes into effect in California, the Legislature should continue to monitor how providers and recipients are faring under the new regulations and ensure that any unanticipated problems with implementation are addressed. Around the time of the May Revision, the three month "non-enforcement" period of workweek caps will expire. Specifically, the Legislature should monitor:

    - **Recipients.** Do recipients understand the workweek caps and how it may affect their providers and the care they receive? Are recipients receiving help to find additional providers, if needed? Are recipients still receiving all of the services they need?

    - **Providers.** Do providers understand the workweek caps and the consequences of exceeding the caps? Have providers received training on how to fill out their timesheets? Are providers receiving additional training once a violation has occurred? How is the violations policy impacting providers? Do providers know if they are eligible under the exemptions policies?

Questions.

1. Please provide an update on FLSA implementation.

2. Please summarize the two exemptions policies developed by the department, and efforts by the department to notify recipients of these exemptions. How many providers have applied for each type of exemption so far? What is the appeals process if the county denies an exemption?

3. Please describe the violations policy, and various stages in the process before a provider would be terminated. What preliminary data is the department seeing in terms of errors? Please discuss continued efforts to train providers.

4. Please clarify the state's policy regarding rescinding violations based on time sheet errors.

5. Does the department feel that providers and recipients, as well as counties and others involved, are ready to implement the violations policy as of May 1st?

6. How has the department responded as issues with implementation have arisen so far? How is the department involving stakeholders in discussions on how to handle bumps in implementation?

Staff Recommendation. Hold open.

Issue 8: Trailer Bill Language: Contract Mode Adjustments to Maintenance of Effort

Governor's Proposal. The Administration proposes to clarify in existing law that counties are responsible for paying the entire nonfederal share of any IHSS cost increase exceeding the maximum amount of the state's participation, and that the counties' share of these expenditures are included in the county IHSS MOE.

Background. Beginning July 1, 2012, all counties in California were required to have a county IHSS MOE, which would be in-lieu of paying the nonfederal share of IHSS costs. Statute specified that the county's IHSS MOE would be based on expenditures from FY 2011-12 and would be adjusted by an inflation factor of 3.5 percent annually, beginning July 1, 2014. In addition, the county IHSS MOE would be adjusted for the annualized costs of increases in provider wages and/or health benefits that were locally negotiated, mediated, or imposed prior to the Statewide Authority assumption of its responsibilities. If DSS approved a rate or benefit increase, the state would be responsible for 65 percent of the nonfederal share of the costs while the county would be responsible for the remaining 35 percent with a limit for the state up to $12.10 per hour for wages and health benefits.

The department notes that this proposal clarifies and affirms the intent of existing law that the increased costs to the contract mode are shared by the counties, consistent with the IHSS MOE.

Advocate concerns. The California State Associate of Counties (CSAC), the County Welfare Directors Association of California (CWDA), and the California Association of Public Authorities (CAPA) have concerns with the current way the TBL is drafted. They are not opposed to TBL that would clarify that the county IHSS MOE's should be increased for the county's share of contract provider wage or health benefit increases resulting from local negotiations, but feel that the proposed language is too broad.

Staff Comment and Recommendation. Hold open. The department indicates it is working with CWDA and others to address concerns that it is too broad, and a revision to the TBL is expected at May Revision.

Questions.

1. Please provide a summary of the proposal.

2. Please explain why the department finds it is necessary to clarify this in TBL.

Issue 9: Budget Change Proposal: In-Home Supportive Services (IHSS) Case Management, Information and Payrolling System (CMIPS) Maintenance and Operations (M&O)

Governor's Proposal. The Administration requests $232,000 ($117,000 General Fund) for two three-year limited-term Associate Governmental Program Analyst positions to address new and ongoing workload with the In-Home Supportive Services (IHSS) Case Management, Information and Payrolling System (CMIPS) to work on the Universal Assessment Tool (UAT).

Background. The UAT is a product of Assembly Bill (AB) 664 and will be implemented in FY 2016-17. Existing law requires the three main Home and Community Based Services (HCBS) programs (IHSS, Community-Based Adult Services (CBAS), and Multipurpose Senior Services Programs (MSSP)) to perform their own eligibility determinations and service assessments. AB 664 establishes the UAT to create a single HCBS assessment to record and improve care coordination and data collection between the HBCS programs. The department asserts that they will need the 2.0 AGPA positions for implementation of the UAT into CMIPS.

Staff Comment and Recommendation. Hold open. Given that the UAT is scheduled to implement in 2016-17, this request should be considered in light of the overall implementation picture for the UAT.

Questions.

1. Please summarize the proposal.

2. Please provide more detail on how the UAT will need CMIPS functionality, and what that will look like.

Issue 10: Proposals for Investment

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

- Simplification of IHSS FLSA Implementation

Budget Issue. The IHSS Coalition has proposed the following policy changes to address concerns they have with current FLSA implementation:

- Extend the grace period to September 1, 2016. Given the significant program changes and challenges in recruiting additional IHSS providers, advocates believe the grace period should be extended before consequences for violating overtime and travel time limits become effective to give additional time to make programmatic changes necessary to comply with FLSA. Advocates cite this as their top priority, and one that would be helpful to almost all other changes they are proposing.

- Ensure that consumers can continue to receive services to remain safely at home. The Coalition asserts that statutory protections are needed to allow for situations when a provider can work above the cap of 66 hours per week in certain situations, including (1) Providers who are the parent, step-parent, grandparent or legal guardian of two or more children, (2) Spouses, domestic partners, adult children caring for parents, adult siblings, and adult grandchildren when no other suitable provider is available; and (3) Individual consumer situations when there is no other suitable provider available, the recipient would be at risk of out-of-home placement, or the recipient's health or safety would be at risk.

- Align IHSS Authorized Hours with FLSA Policy. Current law requires a monthly authorization of hours, while FLSA requires consumers and providers to track their hours by the week. Advocates cite that now consumers have to take an additional step of converting back to a weekly amount, and that this extra step can easily lead to errors in calculation and violations that could end in termination. To address this issue, the Coalition suggests that the department (1) pay providers on a bi-weekly basis in 26 equal pay periods, (2) create equitable caps for IHSS providers, (3) authorize all IHSS tasks by the week, and (4) retain current flexibility in the IHSS program to move hours without having to contact the county to seek permission.

- Pay for Certain Services in Arrears to Align with FLSA. SB 855 allows travel time to be paid in arrears after the travel is incurred. This travel time is not taken from consumers' authorized hours, it is an addition. However, wait time is deducted from authorized hours. Advocates are concerned that this puts consumers with the highest need in jeopardy of providers not assisting them at medical appointments or doing so at the cost of other services. The Coalition would also like to see other, infrequently occurring services, such as yard hazard abatement or heavy cleaning, be paid in arrears along with wait time.

- Permit Waiver Clients to Access Public Authority Registry Services. This proposal would allow consumers of Waiver Personal Care Services to contract the registry to help them identify in-home providers.

Staff Comment and Recommendation. Hold Open.

- Restoration of the IHSS Share of Cost (SOC) Buy-Out.

Budget Issue. Disability Rights California (DRC) requests the restoration of the IHSS SOC buy-out. DRC cites that the 2009 repeal of the IHSS SOC buy-out left some IHSS consumers, who have income above the SSI amount (currently $889.40 for an individual) with substantially less than the SSI level income to live on. To receive IHSS, they must spend down to $600, the Medically Needy amount. This leaves them more at-risk for institutionalization.

Background. The IHSS SOC Buy-Out program was eliminated as part of the 2009-10 budget. Now, IHSS recipients who have no alternative route to Medi-Cal have to meet the higher Medi-Cal SOC on their own before the IHSS program pays for the remaining costs of their services.

Staff Comment and Recommendation. Hold Open.

- CMIPS II Reprogramming for Additional Hours in the CCI

Budget Issue. UDW/AFSCME and several other organizations, including the California Association of Public Authorities for IHSS, Congress of California Seniors, and Disability Rights California request the reprogramming of the Case Management, Information and Payrolling System (CMIPS II) to allow manage care plans to pay IHSS providers for additional hours authorized through the Coordinated Care Initiative (CCI).

Background. The CCI statute includes the provision for managed care plans providing services in CCI to authorize and pay for extra homecare services beyond what an IHSS social worker has authorized for a consumer enrolled in CCI. However, managed care plans are prohibited by statute from paying an individual provider of homecare services directly. Currently, there is no mechanism in statute to pay an individual provider to provide these extra homecare services that are authorized and funded by the managed care plans.

Staff Comment and Recommendation. Hold Open.

- Seven Percent Restoration

Budget Issue. AFSCME, UDW and others request that the seven percent cut be permanently restored, regardless of funding source.

Staff Comment and Recommendation. Hold Open.

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

Issue 11: Overview – Community Care Licensing

Background. The Community Care Licensing (CCL) Division in the Department of Social Services (DSS) oversees the licensure or certification of approximately 66,000 licensed community care facilities that include child care, children's residential, adult and senior care facilities, and home care services. CCL is responsible for protecting the health and safety of individuals served by those facilities. Approximately 516 licensing analysts investigates any complaints lodged, and for conduct inspections of the facilities. The table below indicates facilities licensed by CCL.

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

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

Background Checks. Applicants, licensees, adult residents, and employees of community care facilities who have client contact must receive a criminal background check. An individual submits fingerprint imaging to the California Department of Justice (DOJ). The Caregiver Background Check Bureau, within CCL, processes and monitors background checks. If an individual has no criminal history, DOJ will forward a clearance notice to the applicant or licensee and to the Caregiver Background Check Bureau 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.

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

DSS conducts pre- and post-licensing inspections for new facilities and unannounced visits to licensed facilities under a statutorily required timeframe. Currently, the department must visit all facilities at least once every five years with an additional random sample of 30 percent of facilities each year.

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

CCL Inspections in All Facilities By Type of Inspection and Protocol Fiscal Year 2014-15			
Type of Inspection	**Total of Inspections**	**Percentage of inspections utilized the Key Indicator Tool (KIT)**	**Percentage of inspections that utilized the KIT triggered a comprehensive inspection**
Annual Required Inspection	5,230	4,601 (88.0%)	332 (7.2%)
Random Inspection	22,140	21,322 (96.3%)	983 (4.6%)
Required Five-Yr. Visit	1,029	919 (89.3%)	134 (14.6%)

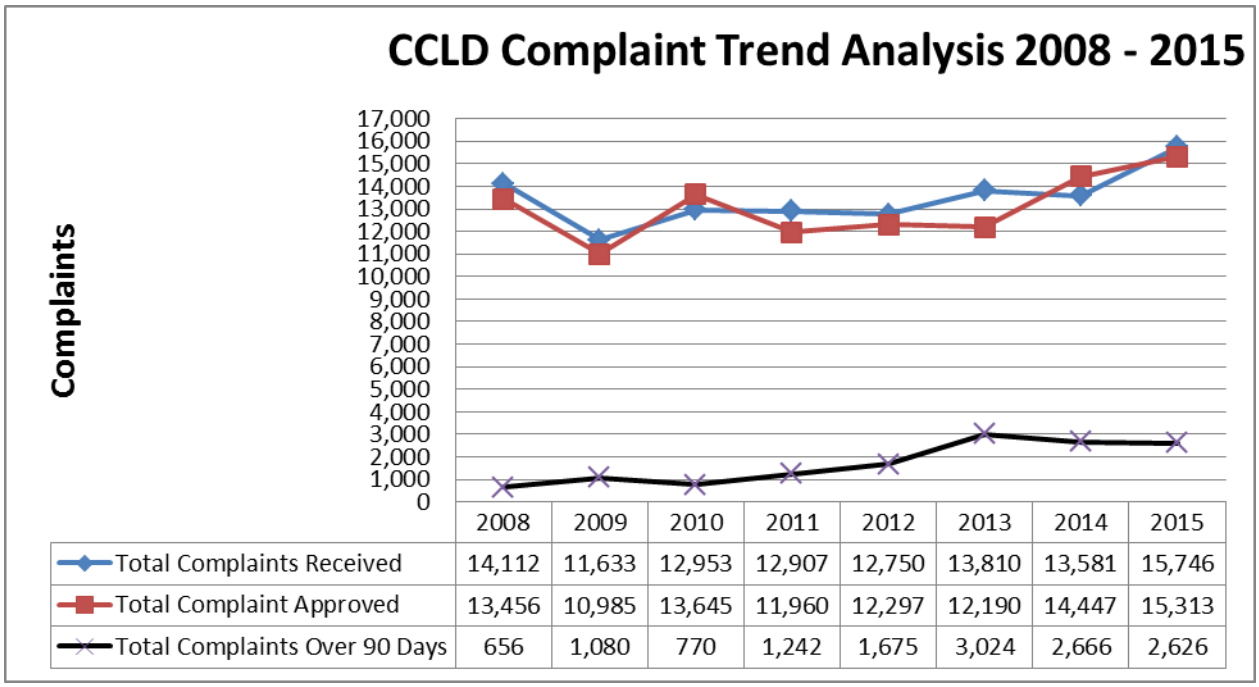
Key Indicator Tool. After various changes in 2003, and because of other personnel reductions,[6] CCL fell behind in meeting the visitation frequency requirements. In response, DSS designed and implemented the key indicator tool (KIT), which is a shortened version of CCL's comprehensive licensing inspection instruction, for all of its licensed programs. The KIT complements, but does not replace, existing licensing requirements. A KIT measures compliance with a small number of rules, such as inspection review categories and facility administration and records review, which is then used to predict the likelihood of compliance with other rules. Some facilities, such as facilities on probation, those pending administration action, or those under a noncompliance plan, are ineligible for a key indicator inspection and will receive an unannounced comprehensive health and safety compliance inspection.

CCL contracted, until December 31, 2014, with the California State University, Sacramento, Institute of Social Research (CSUS, ISR) to provide an analysis and recommendations regarding the development and refinement of the KIT. CSUS, ISR is currently reviewing and analyzing four years of licensing data, both pre and post KIT implementation. However, due to the unforeseen data clean-up and the narrative basis of the data, the project's approach is currently being re-examined.

Complaints. Complaints are handled at regional offices. Licensing analysts, who would otherwise be conducting inspections, stay in the regional office two times a month, to receive complaint calls and address general inquiries and requests to verify licensing status from the public. CCL is required to respond to complaints within 10 days. During calendar year 2015, CCL received 15,746 complaints and initiated 15,557 (99 percent) of these investigations within ten days of receipt. The information below provides an analysis of DSS' complaint activity for the years of 2008 through 2015.

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

COMMUNITY CARE LICENSING DIVISION COMPLAINT ANALYSIS 2008 - 2015								
Year	Total Complaints Rolled Over From Prior Year(s)	Total Complaints Received	Total Complaints Received + Prior Year(s) Rollover	Total Complaint Approved	Current Year Net Loss/gain	Total Complaints Over 90 Days	Total Furlough Days	Authorized Positions*
2008		14,112			2,456	656		589.9
2009	2,456	11,633	14,089	10,985	3,104	1,080	2 - 3 days	515.4
2010	3,104	12,953	16,057	13,645	2,412	770	1 - 3 days	513.4
2011	2,412	12,907	15,319	11,960	3,359	1,242	0 - 1 days.	514.9
2012	3,359	12,750	16,109	12,297	3,812	1,675	0 - 1 days.	491.9
2013	3,812	13,810	17,622	12,190	**5,432**	**3,024**	0 - 1 days.	491.3
2014	5,432	13,581	19,013	14,447	4,566	2,666		501.8**
2015	4,566	15,746	20,312	15,313	4,999	2,626		516.8**
Bolded numbers represent highest complaint rollover to next year and total complaints over 90 days				*Positions include Complaint Specialists **The 516.8 does not include the 20.5 LPA positions allocated to the Central Complaint and Information Bureau (CCIB) in 2015 and the 501.80 does not include 19 positions allocated to CCIB in 2014.			Hiring Freeze 2/11 - 12/11	



Licensing fees and penalties. Licensed facilities must pay an application fee and an annual fee, which is set in statute. The revenue from these fees is used to partially offset the cost of CCL enforcement and oversight activities. In addition to these annual fees, facilities are assessed civil penalties if they are found to have committed a licensing violation. Civil penalties assessed on licensed facilities are deposited into the Technical Assistance Fund, and are required to be used by the department for technical assistance, training, and education of licensees.

Budget actions. In 2014-15, the budget included $7.5 million ($5.8 million GF) and 71.5 positions for quality enhancement and program improvement measures. The additional positions and resources seek

to improve the timeliness of investigations; help to ensure the CCL Division inspects all licensed residential facilities at least once every five years, as statutorily required; increase staff training; establish clear fiscal, program, and corporate accountability; develop resources for populations with medical and mental health needs; and update facility fees. In 2015-16, the budget included an increase of 28.5 positions (13 two-year limited-term positions) and $3 million General Fund in 2015-16 to hire and begin training staff in preparation for an increase in the frequency of inspections for all facility types beginning in 2016-17. The adopted proposal increased the frequency of inspections from at least once every five years to at least once every three years or more frequently depending on facility type. These reforms go into effect incrementally through 2018-19. Below is a table showing the ramp up of inspections by facility type:

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

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

As of March 22, 2016, all positions authorized in the FY in 2014-15 have been filled and for FY 2015-16, 86 percent of positions are filled. The CCL division has utilized these additional resources to strengthen the infrastructure by implementing many programs which have enhanced best practices, improved resources for licensees and implemented several programs identified below:

- **Quality Assurance Unit.** CDSS has implemented a Quality Assurance unit that has developed and implemented performance dashboards for Adult and Senior Care, Child Care and dashboards are currently being developed for Children's Residential programs. These reports will also be developed for pending complaints and applications, fieldwork efficiencies and timely completion of key workloads. The unit has also produced documentation of various types of facilities which informs the priority of resource guides for licensees developed in the Technical Assistance Unit. This unit also developed and implemented a High Risk Facility Analysis, including in-depth case history reviews for over 1,500 individual facilities from all programs that met the criteria for designation as a high risk facility and a database for ongoing monitoring of facilities identified as High Risk. These analyses complement the current monitoring and tracking for oversight of challenged facilities.

- **Technical Assistance Unit.** This unit has re-instituted provider consultation visits. Working from referrals from Regional Offices, this unit works under an agreement with the provider to identify options for issues of non-compliance. Technical assistance may include an evaluation of

the facility, targeted training, sharing of best practices and/or directives; or the identification of grant opportunities to mitigate physical plant issues. This unit has recently published several Resource Guides including medications management (including psychotropic medications), and various others are under development. Upon completion, these Guides are posted on the CDSS website available to licensees and utilized for plans of corrections.

- **Centralized Complaint and Information Bureau.** This bureau was initiated in January 2015 with a staff of 23 to centralize all complaints into a single call center. The call center handles complaints statewide as well facility informational calls. In relation to the call center, the department has developed and widely disseminated toll free phone number that is posted in RCFEs across the state and available to all Community Care Facilities. Between January 2015 and March 2016, the call center has responded to approximately 81,000 calls.

- **Centralized Applications Unit.** This unit was established in May 2015 with 11 staff to process all new Adult and Senior Care applications, as well as monitoring the backlog of previously pending applications throughout the state. This unit was established to closely track the influx of applications and to provide greater statewide consistency.

- **Clinical Expertise.** With the addition of Registered Nurses in the Adult and Senior Care Program, clinical support (previously utilized through contract staff) can be immediately addressed. With immediate clinical knowledge, skills and experience it has enhanced the program's ability to quickly address quality of care of residents, address poor performing facilities, and educate struggling operators.

- **Readiness to move to Stage I of Increased Frequency of Visits.** Administrative positions established have been critical in preparations to initiate the January 1, 2017 State 1 increase in visit protocol. The establishment of the Southern California training unit and expansion of the LPA academy is meant to ensure that staff have the knowledge, skills and competencies in advance of January 1, 2017 implementation date.

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

Questions.

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

2. When can the Legislature expect to see a report on whether the KIT has been successful and accurate in identifying compliance?

Issue 12: Budget Change Proposal: CCL Random Inspections (Technical Fix)

Governor's Proposal. The Administration requests resources to perform annual random inspections required by the Human Services Omnibus Trailer Bill, Senate Bill (SB) 79 (Chapter 20, Statutes of 2015). Specifically, the Administration requests $2.3 million General Fund for 20 positions (two Licensing Program Manager I, 14 Licensing Program Analysts, and four Office Assistants - Typing). This proposal corrects DSS's FY 2015-16 Budget Change Proposal (BCP).

Background. SB 79 increased DSS's inspection protocol to conduct annual random inspections of 30 percent of licensed facilities, with all licensed facilities inspected no less than at least once every three years. The FY 2015-16 BCP included resources for the improvement of the regulatory oversight of Community Care Licensing facilities throughout the state, but inadvertently omitted the staffing resources necessary to perform the annual random inspections required.

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

Questions.

1. Please summarize the proposal.

Issue 13: Budget Change Proposal: Caregiver Background Check: Arrest Only Workload

Governor's Proposal. The Administration requests $892,000 ($816,000 GF) for 5.0 positions to continue reviewing, investigating, and processing criminal record clearances for individuals with an arrest record seeking licensure, employment, or presence in a licensed community care facility. Specifically, the positions requested are three Attorney IIIs and two Senior Legal Analysts.

Background. California Criminal History and Federal Bureau of Investigation checks are required for licensed caregivers, their employees, specified volunteers and non-client adults residing in a facility. When an individual has a criminal history that contains arrest-only information, DSS is required to conduct an investigation. Assembly Bill 2632 (Chapter 824, Statues of 2014) codified a revised process which prohibits DSS from issuing a criminal record clearance prior to conducting an investigation for cases involving only an arrest.

The department asserts that initially they were able to absorb the workload but can no longer sustain the current level of workload without additional legal resources.

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

Questions.

1. Please summarize the proposal.

Issue 14: Budget Change Proposal: Home Care Services Consumer Protection Act (AB 1217)

Governor's Proposal. The Administration requests $1.0 million General Fund loan to implement licensing and registration activities required by the Home Care Services Consumer Protection Act (AB 1217, Lowenthal, Chapter 790, Statutes of 2013). These resources would fund 6.5 permanent positions in the Administration Division and the Community Care Licensing Division, and two-year limited term funding for one position in the Legal Division, specifically:

- 1.0 Accounting Administrator I, Specialist
- 1.0 Senior Accounting Officer, Specialist
- 1.0 Account Clerk II
- 0.5 Mailing Machines Operator I
- 2.0 Investigators
- 1.0 Special Investigator Assistant (non-peace officer)
- 1.0 Attorney III

Background. Prior to AB 1217, Home Care Organizations (HCOs) were not required to be licensed and Home Care Aides (HCAs) were not required to meet any minimum qualifications or screenings. Beginning January 1, 2016, AB 1217 requires DSS to regulate HCOs and provides for background checks and a registry for affiliated HCAs, as well as independent HCAs who wish to be listed on the registry. An approved FY 2105-16 BCP provided additional resources for DSS based on the projection of approximately 2,000 HCOs and 70,000 HCAs in the state that would be subject to fees under this bill. The department has now revised the projection to approximately 3,000 HCOs and 100,000 HCAs.

The department notes that the requested general fund loans for AB 1217 will be repaid with fee revenues from HCOs and HCAs.

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

Questions.

1. Please summarize the proposal.

2. Please explain the change in projected growth since last year's approved BCP. What information has prompted DSS to revise its estimates?

Issue 15: Budget Change Proposal: Community Care Licensing Complaints and Appeals Process (AB 1387) and Residential Care Facility for the Elderly Ownership Disclosure (AB 1387)

Governor's Proposal. The Administration requests $273,000 General Fund for two positions to meet the requirements of AB 601, and $341,000 General Fund to support three Associate Governmental Program Analysts (AGPAs) for another two years, starting July 1, 2017. Currently the three AGPAs are two-year limited-term and expire June 30, 2017.

Background. AB 601 (Chapter 628, Statutes of 2015), requires potential Residential Care Facilities for the Elderly (RCFE) licensees to fully disclose previous ownership/partnerships and compliance with regulations in any type of facility anywhere in the United States. DSS is additionally required to cross-check owner/licensee information with the California Department of Public Health (DPH). This will result in an increase in workload to cross-check information with DPH and compile and analyze additional information provided by RCFE applicants. There are approximately 7,500 licensed RCFEs which will be disclosing ownership and related information combined with a projected 1,200 new RCFE applications expected to be received.

AB 1387 (Chapter 486, Statutes of 2015), restructures the process by which licensees of facilities licensed by DSS may appeal the assessment of a civil penalty or deficiency. The requested funding will support staff who is currently working to develop regulations, update various manuals, communicate with the public, and develop and deliver training related to these changes. DSS initially anticipated this workload to last only two years, but now feel the workload may last another two years.

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

Questions.

1. Please summarize the proposal.

2. Why were the positions for AB 1387 initially approved as two-year limited-term? Please clarify why the workload for these positions has now been extended for another two years.

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

Issue 16: Overview – Adult Protective Services

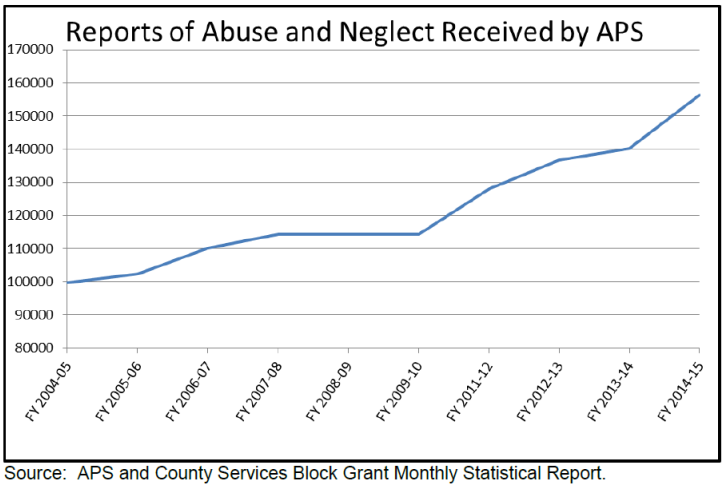
Background. Each of California's 58 counties has an APS agency to help adults aged 65 years and older and dependent adults when adults are unable to meet their needs, or are victims of abuse, neglect, or exploitation. The APS program provides 24/7 emergency response to reports of abuse and neglect of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

Realignment. In 2011, Governor Brown and the Legislature realigned several programs, including child welfare and adult protective services, and shifted program and fiscal responsibility for non-federal costs to California's 58 counties.[7] The Department of Social Services, (DSS) retains program oversight and regulatory and policy making responsibilities for the program, including statewide training of APS workers to ensure consistency. DSS also serves as the agency for federal funding and administration.

Training. Currently, $176,000 ($88,000 General Fund) is allocated to DSS for statewide Adult Protective Services (APS) training. Funding for statewide APS training has not increased in the past 11 years, even as APS reports statewide have risen by 90 percent between 2000-01 and 2014-15.

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

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



Source: APS and County Services Block Grant Monthly Statistical Report.

The 2014 Budget Act included $150,000 in funding for one staffing position within the Department of Social Services to assist with APS coordination and training. In 2015, trailer bill language was adopted that codified that the responsibilities of this staff person include engagement with county APS and other elder and dependent adult justice stakeholders to develop policies and guidelines that support local APS programs in meeting existing mandates, respond to opportunities to build APS infrastructure and expand resources and promote optimal outcomes for seniors and dependent adults.

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

Questions.

1. Please briefly summarize the program and services.

Issue 17: Proposal for Investment

The subcommittee has received the following proposal for investment.

- Adult Protective Services Training Dollars

Budget Issue. The California Commission on Aging, California Justice Coalition, and California Welfare Directors Association request an increase of $5 million General Fund to create a statewide Adult Protective Services (APS) training program for all new APS staff, for supervisor training, and for advance training related to new policy and emerging trends. Advocates note that the level of funding would ensure access to mandated training for mandated reporters, such as physicians and public safety personnel, and training coordination with public guardians, conservators, and administrators.

Background. DSS currently contracts with local universities to deliver training. Currently, $176,000 ($88,000 General Fund) is allocated to DSS for statewide APS training. According to the California Welfare Directors Association, APS funding levels have not been increased for the past 11 years, despite APS caseload increasing by 35 percent between 2001 and 2013 throughout California.

Staff Comment and Recommendation. Hold open.

5180 – DEPARTMENT OF SOCIAL SERVICES – OTHER SPRING FINANCE LETTERS

Issue 18: Spring Finance Letter: Transfer of Commodity Supplemental Food Program

Governor's Proposal. The Administration requests the transfer of one permanent Associate Governmental Program Analyst (AGPA) position and the associated funding from the California Department of Education (CDE) effective July 1, 2016. This position is federally-funded and will support the Commodity Supplemental Food Program (CSFP), which will transfer from CDE to DSS on October 1, 2016.

Background. The CSFP is a United States Department of Agriculture (USDA) program currently administered by CDE through six local food banks. The program was originally designed to improve the health of low-income seniors, women, infants, and children by supplementing their diets with USDA approved foods.

In February 2014, the Agricultural Act of 2014, known as the Farm Bill, was signed into law and amended eligibility requirements of the CSFP. Due to this amendment, state and local agencies began phasing out the participation of women, infants, and children in the CSFP and transitioning it to a low-income, seniors only program. As a result, the CSFP no longer fits into the CDE's mission and fits in better with the mission of DSS. DSS already administers the federal emergency food assistance program (TEFAP), and has agreements with 48 local food banks, including five of the six served by the CSFP.

The department notes that the requested position is federally funded and that this is a General Fund neutral request. The CDE has agreed to this transfer of funding, position, and responsibilities.

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

Questions.

1. Please summarize the proposal.

Issue 19: Spring Finance Letter: Title IV-E California Well-Being Project Budget Bill Language

Governor's Proposal. The Administration requests that language be added to Items 5180-101-0001 and 5180-153-0001 to authorize the expenditure authority between these items to appropriately align funding between counties based on participation in the federal Title IV-E California Well-Being Project. The language is as follows:

"Add Budget Bill language authorizing the Department of Finance to transfer General Fund between Items 5180-101-0001 and 5180-153-0001 to appropriately align funding between Title IV-E Waiver participating counties and nonparticipating counties."

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

Questions.

1. Please summarize the proposal.

2. Please provide additional detail as to why this budget bill language is necessary.

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

Issue 1: Budget Change Proposal: Case Management, Information and Payrolling System (CMPIS II)

Governor's Proposal. The Administration requests a budget year increase of $4.8 million in the OSI spending authority and one permanent position for the CMIPS II project and a corresponding increase of $8.7 million in DSS Local Assistance budget authority. $4.8 million is requested for staffing and annual base operations costs to address workload increases, and $3.9 million is requested to fund data center services.

Background. CMIPS II project costs have increased substantially in the current year due to schedule shifts, a delay in implementing changes related to the Federal Fair Labor Standards Act and workload increases in base operational costs. The CMIPS II project is transitioning into the M&O phase, which will require the procurement of a new systems integrator and begin a new phase that requires the support of experienced counsel. This BCP requests resources to establish an Attorney II position and the corresponding Operating Expense and Equipment (OE&E) for this position. OSI does not currently have sufficient legal resources to meet increased demand. $4.6 million of this proposal is needed for adjustments to prime vendor services, and $3.9 million is needed for data center services to support increased capacity requirements, IHSS caseload growth, and the impact from current legislative changes.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please summarize the proposal.

2. Please provide more information on what the adjustments to prime vendor services costs are.

Issue 2: Spring Finance Letter: County Expense Claim Reporting Information System (CECRIS)

Governor's Proposal. The Administration requests $291,000 ($115,000 General Fund) for three positions (two System Software Specialist IIs and one Associate Information Systems Analyst) to support the CECRIS System as it replaces the County Expense Claim (CEC) and the Assistance Claim (CA 800) systems. OSI also requests funding for the permanent reestablishment with limited-term funding of a Senior Information Systems Analyst that was approved in a 2014-15 BCP for CECRIS.

Background. The CECRIS will also allow the Department to capture all county level expenditures (state, federal, and county funds) in a single system which will result in improved data reporting capabilities.

DSS received approval of Special Project Report (SPR) 1 in February 2012 for the CECRIS project, but subsequent analysis projected a significant increase in both schedule and cost. In December 2014, the project was suspended to allow DSS an opportunity to re-evaluate the proposed solution in order to move forward with the project. The resulting new proposed solution in SPR 2 is meant to be more cost-effective and efficient. During the SPR 2 process, a gap was identified in internal resources for the project. Below are two charts provided by the department that show how the SPRs for CECRIS have changed.

Major Milestones	SPR 1 Completion Dates	SPR 2 Completion Dates	Months Extended
Project Management Plans Updated	10/2014	4/18/2016	18
Implementation Advanced Planning Document Approval	None	5/2016	N/A
Procurement – Solution Vendor (SV)	10/2014	9/2016	23
To-Be End-To-End Process Analysis/Requirements	10/2014	10/2016	24
System Design	5/2015	4/2017	23
System Development	12/2015	3/2018	27
Testing (Integration & User Acceptance)[1]	9/2016	8/2018	23
Rollout	11/2016	1/2019	26
Project Close Out Artifacts	1/12/2017	3/21/2019	26
Post Implementation Evaluation Report	5/2017	6/2020	37

[1] Security functionalities will be tested and validated by CDSS staff or a non-SI vendor.

Cost	SPR 1	SPR 2 Current
Procurement Method	RFP	MSA / RFO
Solution Vendor	$3,570,400	$2,345,600
Solution Vendor Contingency		$231,840
OCM	$0	$427,800
Financial Systems Auditor	$0	$455,800
IPOC	0	$422,100
IV&V	$312,000	$453,250
Other Contracts	$679,190	$529,028
Software/Licenses	$0	(one-time) $292,094 (continuing) $129,708
Hardware	$0	$9,910
BCP Staff and Overhead	$0	$1,394,000
"new" Funding	$4,561,590	$6,691,130
Existing Staff and Overhead	$3,179,004	$3,891,963
TOTAL PROJECT COST	$7,740,594	$10,583,093

The department notes that these workloads are critical to the successful development and implementation of CECRIS that supports $14 billion in assistance and administrative costs for 58 counties.

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

Questions.

1. Please summarize the proposal.

4170 DEPARTMENT OF AGING (CDA)

Issue 1: Overview

With a proposed 2016-17 budget of $201.6 million ($33.7 million General Fund), the California Department of Aging (CDA) administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State. The department is the federally-designated State Unit on Aging, and administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program.

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

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

Overview of Programs.

Senior Nutrition. Provides nutritionally-balanced meals, nutrition education and nutrition counseling to individuals 60 years of age or older at congregate meal sites or for those who are homebound due to illness, disability or isolation, at home.

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

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

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

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

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

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

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

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

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

- Ombudsman Funding Changes. All General Fund local assistance funding for the Ombudsman program was eliminated during FY 2008-09. Between FY 2009-10 and FY 2011-12, several one-time appropriations and funding solutions were utilized to partially backfill lost General Fund and federal Citation Penalties Account monies. In 2012-13 and 2013-14, the implementation of federal sequestration reduced federal Ombudsman funding by about $0.2 million. Local Assistance funding for Ombudsman, currently amounts $6.3 million includes federal and state funds from the Skilled Nursing Facility Quality Assurance Fund and the state Citation Penalties Account funds. According to the department, this is $2.3 million lower than the 2008-09 funding level.

- General Fund. Between FY 2007-08 and FY 2011-12, the department's budget was reduced by approximately $30.1 million General Fund. This includes reduced state local assistance funding for Community Based Services, Supportive Services, Ombudsman and Elder Abuse Prevention, Senior Community Employment, and a reduction in MSSP funding. Please see the chart on the following page.

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

- Chronic Disease Self-Management Demonstration Grant. Through this competitive federal grant, CDA has collaborated with CDPH and Partners in Care Foundation to make the Chronic Disease Self-Management Program available to older and younger adults with chronic health conditions. This six week evidence-based workshop empowers participants to make important behavioral changes to improve their health and wellbeing. Area Agencies on Aging and health departments in Los Angeles, Orange, Napa, San Diego, and Solano counties are among the funded counties. The total grant funding was $1.5 million over four state fiscal years. California has led the nation in this effort with 1,277 workshops conducted and 16,221 adults with chronic health conditions benefiting from these programs.

- Expanding Capacity to Serve Persons with Dementia in the Coordinated Care Initiative. Through this federal grant, CDA has partnered with the Department of Health Care Services, Alzheimers/Greater LA and the Alzheimer's Association Chapter in Northern California, and participating managed care plans to provide training and technical assistance to Cal MediConnect care managers focused on increasing their ability to successfully identify and serve plan members with dementia and refer these individuals and family caregivers to community-based services. Total grant funding was $820,000 over 4 state fiscal years. While the grant officially ends August 31, 2016, the department has met and exceeded all of the performance measures with over 260 care managers from seven health plans trained and 500 family caregivers receiving dementia education and support.

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

Questions.

1. Please provide an overview of the department’s programs and services.

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

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

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

MSSP as Part of the Coordinated Care Initiative. Under California's Coordinated Care Initiative (CCI), most Medi-Cal beneficiaries in CCI counties must be enrolled in a participating Medi-Cal managed care health plan to receive their Medi-Cal benefits, including MSSP. This requirement applies unless the individual lives outside the managed care health plan's covered service area, is awaiting enrollment into a managed care health plan, or is exempt from managed care health plan enrollment. MSSP sites that provide concurrent waiver services in a CCI county have entered into agreements with participating managed care health plans to deliver MSSP waiver services to eligible plan members. MSSP sites serving non-CCI counties continue to deliver MSSP services as a Medi-Cal fee-for-service benefit.

In the CCI counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara), MSSP continues to be a 1915(c) HCBS waiver benefit until it transitions to being a fully integrated managed care health plan benefit that is administered and authorized by the plan. In San Mateo County, this transition occurred on October 31, 2015. In the remaining six CCI counties, this transition must occur no later than December 31, 2017. Full transition of MSSP into managed care in the remaining six CCI counties will affect 12 MSSP sites and approximately 4,856 participants.

CDA is working closely with the Department of Health Care Services (DHCS), MSSP sites, and Medi-Cal managed care health plans to address operational issues associated with providing MSSP waiver services through managed care and prepare for MSSP's transition to a fully integrated managed care plan benefit in CCI counties.

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

Questions.

1. Please provide a brief overview of the MSSP program.

Issue 3: Budget Change Proposal: CBAS Additional Staffing for Mandate Compliance

Governor's Proposal. The Administration requests $705,000 ($319,000 General Fund and $386,000 in Reimbursements from the Department of Health Care Services (DHCS)) for its CBAS Branch to support four additional positions (three Associate Governmental Program Analysts (AGPA) and one Nurse Evaluator II (NE II)) to ensure compliance with current state Medi-Cal program requirements for CBAS provider certification, as well as new federal requirements under California's 1115 Bridge to Reform (BTR) Waiver, the Affordable Care Act (ACA), and the Home and Community-Based Services (HCBS) Settings Rule.

Background. The CBAS program provides skilled nursing care, social services, therapies, personal care, meals, and transportation at outpatient facilities to eligible seniors and adults with disabilities under the BTR waiver. Currently, there are 241 CBAS centers statewide serving approximately 32,000 Medi-Cal participants.

The department notes that since the Adult Day Health Care Program transitioned to the CBAS Program three years ago, the CBAS branch has been unable to fully meet its statutory mandate to perform provider onsite certification renewal surveys every two years. Staffing reductions in FY 2012-13, coupled with the fact that projected significant decreases in the program size did not occur, and added federal requirements, have left the CBAS branch with a backlog and is potentially at risk for federal sanctions.

Staff Comment. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please summarize the proposal

2. Please provide more specific information on the backlog/developing backlog.

Staff Recommendation. Approve.

Issue 4: Budget Change Proposal: CDA Information Technology Branch Staffing

Governor's Proposal. The Administration requests authority for three permanent positions, using $423,000 in existing expenditure authority for its Information Technology Branch. This request will be funded using a combination of existing CDA funding sources including Older Americans Act federal funds and Medi-Cal (General Fund and FFP).

FUND SOURCES	
GENERAL FUND	$154,000.00
FEDERAL FUND (OAA)	$102,000.00
REIMBURSEMENT FROM MEDI-CAL (FFP)	$149,000.00
REIMBURSEMENT FROM OTHER PROGRAMS	$14,000.00
SPECIAL FUNDS	$4,000.00
TOTAL	**$423,000.00**

The department notes that its IT Branch has been minimally staffed over the years and has never been augmented to keep up with workload associated with major technological changes, especially in the area of security-related requirements and reporting to control agencies. At the same time, budget cuts have resulted in the loss of IT resources and positions.

Background. CDA administers funds allocated under the federal Older Americans Act and the Older Californians Act and through the Medi-Cal program. CDA contracts with a statewide network of 33 Area Agencies on Aging, who directly manage a wide array of federal and state-funded services and supports for older and disabled individuals. Through an interagency agreement with the Department of Health Care Services (DHCS), CDA also administers the Multipurpose Senior Services Program (MSSP) and certified Adult Day Health Care (ADHC) centers as Medi-Cal Community-Based Adult Services Program (CBAS) providers. All of these programs, and particularly CBAS, require the services of a fully functioning IT branch, and new federal requirements relating to the Affordable Care Act (ACA) Provider Enrollment Screening, the CMS Home and Community-Based Settings (HCBS) Regulations, and the updated 1115 Waiver, will significantly increase the need for IT support in the Medi-Cal Branch.

At CDA, seven IT Branch staff provides the full range of services to 117 CDA staff. Departments of comparable size have approximately 15 positions.

Staff Comment. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please summarize the proposal.

Staff Recommendation. Approve.

Issue 5: Proposals for Investment

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

- Elder Economic Security Index

Budget Issue. The California Association of Area Agencies on Aging (C4A) requests $50,000 to update the Elder Index.

Background. The Elder Index was established in California state law in AB 138 (Beall, Chapter 669, Statutes of 2011) which requires CDA to use the Elder Index for each service area in its state plan and use it as a reference when making decisions about allocating its existing resources. While the development phase of the Elder Index is now complete, there is no funding for the annual updating of the amounts by county to fulfill the needs of CDA.

Staff Comment and Recommendation. Hold open.

- MSSP Rates

Budget Issue. The MSSP Site Association requests a rate increase of $4 million General Fund. When matched with federal funds, the per-slot rate would increase from $4,285 to $5,142 per year.

Background. The MSSP is a complex case management program for Medi-Cal seniors 65 and older who are certified eligible for skilled nursing placement and require specialized medical and social support services. In its over 30 years, MSSP has received just two cost-of-living adjustments (in 2000 and 2006) followed by funding cuts in 2008 and 2011 due to state budget deficits. MSSP providers cannot make up for program deficits by increasing or decreasing the number of people they serve, reducing program costs, or serving private pay consumers. Advocates cite the closure and turnover of nine sites since 2008 due to funding cuts. Additionally, the costs to do business have increased each year, further making the current rate inadequate.

Staff Comment and Recommendation. Hold open.

- Long-Term Care Ombudsman Funding

Budget Issue. The California Long-Term Care Ombudsman Association (CLTCOA) requests $3.6 million General Fund. This additional funding will enable the program to conduct unannounced monitoring visits to all long-term care facilities in California; recruit, supervise, and train volunteer Ombudsmen; and investigate more complaints per year.

Background. LTCOP is mandated through state and federal law to protect residents' rights and ensure that residents are treated with respect and dignity. Complaints identified by Ombudsmen are often the precursors to more severe cases of abuse and neglect. LTCOPs use certified volunteers in addition to paid staff. In 2008, $3.8 million in General Fund was eliminated for local LTCOPs. Since the cuts to their budget, the local LTCOPs have had to reduce operating hours, scale back services, and greatly

reduce the number of long-term care facilities visited. There were 5,206 facilities in California that did not receive regular quarterly visits from an ombudsman in 2014-15.

Staff Comment and Recommendation. Hold open.

- Senior Nutrition Program

Budget Issue. The California Commission on Aging, the California Association of Area Agencies on Aging, and the Congress of California Seniors request $5.4 million General Fund to augment existing senior nutrition programs. Area Agencies on Aging operate these programs, including Congregate Mealsites and Home-delivered Meals (known as Meals on Wheels).

Staff Comment and Recommendation. Hold open.

- California Senior Legislature

Budget Issue. The California Senior Legislature (CSL) requests $500,000 General Fund to continue its advocacy efforts for seniors.

Background. The CSL was founded in 1980 as a forum for older Californians to develop legislative priorities. Senior representatives are selected from each of the 33 Area Agencies on Aging, and they hold a model legislative session where the top-ten state proposals and top four federal priorities are taken to state and federal legislators.

The CSL is funded through a tax check-off. However, due to issues such as the recession, contributions have been reduced considerably. The 2016-17 Governor's budget assumes that the current fund will yield $320,000 and that this will fund the 1.2 positions provided to the CSL.

Staff Comment and Recommendation. Hold open.

Additionally, advocates have indicated that the following proposal should be considered:

- Include $4 million General Fund for Alzheimer's Day Care Resource Centers

4700 COMMUNITY SERVICES AND DEVELOPMENT (CSD)

Issue 1: Overview

The Department of Community Services and Development (CSD) partners with a statewide network of private, non-profit and public community-based organizations commonly referred to as community Action Agencies or Local Service Providers dedicated to helping low-income families and individuals achieve and maintain self-sufficiency, manage their home energy needs and reside in housing free from the dangers of lead hazards.

Below is a summary of the Governor's proposed funding for FY 2015-16 and FY 2016-17:

Fund Code	Fund	Actual 2014-15*	Estimated 2015-16*	Proposed 2016-17*
0001	**General Fund** - *DEAP*	$ -	$7,500	$7,500
0890	**Federal Trust Fund** - *LIHEAP, CSBG, DOE, LEAD*	239,856	252,153	252,412
0995	**Reimbursements** - *TRP*	-	6,000	-
3228	**Greenhouse Gas Reduction Fund** - *LIWP*	39,170	114,604	75,339
Total Expenditures (All Funds)		**$279,026**	**$380,257**	**$335,251**

CSD's programs include:

- Community Services Block Grant (HHS- CSBG). CSBG is an annual federal grant that provides or supports a variety of local services to alleviate the causes and conditions of poverty with the goal of helping people achieve self-sufficiency. Examples of CSBG supported services and activities include local programs to address employment, education, asset building, housing and shelter, nutrition and emergency services.

- Low-Income Home Energy Assistance Program (HHS -LIHEAP). LIHEAP is an annual federal grant that provides financial assistance to offset the costs of heating/cooling residential dwellings, for energy-related emergencies, and weatherization services to improve the energy-efficiency of homes.

- U.S. Department of Energy Weatherization Assistance Program (DOE-WAP). WAP is an annual federal grant that provides weatherization services to eligible low-income individuals to improve the energy-efficiency of low-income homes and safeguard the health and safety of occupants

- Lead-Based Paint Hazard Control Program (HUD-Lead). LEAD is a competitive federal grant that provides for the remediation of lead-based paint in low-income homes with young children.

- Low-Income Weatherization Program (LIWP). LIWP is funded by state cap-and-trade auction proceeds to provide energy efficiency and renewable energy services such as solar photovoltaic systems. These services are provided to low-income single-family and multi-family dwellings within disadvantaged communities to help reduce greenhouse gas emissions and save energy.

- Drought Emergency Assistance Program (DEAP). DEAP is funded by state general funds and provides supportive services and emergency assistance for low-income workers in agriculture and ancillary industries who have suffered job losses related to the state's drought. DEAP supports a broad range of supportive services in over 24 highly drought impacted counties, including housing assistance, food, transportation, and employment services.

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

Questions.

1. Please provide an overview of the department, programs, and current funding levels.

Issue 2: Budget Change Proposal: MSFW Drought Emergency Assistance Program

Governor's Proposal. The Administration requests $7.5 million General Fund in FY 2016-17 to continue emergency supportive services to vulnerable, low-income populations, including migrant and seasonal farmworkers (MSFW) and individuals experiencing employment impacts due to the drought.

Background. California is in its fourth year of drought. Impacts are far reaching with the most severe impacts affecting water availability, agriculture production, and employment. The Budget Act of 2015 appropriated $7.5 million in General Fund to CSD to augment existing Community Services Block Grant (CSBG) funding to provide emergency supportive services to MSFWs and individuals experiencing employment impacts due to the drought disaster. CSD used these funds to implement Drought Emergency Assistance Program (DEAP), offering support services to low-income workers in agriculture and ancillary industries and their families at or below 100 percent of the Federal Poverty Level. DEAP funds are locally administered by four MSFW nonprofit agencies in 24 of the most drought impacted counties, and provide assistance with rent/mortgage payments, utility assistance, transportation, child care, food, and medical care. DEAP also coordinates with other drought programs, including the Temporary Jobs Program which is administered by the Employment Development Department, and the Drought Food Assistance Program administered by the Department of Social Services.

The department anticipates delivering services to approximately 3,200 low-income MSFW households by the end of the contract term with an average benefit of $2,000 per household.

Staff Comment. Impacts of the drought continue to have negative and far reaching consequences, particularly for the vulnerable, low-income populations, such as the migrant and seasonal farmworkers identified in this proposal. Given that the need is still high, staff recommends approval of this proposal.

Questions.

1. Please provide an overview of the proposal.

Staff Recommendation. Approve.

Issue 3: Budget Change Proposal: Low-Income Weatherization Program (LIWP)

Governor's Proposal. The Administration requests $75 million from the Greenhouse Gas Reduction Fund (GGRF) in FY 2016-17 to support the expansion of existing weatherization and solar programs that improve energy efficiency performance of low-income residential dwellings. These funds will be used for weatherization measures, including the installation of photovoltaic systems, insulation, weather-stripping, caulking, water heater blankets, fixing or replacing windows, refrigerator replacement, energy efficient-lighting upgrades, electric and gas water heater repair/replacement, low flow water devices, and heating and cooling system repair/replacement.

Background. Implementation of the California Global Warming Solutions Act of 2006 (Nunez and Pavley, Chapter 488, Statutes of 2006) includes measures to achieve real and quantifiable cost-effective reductions of greenhouse gas (GHG) emissions. The Air Resources Board (ARB) has developed a market-based Cap-and-Trade Program as a key element of its GHG reduction strategy, where there is a system of tradable permits to emit GHGs, and the market allows exchange of these allowances. A portion of the allowances are sold at auction, with the proceeds deposited in the GGRF has been established for the purpose of funding measures that allow California to achieve its GHG reduction goals.

CSD received $75 million in FY 2014-15 and $74.8 million in FY 2015-16 from the GGRF to fund LIWP to provide residential energy efficiency and solar renewable projects on low-income housing located within disadvantaged communities. CSD traditionally uses its federal funding received for the Low-Income Home Energy Assistance Program (LIHEAP) and the Department of Energy Weatherization Assistance Program to install weatherization measures; however, the department has recognized the increased benefits of installing other clean and renewable energy technologies, such as solar technology.

CSD has received the following Green House Gas Reduction Fund funding for LIWP:

2014-15 Budget Act	$75 million
2015-16 Budget Act	$4.7 million
SB 101 (Amending the 2015-16 Budget Act)	$70.1 million

The department estimates that there are approximately 1.7 million low-income households that reside in disadvantaged communities. CSD plans to serve approximately 14,000 low-income households.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. Please provide a summary of how the $75 million is expected to be used in FY 2016-17.

Issue 4: Budget Change Proposal: Community Services Block Grant Performance Management and Accountability System

Governor's Proposal. The Administration requests position authority for five permanent positions to perform newly required federal mandates, including monitoring of all Community Service Block Grant (CSBG) eligible entities. The department notes this proposal does not require any additional spending authority, and will be funded from CSBG federal funds.

Background. CSBG funding supports projects that lessen poverty in communities, address the needs of low-income individuals, including the homeless, migrant and seasonal farmworkers, youth, and the elderly populations of California, as well as provide services and activities addressing employment, education, financial management of the household, housing, nutrition, emergency services, and/or health.

In response to a federal fiscal year (FFY) 2014 funding proposal from the President, recommending a 50 percent reduction in the allocation of CSBG funding and direction to use the remaining federal funds for a more competitive allocation system to target the highest-performing local assistance agencies, the Federal Administration for Children and Families, Office of Community Services (OCS) has created multiple measuring guidelines, and called for greater accountability and measurable results and will implement these new requirements effective FFY 2016. These requirements include more reporting and monitoring of program efficiency and effectiveness. While CSD is currently required to conduct an onsite monitoring visit of CSBG eligible entities once every three years, annual visits are now required. In particular, the Fields Operations Unit (FOU) will need more staffing to accomplish this.

Additionally, in 2014, CSD contracted with Innovative Government (IG) to conduct a business process analysis of the FOU and identify process refinements to optimize operating efficiency. The IG's conclusion revealed FOU's eligible entity per analyst caseload ratio of 15:1 was the highest of the six states contacted during the assessment process. IG's recommendation to CSD was to reduce its caseload ratio to 9:1.

The department notes that these new resources would allow CSD to be in compliance with federal performance standards. The workload increase cannot be absorbed by existing staff, and noncompliance could result in loss of CSBG funds.

Staff Comment and Recommendation. Approve.

Questions.

1. Please provide an overview of the proposal.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

April 28, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

Consultant: Theresa Pena

OUTCOMES

Item	Department	Action
5180	**Department of Social Services – Immigrations Branch**	
Issue 1	Update – Immigration Services Program	Informational
Issue 2	Proposal for Investment	Hold Open
Issue 3	Overview – SSI/SSP	Informational
Issue 4	TBL: Governor's Proposal to Increase SSP Portion of Grant	Hold Open
Issue 5	Proposals for Investment	Hold Open
Issue 6	Overview – IHSS	Hold Open
Issue 7	Oversight – Fair Labor Standards Act Implementation	Hold Open
Issue 8	TBL: IHSS MOE	Hold Open
Issue 9	BCP: IHSS CMIPS M&O	Hold Open
Issue 10	Proposals for Investment	Hold Open
5180	**Department of Social Services – Community Care Licensing**	
Issue 11	Overview – Community Care Licensing	Informational
Issue 12	BCP: CCL: Random Inspections – Technical Fix	Hold Open
Issue 13	BCP: Caregiver Background Check: Arrest Only Workload	Hold Open
Issue 14	BCP: Home Care Services Consumer Protection Act (AB 1217)	Hold Open
Issue 15	BCP: Complaints and Appeals Process and RCFE Ownership Disclosure	Hold Open
5180	**Department of Social Services – Adult Protective Services**	
Issue 16	Overview – Adult Protective Services	Informational
Issue 17	Proposals for Investment	Hold Open

Item	Department	Action
5180	**Department of Social Services**	
Issue 18	SFL: Transfer of Commodity Supplemental Food Program	Hold Open
Issue 19	SFL: Title IV-E California Well-Being Project BBL	Hold Open
0530	**Health and Human Services Agency, Office of Systems Integration**	
5180	**Department of Social Services**	
Issue 1	BCP: Case Management Information and Payrolling System	Hold Open
Issue 2	SFL: County Expense Claim Reporting Information System	Hold Open
4170	**Department of Aging**	
Issue 1	Overview	Informational
Issue 2	Update – Multi-Purpose Senior Services Program	Informational
Issue 3	BCP: Additional CBAS Staffing	Approve (2-0)
Issue 4	BCP: Information Technology Branch Staffing	Approve (2-0)
Issue 5	Proposals for Investment	Hold Open
4700	**Community Services and Development**	
Issue 1	Overview	Informational
Issue 2	BCP: Drought Emergency Assistance Program	Approve (2-0)
Issue 3	BCP: Low-Income Weatherization Program	Hold Open
Issue 4	BCP: CSBG Performance Management and Accountability System	Approve (2-0)

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, May 5, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Michelle Baass

Item **Department** **Page**

VOTE ONLY

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

VOTE ONLY

4260 DEPARTMENT OF HEALTH CARE SERVICES

The following issues were discussed at the March 17, 2015 Subcommittee No. 3 hearing.

Issue 1: Medi-Cal Eligibility Systems Workload (AB 1 X1, 2013)

Budget Issue. DHCS requests $3,683,000 ($1,788,000 General Fund) to support the ongoing policy and system initiatives required by AB 1 X1 (Pérez), Chapter 3, Statutes of 2013, the federal Affordable Care Act (ACA). This request includes three-year limited-term funding of $3,047,000, and four permanent positions.

Subcommittee Staff Recommendation—Approve.

Issue 2: Outreach and Enrollment Extension

Budget Issue. DHCS requests two-year limited-term special fund resources of $435,000 ($217,000 Special Deposit Fund and $218,000 federal funds) to address the workload performed by existing limited term positons that will expire on June 30, 2016. These resources are needed to support the implementation, maintenance and oversight of the Medi-Cal outreach, enrollment, and renewal assistance work that must be carried out to meet the requirements specified in AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, Sections 70 and 71, and SB 18 (Committee on Budget and Fiscal Review), Chapter 551, Statutes of 2014 and as extended by SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015.

Subcommittee Staff Recommendation—Approve.

Issue 3: Denti-Cal Oversight

Oversight and Budget Issue. DHCS requests four full-time permanent positions and $503,000 ($222,000 General Fund) to address current and anticipated increases in Denti-Cal workload due to ongoing efforts in connection with the findings and recommendations of the California State Auditor (CSA) and the federal Office of Inspector General audits regarding questionable billing for pediatric services.

Subcommittee Staff Recommendation—Approve.

Issue 4: AB 85 Health Realignment

Budget Issue. DHCS requests one permanent position and expenditure authority of $845,000 ($423,000 General Fund), of which $734,000 would be three-year limited-term, to address the ongoing administration of AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, as amended by SB 98 (Committee on Budget and Fiscal Review), Chapter 358, Statutes of 2013.

Subcommittee Staff Recommendation—Approve.

Issue 5: Federally Qualified Health Centers Pilot (SB 147, 2015)

Budget Issue. DHCS requests three-year, limited-term expenditure authority of $240,000, to support the implementation, administration, and evaluation of an alternative payment methodology (APM) pilot for select California Federally Qualified Health Centers (FQHCs), pursuant to the requirements of SB 147 (Hernandez), Chapter 760, Statutes of 2015. One-time contract authority of $300,000 is requested in 2017-18, to prepare an evaluation of the pilot. The contract will be funded 50 percent federal funds and 50 percent reimbursement from a foundation. For 2017-18, DHCS requests expenditure authority of $540,000 ($120,000 General Fund, $270,000 federal funds, $150,000 reimbursement).

Subcommittee Staff Recommendation—Approve.

Issue 6: Health Homes Activities

Budget Issue. DHCS requests three-year limited-term expenditure authority of $1,031,000 ($516,000 federal funds, $515,000 Special Deposit Fund), in support of the Health Homes Program (HHP), beginning July 1, 2016. Included in the request is three-year, limited-term contract funding for a total of $775,000 ($275,000 for year 1, $275,000 for year two, and $225,000 for year three).

Subcommittee Staff Recommendation—Approve.

Issue 7: Third Party Liability Recovery Workload

Budget Issue. DHCS requests $1,136,000 ($284,000 General Fund) and 10.0 permanent, full-time positions to address a growing workload and to increase savings. Federal and state laws and regulations mandate that Medi-Cal recover expenditures in personal injury cases involving liable third parties so that Medi-Cal is the payer of last resort. (The state received an enhanced federal participation rate of 75 percent.)

Subcommittee Staff Recommendation—Approve.

Issue 8: Eliminate Workers' Compensation Information Sunset - Trailer Bill Language

Budget Issue. DHCS proposes trailer bill language to eliminate the sunset provision and indefinitely extend the Department of Industrial Relations (DIR) authority to supply work-related injury or claim data from the Workers' Compensation Information System (WCIS) to the DHCS.

Subcommittee Staff Recommendation—Approve.

Issue 9: Supplemental Drug Rebates Cleanup Trailer Bill Language

Budget Issue. DHCS requests trailer bill language to make minor technical changes to Welfare and Institutions (W&I) Code §14105.436 and §14105.86 as amended by SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014. These technical changes will correct non-sequential lettering errors and inconsistent and erroneously omitted language in order to accurately preserve the intent and purpose of SB 870, to collect supplemental drug rebate revenues for certain prescription drugs based on drug utilization from all eligible Medi-Cal programs.

Subcommittee Staff Recommendation—Approve.

The following issues were discussed at the April 21, 2016 Subcommittee No. 3 hearing.

Issue 10: Foster Care: Psychotropic Medications (SB 238, 2015)

Budget Issue. DHCS requests one full-time permanent research program specialist II (RPS II) and $134,000 ($67,000 General Fund) in 2016-17 and $125,000 ($63,000 General Fund) ongoing, to implement the requirements of SB 238 (Mitchell) Chapter 534, Statutes of 2015.

Subcommittee Staff Recommendation—Approve.

Issue 11: Substance Use Disorders Health Care Reform Implementation

Budget Issue. DHCS requests $1,456,000 ($729,000 General Fund) to convert ten limited-term positions to permanent full-time positions and add one new permanent legal position. The ten two-year limited-term positions are set to expire on June 30, 2016. According to DHCS, the conversion of the positions to permanent full-time positions is necessary to continue to support the requirements set forth in the Affordable Care Act (ACA) and enacted in SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, which enhanced Medi-Cal substance use disorder services. The additional legal position will address litigation workload associated with both SB 1 X1 and AB 848 (Stone), Chapter 744, Statutes of 2015, discussed later in this agenda. The legal position will be phased-in effective January 1, 2017.

Subcommittee Staff Recommendation—Approve.

Issue 12: Residential Treatment Facilities (AB 848, 2015)

Budget Issue. DHCS requests four permanent positions and expenditure authority of $478,000, from the Residential and Outpatient Program Licensing Fund (ROLF), to implement AB 848 (Stone), Chapter 744, Statutes of 2015. Of the four positions, one nurse consultant II position will be phased-in effective January 1, 2017, while the rest will be effective July 1, 2016.

Subcommittee Staff Recommendation—Approve.

4265 DEPARTMENT OF PUBLIC HEALTH

The following issues were discussed at the March 3, 2016 Subcommittee No. 3 hearing.

Issue 1: Richmond Laboratory: Viral Rickettsial Laboratory Enhanced Upgrade

Budget Issue. DPH requests to reappropriate $3.8 million from a capital outlay project approved in 2015-16 to upgrade the DPH's Bio-Safety Level 3 (BSL-3) certified Viral and Rickettsial Disease Laboratory. The upgrades were needed to ensure that DPH retains its BSL-3 Certification from the Federal Center for Disease Control and Prevention (CDC) and National Institutes of Health (NIH). According to DPH, the reappropriation is needed due to the project's delays that were beyond DPH or the Department of General Services' (DGS) control.

Subcommittee Staff Recommendation—Approve.

Issue 2: Timely Infectious Disease Outbreak Detection and Disease Prevention

Budget Issue. DPH requests $1.6 million General Fund in 2016-17, $2.1 million General Fund in 2017-18 and 2018-19, and 14 permanent positions, to provide ongoing support to protect California from infectious diseases through increased disease surveillance and laboratory capacity. The 14 positions will be phased-in.

Subcommittee Staff Recommendation—Approve.

Issue 3: Active Transportation Safety Program

Budget Issue. DPH requests $733,000 in reimbursement expenditure authority and an increase of 4.5 positions to implement the Active Transportation Safety Program with funds provided through an Interagency Agreement with the California Department of Transportation (Caltrans).
Subcommittee Staff Recommendation—Approve.

Issue 4: Protecting Children from the Effects of Lead Exposure

Budget Issue. DPH requests an increase of $8.2 million annually ($1.4 million in state operations and $6.8 million in local assistance) for four years from the Childhood Lead Poisoning Prevention Special Fund and to establish seven positions to extend services to children who have been exposed to lead as now defined by a lower blood lead level by the Centers for Disease Control and Prevention (CDC).

Subcommittee Staff Recommendation—Approve.

Issue 5: California Environmental Contaminant Biomonitoring Program

Budget Issue. DPH requests two permanent positions and $350,000 from the Toxic Substances Control Account for two years. The positions were established as limited-term positions and are set to expire on June 30, 2016.

Subcommittee Staff Recommendation—Approve.

Issue 6: End of Life Option Act (AB 15 X2, 2015)

Budget Issue. DPH requests $323,000 from the Health Statistics Special Fund in 2016-17, $245,000 in 2017-18 and annually thereafter, and two permanent positions to meet the new mandate to establish the End of Life Option Act program as specified in AB 15 X2 (Eggman), Chapter 1, Statutes of 2015, Second Extraordinary Session. This funding will enable DPH to create a secure database to implement and administer the program and provide staffing for the required confidential program management and reporting duties.

Subcommittee Staff Recommendation—Approve.

Issue 7: Collection of Data: Multi-Race or Multi-Ethnic Origin (AB 532, 2015)

Budget Issue. DPH requests $236,000 for fiscal year 2016-17 and $234,000 for fiscal year 2017-18 from the Health Statistics Special Fund to meet the new mandate to tabulate the data for both single and multiple race or ethnic designations in reports provided to other state departments as specified by AB 532 (McCarty), Chapter 433, Statutes of 2015.

Subcommittee Staff Recommendation—Approve.

Issue 8: Lesbian, Gay, Bisexual, & Transgender Disparities Reduction Act (AB 959, 2015)

Budget Issue. DPH requests one-time expenditure authority of $125,000 from the Health Statistics Special Fund to modify existing birth and fetal death registration systems and meet the new mandate to collect voluntary self-identification information pertaining to sexual orientation and gender identity as specified in the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act, AB 959 (Chiu), Chapter 565, Statutes of 2015.

Subcommittee Staff Recommendation—Approve.

Issue 9: Increase Access to HIV Pre-Exposure Prophylaxis (PrEP)

Budget Issue. DPH proposes to expend $2.6 million in federal funds ($1.4 million local assistance and $1.3 million state operations) in 2015-16 and $3.5 million ($1.8 million local assistance and $1.7 million state operations) in 2016-17, and requests the addition of five permanent positions, to implement a three-year Centers for Disease Control and Prevention (CDC) grant awarded to DPH on September 3, 2015.

A Section 28 budget letter, dated October 30, 2015, notified the Legislature of this grant and the related increase in current year federal fund authority.

Subcommittee Staff Recommendation—Approve.

Issue 10: Medical Marijuana (AB 243, AB 266, and SB 643 of 2015)

Budget Issue. DPH requests 37 positions and $12 million in funding from the Medical Marijuana Regulation and Safety Act Fund to be phased-in between fiscal years 2015-16 to 2018-19 to begin the implementation of the mandated provisions specified in AB 266 (Bonta), Chapter 689, Statutes of 2015, AB 243 (Wood), Chapter 688, Statutes of 2015, and SB 643 (McGuire), Chapter 719, Statutes of 2015. DPH requests to phase-in these positions, as follows: six positions and $457,000 in reimbursement authority for 2015-16; eight additional positions and $3,438,000 in 2016-17; two additional positions and $2,520,000 in 2017-18; and the final 21 additional positions and $5,658,000 in 2018-19.

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Trailer Bill Language. It is recommended to approve this proposal. It is also recommended to adopt placeholder trailer bill language to establish a public health surveillance system related to medical marijuana and use the Medical Marijuana Regulation and Safety Act Fund to support this system.

ITEMS FOR DISCUSSION

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Budget 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 $36.1 million ($8.7 General Fund and $6 million federal funds) and about 67 positions for EMSA.

Update on 2015-16 Funding for Medical Assistance Team. The 2015-16 budget included $500,000 General Fund and two permanent Senior Emergency Services Coordinators (SESC) positions beginning July 1, 2016. The additional resources are being utilized to respond to a moderate incident and for an initial response to a catastrophic incident. As of April 2016, both positions have been filled and the Southern California Medical Assistance Team (CAL-MAT) program has been reestablished.

To reestablish the southern California CAL-MAT, EMSA entered into a contract with California Disaster Medical Services Association (CDMSA), a non-profit organization. CDMSA is handling all administrative functions, including the recruitment and retention of volunteers, coordination of training activities, and mobilization and deployment of CAL-MAT for emergency response.

Both SESC positions are supporting California's CAL-MAT program by developing policies, procedures, and minimum standards of training for all CAL-MAT members. They also are coordinating administrative functions, exercise and trainings, assisting with the maintenance of the CAL-MAT caches, and serving as the direct liaison between CAL-MAT members and EMSA. They coordinate closely with California Department of Public Health in the continued development of policies and procedures including catastrophic planning for a flood event in the central valley, Emergency Response Teams, protocols to work in the joint Medical Health Coordination Center**,** and as a partner in revising the Public Health and Medical Emergency Operations Manual.

One of the SESC positions is supporting the AST Program by auditing the Disaster Medical Support Units (DMSU) which are placed with local providers. EMSA has completed 31 audits of 42 deployed DMSUs and EMSA has determined that the local providers are abiding by the state's memorandum of understanding resulting in a program that is robust in day-to-day response, as well as, being prepared to respond to an unexpected event.

Subcommittee Staff Comment. This is an informational item.

Questions.

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

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Budget 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.

Major programs at OSHPD include:

- **Cal-Mortgage**: Provides loan insurance for non-profit healthcare facility development.
- **Facilities Development Division**: Reviews and inspects health facility construction projects.
- **Healthcare Information Division**: Collects data and distributes information on health and healthcare in California.
- **Healthcare Workforce Development Division**: Shortage designation, research, geographic information system, funding, loan repayments, internships, and pilot projects.
- **Health Professions Education Foundation**: Provides scholarships and loan repayments for healthcare professionals and students.

Budget Overview. The budget proposes expenditures of $160.8 million ($1.4 million federal fund and $159.4 million special funds and reimbursements) and 449 positions for OSHPD.

Subcommittee Staff Comment. This is an informational item.

Questions.

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: California Children's Services Program

Budget Issue. DHCS proposes trailer bill language (TBL) to implement the budget-related components of the California Children's Services Program (CCS) Whole Child Model. The TBL clarifies state, county, and Medi-Cal managed care health plan roles and responsibilities in counties where the DHCS implements the CCS Whole Child Model, with CCS services carved into managed care contracts. According to the Administration, the TBL is budget neutral.

The Whole Child Model is proposed to be implemented beginning in January 1, 2017, in some counties with County Organized Health Systems (COHS). The department indicates that it intends to seek additional statutory changes through a policy bill to implement the consumer protection and programmatic policy changes envisioned with the Whole Child Model.

CCS Budget and Caseload. See table below for CCS budget summary (excluding Medi-Cal costs) and caseload.

Table: CCS Summary

	2015-16	2016-17
Funding		
General Fund	$60,780,200	$73,441,100
Federal Funds	$18,515,600	$4,723,000
Total*	**$79,295,800**	**$78,164,100**
Caseload		
CCS-State Only	14,820	13,113
CCS-Medi-Cal/Targeted Low Income Program	169,387	172,114
Total	**184,207**	**185,227**

*Excludes Medi-Cal costs.

Background. The CCS program serves children and youth with special health care needs, primarily through a fee-for-service delivery system for services related to CCS-eligible health conditions, while the Medi-Cal managed care system provides for all other health care services such as primary care. In counties with populations of 200,000 or more, county CCS programs determine financial, residential, and medical eligibility, authorize CCS services, and provide care coordination. In smaller counties, DHCS performs some of the CCS eligibility and authorization services. Under longstanding realignment provisions, counties have a shared fiscal responsibility for some components of the CCS program. DHCS asserts that this complex system of care among fee-for-service providers, health plans, counties, and the state can be challenging for families to navigate and lacks incentives for coordinated, organized care. This is the basis for this proposal. Known as the CCS-carve-out, this arrangement has existed since Medi-Cal children have been mandatorily enrolled in managed care. The initial carve out was for three years. The CCS carve out has been extended repeatedly since then, usually for three or four year periods. The first extension allowed the COHS in the counties of San Mateo, Santa Barbara,

Solano, and Napa to include CCS services. Later extensions also allowed Yolo and Marin counties to include CCS services.

DHCS proposes to incrementally implement an integrated coordinated system of care for the CCS program and consolidate all care for the CCS-eligible child under one system. A CCS Whole Child model will be pursued within the existing COHS managed care model initially and will add the remainder of the COHS counties, except for Ventura. According to DHCS, this approach will continue to use CCS provider standards and provider network of pediatric specialty and subspecialty care providers. The implementation process will be gradual, with readiness and monitoring components that will enable continuity of care and continued access to specialty care.

The first phase of implementation of the Whole Child model is anticipated to begin no sooner than January 2017, into certain COHS counties contingent upon meeting readiness review requirements. DHCS is also proposing the Whole Child model be implemented in up to four counties in the Two-Plan Medi-Cal managed care model. The extension of the Whole Child model to these counties will begin no earlier than July 2017, and will also be subject to a readiness review by DHCS. Current state statute prevents CCS services from being delivered through managed care except in a small number of counties. This carve-out from managed care would have expired January 1, 2016. AB 187 (Bonta), Chapter 738, Statutes of 2015, extended the sunset date by one year for the carve-out of CCS from managed care, to January 1, 2017.

The proposed TBL would:

- Provide authority for the transition of CCS case management and care coordination along with the responsibility for fulfillment of the requirements of Sections 123855,123925, and 123960 of Health and Safety Code from a designated county department to a Medi-Cal managed care plan;
- Explicitly confirm that CCS eligibility determination remains the responsibility of the designated county department;
- Explicitly confirm that the CCS Medical Therapy Program (MTP) remains the responsible of the designated county department;
- Provide authority to implement the Whole Child model by all county letters, health plan letters, CCS numbered letters, plan or provider bulletins, or similar instructions;
- Change the language on treatment plans to be followed by the managed care plan from "treatment plans approved by the CCS Program" to "treatment plans developed in accordance with the requirements of DHCS;"
- Where practical, specify the reference to the CCS Program in the amended sections to either the State or county, so that no new responsibilities accrue to local CCS programs; and,
- Provide flexibility to the state to implement a single combined managed care rate for all health service needs of a CCS-eligible child.

Subcommittee Staff Comment and Recommendation—Reject Proposed Trailer Bill Language. It is not clear why the Administration is proposing pieces of this proposal through the budget process and pieces of the proposal through the policy process, particularly given that the Administration finds that there is no fiscal impact related to the TBL. Consequently, it is recommended to reject the TBL and defer to policy committee to discuss the entire proposal.

It is also recommended to hold the CCS budget open pending May Revision updates.

Questions.

1. Please provide an overview of this issue.

Issue 2: CA-MMIS System Reprocurement

Budget Issue. Through a Spring Finance Letter, DHCS requests one-year limited-term expenditure authority of $3,428,000 ($736,000 General Fund and $2,692,000 Federal Funds). The resources will fund the equivalent of 24 positions (which expire June 30, 2016) to complete the following activities within DHCS' California Medicaid Management Information System (CA-MMIS) Division:

1. Conduct close out activities for Xerox State Healthcare's (Xerox) portion of the CA-MMIS system replacement project (SRP), including determining the disposition of legacy System Development Notices (SDNs) that were deferred as part of the SRP, and identifying salvageable assets;
2. Procurement of new Fiscal Intermediary (FI) contracts to conduct business operations of the legacy CA-MMIS system; and
3. Re-evaluate the procurement approach to replace the legacy system under new system replacement efforts.

The resources requested are for the equivalent of 24 positions that will complete the activities outlined above as summarized in the table below.

Equivalent Positions by Division		**Workload Supported**
Administration (1.0)	• 1.0 Associate Administrative Analyst	This resource will support CA-MMIS Division in close out activities of the Xerox portion of SRP with a focus on financial aspects of the settlement agreement between DHCS and Xerox to include reimbursement of monies to Centers for Medicare and Medicaid Services.
CA-MMIS (16.0)	• 1.0 Data Processing Manager III • 2.0 Data Processing Manager IV • 1.0 Office Technician • 4.0 Senior. Information System Analyst • 2.0 Senior. Information Systems Analyst • 1.0 Staff Information Systems Analyst • 1.0 Staff Service Manager I • 1.0 Associate Administrative Analyst • 1.0 Associate Accounting Analyst • 2.0 Associate Government Program Analyst	These resources are significantly allocated to the close out activities for Xerox portion of SRP and in determining the disposition of legacy SDNs that were deferred as part of the SRP. As the close out activities wind down, they will focus on procurement of new contracts to conduct business operations of the CA-MMIS system.
Enterprise Innovation Technology Services (3.0)	• 1.0 Associate Information Systems Analyst • 1.0 Staff Information Systems Analyst • 1.0 System Software Specialist III	These resources will provide desktop, LAN, software support, and adherence to security policies and procedures as well as providing continuing support for staff involved in both the closeout activities of the Xerox portion of SRP and the procurement of the subsequent FI contract.
Office of Legal Services (3.0)	• 3.0 Attorney III	These resources will support CA-MMIS Division in legal aspects of close out activities of the Xerox portion of SRP and review proposed contract language for upcoming procurements.
Pharmacy Benefits Division (1.0)	• 1.0 Pharmacy Consultant II (Spec)	This resource will support CA-MMIS Division in close out activities of the Xerox portion of SRP and will transition to providing subject matter expertise for upcoming procurements.

Background. DHCS is the single state agency responsible for the administration of California's Medicaid program, known as Medi-Cal, which provides health care for more than 13 million members.

DHCS contracts with a FI to maintain and operate CA-MMIS, which is utilized by Medi-Cal to process approximately 230 million claims annually for payment of medical services provided to Medi-Cal members, resulting in over $23.66 billion a year in payments to health care providers.

In May 2010, DHCS awarded the contract to ACS State Healthcare, LLC (ACS), which was later acquired by Xerox State Healthcare, LLC (Xerox), to provide FI services and to replace the legacy system. The CA-MMIS Division is responsible for overseeing the fee-for-service (FFS) FI contract with Xerox and the ongoing maintenance and operation of CA-MMIS, as well the design, development, and implementation (DD&I) of a new system to replace CA-MMIS.

The Xerox FI contract was structured to provide:

1. Business operational services (including Medi-Cal call center, provider outreach and training, maintaining the Medi-Cal provider manual, etc.),
2. Maintenance and operations of the mainframe and related sub-systems (claims processing and utilization review),
3. Technical services to make system changes to the legacy mainframe system (i.e. systems groups), and
4. Planning for and implementing the system replacement project of the existing CA-MMIS.

The system replacement project was scheduled to be completed by June 30, 2016, which is when the existing limited-term positions are due to expire. However, a number of significant delays occurred in the delivery of the SRP. Eventually, Xerox determined it could not deliver a new system. On October 13, 2015, Xerox notified DHCS that it would not be completing the system replacement project. Subsequently, Xerox entered into negotiations with DHCS on terms and conditions of a settlement to terminate its contractual obligation to fully implement the SRP.

On March 21, 2016, Xerox and DHCS finalized a settlement agreement outlining the terms and conditions for Xerox to suspend all system replacement project activities, which include but are not limited to DD&I, project management, transition, integration, and testing. The settlement agreement (signed on April 8, 2016) includes compensation for the state costs incurred by the state for the system replacement project. Specifically, Xerox will pay DHCS $103.3 million in cash (60% by 4/22/16, 20% on 7/29/16, and 20% by 1/2/17), Xerox shall provide to DHCS $15 million in Xerox or IBM hardware and/or software, Xerox will withdraw and dismiss its claim related to the Provider Application and Validation for Enrollment System (PAVE), and DHCS and Xerox will terminate all other open claims, offsets, credits and refunds. DHCS will be reimbursed by Xerox for all costs related the system replacement project. Federal approval of the settlement agreement is anticipated to occur by April 2016. See table below for summary of state costs and the settlement agreement.

Column	Cost to Date (2/29/16)	Settlement Agreement
Xerox	($9,018,000)	$9,018,000
State (staff, overhead, and contractor)	($45,528,000)	$45,528,000
Settlement Agreement Payment Remainder		$68,757,571
Total	**($54,546,000)**	**$123,303,571**

Source: Department of Health Care Services

Xerox will continue to operate and maintain the current CA-MMIS System until September 30, 2019, or until DHCS has secured other FI services and support.

Per Centers for Medicare and Medicaid Services (CMS) guidance, DHCS will pursue a new, modular Replacement System procurement approach that will benefit from the most up-to-date technology and system design strategies available.

In order to move forward with the system replacement project closure, and initiate a new system replacement project DHCS must identify salvageable assets and re-evaluate the procurement approach to replace the legacy system. The CA-MMIS Division has developed plans to: close out the Xerox portion of the system replacement project; move forward with procurement of new contracts for FI business operations services; and re-evaluate the procurement approach to replace the legacy system.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

Issue 3: Medi-Cal: Coordinated Care Initiative

Oversight Issue. The 2012 budget authorized the Coordinated Care Initiative1 (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits. Under the current memorandum of understanding with Centers for Medicare and Medicaid Services (CMS), Cal MediConnect ends on December 31, 2017. See table below for enrollment summary.

Cal MediConnect Enrollment Summary, as of March 1, 2016

County	Enrollment
Los Angeles	41,778
Orange	17,567
Riverside	13,671
San Bernardino	13,359
San Diego	15,595
San Mateo	9,503
Santa Clara	12,087
Total	**123,560**

In April, DHCS released a set of policy changes to CCI and noted that the goals of these changes are to:

- Strengthen the quality of care and care coordination in Cal MediConnect for beneficiaries;
- Ensure that beneficiary protections remain robust, beneficiary satisfaction remains high and increases, and the beneficiary is always at the center of the program;
- Generate sustainability for the program; and,
- Maintain transparency and stakeholder engagement.

These policy changes are:

1. **Strengthening Long-term Services and Supports (LTSS) Referrals & Care Coordination**
   DHCS is proposing to:
   a. Standardize Health Risk Assessment (HRA) referral questions for MSSP, IHSS, and CBAS to reflect the best practices developed over the early years of the program.
   b. Review plan policies and procedures regarding referrals to these programs to ensure that all beneficiaries who may benefit from them are being offered access to these supports.
   c. Review and expand data collection and reporting on interdisciplinary care teams, and individualized care plan completions, and CBAS, MSSP, and IHSS referrals.

2. **Sharing Best Practices & Lessons Learned**
   a. DHCS is proposing to convene Cal MediConnect plans in a series of meetings to share best practices and ensure all plans are performing to the highest standard.
   b. The kick-off meeting will be in May.

1 Enacted in July 2012 through SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012, and amended by SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013.

3. **Improving Continuity of Care**
   Evaluation data shows that the beneficiary experience would be improved by reducing transition issues and allowing beneficiaries to see their current providers for longer periods of time. In response, DHCS is exploring:
   a. If CMS will extend the continuity of care period for Medicare services from 6 months to 12 months to match the Medi-Cal continuity of care period;
   b. Modifying continuity of care requirements requiring two visits with a specialist within the past 12 months to requiring just one visit as is the case with primary care physicians.

4. **Sustainable Enrollment**
   To sustain the program, DHCS is proposing to expand enrollment, engagement and education efforts.
   a. **Annual Passive Enrollment into Cal MediConnect** – For 2016, for beneficiaries who are newly eligible, DHCS is proposing a two month passive enrollment period in September and October 2016. Beneficiaries newly eligible for Cal MediConnect are those new to Medi-Cal or new to Medicare or new to a CCI county in 2014 or 2015; and who did not participate in a prior CMC passive enrollment process. Beneficiaries will be cross walked from their MLTSS plan to the Cal MediConnect plan to ensure continuity of plans, MLTSS relationships, care management and plan relationships. DHCS will utilize Medicare claims data to assign Medi-Cal FFS members to Cal MediConnect plans.
      For 2017, an annual CMC passive process for the previous year's newly dually eligible population (beneficiaries who become eligible in 2016 would be enrolled in 2017).
   b. **Operationalizing Mandatory MLTSS Enrollment -** Begin monthly mandatory enrollment into MLTSS, with education about CMC option. Includes:
      - Initial month of implementation would include all duals who became newly eligible for MLTSS following the previous passive enrollment period.
      - Dual eligibles who had Medicare and are new to Medi-Cal, duals who move into a CCI county.
   c. **Exploring Potential Extension of Deeming Period**
      - Beneficiaries who temporarily lose their Medi-Cal eligibility are at risk of losing their enrollment in Cal MediConnect, causing beneficiary confusion and transition issues.
      - Based on stakeholder feedback, DHCS implemented a 30-day deeming period to make it easier for beneficiaries to stay enrolled in Cal MediConnect while the health plan helped the beneficiary reestablish their Medi-Cal eligibility.
      - While 30 days is an improvement, stakeholder and health plan feedback indicates that a longer period would help more beneficiaries maintain their Medi-Cal eligibility and enrollment in Cal MediConnect.
      - DHCS proposes to explore operationalizing a two month deeming period.

5. **Streamlined Enrollment -** Allow plans to facilitate enrollment into Cal MediConnect for beneficiaries enrolled in the plan's Medi-Cal MLTSS product. Includes beneficiaries currently enrolled in MLTSS plans and beneficiaries would only be able to use streamlined enrollment to enroll into the CMC plan connected to their MLTSS plan. This would occur through the following process:

a. Cal MediConnect health plans would collect the required information from beneficiaries and directly submit enrollment requests to HCO for processing on a daily basis.
b. HCO would process the request after ensuring the beneficiary was eligible for Cal MediConnect.
c. HCO will regularly share files with the plans to let them know which enrollment requests have been processed.

6. **Targeted Provider Outreach -** DHCS has conducted a detailed analysis of beneficiaries who opted out of Cal MediConnect and their most frequently seen providers. This data allows DHCS to identify providers (including physicians, hospitals, and medical groups) associated with large numbers of beneficiaries who have chosen not to participate in Cal MediConnect. DHCS intends to use these data to more effectively target provider education and outreach activities. These activities will both allow DHCS to engage with providers about their questions on the program, what they or their patients may want to know, and ensure that providers and beneficiaries have sufficient and accurate information about the program and its potential benefits.

Background. The 2012 budget authorized the Coordinated Care Initiative2 (CCI), which expanded the number of Medi-Cal enrollees who must enroll in Medi-Cal managed care to receive their benefits. Under the current memorandum of understanding with Centers for Medicare and Medicaid Services (CMS), Cal MediConnect ends on December 31, 2017. The Administration has indicated to CMS that it is interested in extending this date (as allowed by CMS) but has not committed to an extension. The CCI is being implemented in seven counties[3] (Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).

CCI is composed of three major parts related to Medi-Cal:

- **Managed Long-Term Supports and Services (MLTSS) as a Medi-Cal Managed Care Benefit.** CCI includes the addition of MLTSS into Medi-Cal managed care. MLTSS includes nursing facility care (NF), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Community-Based Adult Services (CBAS). This change impacts about 600,000 Medi-Cal-only enrollees and up to 456,000 persons eligible for both Medicare and Medi-Cal who are eligible to enroll in a Cal MediConnect plan.

- **Cal MediConnect Program.** A three-year demonstration project for persons eligible for both Medicare and Medi-Cal (dual eligibles) to receive coordinated medical, behavioral health, long-term institutional, and home-and community-based services through a single organized delivery system (health plan). No more than 456,000 beneficiaries would be eligible for the duals demonstration in the eight counties. This demonstration project is a joint project with CMS.

  As of March 1, 2016, 123,560 individuals are enrolled in Cal MediConnect.

2 Enacted in July 2012 through SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012, and amended by SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013.
3 Alameda County was initially part of CCI but due to fiscal solvency issues with one of its plans, it will not participate in CCI.

- **Mandatory Enrollment of Dual Eligibles and Others into Medi-Cal Managed Care.** Most Medi-Cal beneficiaries, including dual eligibles, partial dual eligibles, and previously excluded seniors and persons with disabilities (SPDs) who are Medi-Cal only, are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits.

The purpose and goal of CCI is to promote the coordination of health, behavioral health, and social care for Medi-Cal consumers and to create fiscal incentives for health plans to make decisions that keep their members healthy and out of institutions (given that hospital and nursing home care are more expensive than home and community-based care).

Requirements on Fiscal Solvency of CCI. SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013, requires the Department of Finance to annually determine if there are net General Fund savings for CCI. If CCI is not cost-effective, all components of CCI would cease operation. The January budget reflected a net General Fund savings of $191 million; however, the Administration indicates that it is still in the process of updating this calculation given the restructuring of the managed care tax. It is anticipated that more information on this will be forthcoming in the May Revision.

Multipurpose Senior Services Program and CCI. The 2015-16 budget included trailer bill language that extended the CCI MSSP transition to Medi-Cal managed care deadline to December 31, 2017; allowed for an earlier transition in a county or region when the MSSP sites and managed care plans mutually agree they are ready to transition and want to transition early; required that the MSSP sites and managed care plans demonstrate that they have met readiness criteria that is developed by DHCS, California Department of Aging (CDA), MSSP providers, managed care plans and stakeholders; and specified that if CCI is terminated MSSP will revert to a waiver benefit.

MSSP transitioned to a managed care benefit in San Mateo County on October 31, 2015. Reports indicate that this transition has gone smoothly.

DHCS notes that it has provided and utilized multiple communication forums and tools to track specific requirements the health plans must perform such as, the use of interdisciplinary care teams, individual care plans, health risk assessments, and care coordination requirements for the CCI counties, which also apply to MSSP participants and providers. One of these tools is the draft MSSP Site / Health Plan Contract template that has been distributed to stakeholders, which outlines the roles and responsibilities of both parties. DHCS, in partnership with CDA hold bi-weekly calls with MSSP sites and health plans. The MSSP sites and health plans are encouraged to discuss issues at the state facilitated bi-weekly teleconference calls.

DHCS recognizes that there will still be an MSSP population that will remain Fee-For-Service (FFS). The department, in collaboration with CDA, is developing a process that will ensure continuity of care for this population post transition. MSSP will remain a FFS benefit in the CCI counties for only those members that were MSSP participants and exempt from managed care enrollment at the time of transition. As documented in the preliminary CCI MSSP Transition Plan (submitted to the Legislature in May 2015), DHCS and CDA intends to actively request proposals and will contract with an entity (care management agency) or an MSSP provider that focuses solely in providing services to the entire FFS population in the CCI counties post transition. MSSP is not expected to transition until December

31, 2017, therefore it is unknown how many Medi-Cal members, who will also be MSSP participants residing in CCI counties, will be exempt from Medi-Cal managed care at the time of MSSP transition.

Subcommittee Staff Comment and Recommendation—Hold Open. The following issues should be considered in evaluating these proposed changes:

1. **Proposal to Strengthen LTSS Referrals Long Overdue.** DHCS's proposal to strengthen long-term services and supports referrals and care coordination is much needed and overdue. As has long been noted by this Subcommittee, a better understanding about referrals to LTSS services (e.g., MSSP, IHSS, and CBAS), the changes in utilization of these services as a result of CCI, and improved data collection regarding interdisciplinary care teams and completed individualized care plans is crucial to understanding if the CCI is changing health outcomes and consumer experiences.

2. **Concerns Raised with Passive Enrollment and Streamlined Enrollment Proposals.** DHCS has been utilizing a passive enrollment process that requires a person to "opt out" of they do not want to be enrolled in the plan and want to remain in fee-for-service Medicare. This process has resulted in a very high "opt out" rate in most counties. In March the rate ranged from ten percent in San Mateo to fifty-eight percent in Los Angeles. This has also resulted in a level of enrollment well below the expectations of the plans, CMS, and DHCS. In addition, consumer advocates and other organizations who assist this population report instances of confusion and discontinuity of care. For example, it has been reported that patients do not realize they have been enrolled in a plan and can no longer see their physician who does not contract with the plan. The following concerns have been raised by consumer advocates about the passive enrollment and streamlined enrollment proposals:

   a. **Passive Enrollment.** Consumer advocates argue that passive enrollment causes disruption and confusion for beneficiaries and have proposed an affirmative voluntary enrollment process as an alternative. Additionally, advocates note that the proposed timeline does not provide sufficient time to prepare and educate the community. They also find that health plans and Health Care Options do not have the capacity to handle another wave a passive enrollment in such a short timeframe, which will lead to confusion and frustrations with Cal MediConnect. Advocates also point out that the notices proposed to be used have similar deficiencies to those used the first time around and are not tailored to the specific populations.
   b. **Streamlined Enrollment.** Consumer advocates find that an enrollment broker, such as Health Care Options, provides an important and independent function in the Cal MediConnect enrollment process. This function is important because an independent enrollment broker ensures that consumers are not coerced into an enrollment decision about their health care coverage.

   These consumer advocates find that the state should develop a robust voluntary enrollment process that educates consumers clearly about the benefits of Cal MediConnect and that this ultimately will lead to more stable enrollment for this project.

3. **MSSP.** The MSSP Site Association requests to remove the MSSP transition deadline, restore MSSP payment and encounter data as a state responsibility, and initiate a dialogue with DHCS,

CDA, MSSP providers, and health plans to discuss an memorandum of understanding that defines all parties' roles in collaboration with all populations including clients in both Cal MediConnect and MLTSS.

Questions.

1. Please provide a brief update on CCI and an overview of the proposed changes to CCI.

2. How is DHCS working with stakeholders to obtain feedback on these proposals?

3. When does DHCS plan to make a decision on whether or not to implement these changes?

4. Is there a target enrollment number to ensure fiscal solvency of CCI?

5. Does DHCS intend to use the same notices regarding passive enrollment? Has DHCS made any changes to these notices?

Issue 4: Medi-Cal: Behavioral Health Treatment

Oversight and Budget Issue. The proposed budget includes $206.2 million ($90.5 million General Fund) to provide behavioral health treatment (BHT) services for children under the age of 21 with a diagnosis of autism spectrum disorder (ASD).

Background. SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014 requires DHCS to add behavioral health treatment (BHT) services, such as applied behavioral analysis (ABA), as a covered benefit in Medi-Cal to the extent required by federal law. Subsequent to the enactment of the 2014 budget, the federal government issued guidance indicating that BHT should be a covered Medicaid benefit for eligible children and adolescents with autism spectrum disorder (ASD). In response to the guidance, DHCS submitted State Plan Amendment (SPA) 14–026 to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2014 to seek the necessary approval to include BHT as a covered Medi-Cal service for individuals under 21 years of age with ASD. On January 21, 2016, CMS approved this SPA. BHT services are approved retroactively to July 2014.

On November 20, 2015, DHCS and Department of Developmental Services (DDS) jointly issued a transition plan that describes the transition of Behavioral Health Treatment (BHT) services from the regional centers to the Medi-Cal managed care and fee-for-service delivery systems. This transition began in February 2016 and will occur over a period of six months. Approximately, 5,000 individuals (of the estimated 13,000) have transitioned with 92 percent receiving automatic continuity of care with the same provider. The remaining eight percent have transitioned to a new provider.

Comprehensive Diagnostic Evaluation. Generally, Medi-Cal children age three or older would be eligible for BHT when a comprehensive diagnostic evaluation (CDE) indicates that evidence-based BHT services are medically necessary and recognized as therapeutically appropriate. The CDE has multiple components and includes evaluations in cognition, speech and language, and other motor skills.

BHT Grievances Filed with the Department of Managed Health Care. As of October 1, 2015 through April 25, 2016, the Department of Managed Health Care (DMHC) has received nine requests for Independent Medical Reviews (IMR) related to a health plan denial the BHT service. Of these, three grievances are pending, three times the health plan voluntarily reversed its original denial prior to the completion of the IMR, one health plan decision was overturned, one health plan decision was upheld, and one time the patient made the decision to withdraw from the IMR process.

For this same time period, DMHC received four complaints related to BHT coverage/benefit dispute. Of these, two plans were found in compliance (and the health plan provided the benefit as a courtesy to the enrollee), one was found out of compliance, and one was a case in which DMHC did not have jurisdiction.

For this same time period, DMHC received eight complaints related to BHT access. Of these, in six instances the health plan was found in compliance (and the health plan provided the benefit as a courtesy to the enrollee), one health plan was found in non-compliance, and one case is still pending.

Subcommittee Staff Comment and Recommendation—Hold Open. Concerns have been raised regarding waitlists for CDEs. DHCS indicates that it is not aware of any wait lists for CDEs for Medi-Cal beneficiaries. DHCS conducts monitoring of network adequacy through secret shopping; analysis of grievances and appeals, ombudsman calls, and monthly utilization data; stakeholder input; and regular check-ins with Medi-Cal managed care health plans.

No concerns have been raised to subcommittee staff regarding the transition of BHT services from the regional centers to the Medi-Cal managed care and fee-for-service delivery systems.

Questions.

1. Please provide a brief overview of this issue.

2. Is DHCS aware of any wait lists or long waits to get a comprehensive diagnostic evaluation? How is DHCS monitoring this?

Issue 5: Medi-Cal: Full Scope Expansion for Undocumented Children

Budget Issue. The proposed budget includes $177.2 million ($142.8 million General Fund) in 2016-17 and $26.2 million ($20.4 million General Fund) in 2015-16 to expand full-scope Medi-Cal benefits to children under the age of 19 years, regardless of immigration status. This funding includes the costs for specialty mental health services provided by county mental health plans ($3.5 million General Fund in 2015-16 and $25.7 million General Fund in 2016-17).

Background. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015, extends Medi-Cal coverage to children who are otherwise eligible for Medi-Cal except for their immigration status, no sooner than May 1, 2016. DHCS expects to implement all necessary system changes on May 16, 2016. The eligibility effective date (when the system changes and transition plan are implemented) will be May 1, 2016. Medi-Cal is based on full month eligibility, so if an individual is eligible for one day of a given month, they are eligible for the entire month. There are two populations of children impacted by this change in Medi-Cal coverage.

- **New Enrollee Population:** Individuals under the age of 19 who meet all eligibility requirements for SB 75 but are not enrolled in the Medi-Cal program at the implementation of SB 75. These individuals will need to apply for Medi-Cal through the current application process. It is estimated that approximately 55,000 undocumented children under the age of 19 are currently eligible but not enrolled, DHCS estimates 50 percent will take up coverage over a 12-month period, once the program is operational.

- **Transition Population:** Individuals under the age of 19 who are currently enrolled in restricted scope Medi-Cal with unsatisfactory immigration status. The budget estimates that 114,981 children are currently enrolled in restricted-scope Medi-Cal, these children will automatically transition to full-scope Medi-Cal. On April 15, 2016, DHCS mailed an outreach letter to 123,340 beneficiaries under the age of 19 and in restricted aid codes.

Subcommittee Staff Comment and Recommendation—Hold Open. It is estimated that currently 64,000 undocumented children have comprehensive health coverage through a Kaiser Permanente program. SB 997 (Lara) requires that if these children transition to full-scope Medi-Cal under SB 75, they would be enrolled in Kaiser Medi-Cal, in order to maximize continuity of care and coverage. Under DHCS's proposed plan and current law, these children would have to apply to Medi-Cal and choose a health plan, and possibly be placed in fee-for service Medi-Cal pending plan enrollment. Consumer advocates request that SB 997 be included as part of the budget. However, it is not clear how this change could be implemented timely. It is also not clear how DHCS will identify these children, as they are currently in a non-Medi-Cal Kaiser plan.

Questions.

1. Please provide an overview of this issue.

2. Is DHCS on target to implement this change on May 16th? When will the state know if it is able to make the required system changes?

Issue 6: Medi-Cal: 1115 Waiver Renewal - "Medi-Cal 2020" Resources

Budget Issue. Through a Spring Finance Letter, DHCS requests a combination of two-year and five-year limited-term resources of $10,818,000 ($5,409,000 General Fund) to support the implementation of California's new 1115 waiver, "Medi-Cal 2020." Within the expenditure authority requested, $14,200,000 will be used for contractual services over the span of 5 years.

As California continues to be a leader in implementing the Affordable Care Act (ACA), operating the nation's largest Medicaid program, the Brown Administration and California's public hospital systems plan to use the Medi-Cal 2020 to build on the efforts of the previous 1115 waiver, "Bridge to Reform (BTR)," by expanding and sustaining the delivery of high quality, cost effective care over time. The renewal of the Medicaid waiver is a fundamental component to California's ability to continue to successfully implement the ACA beyond the primary step of coverage expansion.

According to DHCS, with the renewal of the 1115 waiver, the goal of the Medi-Cal program will be a transformation of the current health care delivery system and payment structure for the continued success and viability. The positions requested, which span over multiple divisions, will be utilized to help implement and administrate the several proposed programs of Medi-Cal 2020:

- Dental Transformation Initiative Program
- Public Hospital Redesign & Incentives in Medi-Cal Program (PRIME)
    - Alternative Payment Methodology (APM) Benchmark for PRIME Entities
- Whole Person Care Pilots
- Global Payment Program for the Remaining Uninsured
- Other requirements as set forth in the Special Terms and Conditions (STCs)

According to DHCS, these programs, as well as the resources allocated to them, are entirely new concepts that were not included in the BTR waiver and therefore have no existing DHCS employees assigned to them.

Along with these programs, Medi-Cal 2020 also requires several assessments, evaluations, and achievement of benchmarks which will require significant tracking and workload. These administrative requirements include:

- Independent Hospital Assessments (2016 and 2017)
- Independent Assessment of Access
- Global Payment Program Evaluations
- Hospital Redesign and Incentives in Medi-Cal Program (PRIME) Program Evaluations
- Other waiver component evaluations

The following chart identifies organizationally where the resources are located within DHCS, the equivalent of staffing and classifications requested, and the area of Medi-Cal 2020 they will be focusing on:

Organization	**Resources Requested Equivalent to 31.0 Staffing** (7/1/2016 – 6/30/2021)	**Medi-Cal 2020 Program Activity**
Office of the Medical Director	3.0 Limited Term Positions • Medical Consultant I • 2.0 - Associate Gov. Program Analyst	• Hospital Redesign and Incentives in Medi-Cal Program(PRIME) Program
Office of Legal Services	2.0 Limited Term Positions • 2.0 Attorney IV	• Overall legal support for any waiver related activities and intersections with the program at large, which including but is not limited to: o Federal/State and State/local and state negotiations o Draft/review/analyze of legislation, policy, guidance, contracts, etc. o Statutory and regulatory interpretation
Medi-Cal Dental Services Division	12.0 Limited Term Positions • 2.0 - Research Analyst II • 7.0 - Associate Gov. Program Analyst • Dental Hygienist Consultant Staff • 2.0 - Information Systems Analyst Specialist	• Dental Transformation Initiative Program
Managed Care Quality and Monitoring Division	9.0 Limited Term Positions • Staff Services Manager I • 2.0 - Research Program Specialist II • 4.0 - Associate Gov. Program Analyst • Research Analyst II • Health Program Specialist	• Whole Person Care Pilots o Increased Access to Housing and Supportive Services • Independent Assessment of Access • Integration and Care Coordination • Community-Based Adult Services (CBAS) fraud • Alternative Payment Methodologies
Safety Net Financing Division	2.0 Limited Term Positions • Research Analyst II • Research Program Specialist I	• Global Payment Program • Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME) payments
Administration Division	2.0 Limited Term Positions • Associate Personnel Analyst • Associate Accounting Analyst	• Administration – all programs
Research and Analytics Studies Division	1.0 Limited Term Position • Research Scientist III	• Statistical reporting • Analytic data file creation and hierarchical risk modeling • Institutional knowledge and context for all projects • Study design and analyses of health care outcomes, expenditures, and utilization

Background. California's 1115 Waiver Renewal, called Medi-Cal 2020, was approved by the Centers for Medicare and Medicaid Services on Dec. 30, 2015. Medi-Cal 2020 will guide the state through the next five years to transform the way Medi-Cal provides services to its 12.8 million members, and improve quality of care, access, and efficiency. Some of the key programmatic elements of Medi-Cal 2020 are:

- Public Hospital Redesign and Incentives in Medi-Cal (PRIME). This program builds on the success of the state's Delivery System Reform Incentive Program (DSRIP), which was the first such transformation effort in the nation. Under PRIME, Designated Public Hospital (DPH) systems and District Municipal Public Hospitals (DMPHs) will be required to achieve greater outcomes in areas such as physical and behavioral health integration and outpatient primary and specialty care delivery. Additionally, PRIME requires DPHs to transition managed care payments to alternative payment methodologies, moving them further toward value-based payment structures over the course of the waiver. PRIME offers incentives for meeting certain performance measures for quality and efficiency. Over the course of the five-years, federal funding for PRIME for DPHs is $3.27 billion, and for DMPHs is $466.5 million.
- Global Payment Program (GPP). This is a new program aimed at improving the way care is delivered to California's remaining uninsured. GPP transforms traditional hospital funding for DPHs from a system that focuses on hospital-based services and cost-based reimbursement into a value-based payment structure. Under the GPP, DPHs are incentivized to provide ambulatory primary and preventive care to the remaining uninsured through a value-based payment structure that rewards the provision of care in more appropriate settings. This new approach to restructuring these traditional hospital-focused funds allows California to better target funding for the remaining uninsured and incentivize delivery system change, focusing on the provision of primary and preventive care, and shifting away from avoidable emergency room and hospital utilization.
- Dental Transformation Initiative (DTI). For the first time, California's Waiver also includes opportunities for improvements in the Medi-Cal Dental Program. The DTI provides incentive payments to Medi-Cal dental providers who meet certain requirements and benchmarks in critical focus areas such as preventive services and continuity of care. Over the course of the waiver, up to $750 million in annual funding is available under DTI.
- Whole Person Care (WPC) Pilots. Another component of Medi-Cal 2020 will allow for county-based pilots to target high-risk populations. The overarching goal of the WPC pilots is the integration of systems that provide physical health, behavioral health, and social services to improve members' overall health and well-being, with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC pilots may also choose to expand access to supportive housing options for these high-risk populations. The waiver renewal authorized up to $1.5 billion in federal funding over the five-years; WPC pilot lead entities will provide the non-federal share.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

Issue 7: Waiver Personal Care Services and Fair Labor Standards Act

Oversight Issue. On February 1, 2016, a new overtime rule under the federal Fair Labor Standards Act (FLSA) was implemented, requiring overtime pay for In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) providers when they work more than 40 hours in a workweek.

Providers exceeding the maximum number of hours allowed to work in a workweek for WPCS services will receive a violation up to monthly for instances of non-compliance. Initially, a three-month grace period from February 1, 2016, through April 30, 2016, was established to allow a transition period for providers to understand the requirements.

However, on April 27, 2016, DHCS extended this grade period for WPCS participants and their providers, who provide IHSS or WPCS or both, from May 1 to September 1, 2016. Providers will not receive any violations during this extended grace period. DHCS noted that additional time was needed to program information technology systems.

Background. On February 1, 2016 due to federal law, the FLSA, new overtime rule requires overtime pay for IHSS and WPCS providers when they work more than 40 hours in a workweek. Pursuant to state law, the maximum number of hours a provider is allowed to work in a workweek is 70-hours and 45-minutes.

However, WPCS has always been subject to a maximum work day of 12 hours, thus pursuant to new state law personal care services are not to exceed 70-hours and 45-minutes a workweek of IHSS and WPCS combined, or 66 hours a workweek if a provider is providing services to more than one participant. The waiver participant may be required to select one or more additional providers to ensure sufficient hours of care provided each day.

Exemptions. As of May 1, 2016, DHCS will allow some extra overtime hours up to the waiver limit (a 12-hour workday or 360 hours per month) for providers who meet one of the criteria listed in the exemption letter. The exemption criteria apply to WPCS participants who were enrolled in a waiver on January 31, 2016. DHCS will allow more overtime on a case-by-case basis, if:

1. The care provider lives in the same home as the waiver participant. They do not have to be a family member; or
2. The care provider is now giving care to the waiver participant and has done so for two or more years without a break; or
3. DHCS agrees that there are no other possible care providers near the waiver participant's home. The waiver participant must work closely with DHCS care managers to try to find more care providers.

DHCS estimates that 440 participants would likely be eligible for an exemption and 160 would pursue an exemption. (There are 1,800 WPCS participants.)

DHCS indicates that while completing the system requirements for automatic determination of violations in the WPCS programs, staff will be monitoring time cards manually. Providers are reminded that starting May 1, the following limits are in place and must be adhered to:

Providers who work for two or more participants:

- Can work up to 12-hours in a day, and up to a 66-hour work week.

Providers who work for one participant:

- Can work up to 12-hours in a day, and up to a 70-hour and 45-minute work week, not to exceed 283 hours worked in a month.

Waiver participants who have more than one provider working for them and their provider does not work for any other participants:

- Providers can work up to a 70-hour and 45-minute work week.
- The total hours worked by any one provider cannot be more than 283 hours in a month.

DHCS indicates that program staff will work with individual WPCS participants and their providers as necessary to correct inadvertent errors on a provider time card. In addition, DHCS states it will monitor timesheets closely to identify any egregious overtime violations. Should this occur, DHCS states it reserves the right to impose a manual violation on a provider.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. How is DHCS working with stakeholders on messaging this extension?

3. Did DHCS send letters to WPCS participants and providers specifying the process by which to request an exemption? Is the exemption process in effect?

Issue 8: Home and Community-Based Services (HCBS) Federal Requirements

Budget Issue. DHCS requests limited-term resources of $1,112,000 ($491,000 General Fund) to fund the following:

1. **HCBS Federal Requirements.** Three-year limited-term resources to comply with the Centers for Medicare and Medicaid Services (CMS) Federal Regulations (2249-F and 2296-F) on Home and Community-Based Settings Final Rule for existing Home and Community-Based Services (HCBS) providers and beneficiaries promulgated on March 17, 2014.

2. **Statewide Transition Plan (STP).** Four-year limited-term resources to work on the CMS approved Assisted Living Waiver (ALW) program, coordinate activities with the STP and ensure ongoing compliance of ALW providers with the HCBS final rule. Resources will also address continued work to meet existing Community-Based Adult Services (CBAS) workload, coordinate activities with the STP and ensure ongoing compliance of CBAS providers with the HCB Final Rule. The resources will address work done currently by limited-term positions that are set to expire 6/30/16.

Background. California's Medi-Cal Home and Community-Based Services (HCBS) programs are designed to offer safe and appropriate home and community-based care to individuals in lieu of long-term institutional placement. These programs serve about 500,000 individuals and are implemented by various state departments including the Department of Health Care Services (DHCS), the Department of Developmental Services (DDS), the California Department of Aging (CDA), and the California Department of Public Health (DPH). The state receives almost $7 billion annually in federal funds for these programs.

California's HCBS programs are implemented through the following:

- **1915(c) Waivers.** The federal government authorized the "Medicaid 1915(c) Home and Community-Based Services Waiver program" in 1981. The original intent of the HCBS Waiver program was to slow the growth of Medicaid (Medi-Cal in California) spending by providing services in less expensive settings. In order to contain costs, the federal legislation limited waiver services to individuals who would be institutionalized if the services were not provided. However, the costs of those waiver services cannot be higher than what they would cost in an institutional setting.

  The law permitted states to waive certain Medicaid program requirements and in doing so, deviate from Medicaid requirements, such as providing services only in certain geographic areas ("waive statewideness"). The HCBS Waiver program also allowed states flexibility to offer different types of services to individuals with chronic disabilities. Prior to this, with the origin of Medicaid in 1965, beneficiaries could only receive comprehensive long-term care in institutional settings.

  The waiver can be designed for a variety of targeted diagnosis-based groups including individuals who are elderly, and those who have physical, developmental, or mental health disabilities, or other chronic conditions such as Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). The waiver can be designed to offer a variety of services including case

management, personal attendant services, adult day health care services, habilitation services, day treatment services, psychosocial rehabilitation services, mental health services, and other services specifically requested by the state. 1915(c) HCBS waivers have subsequently become mechanisms for many states, including California, to provide Medicaid-funded community-based, long-term care services and supports to eligible beneficiaries.

California's 1915(c) HCBS wavier programs are:

- **Multipurpose Senior Services Program (MSSP) Waiver** (administered by CDA). The objective of this program is to provide opportunities for frail seniors age 65 or older to maintain their independence and dignity in community settings by preventing or delaying avoidable nursing facility placement. There are about 12,000 participants in this program.

- **HIV/AIDS Waiver** (administered by DPH). The purpose of this waiver is to allow persons of all age with mid- to late-stage HIV/AIDS to remain in their homes through a continuum of care designed to stabilize and maintain an optimal level of health, improve quality of life, and provide an alternative to institutional care in hospitals or nursing facilities. There are about 3,200 participants in this program.

- **Developmental Disabilities (DD) Waiver** (administered by DDS). The purpose of this waiver is to serve beneficiaries of all ages in their own homes and community settings as an alternative to placement in hospitals, nursing facilities or intermediate care facilities for persons with developmental disabilities (ICF-DDs). There are about 150,000 participants in this program.

- **Assisted Living Waiver (ALW)** (administered by DHCS). This waiver offers eligible seniors and persons with disabilities age 21 and over the choice of residing in either a licensed Residential Care Facility for the Elderly or an independent publicly subsidized housing with Home Health Agency services as alternatives to long-term institutional placement. There are about 4,000 participants in this program.

- **Nursing Facility/Acute Hospital (NF/AH) Waiver** (administered by DHCS). This waiver offers services in the home to Medi-Cal beneficiaries with long-term medical conditions, who meet the acute hospital, adult subacute, pediatric subacute, ICF-DD-continuous nursing, and nursing facility A/B levels of care with the option of returning and/or remaining in their home or home-like setting in the community in lieu of institutionalization. There are about 3,500 participants in this program.

- **In-Home Operations (IHO) Wavier** (DHCS). This waiver was originally developed for those individuals who had been continuously enrolled in a DHCS administered waiver prior to January 1, 2002 and who primarily receive direct services rendered by a licensed nurse. This waiver offers services to Medi-Cal beneficiaries with long-term medical conditions in their home or a home-like setting in the community in lieu of institutionalization. There are about 125 participants in this program.

- **San Francisco Community Living Support Benefit (SFCLSB) Waiver** (administered by San Francisco Department of Public Health). This waiver utilizes certified public expenditures for provision of waiver services to persons with disabilities age 21 and over who reside in the City

or County of San Francisco and who are either homeless, residing in a nursing facility, or are at imminent risk of entering a nursing facility. There are about 17 participants in this program.

- **Pediatric Palliative Care (PPC) Waiver** (administered by DHCS). This waiver offers children with life limiting conditions a range of home-based hospice-like services while they maintain the option of receiving curative treatment. There are about 1,800 participants in this program.

- **1115 Waiver - Community-Based Adult Services (CBAS).** CBAS offers center-based services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. There are about 32,000 participants in this program.

- **1915(i) State Plan Program.** Starting January 1, 2007, the Deficit Reduction Act of 2005 (DRA) gave states a new option to provide HCBS through their state plans. Once approved by CMS, state plans do not need to be renewed nor are they subject to some of the same requirements of waivers. Under this option, states set their own eligibility or needs-based criteria for providing HCBS. States are allowed to establish functional criteria in relation to certain services. The DRA provision eliminated the skilled need requirement and allowed states to cover Medicaid beneficiaries who have incomes no greater than 150 percent of the federal poverty level and who satisfy the needs-based criteria. The Patient Protection and Affordable Care Act of 2010 created several amendments including elimination of enrollment ceilings, a requirement that services must be provided statewide, and other enrollment changes.

  California currently has an approved 1915(i) State Plan program that allows the state to access federal financial participation for services provided to individuals with developmental disabilities who do not meet the institutional level-of-care criteria required for participation in the 1915(c) HCBS DD Waiver. There are about 32,000 participants in this program.

- **1915(k) Community First Choice (CFC) State Plan Program - IHSS.** This program provides IHSS services to individuals who meet a nursing facility level of care and allows an individual to live safely in his/her own home. CFC-IHSS services are provided in consumer-controlled homes. By being in the community and self-directing care, the individual is able to control their environment to the maximum extent consistent with their capabilities and needs. There are about 220,000 participants in this program.

New Home and Community-Based Setting Requirements. In January 2014, CMS announced it had finalized important rules that affect HCBS waiver programs and 1915(i) state plan programs provided through Medicaid/Medi-Cal, and subsequently published regulations in the Federal Register on January 16, 2014. The rules became effective 60 days from publication, or March 17, 2014. The state must fully comply with these rules by March 17, 2019. If the state does not comply with these rules it would be at risk of losing federal funds.

The purpose of the final rule is to ensure that individuals receive HCBS in settings that are integrated in and support full access to the greater community. The final rule also aims to ensure that individuals have a free choice of where they live and who provides services to them, and that individual rights and freedoms are not restricted, among other provisions.

Prior to the final rule, home and community-based (HCB) setting requirements were based on location, geography, or physical characteristics. The final rule defines HCB settings as more process and outcome-oriented, guided by the consumer's person-centered service plan by:

- Being integrated in and supporting full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

- Giving individuals the right to select from among various setting options, including non-disability specific settings and an option for a private unit in a residential setting.

- Ensuring individuals' rights of privacy, dignity and respect, and freedom from coercion and restraint.

- Optimizing autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.

- Facilitating choice regarding services and supports, and who provides them.

For Medicaid/Medi-Cal provider-owned or controlled HCB residential settings, the provider must offer:

- A legally-enforceable agreement between the provider and the consumer that allows the consumer to own, rent or occupy the residence and provides protection against eviction.

- Privacy in units including lockable doors, choice of roommates and freedom to furnish and decorate units.

- Options for individuals to control their own schedules including access to food at any time.

- Individual's freedom to have visitors at any time.

- A physically-accessible setting.

DHCS Lead State Agency. DHCS acts as the Single State Medicaid Agency for the 1915(c) and 1115 waivers and 1915(i) and 1915(k) state plan programs. DHCS as the Single State Medicaid Agency is responsible for the funding and administration, monitoring and oversight for all of the HCBS programs. DHCS has taken the lead role to ensure all affected departments, programs, and their providers are aware of and collaborate with DHCS to come into compliance with the new federal HCBS setting final rule. On December 19, 2014 and again on August 14, 2015, DHCS submitted its "Statewide Transition Plan (STP) for Compliance with Home and Community Based Settings Rules" to CMS.

In the STP, DHCS highlights the various phases of implementation the state has taken and will take to achieve compliance with the HCB settings requirements:

- Education and Outreach. Information and education on the requirements of the HCB settings requirements and the regulations will be provided to state departments, consumers and families, regional centers, providers, advocacy groups, and other interested stakeholders on an ongoing basis.

- Systematic Assessment of Statutes, Regulations, Policies, and Other Requirements. DHCS and the other state departments have reviewed statutes, regulations, policies, and other requirements for residential and nonresidential HCB settings to determine the extent to which the state's standards comply with federal regulations. Stakeholders participated in and provided input to most aspects of this process.

- Compliance Determination Process for HCB Settings. An initial sample of on-site assessments will be completed as part of the existing monitoring and oversight processes and further on-site assessments will be conducted based on provider/beneficiary self-surveys. The final list of settings to have an on-site assessment will be completed and reported with timeframes for completion of on-site assessments and a plan for bringing sites into compliance as needed.

- Role of Person-Centered Planning. The impacted state departments will use a stakeholder process to evaluate the role of person-centered planning, as it relates to determining compliance with the federal regulations, assessing consumer satisfaction with the setting options, and other possible community integration issues.

- Appeal Process. The state will research existing appeals processes and determine the feasibility of incorporating the HCB setting appeal and complaint process into current structures.

- Compliance Monitoring. Each program will use self-surveys, on-site assessments, and/or other data collection methods to develop remedial strategies and monitor progress toward compliance with the federal regulations.

- Plan Updates and CMS Reporting. Progress on the STP will be continuously monitored and reported to CMS, as needed.

DHCS proposes the following timeline to comply with the new HCBS rules:

Timeline to Comply with New HCBS Rules

2014 THROUGH 2019	START	FINISH
CMS Rules Implemented	----------	03/17/2014
STP Drafted and Reviewed by CMS	09/2014	03/2015
STP Revised with CMS Approval	03/2015	08/2015
Stakeholder & Public Meeting Input	09/2014	12/31/2018
Develop Review, Approval & Publication of On-Site Assessment	05/2014	08/2015
Develop Review, Approval & Publication of Provider self-Assessment Survey	07/2014	12/2016
Develop Review, Approval & Publication of Beneficiary Assessment Survey	09/2015	12/2015
Develop Review, Approval & Publication of Setting Analysis & Remedial Action Timeline	05/2015	12/2016
On-site Evaluations and Assessments	07/2015	12/2018
Assessment of Statutes, Regulations, Polices	07/2014	08/2015
Survey Team Training	06/2015	12/2015
Collect Assessment Data	01/2016	03/2018
Develop & Implement Tracking Database System	07/2015	02/2019
Enter data into tracking system	07/2015	12/2018
Provide Data Reports of Outcome	07/2017	12/2018
Develop, Review, Approve and Implement a Complaint and Appeals Process	06/2015	02/2019
Conduct Remedial & Action Strategies	01/2018	12/2018
Provide Final Report to CMS	09/2018	02/2019
Monitoring and Oversight of Compliance	03/2019	6/30/2019

Subcommittee Staff Comment and Recommendation—Hold Open. The following issues should be considered:

CMS Has Not Yet Approved State's Transition Plan. On November 16, 2015, CMS sent a letter to DHCS indicating that further information regarding, among other things, the settings impacted by the new HCBS rule, the timelines for many of the milestones outlined within the STP, and the state's plan for relocating beneficiaries, if needed. Additionally, CMS noted that:

> *The state has omitted from the STP several key details about the site-specific assessment process including: when provider self-surveys will be completed, how the state will ensure responses from providers, how beneficiary surveys will be matched to provider assessments, how beneficiary and provider surveys will be used to identify settings that require on-site assessment, an estimate of the number of on-site assessments, how the state will ensure coordination across on-site assessments, and how the on-site assessment tool would be used to categorize compliant and non-compliant settings.*

It will be important for DHCS to continue to engage with providers and consumers on defining the outstanding process details to address CMS's concerns and get approval of the STP.

DHCS indicates that it plans to finish discussions with CMS regarding outstanding issues related to the STP by the end of May. At that point, a 75-day clock (including a 30-day public comment period) starts and the state must re-submit the revised STP to CMS.

Coordinated Statewide Approach is Critical. The new federal rules are based on important principals that individuals have a free choice of where they live and who provides services to them, and that individual rights and freedoms are not restricted. It is critical that these principles are implemented consistently across the state's programs and agencies. It is DHCS's responsibility as the Single State Medicaid Agency to oversee this implementation and that it lead other departments in strategies to ensure compliance by 2019.

Early and Frequent Consumer and Provider Education is Essential. Concerns have been raised by providers that the state has not provided sufficient direction on how these new federal rules may impact the various types of providers. While the state is still awaiting direction from CMS, it is essential that state departments, under DHCS's direction, communicate as soon as possible what needs to change and the processes that will be developed to measure and ensure compliance with the new HCBS rule. Clear guidance on what is needed to come into compliance and the state's commitment of resources to support programs to move towards compliance is essential to successful implementation of this new rule.

Questions.

1. Please provide an overview of this issue.

2. When does DHCS plan to resubmit the STP? What outstanding questions/issues remain?

3. Is the state prioritizing its assessment of HCBS programs and settings? If so, what criteria is it using (e.g., maximization of federal financial participation)? Is there a plan to ensure sufficient resources for this process?

4. How is DHCS ensuring a coordinated and consistent statewide implementation of the HCBS rule?

5. How is DHCS sharing best practices on the implementation of this new rule across the impacted state agencies?

6. Has DHCS assessed whether or not some of these services will not comply with the HCBS rule before the March 2019 deadline? Will the state continue to fund these services?

7. Has DHCS reviewed Tennessee's Transition Plan? Is there anything the state can learn from this plan? (Tennessee was the first state to have their HCBS waiver transition plan approved by CMS.)

8. Is the state considering changes to licensing requirements for the facilities impacted by this new federal rule? How is DHCS working with the Department of Social Services on this?

Issue 9: California Community Transitions Demonstration Project

Budget Issue. DHCS requests five-year limited-term resources of $941,000 (federal funds) to continue work related to the federal Money Follows the Person (MFP) Rebalancing Demonstration, which was extended by the Centers for Medicare and Medicaid Services (CMS) for an additional five years through September 30, 2020. The MFP Rebalancing Demonstration is known as the California Community Transitions (CCT) Demonstration Project in the state. This request coincides with the grant period and close out reporting to CMS. The CCT Demonstration Project is 100 percent federally funded through the MFP grant.

The requested resources will address the workload performed by existing limited-term positions currently set to expire on June 30, 2016. Acording to DHCS, these resources are necessary to maintain the current program, meet MFP benchmarks, build the capacity of the Home and Community-Based Services (HCBS) delivery system and providers to sustain institution-to-community transitions beyond the expiration of the MFP grant, and to adequately implement MDS 3.0 Section Q to comply with the U.S. Supreme Court's Olmstead Decision. CCT currently draws down 87 percent Federal Medical Assistance Percentage (FMAP) as compared to 50 percent for standard Medi-Cal beneficiary assistance.

Background. In 2005, Congress authorized the MFP Rebalancing Demonstration and grant funding under the Deficit Reduction Act (P.L. No. 109-171); and in 2010, Congress extended MFP grants through September 30, 2016 under the Patient Protection and Affordable Care Act (P.L. 11-148). Current authorization of the MFP Demonstration is set to expire at the end of 2016; however, federal regulation allows MFP grantees to continue to spend grant funding through September 30, 2020 by way of supplemental budgets awarded in federal fiscal year 2016.

In order for a state to receive authorization to use remaining grant funding for the provision of MFP services, grantees were required to submit a sustainability plan that details projected methods for continuing the program and the steps necessary to continue to rebalance the long-term care system and increase transition activities during the final years of the Demonstration. California's approach to developing a Sustainability Plan was accepted on November 6, 2015. The official approval of the budget through September 30, 2020 will be issued by the CMS Office of Acquisition and Grants Management pending review of the final supplemental budget request submitted on October, 1, 2015.

The MFP Demonstration targets Medicaid beneficiaries of all ages who have nursing level-of-care need, and who have continuously resided in hospitals, nursing facilities (NFs), or intermediate care facilities for persons with developmental disabilities (ICF-DD) for three months or longer. CMS views the MFP Demonstration as part of a comprehensive, coordinated strategy to assist states, in collaboration with stakeholders, to make widespread changes to long-term care delivery systems across the nation.

According to DHCS, the five-year limited-term resources are necessary to ensure the CCT program is supported and run in an efficient manner through the remainder of the grant. The requested resources will address work related to overseeing the day to day operations of the program as well as the ongoing reporting requirements to CMS necessary to draw down grant funding. The workload will also include review of medical documentation and care plans for CCT participants to assess service needs, assess

treatment authorization requests, and determine appropriate waiver service eligibility for potential CCT participants. Additionally, the resources will support monitoring and oversight of the 30 contracted lead organizations responsible for transitioning frail, elderly and disabled beneficiaries out of NFs and will allow DHCS to provide guidance to those organizations when necessary.

According to DHCS, approval of this proposal will allow the state to:

1. Work to transition an additional 2,500 eligible individuals to the community setting of their choice who would otherwise have no option but to live in long-term care institutions.
2. Receive an additional 25 percent in enhanced FMAP for providing qualified HCBS to CCT Participants in their own homes for 365-days after discharge from an inpatient facility. By meeting grant benchmarks, the state can save approximately $100 million in payments to health care facilities in the next five years.
3. Reinvest General Fund savings to provide HCB LTSS to Medi-Cal beneficiaries who are not eligible for CCT, but who prefer to move out of long-term inpatient facilities. As a condition of receiving the federal MFP grant, California is committed to investing the savings it realized from the enhanced FMAP (approximately $27 million) into transitioning additional individuals out of inpatient care facilities.
4. Generate ongoing savings by providing services to individuals in the community instead of in Medi-Cal inpatient facilities. CCT will reduce Medi-Cal inpatient facility expenditures attributed to full scope inpatient facility care by an average of 40 percent by providing services to the same individuals in the community.

The request is for five-year limited-term resources to support the following expected outcomes:

- MFP will meet the benchmark of 2,500 transitions by September 30, 2020.
- Data reports to CMS will be submitted on time for inclusion in national data reporting.
- Nursing facilities will properly refer individuals to LCAs for options counseling.
- MFP will add eight lead organizations for a total of 40 to achieve statewide coverage.
- MFP will save the state $129,526,551 in funding by transitioning 2,500 beneficiaries from nursing facilities to the community (HCBS savings + enhanced FMAP).

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

2. How is the state reinvesting General Fund savings to provide HCB LTSS to Medi-Cal beneficiaries who are not eligible for CCT, but who prefer to move out of long-term inpatient facilities? (As a condition of receiving the federal MFP grant, California is committed to investing the savings it realized from the enhanced FMAP, approximately $27 million, into transitioning additional individuals out of inpatient care facilities.)

Issue 10: Medi-Cal: PACE Modernization

Budget Issue. DHCS proposes trailer bill language to enable modernization of the Program for All-Inclusive Care for the Elderly (PACE). The proposed legislative changes would:

- **Rate Setting**: Standardize rate-setting to DHCS to determine comparability of cost and experience between PACE and like population subsets served through Long-Term Services and Supports (LTSS) integration into managed care health plans under the Coordinated Care Initiative. Statutory change is necessary as DHCS is currently required to use a Fee-for-Service (FFS) equivalent cost/upper payment limit methodology to set capitation rates for PACE Organizations.
- **Remove Cap on the Number of PACE Organizations**: Remove existing statutory language that caps the number of PACE Organizations with which DHCS can contract.
- **Remove Not-for-Profit Requirement**: Remove existing statutory language to align with updated PACE federal rules and regulations.
- **PACE Flexibilities**: Add new statutory language enabling DHCS to seek flexibility from the Centers for Medicare and Medicaid Services (CMS) on several issues including the composition of the PACE interdisciplinary team (IDT), the frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and development of a streamlined PACE waiver process.

Background. PACE enrollment in the state is voluntary for Medi-Cal beneficiaries. Federal regulations (Title 42, Code of Federal Regulations, Section 460.162) specify that a PACE participant may voluntarily disenroll from the program without cause at any time. Participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. The PACE program becomes the sole source of Medicare and Medi-Cal services for PACE participants.

The PACE model of care provides a comprehensive medical/social service delivery system using an IDT approach that provides and coordinates all needed preventive, primary, acute and LTSS. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model affords eligible individuals to remain independent and in their homes for as long as possible. The PACE plan receives a monthly Medicaid and/or Medicare capitation payment for each enrolled participant and retains full risk for the cost of all Medicare and Medi-Cal services as well as any additional services determined necessary by the PACE IDT.

The PACE population is comprised predominantly of beneficiaries dually eligible for Medicare and Medi-Cal, and the seniors and persons with disabilities (SPD) Medi-Cal only population. These populations have been transitioned to the Medi-Cal managed care delivery system over the past five years under California's Bridge to Reform Section 1115 Medicaid Waiver. As a result, the enrollment base for PACE Organizations has changed from a majority FFS population to a managed care population over the last four years.

Rate Setting: The PACE FFS rate methodology does not take into account plan-specific experience and utilization when setting PACE rates. Pursuant to subdivision (e)(1) of Welfare and Institution (W&I) Code Section 14593, DHCS is required to "establish capitation rates paid to each PACE organization at no less than 95 percent of the FFS equivalent cost, including DHCS's cost of administration, that DHCS estimates would be payable for all services covered under the PACE organization contract if all those services were to be furnished to Medi-Cal beneficiaries." However, there is an erosion of FFS data as Medi-Cal transitions to a managed care delivery system creating a fundamental issue with the current FFS equivalent PACE rate methodology DHCS is required to use to set rates. In December 2015, CMS issued guidance updating rate setting criteria for PACE Medicaid capitation rates. As part of this guidance, CMS has stated that new managed care rates must be based on data no older than three years. The current rate methodology needs to change to address any future data credibility issue(s) regardless of what type of new methodology is established.

Consequently, legislation is required to move away from the traditional FFS equivalent rate methodology to set capitation rates for the PACE organizations and instead implement actuarially sound rates based on plan-specific cost, service utilization, quality and performance based measures utilized for other managed care health plan models contracting with DHCS. The FFS equivalent rate methodology specified in state statute is not in alignment with the plan-specific cost and experience-based rate methodology that is utilized for other managed care health plans contracting with DHCS. The scope of the rate methodology utilized for managed care health plans is defined in W&I Code Section 14301.1. A change to the current rate calculation methodology is necessary and alignment of rate methodologies between PACE and managed care health plans is appropriate. Standardizing rate-setting will allow DHCS to determine comparability of cost and experience between PACE and like population subsets served through managed care health plans that provide care to similar populations.

Cap on the Number of PACE Organizations: Removal of the existing cap on the number of PACE organizations with which DHCS can contract, as proposed, will promote better alignment with DHCS's Strategic Plan initiative 2.1 to support integrated linkages between systems of care. Removing the PACE organization cap will allow continuing expansion of PACE in California, which aligns with ongoing DHCS efforts to transition to a statewide managed care delivery system. Currently, there are eleven PACE organizations that are in operation with three additional interested applicants.

To achieve this goal, a statutory change is necessary as DHCS is currently limited by subdivision (a)(2) of W&I Code Section 14593 to contracting with no more than 15 PACE organizations (language removing the cap will be contingent upon federal approval of the experience-based rate methodology).

Not-for-Profit Requirement: Removal of the existing specification that DHCS enter into contracts only with nonprofit organizations for the purpose of implementing PACE aligns with recently released federal guidance permitting for-profit entities to apply as PACE organizations. Removal of the nonprofit specification will also align with ongoing DHCS efforts to transition to a statewide managed care delivery system by further enabling continuing expansion of PACE in California.

To achieve this goal, a statutory change is necessary as DHCS is currently limited by subdivision (a)(1) of W&I Code Section 14593 to contracting with public or private "nonprofit" organizations for implementation of the PACE program. A related change in W&I Code Section 14592 that would modify the reference to federal law is intended to assure that an outdated federal regulation will not be a barrier to this clarification.

PACE Flexibilities: PACE continues to grow at a rate much faster than anticipated, expanding and evolving with the advent of newer health care delivery practices and methods, much unlike the rules governing PACE. Federal PACE regulations do not provide any flexibility in requirements of the composition of the PACE IDT and frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and the PACE waiver process. The lack of flexibility in the PACE regulations hinders PACE organizations from keeping up with current best practices and as a result disservices California participants that may benefit from newer methods. Enabling DHCS to seek flexibility in the federal PACE regulations allows for continued modernization of the program in addition to assisting PACE organizations in their efforts to provide the highest quality of care to Californians.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. Please describe how the new methodology is likely to impact existing rates?

3. What criteria does DHCS use to evaluate new PACE provider application? Who does DHCS consultant with on this evaluation?

Issue 11: Every Women Counts Program

Budget Issue. DHCS requests three-year, limited-term federal funds authority of $399,000 to perform programming, data analysis, and data management functions for the Every Woman Counts (EWC) program.

The proposed budget includes $32.2 million (special fund and federal fund) for EWC, a $5.7 million decrease from the 2015-16 estimate of $37.9 million, which primarily reflects a decrease in caseload as a result of the federal Affordable Care Act and the transition of EWC caseload to Covered California or Medi-Cal.

Background. The EWC provides breast and cervical cancer screenings to Californians who do not qualify for Medi-Cal or other comprehensive coverage. The EWC was transferred to DHCS from the Department of Public Health in 2012.

On January 30, 2015, the CDC issued a policy requiring EWC to implement a Patient Navigation/Case Management system and track outcomes for all women's breast and cervical cancer screenings, regardless of health coverage payer source. To meet the CDC grant requirement to monitor the quality of screening procedures, EWC collects recipient enrollment and outcome data from enrolled primary care providers through a web-based data portal known as DETEC. Recipient data is reported to CDC biannually and assessed for outcomes per CDC prescribed Core Program Performance Indicators (CPPI). Specific outcomes indicators include number of women rarely or never screened for cervical cancer and length of time from screening to diagnosis to treatment.

This proposal seeks to continue to provide the necessary resources to meet statutory mandates set forth by state and federal legislation. The CDC grant requires EWC to monitor the quality of screening procedures, collect recipient enrollment and outcome data from enrolled primary care providers. Recipient data is reported to the CDC biannually and assessed for outcomes per CDC prescribed Core Program Performance Indicators. Specific outcome indicators include the number of women who are rarely or never screened for cervical cancer and length of time form screening to diagnosis to treatment. Additionally, state law requires annual reports on the number of women served by EWC by race/ethnicity/geography, number diagnosed with cancer, number of women referred to treatment service and to project quarterly and annual expenditure reports and caseload data.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

Issue 12: Office of Family Planning Contract Conversion

Budget Issue. DHCS requests ten permanent, full-time state civil service positions and $1,458,000 ($637,000 General Fund) for 2016-17 and $1,368,000 ($596,000 General Fund) on-going to replace existing contracted staff. The requested positions will ensure adequate staffing levels to meet state Office of Family Planning (OFP) requirements and comply with Government Code Section 19130, which prohibits contracting out for services that can be performed by state civil servants.

The current contract funding is built within the Medi-Cal Local Assistance Estimate. DHCS proposes to discontinue the policy change in order to build the expenditure authority in the state operations budget. The current contract is annually budgeted at $2,861,000 ($1,430,000 General Fund). With the contract conversion to state civil service positions, there is an anticipated cost savings of approximately $1,403,000 ($793,000 General Fund) in year one and $1,493,000 ($834,000 General Fund) in year two and on-going.

Background. The OFP is established by Welfare and Institutions (W&I) Code §14500-14512. OFP is charged "to make available to all citizens of the state, who are of childbearing age, comprehensive medical knowledge, assistance, and services relating to the planning of families". The Family Planning, Access, Care and Treatment (Family PACT) program is administered by OFP and has been operating since 1997 to provide family planning and reproductive health services at no cost to California's low-income residents of reproductive age. Family PACT serves 1.8 million income-eligible men and women of childbearing age through a network of 2,300 public and private providers. Pursuant W&I Code §14501, other OFP functions and duties charged by the California Legislature include, but are not limited to:

- Establishing goals and priorities for all state agencies providing or administering family planning services.
- Coordinating all family planning services and related programs conducted or administered by state agencies with the federal government so as to maximize the availability of these services by utilizing all available federal funds.
- Evaluating existing programs and establishing in each county a viable program for the dispensation of family planning.
- Developing and administering evaluation of existing and new family planning and birth control techniques.

W&I Code §14501 requires OFP to conduct ongoing monitoring and evaluation of family planning services. OFP has historically used a personal services contract to hire staff to meet this mandate and to assist with the administration of the Family PACT program. Family PACT was previously operated under the authority of a Section 1115 demonstration waiver with a requirement to have an independent evaluation of the waiver's impact on reproductive health outcomes, utilization and costs, and access. The Centers for Medicare and Medicaid Services (CMS) required the waiver's impact to be monitored and evaluated to measure the program's goals. State Plan Amendment 10-014, approved by CMS in 2011 transitioned the Family PACT program into the Medicaid State Plan. The transition from a waiver program to a program under the Medicaid State Plan eliminated the requirements to have an independent evaluator provide monitoring and evaluation of the program's goals. However, the W&I

Code §14501 mandate remains, which requires OFP to conduct ongoing monitoring and evaluation of family planning services.

Since 1997, the Bixby Center for Global Reproductive Health at the University of California, San Francisco (UCSF) has had business agreements with OFP to provide data for policy and programmatic decisions through a multi-method approach that includes analysis of administrative data; assessment of provider and client perspectives; and medical record reviews. The UCSF business agreement includes a medical consultant who advises OFP regarding evidenced-based and clinical practice guidelines published by professional organizations with respect to reproductive health services.

The 2012 Budget Act transferred OFP/Family PACT from the California Department of Public Health (CDPH) to DHCS, effective July 1, 2012. In response to OFP's transition from the CDPH to DHCS, OFP and UCSF executed a contract amendment that changed the scope of services for years four and five of the UCSF 2010-2015 business agreement. The scope of services was expanded from evaluation and monitoring of Family PACT to the evaluation and monitoring of Medi-Cal family planning services. OFP has a longstanding commitment to evidence-driven policies and to quality improvement/utilization management (QI/UM) activities with respect to family planning and family planning-related services. Recently, OFP renewed its business agreement with UCSF for three years (Fiscal Years 2015-2016 through 2017-2018) to continue to perform on-going assistance in monitoring and evaluating the State's family planning programs to fulfill OFP's statutory requirement.

According to DHCS, the existing personal services contract does not meet the Government Code Section 19130 exemption requirements.

Below, lists the requested ten permanent positions, which are requested to perform critical functions for OFP, such as data programming, data collection and management activities to monitor the State's family planning programs:

- Medical Consultant I
- Pharmacy Consultant I
- Staff Services Manager II (Managerial)
- Research Scientist Supervisor I
- Research Scientist III
- Research Scientist II
- Staff Programmer Analyst
- Research Analyst II
- Research Analyst I (Demography)
- Research Analyst I (Geographic Information Systems)

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide an overview of this issue.

2. How will the state ensure that the evaluation remains objective?

Issue 13: Medi-Cal: Dental Fiscal Intermediary Turnover-Takeover

Budget Issue. Through a Spring Finance Letter, DHCS requests three-year expenditure authority of $2,052,000 ($514,000 General Fund) to support the equivalent of seven three-year limited-term positions and contractual services to address workload related to the conversion of the current Medi-Cal Dental Fiscal Intermediary. DHCS is presently securing two contracts, one for the dental Administrative Services Organization (ASO) and one for the dental California Dental Medicaid Management Information System (CD-MMIS) Fiscal Intermediary (FI) services. These resources are necessary to perform the turnover-takeover efforts of the FI and ASO from the current vendor.

Included in this request is $500,000 for an independent verification and validation consultant to provide oversight of this turnover-takeover and $500,000 for a project manager contract to assess the project's status, performance trends, milestones, and project completion.

Background. From 1966 to 1972, all claims for dental health care services rendered to Medi-Cal recipients were paid by a single FI and the state assumed full responsibility for costs. In 1973, with passage of the Waxman-Duffy Act, the State Legislature provided the opportunity for the State of California to explore the possibility of delivering dental care on a prepaid, at-risk basis (for services and administrative cost).

Under the provisions of the Waxman-Duffy Act, which became effective January 1, 1974, the state entered into a four year pilot project with California Dental Services, a.k.a. Delta Dental Plan of California, to provide dental care services on a prepaid, at-risk basis. Legislative action allowed the state to extend the pilot project leading to the first of several competitively bid contracts, under a prepaid, at-risk model. Since awarding the first contract to Delta Dental, it has subsequently prevailed as the incumbent contractor.

In 2011, Delta Dental was again selected as the awardee for the dental fee-for-service (FFS) contract which included both FI and ASO responsibilities on an at-risk basis. However, the Center for Medicare and Medicaid Services (CMS), upon review of the contract, determined the contract did not meet certain regulatory criteria and conditions under 45 Code of Federal Regulation (C.F.R.) Part 95 and 42 C.F.R. Part 433 as a MMIS related acquisition. CMS expressed significant concerns with the procurement of the 2011 contract structure and asked DHCS to modify the contracting delivery model or risk losing 75/25 federal financial participation (FFP) enhanced funding for MMIS activities. The main concerns identified by CMS are as follows:

- Non-compliance with Management Information System (MMIS) requirements.
- Use of an underwriting shared risk.
- Non-enforcement of Knox-Keene licensure requirements; and
- Use of a hybrid model of MMIS and administration within one (1) contract with underwriting risk sharing.

DHCS notified Delta Dental the 2011 contract award would not be approved by CMS and a re-procurement would be required. The current contract in place (which is an extension of the last fully executed contract from 2004 as approved by CMS) between DHCS and Delta Dental is set to expire on June 30, 2016.

DHCS is currently requesting approval for an additional extension of the current contract with Delta Dental to ensure a smooth one-year transition to the new ASO and FI contractors, and to allow enhanced FFP for MMIS activities during the re-procurement period leading up to the implementation of the new contracts on July 1, 2017. DHCS is also seeking federal approval of the Planning Advanced Planning Document (PAPD) for enhanced funding to procure the two new Contracts for the CD-MMIS FI services and the dental ASO. DHCS anticipates announcing the successful awardees in May 2016.

The selected FI contractor will be responsible for the turnover, operation, and eventual takeover of the California Dental Medicaid Management Information System (CD-MMIS), and for effective and efficient auto adjudication of claims and related documents. The selected contractor will take over the existing CD-MMIS and operate it to the satisfaction of State and federal regulations and requirements for FI services for Medi-Cal and other state health programs that provide dental services. Programs that currently utilize CD-MMIS for dental claims, Treatment Authorization Requests (TARs) processing and other dental related services include Medi-Cal, California Children's Services Program (CCS), the Genetically Handicapped Persons Program (GHPP) and Regional Center consumers.

The selected ASO Contractor will operate with the dental FI Contractor using the existing CD-MMIS. The ASO contractor will be responsible for the administrative functions that consist of monitoring and maintaining systems related to the operations portion of providing services to Medi-Cal beneficiaries. Those responsibilities include TAR and Adjudicated Claim Service Lines (ACSL) processing, maintaining the Telephone Service Center (TSC), and providing outreach efforts to both maintain and increase utilization.

The turnover and takeover of the existing FI and ASO responsibilities, managing two separate contracts for FI and ASO functions once the new contracts have been awarded, and overseeing the relationship between the existing and new FI and ASO vendors so that collaboration is achieved to best support the dental program is new workload that cannot be absorbed within existing resources. The requested resources will be located within the MDSD, Office of Legal Services (OLS), and Enterprise, Innovation, and Technology Services (EITS) – via managed resources.

CMS recently expressed concerns with certain elements of the current Dental FI Contract, including the fact that California operates two Medicaid Management Information Systems. In order to address CMS' concerns and with DHCS currently evaluating alternatives for the eventual migration to a single MMIS, DHCS released two competitive RFPs. One RFP solicited bids to provide administrative services for the Medi-Cal Dental Program and the other RFP was to obtain an FI that will support the CD-MMIS. This proposal requests the resources necessary to transition the ASO and FI functions and complete the turnover-takeover process. This is the first time DHCS is procuring for these functions separately, providing oversight, and making certain of collaboration between two vendors. Existing staff cannot perform or absorb the magnitude of management and administration required for a successful turnover-takeover process. These positions will provide the necessary resources to perform the required oversight throughout the turnover-takeover process. Without these resources, the department will be unable to perform the administration and oversight needed, and could result in a loss of enhanced federal funding.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

2. What improvements will this bring to the Denti-Cal program such as, improved access and utilization, expedited provider enrollment and beneficiary outreach?

Issue 14: Robert F. Kennedy Farm Workers Medical Plan (SB 145, 2015)

Budget Issue. DHCS requests five-year limited-term funding of $220,000 General Fund to implement provisions of SB 145 (Pan), Chapter 712, Statutes of 2015 and $100,000 General Fund is requested for a one-time system upgrade.

SB 145 requires DHCS to reimburse the Robert F. Kennedy Farm Workers (RFK) Medical Plan up to $3,000,000 annually for claim payments that exceed $70,000 on behalf of an eligible employee or dependent for a single episode of care, until January 1, 2021.

Background. RFK Medical Plan is a non-governmental, self-funded, self-insured health plan that is subject to collective bargaining agreements between the United Farm Workers (UFW) and multiple agricultural employers. The Affordable Care Act (ACA) bans annual and lifetime limits to plan coverage. The ACA allows for multi-employer plans with collective bargaining agreements to maintain a "grandfathered" status for some provisions, but not the annual and lifetime limits. Due to these prohibitions, RFK Medical Plan has stated that it will not be financially viable to continue without a subsidy. SB 145 requires DHCS to review claims submitted by RFK Medical Plan and reimburse the plan.

DHCS's Special Collection and Process Innovation Section is responsible for consultative and analytical work for a wide variety of Medicaid recovery and collections programs. The section is responsible for requesting and analyzing eligibility and service data to determine claim amounts, supporting litigation and collection activities, responding to customer inquiries, and developing new collection processes. DHCS is proposing to implement SB 145 requirements within this section.

In 2016-17, the requested resources will allow the department to make the following technical changes and procedural developments including:

- Develop regulations and departmental policies
- Develop standardized correspondence and departmental procedures
- Process and review incoming correspondence
- Make recommendations to help develop and implement technical infrastructure to house and pay claims received
- Respond to inquiries via phone and e-mail from the RFK Medical Plan, stakeholders, and members
- Prepare data releases for exchange of Protected Health Information (PHI) in accordance with Health Insurance Portability and Accountability Act (HIPAA) guidelines

In 2017-18, the department will shift from implementation related work to support and oversight, including:

- Continue to develop standardized correspondence and departmental procedures as needed
- Process and review incoming correspondence
- Review and analyze individual claims for 11,000 members (ongoing caseload), relating to a single episode
- Calculate reimbursements
- Track and monitor fund balance

- Create and route claims and invoices for payment
- Facilitate compliance with statutory timeframes
- Advise and provide recommendations to management
- Monthly meetings of internal technical group to meet ongoing program requirements

Also, according to DHCS, in 2016-17, the case management system will require a one-time system design notice at a cost of $100,000 to store claims data, create invoices, and provide necessary analytics/reports.

Maintaining these resources until 2021-22 will allow DHCS to process the final year of data which occurs beyond the sunset date of January 1, 2021, to provide reimbursement to the RFK Medical Plan.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

Issue 15: Hospital Quality Assurance Fee Extension

Issue. The California Hospital Association (CHA) requests that the Subcommittee consider trailer bill language to extend the sunset date of the hospital quality assurance fee (QAF); the current QAF sunsets January 1, 2017. CHA requests the sunset date be extended one year to January 1, 2018.

The existing hospital QAF is estimated to provide, annually, approximately $800 million in savings to the General Fund, with a certain portion of the fee revenue offsetting General Fund costs for providing children's health care coverage.

The budget assumes that the QAF sunsets and; consequently, only includes about $150 million in General Fund savings.

Background. Beginning in 2009, the Legislature has imposed a quality assurance fee on private hospitals in California. The current fee program was established through SB 239 (Hernandez/Steinberg), Chapter 657, Statutes of 2013. During that time the QAF has resulted in nearly $10 billion in new federal funding for Medi-Cal patients that seek care in hospitals for inpatient and outpatient traditional and managed care services as well as specialty care including trauma, high acuity, inpatient psychiatric, subacute care, and transplant services. SB 239 also established an alignment between hospitals and the state to ensure the maximum amount of federal funds are received for hospital care for Medi-Cal patients, including seniors, persons with disabilities, and children enrolled in the Medi-Cal program. The state has been receiving 24 percent of the net increase in payments for hospital services created by the fee program which is used to pay for health care coverage for children.

The current hospital fee sunsets on January 1, 2017. CHA is sponsoring a November 2016 ballot initiative to make the QAF permanent, if passed by the voters. CHA proposes that the sunset of the current fee be extended by one year in the unlikely event that the initiative does not pass in November. With the sunset date moving forward, the fee program will be able to continue into 2017.

Legislative Analyst's Office (LAO). The LAO recommends the Legislature extend the hospital QAF in this legislative session because it is both a benefit to the General Fund and the hospital industry.

Subcommittee Staff Comment and Recommendation—Hold Open. Even if the QAF was extended a year through trailer bill language, a full year of savings would not occur in the budget year given the anticipated time it would take to get the extension approved by the federal Centers for Medicare and Medicaid Services. However, these accrued savings would be realized in future years.

Questions.

1. Please provide an overview of this issue.

2. Does the Administration have any concerns with extending the QAF for one year?

Issue 16: Medi-Cal Payment Reductions, Rates, and Access

Budget Issue. The budget continues the AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, Medi-Cal payment reductions. Total fund savings from AB 97 with the changes implemented in AB 1 X2 (Thurmond), Chapter 3, Statutes of 2016 (special session legislation related to the managed care tax and developmental services) is $433 million (about $216 million General Fund). See table below for a summary of the savings.

Table 1: AB 97 Medi-Cal Provider Payment Reduction Summary in January Budget and Special Session Legislation (AB 1 X2 (Thurmond), Chapter 3, Statutes of 2016)*

AB 97 Payment Reductions (Total Fund)							
(dollars in thousands)							
Provider Type	Retroactive Savings Period	Total Retroactive Savings	On-Going Annual Savings	FY 2015-16		FY 2016-17	
				On Going	Retro	On Going	Retro
Nursing Facilities - Level A	6/1/11-6/30/12	$246	$254	$254	$0	$254	$0
ICF/DDs				$8,340	$0	$0	$0
ICF/DD-Habilitative							
ICF/DD-Nursing							
FS Pediatric Subacute	Exempt						
AB 1629 Facilities (3)	N/A						
DP/NF-B							
Phase 1 Providers (4)	6/1/11-12/20/11	$14,458	$29,175	$29,175	$0	$29,175	$0
Physician 21 yrs+		$0	$49,746	$49,746	$0	$49,746	$0
Medical Transportation		$0	$14,461	$14,461	$0	$14,461	$0
Medical Supplies and DME	6/1/11-10/23/13	$39,428	$17,394	$17,394	$1,878	$17,394	$7,510
Dental (5)		$0	$0	$0	$0	$0	$0
Clinics		$0	$18,512	$18,512	$0	$18,512	$0
Pharmacy (6)	6/1/11-2/6/14	$80,576	$30,891	$30,891	$20,144	$30,891	$26,859
Phase 3 Providers		$0	$2,414	$2,414	$0	$2,414	$0
Managed Care(w/ ACA)		$0	$235,797	$184,306	$0	$235,797	$0
Grand Total		**$134,708**	**$398,644**	**$355,493**	**$22,022**	**$398,644**	**$34,369**
Note:							
(1) Data Source: Nov 2015 Estimate and AB1 X2 (Thurmond), Chapter 3, Statutes of 2016							
(2) AB 97 injunctions were lifted on 6/25/2013.							
(3) AB 1629 facilities includes Freestanding (FS) NF-B and FS Adult Subacute facilities. Implementation of payment reduction began May 1, 2012 and ended July 31, 2012. The Department paid back the 10% payment reduction to this facility type in December 2012.							
(4) Phase I includes all subject providers, including the Pediatric Day Health Care (PDHC) and Audiology Program, except for the enjoined providers and the Child Health and Disability Prevention (CHDP) program.							
(5) SB 75 (2015): Effective July 1, 2015, dental providers were exempt from the 10% payment reduction.							
(6) The pharmacy retro recoupment implementation date and schedule has been updated. Implementation date shifted from from 4/2016 to 10/2015, and recoupment schedule is now estimated to take place over 36 months instead of 66 months.							

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

Background. As a result of the state's fiscal crisis, AB 97 required DHCS to implement a ten percent Medi-Cal provider payment reduction, starting June 1, 2011. This ten percent rate reduction applies to all providers with certain exemptions and variations. Certain exemptions were specified in AB 97 and

some are a result of an access and utilization assessment. AB 97 provides DHCS the ability to exempt services and providers if there are concerns about access. DHCS has formally established a process for pharmacy providers to seek exemption from the provider payment reductions.

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

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

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

The 2015-16 budget eliminated the AB 97 reduction related to dental providers effective July 1, 2015.

AB 1 X2 eliminated the AB 97 reduction for intermediate care facilities for the developmentally disabled and eliminated the recoupment of reductions related to the AB 97 payment reductions and rate freezes for skilled nursing facilities that are distinct parts of general acute care hospitals, referred to as distinct part nursing facilities, for dates of service on or after June 1, 2011, and on or before September 30, 2013.

Recoupment of Retroactive Savings. DHCS has begun the recoupment of retroactive savings for all affected providers except durable medical equipment, it is anticipated that this recoupment will begin in August.

Managed Care and Actuarial Soundness of Rates. Managed care rates can only be reduced by AB 97 on an actuarial basis and must support the required services. Consequently, as more and more individuals shift into Medi-Cal managed care, the negative impact of these reductions to access of Medi-Cal services is reduced. This is because health plans must meet access standards and a health plan's rate must be actuarially sound (i.e., generally, the rate cannot be reduced to a level that does not support the required services).

In the Governor's budget, the AB 97 reductions to managed care plans as a percentage of their base rates are 0.54 percent in 2015-16 and 0.74 percent in 2016-17. If the reductions applicable to the elimination of the primary care physician rate increase are considered, then the reductions as a percentage of health plan base rates are 0.54 percent in 2015-16 and 0.81 percent in 2016-17.

New Federal Rule on Fee-For-Service Access Monitoring. In November 2015, CMS released a rule describing a process for states to document whether Medicaid payments are sufficient to enlist providers to assure beneficiary access to covered care and services consistent with Section 1902(a)(30)(A) of the Social Security Act (the Act) and to address issues raised by that process. This rule became effective January 4, 2016. DHCS has begun implementation of the rule, related to the requirement that beginning October 1, 2016, state agencies are required to develop an access monitoring review plan. (This access plan was originally due July 1, 2016, but was delayed by CMS.)

At a high level, the rule requires the state to develop an access monitoring plan and update the plan annually. The rule also requires DHCS to submit a detailed analysis of providers and services every three years. Such analyses must include primary care physicians, specialists, behavioral health, pre-and-post natal obstetrics, and home health providers. Additionally, the rule requires for any state plan amendment submitted that changes, through reduction or restructuring, provider payments, a new monitoring plan must be submitted. When submitted, it must include an analysis of access for the prior 12 months, the anticipated effect of the proposed change on access, and input from beneficiaries, providers, and other stakeholders on the proposed changes. In addition to the established monitoring procedures, it must create additional procedures to monitor the effects of the changes. Finally, the rule states to implement ongoing mechanisms for beneficiary and provider input on access to care and states will need to promptly respond to input citing specific access problems with an appropriate investigation, analysis and response.

To address the minimum, ongoing requirements of the rule, the department must redesign its current access monitoring plan. The rule requires DHCS to significantly increase the number of providers it monitors, as well as associated metrics, such as geographic location of those providers. DHCS must also expand current monitoring efforts to include rate comparisons of Medi-Cal payments to those of other payers (both public and private). DHCS will be required to solicit input from providers and beneficiaries and publish the proposed monitoring plan for public feedback prior to final submission by October 1, 2016. Additionally, should DHCS propose provider rate reductions or restructuring, the rule requires additional monitoring mechanisms, public input, and more periodic analyses (at least annually).

Stakeholder Concerns. Consumer advocates, providers, provider associations, and other stakeholders are concerned that the existing Medi-Cal rates, payment reductions, and rate freezes directly impact an enrollee's ability to access Medi-Cal services. These stakeholders find that the existing payments do not cover the costs to provide services to Medi-Cal enrollees and are not sufficient enough to sustain their operations.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as updated information will be received at the May Revision and discussions continue on this topic.

Questions.

1. How does DHCS proactively evaluate the impact of the AB 97 reductions to each specific provider type to ensure that access is not compromised? Please explain what data sources and other information the department uses to evaluate access.

2. Please provide an update DHCS's development of an access monitoring review plan per the new federal rule.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Women, Infants, and Children Program

Budget Issue. DPH proposes total expenditures of $1.4 billion in 2016-17, a $20.5 million (1.5 percent) increase over the revised estimate for 2015-16, and a $46.5 million (3.3 percent) decrease from the 2015 Budget Act for the Women, Infants, and Children (WIC) Program. DPH estimates that 1,258,598 average monthly WIC participants in 2015-16 and 1,230,676 in 2016-17.

Table: WIC Expenditure Summary

	2015 Budget Act	2015-16 Estimate	2016-17 Proposed
Local Assistance (Federal Funds)	$1,126,206,368	$1,075,229,926	$1,094,093,548
Local Assistance (Rebate Funds)	$237,437,089	$221,369,550	$216,739,700
State Operations	$55,140,136	$55,140,136	$61,429,198
Total Expenditures	**$1,418,783,593**	**$1,351,739,612**	**$1,372,262,446**

In addition, the budget requests the following:

a. **Increase Enrollment of Children.** Four permanent positions and $513,000 in federal fund expenditure authority to WIC Division's outreach activities and improve data-sharing with the California Department of Social Services' (CDSS) CalFresh Program to increase child enrollment in both programs.

b. **eWIC.** To redirect three permanent positions to the Office of Systems Integration (OSI) and increase federal fund expenditure authority by $5.78 million for fiscal year 2016-17 to replace WIC paper checks with an electronic debit card, and replace the current WIC Management Information System (WIC MIS) with a United States Department of Agriculture (USDA) approved, Electronic Benefits Transfer (EBT)-ready Management Information System (MIS). The total request for the project is $39 million ($7.9 million for EBT and $31.1 million for the MIS) over five years. (This issue was also discussed at the March 3, 2016 Subcommittee No. 3 hearing under the Office of Systems Integration.)

Background: WIC. The WIC program is a federal supplemental nutrition program that provides supplemental food benefits to WIC participants. The food benefits are redeemed as vouchers at WIC authorized food vendors. These vendors provide an economic stimulus in local economies, as well as provide nutritional benefits during critical phases in a child's development. In the long term, the breastfeeding education and supplemental foods address child hunger. Children who are fed adequate and nutritious foods have improved development and have fewer health issues.

The WIC Division at DPH operates a $1.3 billion program serving approximately 1.3 million of California's economically and nutritionally-vulnerable residents. The WIC program is not an entitlement program; rather it is fully funded by an annual grant from the U.S. Department of Agriculture. WIC provides nutrition services and food assistance to low-to-moderate income families for pregnant and postpartum women, infants, and children up to their fifth birthday. In addition to the

categorical eligibility requirement, participants must be at or below 185 percent of the federal poverty level, and have a nutritional risk. Applicants are deemed eligible due to participation in other programs such as Medi-Cal, CalFresh, and California Work Opportunity and Responsibility to Kids (CalWORKS). The WIC program assists families by providing nutrition education, breast feeding support, vouchers to purchase healthy supplemental foods, and referrals to healthcare and other community services.

Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

- **Food**. Funds that reimburse WIC authorized grocers for foods purchased by WIC participants.
- **Nutrition Services and Administration.** Funds that reimburse local WIC agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition, education, breastfeeding support, and referrals to health and social services, as well as support costs.
- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with Infant Formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down federal WIC food funds.

Background: WIC Enrollment. According to the National Center for Children in Poverty, about 48 percent of California's young children under the age of six live in low-income households. Of the total amount of young children, 23 percent live in households with incomes that are between 100-200 percent of the federal poverty level. Food insecurity, defined as a lack of consistent access to adequate food, has been rising among California households with children. In 2001-2002, 11.7 percent of households reported food insecurity, which rose to 15.6 percent of households in 2010-2012. Statistically significant findings related to health and food insecurity in children include: lower bone mineral content in adolescent boys, iron deficiency anemia among children, less mental proficiency in toddlers, higher rates of developmental risk, more frequent minor complaints like stomach aches, headaches, and colds, higher hospitalization rates, increased behavioral problems, poorer psychosocial functioning, higher rates of depression and anxiety, lower math achievement and reading gains, and increased risk of repeating a grade level.

While California is more successful than any other state in reaching individuals eligible for the WIC program (82 percent in 2012 compared to the national average of 63 percent), California's coverage rates vary across participant categories, namely pregnant women, postpartum women, infants, and children. The most recent 2011 California-specific data indicates that while the largest participation category served is children, the child coverage rate is the lowest at 73 percent; coverage for postpartum women is the highest at 91.2 percent, followed by infants at 90.7 percent, and pregnant women at 83.4 percent. Applying this 73 percent coverage estimate to the current number of children served results in an estimated 270,000 California children (age 1 year to under 5) eligible for, yet not enrolled in, the WIC program. To date, WIC has been unable to close the gap between those who are eligible for services and do not apply, as well as those who have been certified but do not actively receive benefits. WIC data analyses suggest a smaller decline in WIC participants if they were also enrolled in CDSS/CalFresh and/or Medi-Cal. This proposal seeks to increase participation rates by researching and developing data and program linkages.

WIC and CDSS/CalFresh have made a commitment to work together to increase enrollment of children in these programs. The goal is to increase California's coverage rate of eligible children participating in WIC by five percent, or 48,000 children, and to assist CDSS with increasing their enrollment of children in CalFresh by 400,000 by June 30, 2018.

According to DPH, the permanent positions requested in this proposal will be a team of professionals dedicated to work with counties to improve outreach to child populations, and to improve county WIC administrative processes to lower barriers to application and household retention in the WIC program. By having resources to address participation rates, DPH finds that the WIC program will be able to identify families that have enrolled in either CalFresh or WIC, but not the other; identify families that are enrolled in WIC but no longer actively participate in the program; and, identify barriers that will lead to effective strategies to improve participation.

Linking WIC program data to CalFresh and Medi-Cal data allows WIC to identify children enrolled in CalFresh and Medi-Cal, but not in the WIC program. Once eligible but unserved children are identified through the data matches, data analytics and Geographical Information System (GIS) mapping can identify hot spots of unserved geographical areas for targeted outreach activities. By using GIS to map the location of children in California, WIC plans to target outreach efforts to increase participation in hot spots (for example, areas with a high concentration of eligible but unenrolled children) and identify best-practices from cold spots (for example, areas with low concentration of eligible but unenrolled children).

Working collaboratively with CDSS will allow WIC to focus on the following key areas to improve participation rates:

a. County-level analysis of CalFresh and WIC program dual-enrollment and retention rates;

b. County-level analysis of inter-program referrals and "warm" hand-off models, both WIC ↔ SNAP and Medi-Cal ↔ WIC, and including connections between each of the program's management information systems; and

c. Targeted outreach and promotion efforts aimed at identified gaps in enrollment (such as pre-schoolers age 2 and up until the 5th birthday).

Background: eWIC. The United States Department of Agriculture's Special Supplemental Nutrition Program for WIC is a federally-funded nutrition education and supplemental food program established in 1972 under Public Law 92-433. DPH administers the WIC Program in California, contracting with 84 local agencies throughout California (in all 58 counties) to provide WIC services at over 650 sites, with approximately 1.4 million participants served on a monthly basis.

The federal Healthy, Hunger-Free Kids Act of 2010 requires all states to migrate from a WIC paper-based food benefits delivery system to an EBT system by 2020. Without an EBT system automating WIC benefits by October 1, 2020, California will not be in compliance with federal law, which may jeopardize millions of dollars in federal funding for the California WIC Program. DPH performed a detailed analysis that revealed the current WIC MIS was outdated and not EBT-compliant; therefore,

DPH received both federal and state approvals to begin the procurement to solicit bids and contract for the services of a design, development, and implementation systems integrator. DPH also contracted with the OSI (via an interagency agreement) to leverage the new California EBT Services contract to automate the issuance of WIC food benefits via the California EBT system.

The new eWIC MIS must be fully operational in California before WIC food benefits can be issued via EBT. In its June 2015 eWIC MIS Project Status Report, the California Department of Technology (CDT) gave the project an overall rating of "Yellow" (which indicates a project is slipping). This report also identified other possible delays that will likely cause the project to slip even further behind schedule. With the approaching federal deadline of October 1, 2020, DPH decided to leverage OSI's experience and have OSI manage the project. This would include the OSI assuming responsibility for completing the procurement; entering into a contract with the successful system integrator; managing design, development, testing, pilot, and statewide implementation activities; being responsible for contract and financial management; and providing other needed services.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these items open pending the May Revision updates.

Questions.

1. Please provide an overview of the WIC budget and these proposals.

2. How does the WIC program work with stakeholder community? Is there an ongoing standardized process for this engagement?

Issue 2: Genetic Disease Screening Program

Budget Issue. DPH proposes $92.2 million, a $7 million increase (8.2 percent) over the current year (2015-16) budget of $84.1 million for the Genetic Disease Screening Program (GDSP). Of the proposed $92.2 million, $13.4 million is for state operations while $78.8 million is proposed for local assistance. The 8.2 percent increase in the program budget primarily reflects the implementation of screening for adrenoleukodystrophy (ALD), required through AB 1559 (Pan), Chapter 565, Statutes of 2014. According to DPH, the decrease in expenditures between the 2015 Budget Act and the current year November estimate reflects changing caseload estimates.

Genetic Disease Screening Program Budget

	2015 Budget Act	2015-16 Estimate	2016-17 Proposed
PNS Local Assistance	$39,975,652	$35,724,295	$36,002,304
NBS Local Assistance	$36,357,366	$36,039,031	$42,769,479
State Operations	$13,379,000	$13,379,000	$13,379,000
TOTAL	**$89,712,018**	**$85,142,327**	**$92,150,783**

Background. GDSP 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 to patients. 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.

Prenatal Screening Program (PNS). This program screens pregnant women who consent to screening for serious birth defects. The fee paid for this screening is about $207. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests for pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester. 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.

Newborn Screening Program (NBS). This 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 $111.70 (and is proposed to be increased to $122.70 in the budget, as described below). Where applicable, this fee is paid by prepaid health plans and insurance companies. Medi-Cal also covers the fee for its enrollees. The NBS 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 that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions, and referral information is provided where applicable.

AB 1559 Newborn Screening 2015 Budget Change Proposal. The 2015-16 budget included an augmentation of one permanent position and $1.975 million Genetic Disease Testing Fund. Of this request, $1.825 million is one-time funding to upgrade the computer system and $150,000 is ongoing. DPH requested these resources to comply with AB 1559 which expands the NBS program to include screening for adrenoleukodystrophy (ALD) as soon as ALD is added to the federal Recommended Uniform Screening Panel (RUSP), which occurred earlier this year.

The NBS is fully supported by fees, paid by insurance or individual patients, and therefore DPH proposes to raise the fee in order to cover the costs of this proposal. DPH proposes to raise the fee by $11.00 for a total fee of $122.70 beginning July 2016. DPH states that the new funding will cover the costs of: upgrading the Screening Information System, processing blood specimens, performing blood screens, testing chemicals, equipment and supplies used to assay results, and follow-up costs for screen positive cases, including case management, diagnostic work-up, confirmatory processing, provider and family education, and informative result mailers.

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

Questions.

1. Please provide an overview of the Genetic Disease Screening Program and the fee increase proposed in the budget.

Issue 3: California Personal Responsibility Education Program

Budget Issue. DPH requests $6.4 million ($700,000 in state operations and $5.7 million in local assistance) in federal fund expenditure authority, and the conversion of five limited-term positions to permanent positions, to continue the California Personal Responsibility Education Program (CA PREP), which is administered through the Maternal, Child and Adolescent Health Program.

Background. The Patient Protection and Affordable Care Act (ACA) of 2010 amended Title V of the Social Security Act (42 U.S.C. 701 et. seq.) to include a new formula grant program entitled the Personal Responsibility Education Program (PREP). The purpose of PREP funding is to reduce birthrates and sexually transmitted infections among high-need adolescents through evidence-based sexual health education.

The adolescent birth rate in the United States decreased significantly over the past 30 years, reaching a record low of 26.5 live births per 1,000 female youth aged 15 to 19 in 2013. In California, the decline has been even more substantial, from an adolescent birth rate of 70.9 per 1,000 in 1991 to 23.2 per 1,000 in 2013. While great progress has been made, there are still substantial disparities in rates of adolescent childbearing and sexually transmitted infections based on race, ethnicity, geography, and other social and demographic characteristics. Notably, in California nearly three out of four adolescent births are to Hispanic mothers, although Hispanic females account for only one-half of the adolescent population. Other vulnerable populations include youth in the foster care and juvenile justice systems, homeless/runaway youth, female adolescents with major mental illnesses, and male and female youth who identify as lesbian, gay or bisexual. These populations tend to have higher rates of early pregnancy, childbearing and/or sexually transmitted infections including the Human Immunodeficiency Virus when compared to other adolescents. Thus, these vulnerable adolescents are in substantial need of targeted sexual health education and support services.

CA PREP has received five years of continuous funding. This funding was extended through federal fiscal year 2017. California will receive $6.4 million of this national allocation in federal fiscal year 2016, which began October 1, 2015. Given that CA PREP is part of the ACA, DPH anticipates annual funding to continue beyond the current federal fiscal year 2017 extension, based on strong federal interest in and support for evidence-based adolescent pregnancy prevention.

CA PREP is designed to reduce rates of adolescent births and sexually transmitted infections through evidence-based sexual health education. CA PREP provides medically accurate, age-appropriate information about sexual and reproductive health that many youth do not receive from any other source. The curricula used are evidence-based; initial CA PREP program knowledge outcomes strongly support the effectiveness of the curricula.

There are currently 22 local entities participating in CA PREP, consisting of six county government agencies and 16 non-profit community-based organizations in 20 counties. Only California counties with a high need for adolescent sexual health education and services are eligible to participate in the program. CA PREP agencies are required to: 1) educate California's highest-need and most vulnerable adolescents on both abstinence and contraception through implementing evidence-based program models; 2) address at least three adulthood preparation subjects such as Adolescent Development,

Healthy Life Skills, and Parent Child Communication; 3) create family planning clinical linkages; and 4) maintain a community coalition of stakeholders to engage community members in actions that change social norms. The goals of these activities are to: decrease adolescent pregnancies and sexually transmitted infections; support meaningful opportunities to increase resiliency and self-efficacy to avoid harmful behaviors; ensure access to youth-friendly reproductive health services; and increase community support of healthy youth development and reduction of risky sexual behaviors. Since program implementation began in 2012, over 35,723 youth have been served.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this proposal.

Issue 4: Office of Health Equity

Oversight Issue. The 2012 budget provided DPH with $60 million in Proposition 63 funding to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system. DPH has just recently awarded some of these funds. While DPH has been complimented by various stakeholders on conducting an inclusive and thoughtful process regarding the California Reducing Disparities Project, the delay in awarding these funds has postponed the ability of these funds to make any impact on the improvement of the public mental health system.

Background. AB 1467 (Committee on Budget), Chapter 23, Statues of 2013 created the Office of Health Equity (OHE) at DPH. The OHE was created by consolidating the Office of Multicultural Health at DPH, the Office of Women's Health at the Department of Health Care Services (DHCS), the Office of Multicultural Services at the Department of Mental Health (this department was eliminated in 2012), the Health in All Policies Task Force at DPH, and the Healthy Places Team at DPH.

OHE was tasked to accomplish all of the following (1) achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically-isolated communities; (2) work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health; (3) advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically-competent health and mental health care and services; and (4) improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.

Office of Health Equity - Budget by Fund Source [1]

Fund	**2014-15**	**2015-16**	**2016-17**
General Fund	$362,000	$362,000	$426,000
Air Pollution Control Fund [2]	$111,000	$112,000	$0
Unallocated Account, Cigarette and Tobacco Surtax Fund	$222,000	$221,000	$236,000
Federal Trust Fund	$315,000	$191,000	$595,000
Mental Health Services Fund	$18,557,000	$50,072,000	$18,068,000
Cost of Implementation Account, Air Pollution [2]	$211,000	$210,000	$389,000
Grand Total	**$19,776,000**	**$51,167,000**	**$19,714,000**

[1] Numbers may not add or match to other statements due to rounding of budget details. Dollars rounded to the nearest thousands.

[2] This transfer of budget allotment is a technical adjustment because Fund 0115 appropriations support activities from the Center of Chronic Disease Prevention & Health Promotion and Fund 3237 appropriations support the CDPH's Climate Action Team activities.

California Reducing Disparities Project (CRDP). One of OHE's responsibilities is the CRDP. The CRDP is a statewide policy initiative (funded with Mental Health Services Act Funds—Proposition 63) to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system.

The project focuses on five populations: African-American; Latino; Native American; Asian and Pacific Islander; and Lesbian, Gay, Bisexual, Transgender, and Questioning individuals. These groups produced population-specific reports that formed the basis of a statewide comprehensive strategic plan on reducing disparities.

All of the five population reports have been approved and posted on the DPH website. Recommendations from these reports will be incorporated into a comprehensive draft strategic plan. Once finalized, the California Reducing Disparities (CRD) Strategic Plan will be used as a guide to identify new service delivery approaches from multicultural communities using community-defined evidence to improve outcomes and reduce disparities. Furthermore, the strategic plan will serve as a blueprint to implement these strategies at the local level.

Solicitation/Contract	**Original Timeline to Award Contract**	**Current Timeline to Award Contract**	**Amount (over six years)**
Statewide Evaluator	August 2015	Awarded in February 2016 to Loyola Marymount University	~$4 million
Five Technical Assistance Provider (TAP) Contracts*	August 2015	Awarded in February 2016 to the following:	
		ONTRACK Program Resources, Inc. – African American TAP	~$2.4 million
		Special Services for Groups – Asian/Pacific Islander TAP	~$2.4 million
		Regents of the University of California, UC Davis (Center for Reducing Health Disparities) – Latino TAP	~$2.4 million
		Center for Applied Research Solutions – LGBTQ TAP	~$2.4 million
Fifteen Capacity Building Pilot Projects	September 2015	Intent to award announced on May 2, 2016, see below for more details.	
Twenty Implementation Pilot Projects	September 2015	May 2016	
Education, Outreach and Awareness	Fall 2016	Fall 2016	

*The TAP for the Native American population was reissued on February 24, 2016, due to CDPH's need to request additional information and specificity related to the proposer's organization and their work with California Native American populations. The proposal submission date for this solicitation is April 22, 2016.

On May 2, 2016, DPH announced the awards for the Implementation Pilot Projects. Responsibilities for the Implementation Pilot Projects include addressing culturally and linguistically appropriate mental health services within communities of their respective target population. The primary goal of these projects is to validate community-defined evidence-based practices through rigorous evaluation. The awards were to:

African American:
1. Catholic Charities of the East Bay – Alameda County
2. Safe Passages – Alameda County
3. The Village Project, Inc. – Monterey County
4. West Fresno Health Care Coalition – Fresno County

Asian and Pacific Islander *:
1. Asian Community Mental Health Services – Alameda County
2. Cambodian Association of America – Los Angeles County
3. East Bay Asian Youth Center – Alameda County
4. HealthRIGHT 360 – San Mateo County
5. Korean Community Services – Orange County

*Five awardees were selected as there were only two Capacity Building Pilot Project applications submitted.

Latino:
1. Health Education Council – Yolo County
2. La Clínica de la Raza, Inc. – Alameda County
3. La Familia Counseling Center, Inc. – Sacramento County
4. Mixteco/Indígena Community Organizing Project – Ventura County

LGBTQ:
1. Asian & Pacific Islander Wellness Center – City and County of San Francisco
2. Gender Spectrum – Alameda County
3. On The Move – Napa County
4. Openhouse – City and County of San Francisco

Native American **:
1. Friendship House Association of American Indians, Inc. – City and County of San Francisco
2. Indian Health Center of Santa Clara Valley – Santa Clara County
3. Indian Health Council, Inc. – San Diego County
4. Native American Health Center – Alameda County
5. United American Indian Involvement, Inc. – Los Angeles County

**Five awardees were selected as there were no Capacity Building Pilot Project applications submitted and these organizations met or exceeded the minimum scoring requirements.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions.

1. Please provide a status update on the CRDP and contract awards.

2. When will the Capacity Building Pilot Project awards be announced?

3. How much is expected to be awarded for the Capacity Building Pilot Projects and Implementation Pilot Projects?

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

May 5, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

Consultant: Michelle Baass

OUTCOMES

Item	Department	Action

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Eligibility Systems Workload (AB 1 X1, 2013)

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 2: Outreach and Enrollment Extension

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 3: Denti-Cal Oversight

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 4: AB 85 Health Realignment

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 5: Federally Qualified Health Centers Pilot (SB 147, 2015)

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 6: Health Homes Activities

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 7: Third Party Liability Recovery Workload

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 8: Eliminate Workers' Compensation Information Sunset - Trailer Bill Language

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 9: Supplemental Drug Rebates Cleanup Trailer Bill Language

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 10: Foster Care: Psychotropic Medications (SB 238, 2015)

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 11: Substance Use Disorders Health Care Reform Implementation

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 12: Residential Treatment Facilities (AB 848, 2015)

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Richmond Laboratory: Viral Rickettsial Laboratory Enhanced Upgrade

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 2: Timely Infectious Disease Outbreak Detection and Disease Prevention

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 3: Active Transportation Safety Program

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 4: Protecting Children from the Effects of Lead Exposure

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 5: California Environmental Contaminant Biomonitoring Program

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 6: End of Life Option Act (AB 15 X2, 2015)

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 7: Collection of Data: Multi-Race or Multi-Ethnic Origin (AB 532, 2015)

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 8: Lesbian, Gay, Bisexual, & Transgender Disparities Reduction Act (AB 959, 2015)

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 9: Increase Access to HIV Pre-Exposure Prophylaxis (PrEP)

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 10: Medical Marijuana (AB 243, AB 266, and SB 643 of 2015)

- Motion – Approve staff recommendation.
- Vote – 2-0 (Stone not voting)

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Trailer Bill Language. It is recommended to approve this proposal. It is also recommended to adopt placeholder trailer bill language to establish a public health surveillance system related to medical marijuana and use the Medical Marijuana Regulation and Safety Act Fund to support this system.

ITEMS FOR DISCUSSION

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Budget Overview

- Information item.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Budget Overview

- Information item.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: California Children's Services Program

- Motion – Reject proposed trailer bill language.
- Vote – 2-0 (Stone not voting)

Issue 2: CA-MMIS System Reprocurement

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 3: Medi-Cal: Coordinated Care Initiative

- Held open

Issue 4: Medi-Cal: Behavioral Health Treatment

- Held open

Issue 5: Medi-Cal: Full Scope Expansion for Undocumented Children

- Held open

Issue 6: Medi-Cal: 1115 Waiver Renewal - "Medi-Cal 2020" Resources

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 7: Waiver Personal Care Services and Fair Labor Standards Act

- Held open

Issue 8: Home and Community-Based Services (HCBS) Federal Requirements

- Held open

Issue 9: California Community Transitions Demonstration Project

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 10: Medi-Cal: PACE Modernization

- Held open

Issue 11: Every Women Counts Program

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 12: Office of Family Planning Contract Conversion

- Held open

Issue 13: Medi-Cal: Dental Fiscal Intermediary Turnover-Takeover

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 14: Robert F. Kennedy Farm Workers Medical Plan (SB 145, 2015)

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 15: Hospital Quality Assurance Fee Extension

- Held open

Issue 16: Medi-Cal Payment Reductions, Rates, and Access

- Held open

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Women, Infants, and Children Program

- Held open

Issue 2: Genetic Disease Screening Program

- Held open

Issue 3: California Personal Responsibility Education Program

- Motion – Approve as budgeted
- Vote – 2-0 (Stone not voting)

Issue 4: Office of Health Equity

- Held open

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

May 12, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

ISSUES RECOMMENDED FOR VOTE-ONLY

CONTINUED

ISSUES FOR DISCUSSION

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

ISSUES RECOMMENDED FOR VOTE ONLY

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Trailer Bill Language: Approved Relative Caregiver (ARC) Child Support Pass-Through

The Administration proposes to clarify that children participating in the ARC Program should receive a $50 child support disregard.

The department notes that this language will create consistency between Welfare and Institutions Code (WIC) and Family Code (FC). WIC Section 11475.3 and FC Section 17504 both require that the first $50 of child support collected to be passed-through or "disregarded" to CalWORKs recipients before any money is distributed to federal, state, and county governments for child support recoupment. Currently this rule does not explicitly apply to foster care recipients.

Recommendation. Approve proposed trailer bill language as placeholder. This subcommittee heard and discussed this item during its March 10, 2016 hearing. No concerns have been raised.

Issue 2: Trailer Bill Language: County Sharing Ratio Alignment for the Safety Net, Fleeing Felon and Long-Term Sanction Populations

The Administration proposes trailer bill language that seeks to align the county sharing ratio for specified populations. Because the Safety Net, Fleeing Felon or Long-Term Sanctions populations include those whose cash aid under their former aid payment included federal funds, their funding ratios were established to reflect a lower county share of funding of 2.5 percent with a state share of funding of 97.5 percent. This alleviated the cost to counties for adults transitioning from being aided to unaided. However, WIC Section 15200 requires that the county's share of funding is five percent for programs after deducting any available federal funding. There is an inconsistency between WIC and current practice.

The department notes that this is clean-up language and there is no cost associated with this trailer bill language.

Recommendation. Approve proposed trailer bill language as placeholder. This subcommittee heard and discussed this item during its March 10, 2016 hearing. No concerns have been raised.

Issue 3: Trailer Bill Language: Eliminate the Temporary Assistance Program

The Administration proposes to eliminate the Temporary Assistance Program (TAP). The TAP program was intended to increase the federal Temporary Assistance for Needy Families (TANF) work participation rate (WPR). Implementation was suspended due to obstacles associated with the federal child support distribution rules, and concerns that these issues would result in a potential negative effect on TAP recipients. Due to these concerns, implementation of TAP has been repeatedly postponed, with a current implementation date of October 1, 2016, as established in SB 855 (Budget and Fiscal Review, Chapter 29, Statutes of 2014).

The Department of Social Services (DSS) claims that TAP is no longer necessary as they have adopted an alternate move-out strategy for removing safety net and long-term sanctioned cases from being included in the determination of the state's TANF WPR calculation. The department notes that this language results in cost avoidance associated with the elimination of the program in FY 2016-17 and beyond.

Recommendation. Approve proposed trailer bill language as placeholder that would change current statute to remove the date for implementation of TAP and make the implementation contingent upon further action of the Legislature in any given year. This action will conform with the Assembly. This subcommittee heard and discussed this item during its March 10, 2016 hearing.

Issue 4: Budget Change Proposal (BCP): IHSS CMIPS M&O

The Administration requests $232,000 ($117,000 General Fund) for two three-year limited-term Associate Governmental Program Analyst positions to address new and ongoing workload with the In-Home Supportive Services (IHSS) Case Management, Information and Payrolling System (CMIPS) to work on the Universal Assessment Tool (UAT). AB 664 (Dodd), Chapter 367, Statutes of 2015 establishes the UAT to create a single Home and Community-Based Services (HCBS) assessment to record and improve care coordination and data collection between the HCBS programs. The department asserts that they will need the positions for implementation of the UAT into CMIPS.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 28, 2016 hearing. No concerns have been raised.

Issue 5: Spring Finance Letter: Transfer of Commodity Supplemental Food Program

The Administration requests the transfer of one permanent Associate Governmental Program Analyst position and the associated funding from the California Department of Education (CDE), effective July 1, 2016. This position is federally-funded and will support the Commodity Supplemental Food Program (CSFP), which will transfer from CDE to DSS on October 1, 2016. The CSFP no longer fits into the CDE's mission and fits in better with the mission of DSS. DSS already administers the federal emergency food assistance program, and has agreements with 48 local food banks, including five of the six served by the CSFP.

The department notes that the requested position is federally-funded and that this is a General Fund neutral request. The CDE has agreed to this transfer of funding, position, and responsibilities.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 28, 2016 hearing. No concerns have been raised.

Issue 6: Spring Finance Letter: Title IV-E CA Well Being Project Budget Bill Language

The Administration requests that language be added to Items 5180-101-0001 and 5180-153-0001 to authorize the expenditure authority between these items to appropriately align funding between counties based on participation in the federal Title IV-E California Well-Being Project. The language is described as follows:

"Add Budget Bill language authorizing the Department of Finance to transfer General Fund between Items 5180-101-0001 and 5180-153-0001 to appropriately align funding between Title IV-E Waiver participating counties and nonparticipating counties."

Recommendation. Approve. This subcommittee heard and discussed this item during its April 28, 2016 hearing. No concerns have been raised.

Issue 7: Spring Finance Letter: County Expense Claim Reporting Information System (CECRIS)

The Administration requests $291,000 ($115,000 General Fund) for three positions (two System Software Specialist IIs and one Associate Information Systems Analyst) to support the CECRIS System as it replaces the County Expense Claim (CEC) and the Assistance Claim (CA 800) systems. OSI also requests funding for the permanent reestablishment with limited-term funding for a Senior Information Systems Analyst that was approved in a 2014-15 BCP for CECRIS.

DSS received approval of Special Project Report (SPR) 1 in February 2012 for the CECRIS project, but subsequent analysis projected a significant increase in both schedule and cost. In December 2014, the project was suspended to allow DSS an opportunity to re-evaluate the proposed solution in order to move forward with the project. The resulting new proposed solution in SPR 2 is meant to be more cost-effective and efficient. During the SPR 2 process, a gap was identified in internal resources for the project.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 28, 2016 hearing. No concerns have been raised

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

Issue 8: Budget Change Proposal: CCL: Random Inspections – Technical Fix

The Administration requests resources to perform annual random inspections required by the Human Services Omnibus Trailer Bill, SB 79 (Committee on Budget and Fiscal Review), Chapter 20, Statutes of 2015. Specifically, the Administration requests $2.3 million General Fund for 20 positions (two Licensing Program Manager I, 14 Licensing Program Analysts, and four Office Assistants - Typing). This proposal corrects DSS's FY 2015-16 BCP which included resources for the improvement of regulatory oversight of CCL facilities throughout the state, inadvertently omitted the staffing resources necessary to perform the annual random inspections required.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 28, 2016 hearing. No concerns have been raised.

Issue 9: Budget Change Proposal: Caregiver Background Check: Arrest Only Workload

The Administration requests $892,000 ($816,000 General Fund) for five positions to continue reviewing, investigating, and processing criminal record clearances for individuals with an arrest record seeking licensure, employment, or presence in a licensed community care facility. Specifically, the positions requested are three Attorney IIIs and two Senior Legal Analysts.

The department asserts that initially they were able to absorb the workload but can no longer sustain the current level of workload without additional legal resources.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 28, 2016 hearing. No concerns have been raised.

Issue 10: Budget Change Proposal: Home Care Services Consumer Protection Act (AB 1217)

The Administration requests a $1.0 million General Fund loan to implement licensing and registration activities required by the Home Care Services Consumer Protection Act (AB 1217(Lowenthal), Chapter 790, Statutes of 2013). These resources would fund 6.5 permanent positions in the Administration Division and the Community Care Licensing Division, and two-year limited term funding for one position in the Legal Division.

Prior to AB 1217, Home Care Organizations (HCOs) were not required to be licensed and Home Care Aides (HCAs) were not required to meet any minimum qualifications or screenings. Beginning January 1, 2016, AB 1217 requires DSS to regulate HCOs and provides for background checks and a registry for affiliated HCAs, as well as independent HCAs who wish to be listed on the registry. An approved FY 2105-16 BCP provided additional resources for DSS based on the projection of approximately 2,000 HCOs and 70,000 HCAs in the state that would be subject to fees under this bill. The department has now revised the projection to approximately 3,000 HCOs and 100,000 HCAs.

The department notes that the requested General Fund loan for AB 1217 will be repaid with fee revenues from HCOs and HCAs.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 28, 2016 hearing. No concerns have been raised.

Issue 11: Budget Change Proposal: Complaints and Appeals Process and RCFE Ownership Disclosure

The Administration requests $273,000 General Fund for two positions to meet the requirements of AB 601(Eggman), Chapter 628, Statutes of 2015, and $341,000 General Fund to support three Associate Governmental Program Analysts (AGPAs) for another two years, starting July 1, 2017. Currently the three AGPAs are two-year limited-term and expire June 30, 2017.

AB 601 requires potential Residential Care Facilities for the Elderly (RCFE) licensees to fully disclose previous ownership/partnerships and compliance with regulations in any type of facility anywhere in the United States. DSS is additionally required to cross-check owner/licensee information with the California Department of Public Health (DPH). There are approximately 7,500 licensed RCFEs which will be disclosing ownership and related information combined with a projected 1,200 new RCFE applications expected to be received.

AB 1387 (Chu), Chapter 486, Statutes of 2015, restructures the process by which licensees may appeal the assessment of a civil penalty or deficiency. The requested funding will support staff currently working to develop regulations, update various manuals by DSS, communicate with the public, and develop and deliver training related to these changes. DSS initially anticipated this workload to last only two years, but now feel the workload may last another two years.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 28, 2016 hearing. No concerns have been raised.

5160 DEPARTMENT OF REHABILITATION

Issue 1: Budget Change Proposal: WIOA: Competitive Integrated Employment

The Administration is requesting 11 permanent full-time positions to establish a new Vocational Rehabilitation Service Delivery (VRSD) team through redirection of $1.5 million in federal funds that are currently used for group employment placement services. Under the WIOA, the DOR can no longer close the record of services for a consumer who is in non-competitive employment, such as group employment services. Currently, DOR does not have the capacity to meet these new requirements.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 7, 2016 hearing. No concerns have been raised.

Issue 2: Budget Change Proposal: Resources for Federal Grant and RSA-911 Reporting

The Administration requests five permanent full-time positions funded through the redirection of $653,000 in existing Federal Funds, previously used for consulting services, to address the increased workload mandated by the U.S. Department of Education (USDOE) and the Rehabilitation Services Administration (RSA). The department does not have the current staff resources to address these mandated changes.

The department notes that lack of compliance with federal requirements could result in enforcement action, including the loss of federal funds.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 7, 2016 hearing. No concerns have been raised.

Issue 3: Budget Change Proposal: Traumatic Brain Injury Supplemental Funding

The Administration is requesting a one-time allocation of $360,000 to the TBI Fund from the Driver Training Penalty Assessment Fund. TBI Fund revenues stem from penalties paid for various violations of California's Vehicle Code. However, the State Penalty Fund (SPF) is facing declining revenues and the current allocation of 0.66 percent will not be sufficient to fund all TBI functions mandated by statute. This proposal provides continued minimum funding for the critical support services provided by the TBI network, as well as associated administrative costs.

In FY 2014-15, DOR received a one-time allocation of $500,000 from the Driver Training Penalty Assessment Fund to augment the TBI Fund.

Recommendation. Approve. This subcommittee heard and discussed this item during its April 7, 2016 hearing. No concerns have been raised.

ISSUES FOR DISCUSSION

Public testimony will be taken at the end for all items listed in this section.

MULTIPLE DEPARTMENTS

Issue 1: Proposal for Investment

The subcommittee has received the following proposals for investment.

- California Farm to Food Bank Tax Credit

Budget Issue. The California Association of Food Banks and others are requesting to extend California's current tax credit for farm donations to food banks from 2017 to 2022, increase the credit from 10 percent to 15 percent, expand the list of qualified donation items, and value items at wholesale cost.

Background. AB 152 (Fuentes), Chapter 503, Statues of 2011, created the existing 10 percent tax credit for donations of fresh fruits and vegetables to a qualified nonprofit entity and required DSS to establish and administer a State Emergency Food Assistance Program. This proposal is also included in a bill, AB 1577 (Eggman), currently on the Assembly Appropriations Committee suspense calendar, and is similar AB 515 (Eggman), which was vetoed last year with a host of other tax credit bills. The Governor's veto message stated that tax credits needed to be considered comprehensively as part of the budget process.

Advocates argue that extending the credit would increase access to healthy foods for low-income Californians.

Staff Comment and Recommendation. Hold open.

Appendix A

Appendix A lists other human services-related proposals that have been discussed previously, including:

March 10, 2016

Department of Social Services – CalWORKs		
Issue	**Description**	**Cost/Amount Requested**
Maximum Family Grant (MFG)	Repeal MFG	approx. $260-$310 million GF
Housing Support Program	Augment the CalWORKs Housing Support Program	$15 million GF ongoing
CalWORKs	Increase CalWORKs grants and restore COLA	Varies
Additional proposals	• Restore the 60-month time clock • Reduce the number of sanctions and eliminate long-term sanctions • Prohibit sanctions when an adult is meeting work participation • Oppose TANF transfer to Student Aid Commission • Repeal the Child Deprivation Rule for Two Parent Families • Repeal limiting homeless assistance to once-in-a-lifetime • Make various changes to the Housing Support Program, including adding several requirements for counties, prioritizing families experiencing domestic abuse, and giving counties discretion to extend rental assistance beyond six months • Simplify the subsidized employment programs • Require that counties direct families into Family Stabilization if they get a recommendation for mental health, domestic abuse, sexual exploitation, human trafficking or homeless from OCAT • Stop the 48-month time clock from running while family is on Family Stabilization in addition to not running the 24-month clock • Add various requirements regarding specific OCAT and Family Stabilization data	Varies

CONTINUED

Department of Social Services – CalFresh		
Issue	**Description**	**Cost/Amount Requested**
State Emergency Food Assistance Program (SEFAP)	Increase funding for SEFAP	$10 million GF
Additional Proposals	• Increase funding for school breakfast meal reimbursements and start-up grants • Require CalFresh certification periods on the maximum allowable period under Federal law	Varies

April 21, 2016

Department of Social Services – Child Welfare Services		
Issue	**Description**	**Amount Requested**
Child Care	Increase access to child care to enable larger pool of families to become foster parents	$31 million GF
Continuum of Care Reform	Clarify statutes governing child care system for foster youth	Unknown
Commercially Sexually Exploited Children	Increase funding for CSEC program	$19.7 million GF
Bringing Families Home	Establish a county matching grant program for child-welfare involved families that may be experiencing homelessness.	$10 million GF
Chafee Education and Training Voucher	Provide Chaffee grants to all eligible foster youth	$3.63 million GF for first year plus ongoing
Foster Youth	Create county opt-in program to prevent pregnancy among foster youth	$10 million GF
Transitional Housing Program-Plus (THP+) for Nonminor Dependents Aging Out of Care and to Homeless Youth	Expand THP+ for youth who would be eligible if they were in foster care on or after age 16	$5 million GF
Continuum of Care Reform	Fund series of trainings and build cohort of implementation pilot counties to implement specialized permanency services	$1.1 million GF
Psychotropic medications	Hire additional Public Health Nurses to meet requirements of recent legislation regarding psychotropic medications among foster youth	$1.65 million GF (with assumed $4.95 million federal match)

Health and Human Services Agency, Office of Systems Integration		
Issue	**Description**	**Cost/Amount Requested**
CWS-NS	Trailer Bill Language to codify county role in Agile approach	None

April 28, 2016

Department of Social Services – Immigration Services Branch		
Issue	**Description**	**Cost/Amount Requested**
Immigration Services	Increase funding for Immigration Services program	$25 million GF (for $40 GF million total)

Department of Social Services – Supplemental Security Income/State Supplementary Payment (SSI/SSP)		
Issue	**Description**	**Cost/Amount Requested**
SSI/SSP	Restore SSI/SSP grant cuts and restore the COLA to bring individuals at or above the Federal Poverty Level	Varies
SSI	Expand SSI advocacy for GA/GR recipients	Unknown

Department of Social Services – In-Home Supportive Services (IHSS)		
Issue	**Description**	**Amount Requested**
FLSA implementation	Extend the grace period for overtime violations to September 1, 2016	Unknown
FLSA implementation	Expand overtime exemptions	Unknown
FLSA implementation	Align IHSS authorized hours with Fair Labor Standards Act (FLSA) policy	Unknown
FLSA implementation	Pay for certain services in arrears to align with FLSA	
IHSS	Restore IHSS share of cost buy-out	Unknown
CCI	CMIPS II reprogramming for additional hours in the Coordinate Care Initiative (CCI)	$3 million GF one-time costs and $1 million GF ongoing

Department of Social Services – Adult Protective Services (APS)		
Issue	**Description**	**Amount Requested**
Adult Protective Services	Increase training dollars for APS	$5 million GF

Department of Aging		
Issue	**Description**	**Amount Requested**
Elder Economic Security Index	Funding to update the Elder Economic Security Index	$50,000 GF
Multi-purpose Senior Services Program (MSSP)	Increase MSSP rates	$4 million GF
California Long-Term Care Ombudsman	Additional funding for Long-Term Care Ombudsman	$3.6 million GF (or other special funds)
Senior Nutrition Programs	Additional funding for senior nutrition programs	$5.4 million GF
California Senior Legislature	Funding to continue advocacy efforts for seniors	$500,000 GF

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

May 12, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

OUTCOMES

ISSUES RECOMMENDED FOR VOTE-ONLY

Item	Department	Action
5180	**Department of Social Services**	
Issue 1	TBL: ARC Child Support Pass Through	Approve (3-0)
Issue 2	TBL: County Sharing Ratio Alignment	Approve (3-0)
Issue 3	TBL: Eliminate the Temporary Assistance Program	Approve (2-1)
Issue 4	BCP: IHSS CMIPS M&O	Approve (3-0)
Issue 5	SFL: Transfer of Commodity Supplemental Food Program	Approve (3-0)
Issue 6	SFL: Title IV-E CA Well Being Project Budget Bill Language	Approve (3-0)
Issue 7	SFL: County Expense Claim Reporting Information System	Approve (3-0)
5180	**Department of Social Services – Community Care Licensing**	
Issue 8	BCP: CCL: Random Inspections – Technical Fix	Approve (3-0)
Issue 9	BCP: Caregiver Background Check: Arrest Only Workload	Approve (3-0)
Issue 10	BCP: Home Care Services Consumer Protection Act (AB 1217)	Approve (2-1)
Issue 11	BCP: Complaints and Appeals Process and RCFE Ownership Disclosure	Approve (3-0)
5160	**Department of Rehabilitation**	
Issue 1	BCP: WIOA: Competitive Integrated Employment	Approve (3-0)
Issue 2	BCP: Resources for Federal Grant and RSA-911 Reporting	Approve (3-0)
Issue 3	BCP: Traumatic Brain Injury Supplemental Funding	Approve (3-0)

ISSUES FOR DISCUSSION

Item	Department	Action
	Multiple Departments	
Issue 1	Proposal for Investment	Hold Open
APPENDIX A		Informational

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, May 12, 2016
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Part B

Consultant: Michelle Baass

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

4150 DEPARTMENT OF MANAGED HEALTH CARE (DMHC)

Issue 1: Coordinated Care Initiative

Budget Overview. Through a Spring Finance Letter, DMHC requests to extend limited-term expenditure authority set to expire June 30, 2016, in the amount of $ 1,460,000 for 2016-17 and $522,000 for 2017-18 to address the continuation of workload associated with transitioning dual eligible enrollees in participating counties into managed health care and providing consumer assistance through the California's Cal MediConnect Ombudsman Program (Ombudsman Program) through December 31, 2017, and reimbursement authority in the amount of $ 1,070,000 for 2016-17 and $432,000 for 2017-18.

Summary of Requested Funding

	2016-17	2017-18
Consulting Services for Medical Plan Surveys	$165,000	$0
Consumer Assistance Consulting Services/Contracts	$800,000	$400,000
DMHC staff	$495,000	$122,000
Total	**$1,460,000**	**$522,000**

This proposal will be funded by a combination of special funds and reimbursement from the Department of Health Care Services (DHCS); who is currently receiving federal grant funds for these efforts. DHCS will reimburse the DMHC for 50 percent of costs associated with Cal MediConnect, and 100 percent of consulting services costs incurred to operationalize the Ombudsman Program.

Background. AB 1468 (Committee on Budget), Chapter 438, Statutes of 2012, required the DHCS to enter into an interagency agreement with the DMHC to perform certain oversight and readiness review activities, including:

- Provide consumer assistance to beneficiaries.
- Conduct medical plan surveys.
- Conduct financial audits.
- Conduct financial solvency audits.
- Conduct reviews of the adequacy of provider networks of participating health plans.

The request resources would be used to:

1. **Help Center -** The Help Center is requesting limited-term expenditure authority equivalent to the following positions and consultant services to perform workload from July 1, 2016, to December 31, 2017:

   <u>One Associate Governmental Program Analyst (July 1, 2016 to December 31, 2017)</u> - To manage the Ombudsman contract, develop and organize Ombudsman guidelines, facilitate meetings, provide training and reports, analyze data and communicate trends, review and assess Cal MediConnect weekly systemic issues and track proposed solutions and workflows, serve as the point of contact for DHCS, Cal MediConnect Ombudsman, and CMS, and assist dual eligible enrollees with disabilities to understand the Help Center's processes.

Consulting Services - The Ombudsman contract enables the DMHC to partner with California community-based organizations to provide dual eligible consumers with local hands-on assistance with enrollment into Cal MediConnect health coverage, filing of complaints and appeals, and informational materials. Based on the federal Centers for Medicare and Medicaid Services (CMS) grant award for 2015-16 and analysis of resource needs, the DMHC is requesting $800,000 for 2016-17 and $400,000 for 2017-18 to continue the level of service currently being provided to the participating counties through December 31, 2017.

2. **Division of Plan Surveys** – This division is requesting limited-term expenditure authority equivalent to the following positions and consultant services to conduct and finalize the four pending surveys by June 30, 2017:

   One Associate Health Care Service Plan Analyst (July 1, 2016 to June 30, 2017) – To manage and plan all facets of each dual eligible survey, including planning, coordinating, and leading the medical survey teams.

   One Health Program Specialist I (July 1, 2016 to June 30, 2017) - To provide technical assistance and oversee the dual eligible survey activities, review survey reports and serve as the DPS' liaison to the DHCS and other agencies. This position also will coordinate the remaining medical survey tools and training materials and maintain the technical assistance guides supporting medical survey activities.

   Consulting Services – $165,000 for 2016-17 to fund consultants currently assisting the DMHC with conducting two dual eligible medical surveys scheduled to commence during the fourth quarter of 2015-16, but not be finalized until 2016-17, and two surveys scheduled to start the first quarter of 2016-17. Funding for these services was previously approved in 2013-14, but is set to expire June 30, 2016.

3. **Office of Plan Licensing –** This office analyzes the utilization patterns of the dual eligible population and evaluates health plan networks serving this population. In order to facilitate the workload associated with long-term supports and services (LTSS), this office is requesting limited-term expenditure authority equivalent to the following position to perform workload from July 1, 2016, to December 31, 2017:

   One Health Program Specialist I (July 1, 2016 to December 31, 2017) - To organize, review and analyze the provider network data and access network adequacy of the various needs, criteria, and complexity of each of the LTSS services (Community-Based Adult Services [CBAS], In-Home Supportive Services [IHSS], Custodial Nursing Facilities/Institutional Care [NF], and Multipurpose Senior Services Program [MSSP]) that are submitted to review pursuant to the interagency agreement with the DHCS.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this proposal.

Issue 2: Health Insurance Premium Rate Review Grant Reappropriation

Budget Overview. Through a Spring Finance Letter, DMHC requests to reappropriate $100,000 for the Health Insurance Premium Rate Review Cycle II Federal Grant. According to DMHC, these resources will enable DMHC to compete the activities started on July 1, 2012. These activities include collecting premium rate data, improving rate filing requirements, enhancing the rate review process, reporting data to the federal government, and expanding consumer participation in the rate review process.

The following budget bill language is requested:

> 4150-491—Reappropriation, Department of Managed Health Care.
> The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2017:
> 0890—Federal Trust Fund
> Item 4150-001-0890, Budget Act of 2013 (Ch. 20, Stats. 2013)
> Provisions:
> 1. The funds reappropriated in this item shall be to administer the Health Insurance Premium Rate Review Cycle II Federal Grant to enhance the Department of Managed Health Care's capabilities in collecting premium rate data, improving rate filing requirements, enhancing the rate review process, reporting data to the United States Department of Health and Human Services, and disclosing rate information to consumers.

Subcommittee Staff Comment and Recommendation—Approve.

Questions.

1. Please provide an overview of this proposal.

MULTIPLE DEPARTMENTS

Issue 1: Health-Related Proposals for General Fund or Special Fund Investment

Various stakeholders have submitted proposals to the Subcommittee for General Fund and Special Fund investment. The table below lists these issues.

Table: Health-Related Proposals for General Fund or Special Fund Investment

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
California Health and Human Services Agency		
1. Interagency Task Force on Strategic Plans to Address HIV, Hepatitis C (HCV), Sexually Transmitted Infections, Drug User Health	The California HIV Alliance, Project Inform, and CalHEP request funding to establish an interagency task force to address HIV, HCV, sexually transmitted infections, and drug user health.	$500,000
2. CalQualityCare Website	Senators Allen, Liu, and McGuire and other stakeholders request funding to support the CalQualityCare website which provides information on state citations, quality comparisons, staff salaries, finances, and costs for an array of long-term services and supports including nursing facilities, hospice, assisted living, continuing care retirement communities, adult day care, adult day health care, and intermediate care facilities for the developmentally disabled.	$500,000 Special Fund (license fees)
Department of Health Care Services		
3. Expand Medi-Cal to Cover Remaining Uninsured Regardless of Immigration Status	Various stakeholders request to expand Medi-Cal to cover adults who are otherwise eligible for Medi-Cal except for their immigration status.	Unknown, likely hundreds of millions
4. Medi-Cal Estate Recovery	Multiple stakeholders, including Western Center on Law and Poverty, Health Access, CPEN, and Consumers Union, request to limit estate recovery in the Medi-Cal program by requiring collection for only those health care services required to be collected under federal law, to make it easier for individuals to pass on their assets by using a narrower	$26 million

		definition of "estate" in federal Medicaid law, and to allow a hardship exemption from estate recovery for a home of modest value.	
5.	Medi-Cal Aged and Disabled Program increase to 138% FPL	Western Center on Law and Poverty (WCLP) requests to increase the amount of income that is disregarded in calculating eligibility for purposes of the Medi-Cal aged and disabled (A&D) program. The A&D program was enacted in 2000, with an income eligibility standard of 199% federal poverty level (FPL) plus income disregards, making the eligibility criteria equivalent to 133% of the FPL. However, WCLP notes that the disregards lose real value every year, with the resulting income standard today at only 123% of the FPL.	$30 million
6.	Delay of NQI Wrap	Advocates seek a one-year delay in implementation of the newly qualified immigrant (NQI) wrap in Medi-Cal. Currently, "qualified" immigrants within the five-year bar, ages 21-64, without children, and with incomes below 138 percent of FPL are enrolled in full-scope Medi-Cal (state-only funding). Starting in 2017, these immigrants would be given the option to dually enroll in Covered California and Medi-Cal via the NQI wrap program.	$31.8 million
7.	Restoration of Medi-Cal Optional Benefits	The 2009 budget eliminated several Medicaid optional benefits from the Medi-Cal program. These benefits were eliminated for budgetary, not policy, reasons in response to the fiscal crisis. There is considerable support for restoring these benefits to the Medi-Cal program.	
		Acupuncture	$2.1 million
		Audiology	$2.4 million
		Chiropractic	~~$3 million~~ $305,000
		Incontinence Cream and Washes	$5.6 million
		Optician / Optical Lab	$5.9 million
		Podiatry	~~$13.5 million~~ $1.35 million
		Speech Therapy	$160,000
		Adult Dental (full restoration)	$98 million
8.	Clinical Laboratories - AB 1494 Retroactive Reductions	The California Clinical Laboratory Association requests the elimination of the retroactive recoupment of rate reductions pursuant to AB 1494 (Committee on Budget), Chapter 28, Statutes of 2012.	$31-81 million (depending on ability to use federal funds) (one-time)
9.	Eliminate Ongoing AB 97 Reductions	Various stakeholders, including the California Dialysis Council and dialysis providers, the California Birth Center Association, the California Medical Transportation Association, the California Medical Association, and the California Clinical Laboratory Association, request the	~$200 million

		elimination of the AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, Medi-Cal payment reductions.	
10.	Eliminate Retroactive Recoupment of AB 97 Reductions	Various stakeholders request the elimination of the recoupment of retroactive Medi-Cal payment reductions pursuant to AB 97.	$135 million (one-time)
11.	AIDS Medi-Cal Waiver Program Rates	The California HIV Alliance proposes a rate increase for the AIDS Medi-Cal Waiver program. It notes that provider reimbursement rates for this program are lower than Medi-Cal rates for the same services.	$4.8 million
12.	CBAS and PACE Grants or Low-Interest Loans	The California Collaborative for Long Term Supports and Services requests an unknown amount to provide one time grants or low-interest loans to incentivize expansion of CBAS and PACE programs that keep people in the community and out of nursing facilities.	Unknown
13.	Community Clinic Reimbursement for Drugs and Supplies	Planned Parenthood requests to revise the Medi-Cal and Family PACT reimbursement formula for drugs and supplies dispensed by specified clinics by requiring the clinic dispensing fee to be the difference between the actual acquisition cost of a drug or supply and the Medi-Cal reimbursement rate, and remove the maximum dispensing fee caps in existing law.	$6 million
14.	Collection of Race, Ethnicity, Language, and SOGI Data in Medi-Cal	The California Latino Legislative Caucus and other stakeholder groups request $200,000 to align Medi-Cal's health plan data collection and reporting requirements for race/ethnicity, language, and sexual orientation and gender identity (SOGI) data with Covered California's proposed 2017 qualified health plan standards.	$200,000
15.	Interpreters for Medi-Cal	Various stakeholders, including the California Latino Legislative Caucus and AFSCME, requests $15 million for interpreters in the Medi-Cal program.	$15 million
16.	Physical Therapists Performing Electroneuromyography (EMG) in Medi-Cal	Physical therapists request to lift a restriction on physical therapists performing electroneuromyography (EMG) in Medi-Cal. An EMG enhances the understanding of nerve damage.	Unknown
17.	Pediatric In Home Care Expansion Act (SB 1401)	Senator McGuire requests Medi-Cal rate increases for licensed home health agencies for private duty nursing services provided to children in three regional pilot areas that are currently facing access to care challenges. SB 1401 (McGuire) would implement this proposal.	$7 million
18.	School-Based Health Centers Request	Assembly Member Ridley-Thomas requests to fund two limited-term positions (24 months) to provide technical assistance to assist in the development and expansion of school-based health centers.	$600,000 Special Fund (Tobacco Settlement Fund)

Department of Public Health			
19.	Children's Dental Disease Prevention Program (DDPP)	Advocates propose to restore funding for DDPP. From 1980 to 2009, the DDPP provided school-based oral health prevention services to approximately 300,000 low-income school children in 32 counties in California. Participating sites provided fluoride supplementation, dental sealants, plaque control, and oral health education.	$3.2 million
20.	Virtual Dental Homes	Various stakeholders, including The Children's Partnership and First 5 Association of California, request funds to establish a Virtual Dental Home Grant program to expand services to about 20 additional communities. This program utilizes telehealth technologies (tools and training) for dental hygienists to travel to sites within underserved access areas of the state, at schools, preschools, nursing homes, etc. and can see three times the patients in a day as in a regular dental office.	$4 million (one-time)
21.	Adolescent Family Life Program (AFLP)	Various stakeholders, including California Legislative Black Caucus, the March of Dimes, and the California WIC Association, request funding for AFLP. AFLP addresses the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to expectant and parenting teens and their children.	$6 million
22.	Sexually Transmitted Disease (STD) Prevention	The AIDS Healthcare Foundation requests an augmentation for the Sexually Transmitted Disease (STD) Control Branch at DPH for STD prevention.	$10 million
23.	Drug Overdose Prevention (Naloxone)	The Drug Policy Alliance (DPA) requests to establish a grant program for local agencies and community-based organizations in order to reduce the rate of fatal drug overdose caused by prescription analgesics and other drugs. DPA estimates this investment would save an estimated 1,200 lives. Furthermore, hospitalization rates for treatment of effects of non-fatal but debilitating overdoses would also be reduced.	$3 million
24.	Hepatitis Initiatives	Stakeholders, such as CalHEP and Project Inform, request: 1) $100,000 for DPH to purchase and distribute hepatitis B (HBV) vaccine to local health jurisdictions to vaccinate high risk adults; 2) $600,000 for DPH to purchase hepatitis C (HCV) rapid test kits to distribute to community-based testing programs; 3) $500,000 for DPH to certify non-medical personnel to perform rapid HCV and HIV testing in community-based settings; and 4) $200,000 to the DPH Office of AIDS for technical	$1.4 million

		assistance to local governments and to increase the number of syringe exchange and disposal programs throughout California and the number of jurisdictions in which syringe exchange and disposal programs are authorized.	
25.	Biomonitoring Program	Various advocates, including the Natural Resources Defense Council and the Breast Cancer Fund, request an augmentation for the biomonitoring program to increase and support the scientific work of this program. This funding would be split between DPH, the Department of Toxic Control, and the Office of Environmental Health Hazard Assessment.	$1 million
26.	Early Detection and Diagnosis of Alzheimer Disease	Various stakeholders, including the Alzheimer's Association, request funds for the California Alzheimer Disease Centers for early detection and diagnosis of Alzheimer disease. Funds would be used to determine the standard of care in early and accurate diagnosis, provide professional outreach and education, and evaluate the educational effectiveness of these efforts.	$2.5 million (one-time)
27.	LabAspire	The Health Officers Association of California requests $1.2 million to reinstate the LabAspire program (or a similar program). This funding would support six assistant lab directors as they train and gain experiences to become public health lab directors.	$1.2 million
28.	Tuberculosis (TB) Control	The Health Officers Association of California requests funding to implement recent innovations in TB prevention, which are essential elements to achieve TB elimination by 2040.	$10 million
29.	Community Health Improvement and Innovation Fund	The Health Officers Association of California requests to create a public fund (using General Fund) that would be used to help people stay healthy and avoid the costs, both personal and economic, associated with chronic illnesses such as heart disease, stroke, diabetes, and cancer. These conditions are the leading causes of premature death and disability in California.	$390 million
30.	Parkinson’s Disease Registry	Advocates and individuals with Parkinson's propose to fund the California Parkinson’s Disease Registry to support competitive grants/contracts to research institutes, universities and nonprofit organizations to implement and maintain a comprehensive Parkinson’s disease registry.	$3.7 million
31.	Strong California - Boys and Men of Color Investment	The Assembly Select Committee on the Status of Boys & Men of Color in California requests funds to provide support to qualified nonprofit organizations to support (1) health equity, (2) educational success, (3) youth development, (4) improved employment and labor force participation, and to (5) decrease contact with child welfare, law enforcement, and the juvenile and criminal justice systems.	$100 million (one-time)

32.	End of Lift Option Act - Telephone Line (SB 1002)	Senator Monning requests funds ($150,000) to establish a telephone line for answering End of Life Option Act inquiries and require that the individuals answering be bilingual. SB 1002 (Monning) would implement this request.	$150,000
33.	Eliminate Cost-sharing for Individuals Enrolled in the AIDS Drug Assistance Program (ADAP)	The California HIV Alliance requests to eliminate cost-sharing for individuals enrolled in the AIDS Drug Assistance Program with annual incomes between 400 percent and 500 percent of the Federal Poverty Level. DPH estimates that 112 ADAP clients paid an ADAP share of cost (SOC). By eliminating the ADAP SOC obligation for these 112 ADAP SOC clients, ADAP would have saved $67,705 in calendar year 2015.	$0
34.	Pre-Exposure Prophylaxis (PrEP) Affordability Program	The California HIV Alliance proposes the development of a PrEP affordability program to cover PrEP-related copays, coinsurance, and deductibles incurred by all individuals accessing PrEP in California with annual incomes below 500 percent of the federal poverty level.	$1 million Special Fund
35.	Office of AIDS' Health Insurance Premium Payment Program to Cover Premiums, Copays, Coinsurance, and Deductibles	The California HIV Alliance requests that the Office of AIDS' Health Insurance Premium Payment (OA-HIPP) Program cover premiums, copays, coinsurance, and deductibles incurred by all eligible people living with HIV/AIDS in California. DPH estimates that 5,966 private insurance ADAP clients did not receive premium payment assistance from OA-HIPP Program. Consequently, this proposal would result in expenditures of $8.6 million in 2016-17 (based on calendar year 2015 data).	$8.6 million Special Fund
Office of Statewide Health Planning and Development			
36.	Primary Care Workforce Development	Various stakeholders, including the California Medical Association, the California Academy of Family Physicians, and the California Primary Care Clinic Association, request funding ($82.5 million) for Song Brown Program to increase residency programs for primary care physicians and funding ($17.5 million) to establish new teaching health center sites offering additional primary care residencies, and other efforts related to graduate medical education.	$100 million (one-time)
37.	Expansion of State Loan Repayment Program and Allied Health Loan Repayment Program for CMSP Counties	The County Medical Services Program (CMSP) requests to expand the State Loan Repayment Program and the Allied Health Loan Repayment Program in CMSP counties using CMSP funds. The CMSP Governing Board would provide funding for this purpose over a three year period, with an estimated cost of $4.85 million, including $350,000 for OSHPD to administer.	$4.85 million in Non-state Funds

Subcommittee Staff Comment and Recommendation—Hold Open. At the May Revision, the Legislature will have an updated understanding of the state's fiscal situation and can better evaluate proposals for investment.

Subcommittee staff has requested LAO to provide a brief overview of these proposals.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

May 12, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol
Part B

Consultant: Michelle Baass

OUTCOMES

4150 DEPARTMENT OF MANAGED HEALTH CARE (DMHC)

Issue 1: Coordinated Care Initiative

- Motion – Approve as budgeted
- Vote – 3-0

Issue 2: Health Insurance Premium Rate Review Grant Reappropriation

- Motion – Approve as budgeted
- Vote – 3-0

MULTIPLE DEPARTMENTS

Issue 1: Health-Related Proposals for General Fund or Special Fund Investment

- Held open

Senate Budget and Fiscal Review — Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

May 17, 2016
1:30 p.m., or Upon Call of the Chair
Room 4203, State Capitol

Consultant: Theresa Pena

ISSUES RECOMMENDED FOR VOTE ONLY

ISSUES FOR DISCUSSION

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

ISSUES RECOMMENDED FOR VOTE ONLY

5160 DEPARTMENT OF REHABILITATION

Issue 1: Supported Employment Rate Increase (Issue 401-MR)

May Revision. The Administration requests an increase of $500,000 General Fund to reflect an increase to the supported employment hourly rate consistent with the provisions of AB 1 X2 (Thurmond), Chapter 3, Statutes of 2016 Second Extraordinary Session, which required the Department of Developmental Services to increase the supported employment hourly rate by $3.42. The Department of Rehabilitation believes establishing this identical rate increase is necessary to avoid competition among services providers.

Staff Recommendation. Approve as requested. No concerns have been raised.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES

Issue 1: May Revision Estimate (Issue 401-MR)

May Revision. The Administration proposes to decrease the amount in the department's state operations funding by $407,000, and to offset the reduction with a corresponding increase in federal funds by $407,000, to reflect a projected increase in Federal Performance Incentive Funds and a corresponding decrease in Child Support Collection Recovery Funds.

Background. There are federal incentives tied to a list of performance measures that apply to the process of establishing parentage, the collection of child support, the overall cost of collecting child support, the establishment of cases with support orders, and collection on arrears. Gains made in these areas have led to an increase in Federal Performance Incentive funds.

Staff Recommendation. Approve as requested. No concerns have been raised.

Issue 2: Child Support Non-Custodial Parent Employment and Demonstration Project Carryover (Issue 403-MR)

May Revision. The Administration requests an increase of $587,000 to reflect the estimated amount of unspent federal Child Support Non-Custodial Parent Employment Demonstration (CSPED) Project funds carried forward to fiscal year (FY) 2016-17. These one-time grant funds will be used to continue efforts to engage low-income non-custodial parents with job placement and retention, provide child support case management, and provide parenting peer support. The unspent funds result from a projected decrease in 2015-16 enrollments in the demonstration project.

Background. The CSPED project in California is being conducted in Stanislaus County, and the federal grant is in the fourth year of a five year project period. The goal of the project is to improve reliable payment of child support.

Staff Recommendation. Approve as requested. No concerns have been raised.

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

Issue 1: Budget Change Proposal: Child Welfare Services – New System (CWS-NS)

Governor's Budget. The Administration requests one new permanent position, the conversion of eight limited-term positions to permanent, and a net increase of $171,000 in the Office Of Systems Integration (OSI) spending authority for the Child Welfare Services – New System (CWS-NS) Project.

Background. The OSI and DSS have been working for some time to develop a new system to replace the CWS/CMS, which does not provide all functional capabilities required, is outdated, and is cost prohibitive to maintain and operate. The CWS-NS Project will implement an updated, web-based computing infrastructure that should have more flexibility. The department notes that CWS-NS, due to its modern architecture and underlying commercial-off-the-shelf platform, is projected to be less costly to maintain and enable upgrades and enhancements to be deployed more quickly.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its April 21, 2016 hearing. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – STATE HEARINGS DIVISION

Issue 1: Budget Change Proposal: Affordable Care Act Caseload (ACA)

Governor's Budget. The Administration requests to make permanent the extension of 56 limited-term positions to continue to provide the required due process for Medi-Cal and Covered California (Covered CA) recipients. These positions were approved as limited-term in FY 2014-15 to adjudicate appeals associated with the ACA. The department is also seeking permanent funding for one Associate Informations Systems Analyst and one Office Technician (Typing). The cost for all 58 positions is approximately $7.3 million.

Background. As of May 2015, 1.3 million Californians have active health insurance under Covered California. Under the ACA, California's expansion of Medi-Cal has increased by three million enrollees from 2013 to 2015. The impact of expansion of Medi-Cal has resulted in an 85 percent increase in the category of scope of benefit hearings, and a similar increase is anticipated from the category of Medi-Cal redeterminations.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its March 10, 2016 hearing. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – CALWORKS

Issue 2: CalWORKs Minimum Wage Impact

May Revision. The Administration requests a decrease of $457,000 General Fund and a decrease of $5.5 million in federal funds to reflect the impact of SB 3 (Leno), Chapter 4, Statutes of 2016, which increases the state minimum wage from $10.00 to $10.50 per hour, effective January 1, 2017.

Background. SB 3 provides incremental increases to the state minimum wage up to $15 by January 1, 2022, as well as an annual, automatic adjustment commencing January 1, 2023. The adjustment would be calculated using the Consumer Price Index.

Cases with working adults who have increased earnings as a result of the wage increase will have reduced grants. For cases that will income off of CalWORKs due to the increase in earnings, there will be a decrease to grant, administration and services costs.

Staff Recommendation. Approve as requested. No concerns have been raised.

Issue 3: Temporary Assistance for Needy Families (TANF) Block Grant Funds Transfer to California Student Aid Commission (Issue 405-MR)

May Revision. The Administration requests an increase of $282,965,000 in federal funds to reflect an increase in the amount of federal TANF block grant funds available to offset General Fund costs in the Cal Grant program administered by the California Student Aid Commission. An increase in unspent TANF funds from prior years, decrease in the CalWORKs caseload projection, an increase in 1991-92 realignment revenues, and other TANF and TANF maintenance-of-effort funding adjustments result in excess TANF funds.

Staff Recommendation. Approve as requested. No concerns have been raised.

Issue 4: Reappropriation of Funding for CalWORKs Housing Support Program and Fraud Recovery Incentive Payments (Issue 420-MR)

May Revision. The Administration requests to extend the availability of funds appropriated in the 2015 Budget Act for the Housing Support Program for an additional year. In addition, a technical change is requested to extend the availability of federal funds for fraud recovery incentive payments to counties until June 30, 2016.

Background. The 2015 Budget Act included $35 million General Fund for the Housing Support Program. Twenty four counties were newly awarded grants in 2015-16 and require additional time to fully expend their allocations as they ramp up program activities.

Staff Recommendation. Approve as requested. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – CALFRESH

Issue 5: Able-Bodied Adults Without Dependents (ABAWD) Automation (Issue 419-MR)

May Revision. The Administration requests an increase of $1,484,000 General Fund and an increase in federal funds by $2,120,000 for automation costs related to the expiration of the statewide federal ABAWD waiver.

Background. ABAWDs between the ages of 17 and 50 years are required to meet federal Supplemental Nutrition Assistance Program work requirements in order to receive CalFresh program benefits. Since October 2008, the state has operated under a statewide waiver that exempts ABAWDs from federal work requirements. The federal waiver is set to expire on December 31, 2017. Prior to the expiration of the waiver, the Statewide Automated Welfare System will need to be updated to track the affected population.

Staff Recommendation. Approve as requested. No concerns have been raised.

Issue 6: California Food Assistance Program Minimum Wage Impact

May Revision. The Administration is requesting a decrease of $159,000 General Fund to reflect the impact of SB 3 (Leno), Chapter 4, Statutes of 2016, which increases the state minimum wage from $10.00 to $10.50 per hour, effective January 1, 2017.

Background. SB 3 provides incremental increases to the state minimum wage up to $15 by January 1, 2022, as well as an annual, automatic adjustment commencing January 1, 2023. The adjustment would be calculated using the Consumer Price Index.

Staff Recommendation. Approve as requested. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 7: Budget Change Proposal: Child Welfare Services Case Reviews

Governor's Budget. The Administration requests resources seven positions to establish a Child Welfare Services Case Reviews unit in response to the federal Administration for Children and Families (ACF) notification that the Department of Social Services oversight of Child Welfare Services is inadequate and needs a quality assurance program as required in the Child and Family Services Review (CFSR).

Background. The federal ACF expressed their concern in a letter dated May 12, 2015, and concluded that the state had insufficient resources to provide the necessary oversight and effective quality assurance management principles to obtain federal approval of the case review process that is required. Last year, ACF had completed the rule-making process to modify the existing CFSR, including that all states must use a comprehensive review process in place of the current traditional case review methodology.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its April 21, 2016 hearing. No concerns have been raised.

Issue 8: Budget Change Proposal: Psychotropic Medication Oversight in Foster Care

Governor's Budget. The Administration requests resources to meet the requirements of SB 238 (Mitchell) Chapter 534, Statutes of 2015 and SB 484 (Beall) Chapter 540, Statutes of 2015. Specifically, to meet the requirements of SB 238, the Administration is requesting $149,000 ($100,000 General Fund) in contract funding to develop monthly, county-specific reports for children in foster care who are prescribed psychotropic medications through Medi-Cal. To meet the requirements of SB 484, the Administration is requesting two-year limited-term funding of $833,000 ($684,000 General Fund) to support approximately five positions (three Licensing Program Analysts (LPA), 0.5 Licensing Program Manager I, 0.5 Office Assistant, one Associate Governmental Program Analyst), effective July 1, 2016.

Background. SB 238 requires monthly data reports to highlight instances when a child received a Medi-Cal pharmacy paid claim but did not have appropriate court approval and authorization from the juvenile court. SB 484 mandates additional review and increased standards regarding psychotropic medication usage in group homes, and creates new data collection and notification requirements for the Community Care Licensing Division (CCLD) within DSS in order to identify and mitigate inappropriate levels of psychotropic medication use by children in foster care residing in group homes.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its April 21, 2016 hearing. No concerns have been raised.

Issue 9: Reappropriation of Funding for Various Child Welfare Services Issues (Issue 421-MR)

May Revision. The Administration requests to extend the availability of funds appropriated in the 2015 Budget Act for counties to perform various child welfare services administrative activities.

Background. The 2015 Budget Act appropriated $49 million General Fund for counties to comply with new state and federal child welfare services requirements. Counties require additional time to expend these funds.

Staff Recommendation. Approve as requested. No concerns have been raised.

Issue 10: Trailer Bill Language: Tribal ARC Program

May Revision. The Administration proposes to allow non-federally eligible foster youth placed with relative caregivers under the jurisdiction of the tribal court receive a foster care basic rate amount equal to payments made to federally eligible relative caregivers in tribes that possess a Title IV-E Agreement with the state. Although two tribes currently provide child welfare services in their respective jurisdictions under Title IV-E agreements with the State, they are not authorized to participate in this optional program as it is only applicable to counties.

Background. Currently, the county optional ARC program provides an additional amount above the CalWORKs grant to bring the total payment for non-federally eligible children placed with relative caregivers up to the same amount as the rate paid for federally eligible children in AFDC-FC eligible homes. The department notes that this language would provide for parity across programs.

Staff Recommendation. Approve as requested. No concerns have been raised.

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

Issue 11: IHSS Minimum Wage Impact (Issues 422-MR and 423-MR)

May Revision. The Administration requests an increase of $18,433,000 General Fund and an increase in reimbursements of $21,190,000 to reflect costs associated with SB 3 (Leno), Chapter 4, Statutes of 2016, which increases the state minimum wage from $10.00 to $10.50 per hour, effective January 1, 2017.

Background. SB 3 provides incremental increases to the state minimum wage up to $15 by January 1, 2022, as well as an annual, automatic adjustment commencing January 1, 2023. The adjustment would be calculated using the Consumer Price Index. The first in a series of sick leave days available to IHSS providers will start on July 1, 2018 and will have no impact in FY 2016-17.

Staff Recommendation. Approve as requested. No concerns have been raised.

Issue 12: Universal Assessment Tool (Issues 413-MR and 414-MR)

May Revision. The Administration requests a decrease of $1,255,000 General Fund and reimbursements to be decreased by $1,245,000 to reflect a delay in implementation of the Universal Assessment Tool pilot. The updated cost estimate reflects an updated timeline which includes finalizing the assessment tool to be used for pilot testing, implementing the pilot testing in the selected counties, and assessing the impact of the tool on counties and information technology systems.

Background. In 2012, the Legislature authorized the development and pilot implementation of a universal assessment tool (UAT). The Department of Health Care Services, DSS, and the Department of Aging must develop a UAT to assess a Medi-Cal beneficiary's need for Home and Community-Based Services. The goal is to enhance personalized care planning under the Coordinated Care Initiative, 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.

Staff Recommendation. Approve as requested. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – MISCELLANEOUS

Issue 13: Commodity Supplemental Food Program Transfer (Issue 406-MR)

May Revision. The Administration requests an increase of $4,433,000 in federal funds to reflect the transfer of the federal Commodity Supplemental Food Program (CSFP) from the California Department of Education (CDE) to DSS.

Background. The CSFP originally provided food assistance to low-income seniors, women, infants, and children. However, changes to federal law in 2014 restricted program eligibility to low-income seniors. CDE and DSS felt that the program's new target population more closely aligned with the mission of DSS, and CDE agreed to transfer the program. This will be offset in both years by a commensurate reduction in CDE's local assistance budget. The local assistance expenditure authority will be used to reimburse local agencies for charges associated with administering the CSFP.

A corresponding Budget Change Proposal position for this transfer was approved by this Subcommittee on May 12, 2016.

Staff Recommendation. Approve as requested. No concerns have been raised.

ISSUES FOR DISCUSSION

Public testimony will be taken at the end for all items listed in this section.

5180 DEPARTMENT OF SOCIAL SERVICES – MISCELLANEOUS

Issue 14: May Revision Caseload Adjustments (Issues 401-MR and 402-MR)

May Revision. The May Revision proposes a net increase of $161,243,000 (increases of $81,380,000 General Fund, $375,460,000 reimbursements, $1,053,000 Child Support Collections Recovery Fund, $164,000 State Children's Trust Fund, partially offset by a decrease of $296,814,000 Federal Trust Fund) primarily resulting from updated caseload estimates since the Governor's Budget. Realigned programs are displayed for the purpose of federal fund adjustments and other technical adjustments. Caseload and workload changes since the Governor's budget are displayed in the following table:

Program	Item	Change from Governor's Budget
California Work Opportunity and Responsibility to Kids (CalWORKs)	5180-101-0001 5180-101-0890 Reimbursements	-$32,628,000 -$264,811,000 $14,000
Kinship Guardianship Assistance Payment	5180-101-0001	-$1,295,000
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	5180-111-0001	-$39,826,000
In-Home Supportive Services (IHSS)	5180-111-0001 Reimbursements	$184,401,000 $415,908,000
Other Assistance Payments	5180-101-0001 5180-101-0890	-$2,670,000 -$33,000
County Administration and Automation Projects	5180-141-0001 5180-141-0890 Reimbursements	-$28,487,000 -$49,295,000 $59,711,000
Community Care Licensing	5180-151-0001 5180-151-0890	-$1,430,000 -$165,000
Special Programs	5180-151-0001	$35,000
Realigned Programs		
Adoption Assistance Program	5180-101-0001 5180-101-0890	-$23,000 $1,008,000

Program	Item	Change from Governor's Budget
Foster Care	5180-101-0001 5180-101-0890 5180-101-8004 5180-141-0001 5180-141-0890	$132,000 $3,603,000 $1,053,000 $3,000 -$182,000
Child Welfare Services (CWS)	5180-151-0001 5180-151-0803 5180-151-0890 Reimbursements	$3,054,000 $164,000 $11,663,000 -$110,598,000
Title IV-E Waiver	5180-153-0001 5180-153-0890	$114,000 $1,398,000
Adult Protective Services	Reimbursements	$10,425,000

The updated 2016-17 caseload estimates for the largest programs are summarized below:

Program[1]	January estimate	May Revision
CalWORKs	496,558	485,851
SSI/SSP	1,311,082	1,290,781
IHSS	489,775	490,797

Additionally, the Administration notes the following local assistance adjustments:

- Local assistance expenditures for DSS are estimated to increase by a net amount of $649,936,000. This increase is comprised of $443,202,000 General Fund, $1,053,000 Child Support Collections Recovery Fund, $164,000 State Children's Trust Fund, and $455,353,000 reimbursements, partially offset by decreases of $236,210,000 Children's Health and Human Services Special Fund and $13,626,000 Federal Trust Fund.

LAO Comments. In response to the May Revision, the LAO makes the following comments:

- SSI/SSP caseload assumptions appear reasonable, but lower than expected. The May Revision estimates are slightly below the roughly 1 percent growth the program has experienced in the last few years.

- Administration's CalWORKs caseload estimates appear reasonable. The administration's estimates show a declining trend in the number of cases that will need cash assistance and

[1] Total average caseload, by program

employment services. This is consistent with recent actuals and continuing improvement in the labor market.

- Increases in caseload, hours per case, and cost per hour relative to January, estimates appear reasonable. These increases are largely due to faster growth in caseload, hours per case, and provider wages than what was estimated in January.

- Estimates for full year of FLSA implementation in 2016-17 slightly higher than January estimates. The May Revision includes $437 million General Fund in 2016-17 for a full year of implementation of the new FLSA regulations. This is an increase of $43 million General Fund over the Governor's January estimate. About half of this increase is attributable to new exemptions to the workweek cap for certain groups of providers. The remaining increase is attributable to higher-than-previously-estimated caseload growth and hours per case growth.

- The May Revision includes 2015-16 Savings from delayed FLSA implementation. The Governor's January estimate for FLSA costs in 2015-16 did not reflect savings due to delayed implementation of the new FLSA regulations. The May Revision reflects $62 million in General Fund savings due to delayed FLSA implementation in 2015-16.

- Costs of the three-month overtime grace period higher than estimated in January. The savings from delayed FLSA implementation reflected in the May Revision are not as high as was estimated in January largely due to a higher-than-previously-estimated cost of the three-month grace period. The department has indicated that this revision is in light of one month of actual spending data following FLSA implementation (February 1, 2016). We note than the Legislature has requested actual data through March 2016 that could help to further refine the estimated cost of the grace period.

Questions.

1. DSS: Please provide an overview of the May Revision estimates for major programs.

2. DSS: What factors are contributing to increases in caseload and hours-per-case growth in IHSS?

3. DSS: Is there any updated data related to overtime costs that would change the estimates included in the May Revision?

4. LAO: Are the estimates reasonable?

Staff Recommendation. Approve May Revision caseload estimate changes, subject to additional conforming changes made by other legislative actions.

5180 DEPARTMENT OF SOCIAL SERVICES – CALWORKS

Issue 15: Trailer Bill Language: ARC Program Parity

May Revision. The Administration proposes to clarify that a relative who has been approved under the resource family approval (RFA) process and who is federally ineligible for Aid to Families with Dependent Children-Foster Care (AFDC-FC) is authorized to receive a CalWORKs grant and a supplement amount equal to the resource family basic amount paid to children who are federally eligible for AFDC-FC.

Background. The ARC program allows counties that opt in to provide payments to federally ineligible relative caregivers an amount equal to the foster care basic rate received by federally eligible relative caregivers of dependent children. Approved relatives in these counties would receive a grant payment which would consist of funds from CalWORKs, General Fund, and county, if necessary.

Advocate Concerns. The Alliance for Children's Rights has strong concerns about the proposed TBL. They feel that the TBL as currently drafted does the opposite of what it intends, and actually builds inequities into resource family approval process by making it clear that relatives are not included when caring for non-federally eligible children, except at the counties' option and through an entirely different program.

Staff Comment and Recommendation. Hold open. Staff recommends the item remain open to allow for further discussion.

Questions.

1. DSS: Please provide an overview of the proposal and need for the language.

2. Please comment on advocate concerns referenced in this agenda. Are you working with advocates to address these concerns?

Issue 16: Trailer Bill Language: Workforce Innovation and Opportunity Act Career Pathways – 24-Month Time Clock Approval

May Revision. The Administration proposes to require that welfare-to-work participants in an Approved Workforce Innovation and Opportunity Act (WIOA) Career Pathway are deemed to meet the 24-month time clock (MTC) hourly requirements, regardless of the actual number of hours participated, if participants are making satisfactory progress. The department also proposes to define Approved WIOA Career Pathways and to require WIOA Career Pathways to be approved by the Local Workforce Development Boards, which operate One-Stop Career Centers.

Background. WIOA replaced the Workforce Investment Act effective July 1, 2014, and made TANF programs mandatory partners with WIOA/One-Stop Career Centers. An Approved WIOA Career Pathway results in industry-recognized credentials or degrees in occupations recognized as high demand by Local Workforce Development Boards. WIOA mandates that individualized career services must be given on a priority basis to public assistance recipients. In the California WIOA plan (effective July 1, 2016), DSS, in conjunction with the California Workforce Development Board, committed to promote the building of career pathway programs and elevate service delivery to improve client outcomes. This proposal would result in 24-MTC hourly requirements for any/all aided members of the CalWORKs household who participate in an Approved WIOA Career Pathway, even when actual hours are less than the 24-MTC hours required.

Staff Recommendation. Approve proposed trailer bill language as placeholder. No concerns have been raised.

Questions.

1. DSS: Please provide a summary of this proposal.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 17: Trailer Bill Language: Child Near Fatalities Reporting and Disclosure

May Revision. The Administration proposes trailer bill language for near fatalities that contains the following provisions:

- Defines "near fatality" as the identical meaning in federal law, except in specified circumstances.

- Defines a "near fatality case" as one that meets all of the following conditions:
  - A licensed physician determines that the child is in serious or critical condition.
  - A child's condition is the result of abuse or neglect, as defined in federal law.

- Establishes that abuse or neglect is determined to have resulted in a child's near fatality if one of the following conditions is met:
  - A law enforcement investigation concludes that child abuse or neglect occurred.
  - A county child welfare services agency determines that the child abuse or neglect was substantiated.

- Establishes that abuse or neglect does not included near fatalities caused by an alleged perpetrator who was unknown to the child or family prior to the abuse that caused the near fatality, or a minor (unless acting in the role of caretaker) who is alleged to have caused the near fatality.

- Requires that findings or information disclosed regarding the child near fatalities, upon request, must consist of a written report that includes all of the following information:
  - A child's age and gender;
  - The date the abuse or neglect occurred that resulted in the near fatality, and the date that a licensed physician determined the child victim to be in serious or critical medical condition, if known;
  - Whether the child resided in foster care or in the home of his or her parent or guardian at the time of the near fatality.
  - The cause and circumstances of the near fatality.

- Requires a description of reports received, child protective or other services provided, and actions taken by the county child welfare services agency regarding all of the following:
  - Suspected or substantiated abuse or neglect of the child near fatality victim, and suspected or substantiated abuse or neglect of other children pertinent to the abuse or neglect of the near fatality victim.
  - A written narrative that includes the dates of reports, investigations, services rendered, actions taken, and the investigative disposition for each report.

- Requires a county welfare department or agency to disclose to the public, upon request, all risk and safety assessments related to the near fatality victim.

- Requires a county welfare department or agency to release all required findings and information to the public, if disclosure is requested, within 30 calendar days (instead of the timeframe under

existing law of 10 days) of either the request or the disposition of the investigation, whichever is later.

- Provides that a county may choose to establish its own policy that is in compliance with certain provisions of this section, through the disclosure of the emergency response referral information form and the emergency response notice of referral disposition form completed by the county child welfare agency relating to the abuse or neglect that caused the near fatality.
    - A county that implements such a policy would disclose those redacted case file documents in place of a detailed written description.

- Prohibits the following information and records from being disclosed:
    - Names, addresses, telephone numbers, ethnicity, religion, or any other identifying information of any person or institution, other than the county or the Department of Social Services.
    - Any information that would jeopardize a criminal investigation or proceeding.
    - Any psychiatric, psychological, therapeutic evaluations, clinical or medical reports, evaluations or other similar materials pertaining to the child or child's family.

- Requires the county welfare department or agency to notify and provide a copy of the request to counsel for any child who is connected to the juvenile case file, and that if counsel for a child objects to the release of any part of the information, they may petition the court to prevent the release of any document or part of a document requested.

- Provides that juvenile case file records that are not subject to disclosure pursuant to this section shall only be disclosed upon an order by the juvenile court pursuant to Section 827.

- Authorizes the Department of Social Services (DSS) or county welfare department to comment on the case once documents have been released. If a county welfare department or agency comments on the case, the social worker on the case may also comment publicly about the case.

- Establishes that this law shall only apply to near fatalities that occur on, or after, January 1, 2017.

- Clarifies that nothing in this section of law requires a county welfare department or agency to obtain documents not in the case file.

The Administration has also proposed changes to current statute regarding fatalities, including:

- Establishes that abuse or neglect does not included near homicides committed by an alleged perpetrator who was unknown to the child or family prior to the abuse that caused the fatality, or a minor (unless acting in the role of caretaker) who is alleged to have caused the fatality.

- Adds that a description of child protective or other services provided, and actions taken by the county child welfare services agency regarding any services and actions not otherwise disclosed within other documents required to be released.

- Requires a county welfare department or agency to release all required findings and information to the public, if disclosure is requested, within 30 calendar days (instead of 10 days) of either the request or the disposition of the investigation, whichever is later.

- Requires that any information for an adult whose activities are not related to the abuse or neglect that led to the child fatality be redacted.

- Provides that juvenile case file records that are not subject to disclosure pursuant to this section shall only be disclosed upon an order by the juvenile court pursuant to Section 827.

Background. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states receiving funds under CAPTA must disclose to the public findings and information about child abuse and neglect cases that result in fatalities or near fatalities. On December 8, 2015, the federal Administration for Children, Youth, and Families (ACYF) notified DSS of non-compliance with federal guidelines regarding public disclosure procedures in cases where a child dies or nearly dies as the result of abuse or neglect.

Last year, the department proposed language to bring state law in to compliance with federal requirements. However, there was no consensus among stakeholders regarding whether it would be most appropriate for the state to model its disclosures in the cases of near-fatalities after the requirements established by SB 39 (Migden), Chapter 468, Statutes of 2007 for disclosures in the cases of fatalities, or to create different procedures. Ultimately, no action was taken by the Legislature.

If the state is unable to comply with federal reporting requirements, California could lose up to a total of $4.8 million in CAPTA funds. A number of approaches would satisfy the federal requirement, including the current Administration proposal, which the Administration has vetted with the federal AYCF.

Advocate Concerns. Last year, California Newspaper Publishers Association had raised concerns with the department writing a summary of events in the case, and preferred to be able to have the original documents.

Staff Comment and Recommendation. Hold open. Staff recommends the item remain open to allow for further discussion.

Questions.

1. Please provide a brief overview of the issue and a summary of new language regarding near fatalities, and of changes to the language regarding fatalities.

2. Can the department describe how it envisions the summary information will be prepared, approved and disseminated by a county?

3. Does this statute affect any other entity's ability to obtain records, or is it only related to public requests for information?

4. Both the near fatality and fatality language now read that when disclosure is requested, all required findings and information be released to the public within 30 calendar days of either the request or the disposition of the investigation, whichever is later. Existing statute provides for the release of

documentation within 10 days, or at the disposition of the investigation. Can the Administration explain why it is necessary to modify existing statute relating to child fatalities?

5. Were stakeholders involved in the process of drafting this language?

Issue 18: Continuum of Care Reform (Issue 407-MR)

May Revision. The Administration requests an additional $59.9 million General Fund in 2016-17 to fund the implementation of the Continuum of Care Reform (CCR) enacted by AB 403 (Stone), Chapter 773, Statutes of 2015, and to implement revisions to the state's current rate-setting system, services and programs serving children and families in the continuum of Aid to Families with Dependent Children - Foster Care (AFDC-FC) eligible placement settings.

The requested $59.9 million General Fund funds the following activities:

- An increase from the 2016-17 Governor's Budget of $16.7 million total funds ($25.3 million GF) due to increased administrative costs including additional caseworker time and updated caseworker costs for participatory case planning in child and family teams as well as increased administrative costs related to foster parent recruitment, retention and support.

- The 2016 May Revision includes $4.6 million total funds ($1.6 million GF) for training for social workers, probation officers and county mental health staff related to CCR efforts.

- Adjustments will be made for implementation of the new Home-Based Family Care rate structure totaling $37.7 million total funds ($32.9 million GF).

The table below provides a detailed breakdown of the proposed funding, including funding for the Department of Health Care Services for a combined total of $127.3 million General Fund.

Continuum of Care Reform (CCR) Summary*

The CCR has costs listed in several sections in the budget tables. This chart provides a consolidated view of all of the costs included in the budget tables for FY 2015-16 and FY 2016-17 for the CCR.

(in 000's)

	2016 May Revision					
	FY 2015-16			FY 2016-17		
Item	Total	Federal	GF	Total	Federal	GF
Home-Based Family Care Rate	-	-		$35,703	$2,764	$32,939
Foster Family Agency – Social Worker Rate Increase	$7,258	-	$7,258	$3,786	-	$3,786
Accreditation	-	-	-	$2,827	$1,414	$1,413
Outcomes, Accountability and Automation	-	-	-	$3,000	$1,070	$1,930
Child and Family Teams	-	-	-	$27,441	$5,423	$22,018
Second Level Administration Review	-	-	-	$29	$6	$23
Case Planning Assessment	-	-	-	$3,500	$1,148	$2,352
Foster Parent Recruitment, Retention and Support	$21,827	$4,634	$17,193	$54,729	$11,469	$43,260
Resource Family Approval	-	-	-	$12,042	$4,012	$8,030
Training	-	-	-	$4,585	$3,010	$1,575
CDSS Local Assistance Total	**$29,085**	**$4,634**	**$24,451**	**$147,642**	**$30,316**	**$117,326**
CDSS State Operations	**$5,500**	**$2,500**	**$3,000**	**$5,500**	**$2,500**	**$3,000**
Short Term Residential Treatment Program, Certification-State Operations	-	-	-	$350	$175	$175
Child and Family Teams	-	-	-	$10,247	$5,124	$5,123
Mental Health Assessments	-	-	-	$277	$138	$139
Mental Health Training	-	-	-	$1,515	-	$1,515
DHCS Total	-	-	-	**$12,389**	**$5,437**	**$6,952**
CCR Total	**$34,585**	**$7,134**	**$27,451**	**$165,531**	**$38,253**	**$127,278**

Note:
Federal Title IV-E funds are not included for the CDSS Title IV-E California Well-Being Project Counties, as federal funds for the Project are capped.

It is recognized that there will be some savings as a result of implementing the proposed changes. However, due to the uncertainties surrounding CCR implementation, such as the actual pace at which children will move from group homes to home-based settings, DSS recognizes the need to ensure there are sufficient up-front costs. The 2016 May Revision CCR estimate does not reflect savings from cases moving to lower levels of care in FY 2016-17. A reconciliation of actual savings and expenditures will be reached in the future when caseload movement is verified. Some administration estimates are offset by subsumed activities no longer being completed.

The Administration has also proposed a new Home-Based Family Care (HBFC) Rate structure:

Continuum of Care Reform (CCR) Summary*
Home-Based Family Care Rate Structure
Based on Level of Care (LOC)

A	**Pay to Resource Family for Basic Rate**	**LOC-1**	**LOC-2**	**LOC-3**	**LOC-4**
	Basic Rate	$889	$989	$1,089	$1,189
B	**Pay to Foster Family Agency (FFA)**	**LOC-1**	**LOC-2**	**LOC-3**	**LOC-4**
	Social Worker	$340	$340	$340	$340
	Social Services & Support	$0	$200	$244	$323
	Resource Family Approval	$48	$48	$48	$48
	Administration	$672	$672	$672	$672
	Total	**$1,060**	**$1,260**	**$1,304**	**$1,383**
C	**Pay to Resource Family for Treatment Foster Care (TFC)**				
	TFC Rate	$2,259			
	Pay to FFA including TFC Admin				
	TFC Administration	$3,482			
	TFC Social Services & Support	$200			
	Total	**$5,941**			
D	**Pay to Short-Term Residential Therapeutic Program (STRTP)**				
	STRTP Rate	$11,770			

E	**Pay to FFA For Services Only**	**LOC-1**	**LOC-2**	**LOC-3**	**LOC-4**
	Social Worker	$0	$340	$340	$340
	Social Services & Support	$0	$200	$244	$323
	Administration	$0	$200	$200	$200
	Total	**$0**	**$740**	**$784**	**$863**

Reimbursement rates for 14 separate group home levels will be replaced by a new set of rates, beginning January 1, 2017. These new rates are intended to reflect the expanded set of responsibilities of Short Term Residential Therapeutic Programs (STRTPs) and Foster Family Agencies (FFAs) under CCR. The rate structure is based on the needs of the child, which will be determined by a still in development assessment tool to be used by county social workers and child and family teams, unlike the previous structure which centered around the age of the child.

The FFA rate is separated into two components. The first goes to the family caregiver as an assistance payment, and the second goes to the FFA for administrative and social work activities. Similarly, the Therapeutic Foster Care (TFC) model divides the TFC rate into two components, one of which is paid to the TFC caregiver and the second which is paid to the FFA for administrative and supportive services.

CCR also allows counties to pay FFAs to provide services to children who are not placed in FFAs, allowing children in relative and county-approved homes to access supportive services if the county chooses to provide funding. The rates paid to FFAs to provide these services are called the FFA services only rates.

Below is a table showing the estimated percentage of foster children for each level of care:

Figure 1: Estimated Percentage of Foster Children in Each Level of Care (LOC)

LOC	Percent of All Foster Children in Home-Based Family Care
1	55%
2	15%
3	15%
4	15%

Background. Last year, the Legislature passed AB 403 (Stone), Chapter 773, Statutes of 2015 to implement the Continuum of Care Reform (CCR), which seeks to improve the assessment of child and families, emphasize home-based family care, support placement with available services, and increase transparency for child outcomes.

Some of the main components of AB 403 include:

- Short-Term Residential Treatment Placements (STRTPs), which are intended to provided short term, therapeutic services to stabilize children so that they may quickly return to a home-based family care setting.

- FFAs and STRTPs will be required to ensure access to specialty mental health services and strengthen their permanency placement services.

- Additional integration between child welfare and mental health services.

- Under CCR, FFAs and STRTPs are required to obtain and maintain accreditation from a nationally-recognized body in order to improve quality and oversight. CCR also calls for the development of publicly available FFA and STRTP performance measures.

- Resource Family Approval (RFA) is a new, streamlined assessment that replaces the existing multiple approval, licensing, and certification processes for home-based family caregivers.

- CCR mandates the use of child and family teams in decision-making.

- CCR calls for the creation of a new, comprehensive strengths and needs assessment upon entering the child welfare system in order to improve placement decisions and ensure prompt access to supportive services.

- New STRTC and FFA payment rates.

The Governor's budget included approximately $61 million General Fund to implement the various components of the CCR. The table below provides a high-level summary of changes between the Governor's budget and May Revision:

Funding (In Millions)	2016-17 Governor's Budget		2016 May Revision		Change		
	FY 2015-16	FY 2016-17	FY 2015-16	FY 2016-17	FY 2015-16 Change From Governor's Budget**	FY 2016-17 Change From Governor's Budget	May Revision Year-to-Year Change
Total*	$33.1	$88.6	$29.1	$147.6	-$4.0	$59.0	$118.5
Federal/ TANF	$11.6	$31.1	$4.6	$30.3	-$7.0	-$0.8	$25.7
State	$21.5	$57.5	$24.5	$117.3	$3.0	$59.8	$92.8

* Total TANF/GF impact prior to Subaccount funds. Total includes county funds.
** Referenced in the 2016-17 Governor's Budget Binder as the 2015-16 Revised Budget.

Advocate Concerns. On the administrative side of things, advocates are overall pleased to see a substantial increase in funding for the CCR in 2016-17. However, there are still concerns that the amount of time the Administration has proposed for CFT meetings are not enough, and they are unsure if the social worker cost is where it needs to be. There is also some concern with the funding of the RFA piece.

Advocates have expressed strong concern with the proposed rate structure, given that there has not been sufficient time to review the new rates and assess their impact on the CCR effort. At this point, however, they feel the proposed rates to be insufficient given the expected services and supports these homes will be required to provide, and are unclear if counties are supposed to pick up the tab on anything not covered in the rates. They also feel there is not enough information on details surrounding the levels of care and the assessment tool, which will be instrumental in how children are placed into homes and how the rate structure works within the larger goals of CCR. They are also concerned that the rates do not account for regional differences.

LAO Comments. The Legislative Analyst's Office makes the following comments and raises some initial questions:

- It is uncertain at this time how the new HBFC rates take into account new service requirements. While DSS has promulgated guidance around what services will be required, it remains uncertain which children will be entitled to what services and what levels of services are expected. Without further policy detail on how the new CCR service requirements will be implemented, it is difficult to assess the adequacy of the proposed HBFC rate structure.

- How did DSS determine the HBFC rates of the four LOCs and how do the increments reflect the additional care and services needs of children?
- How Did DSS Estimate the Number of Children in Each LOC? The Legislature has requested additional information from DSS on the differences between the LOCs.
- How will DSS ensure the consistent application of LOC determinations across counties both during and after the assessment pilot?
- How and when will the initial LOC assessment be made so children can receive the appropriate LOC HBFC rate beginning in January 2017?
- The Legislature may wish to consider what kinds of monitoring and reporting on CCR implementation it would like in order to ensure adequate legislative oversight. Such monitoring could be accomplished through supplemental reporting language or regularly required briefings from DSS. Topics of the reports or briefings may change depending on where CCR is in the implementation process, but could include such things as (1) the status of DSS guidance to counties and stakeholders on the various components of CCR implementation, (2) county costs and savings related to CCR implementation, and (3) foster child outcomes like the number of children transitioning out of group homes and STRTPs into home-based family placements.

Staff Comment and Recommendation. Staff is also concerned that there has not been sufficient time to review the new rates, and that there is a lack of detailed information concerning the levels of care and assessment tool. Staff recommends that this item remain open at this time.

Questions.

1. Please summarize the proposal and the differences between the Governor's budget.

2. How were advocates and stakeholders involved in the process of drafting the new rate structure?

3. Please provide more detail on the levels of care and the new assessment tool.

4. Given that the assessment tool is still in development, what guidance have you provided counties with so that they can still place children within the new rate structure?

5. Please comment on the advocate concerns outlined in this agenda.

6. Do you intend that there be additional oversight or review of the rate structure as it implements?

Issue 19: Budget Change Proposal: Funding Continuum of Care Reform Implementation

Governor's Budget. The Administration requests $5 million ($2.5 million General Fund) on a three-year limited term basis to support approximately 34 positions to implement AB 403 (Stone), Chapter 773, Statutes of 2015.

Background. AB 403 seeks to achieve the goal that all children as members of committed, nurturing, and permanent families, and that these children and their families must have local access to a broad continuum of services and supports. This legislation fundamentally changed the manner in which foster care and other entities coordinate and deliver services to foster children. Workload includes the development of 228 new procedures, processses, or protocols; 26 consultations with varying combinations of 18 specified or open-ended stakeholder groups; development of 19 sections of regulations; development of eight new training programs or new curriculum for existing programs; and reports to the Legislature or to publicly publish information.

The department asserts that a group of dedicated personnel is required to carry out AB 403 activities, particularly to meet the January 1, 2017 implementation deadline. The requested staff will be used to achieve the following goals: limit reliance on congregate care; increase capacity for home-based family care; increase engagement with foster children/youth and families; revise the foster care rate structure; increase accountability and performance; reporting; and legal support.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its April 21, 2016 hearing. No concerns have been raised.

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

Issue 20: Trailer Bill Language: IHSS MOE

Governor's Budget. The Administration proposes to clarify in existing law that counties are responsible for paying the entire nonfederal share of any IHSS cost increase exceeding the maximum amount of the state's participation, and that the counties' share of these expenditures are included in the county IHSS MOE.

Background. Beginning July 1, 2012, all counties in California were required to have a county IHSS MOE, which would be in-lieu of paying the nonfederal share of IHSS costs. Statute specified that the county's IHSS MOE would be based on expenditures from FY 2011-12 and would be adjusted by an inflation factor of 3.5 percent annually, beginning July 1, 2014. In addition, the county IHSS MOE would be adjusted for the annualized costs of increases in provider wages and/or health benefits that were locally negotiated, mediated, or imposed prior to the Statewide Authority assumption of its responsibilities. If the department approved a rate or benefit increase, the state would be responsible for 65 percent of the nonfederal share of the costs while the county would be responsible for the remaining 35 percent with a limit for the state up to $12.10 per hour for wages and health benefits.

The department notes that this proposal clarifies and affirms the intent of existing law that the increased costs to the contract mode are shared by the counties, consistent with the IHSS MOE.

Advocate concerns. The California State Associate of Counties (CSAC), the County Welfare Directors Association of California (CWDA), and the California Association of Public Authorities (CAPA) have concerns with the current way the TBL is drafted. They are not opposed to TBL that would clarify that the county IHSS MOE's should be increased for the county's share of contract provider wage or health benefit increases resulting from local negotiations, but feel that the proposed language is too broad.

Staff Recommendation. Hold open.

Questions.

1. DSS: The department had previously stated that it was working with advocates and that modified trailer bill language would be forthcoming at May Revision; however, there was no new language proposed. Where is the department now in its conversations with stakeholders?

Issue 21: IHSS Overtime Restriction Exemptions (Issues 417-MR and 418-MR)

May Revision. The Administration requests an increase of $22,277,000 General Fund and reimbursements to be increased by $25,122,000 to reflect costs associated with exempting providers who meet specified criteria from IHSS overtime restrictions contained in SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014.

Background. Exemptions will be available for live-in family care providers who, as of January 31, 2016, reside in the home of two or more disabled minor or adult children or grandchildren for whom they provide services. A second type of exemption will be considered for recipients with extraordinary circumstances and granted on a case-by-case basis. Under either exemption, the maximum number of hours for a provider may work cannot exceed 360 hours per month.

Advocate Concerns. Advocates have raised concerns that consumers with high needs who may be entitled to the second exemption have not been properly notified and may be in jeopardy of entering institutional based-care, given that they may be unaware of their options.

Staff Recommendation. Hold open.

Questions.

1. Please summarize the proposal.

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

Issue 22: Spring Finance Letter: CWS-NS

Governor's Budget. The Administration requests an augmentation of $32.1 million in combined state and federal funding for DSS local assistance costs, as well as $28.66 million in expenditure authority for OSI to develop and implement CWS-NS. This funding will be available until project completion and reviewed on an annual basis. Budget bill language is also being requested which will allow for increased project funding beyond the appropriation authority, funds to be transferred to state operations for project-related activities, and provides various reporting requirements.

Background. In November 2015, the state changed its typical procurement approach from a monolithic, multi-year Request for Proposal to pursue an agile development aproach for numerous smaller modules of functionality reflecting the same ultimate scope as the prior efforts.

The department notes that it requests additional resources for the CWS-NS project in light of uncertainty in the Agile development process, and the need to be flexible in administrative processes and contracting, and uncertainty in vendor competition and performance.

Staff Comment and Recommendation. Hold open. Staff has requested that the LAO draft budget bill language that clarifies that the flexibility should not increase total project costs, and that the Legislature have adequate notification before funds are increased. Staff recommends to hold this item open to allow for further discussion. Below is the language that the LAO has provided:

Of the funds appropriated in Schedule (1) of this item, $29,179,000 is for the support of activities related to the Child Welfare Services-New System (CWS-NS) project. Expenditure of these funds is contingent upon approval of project documents by the Department of Finance and the Department of Technology. This amount may be increased by the Department of Finance, up to a maximum of $5,000,000 during the 2016-17 fiscal year, upon approval of revised project documents. Such an increase shall only be used to support an acceleration of planned project activities, and shall not be used to increase total project costs. Any such increase shall be authorized no less than 30 calendar days following written notification to the Chairperson of the Joint Legislative Budget Committee, or a lesser period if requested by the department and approved by the Chairperson of the Joint Legislative Budget Committee or his or her designee. ~~upon notification to the Legislature.~~

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Wednesday, May 18, 2016
9:30 a.m.
State Capitol - Room 4203

Consultant: Michelle Baass

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

VOTE ONLY

MULTIPLE DEPARTMENTS

Issue 1: Health-Related General Fund Investments

As discussed at the May 12th hearing, the Subcommittee has received multiple requests for General Fund augmentations for health-related programs.

Subcommittee Staff Recommendation—Approve. Given the state's fiscal situation, it is recommended to approve the following General Fund augmentations and to adopt any needed placeholder trailer bill language to effectuate these proposals:

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
Department of Health Care Services		
1. Medi-Cal Estate Recovery	Multiple stakeholders, including Western Center on Law and Poverty, Health Access, CPEN, and Consumers Union, request to limit estate recovery in the Medi-Cal program by requiring collection for only those health care services required to be collected under federal law, to make it easier for individuals to pass on their assets by using a narrower definition of "estate" in federal Medicaid law, and to allow a hardship exemption from estate recovery for a home of modest value.	$26 million
2. Interpreters for Medi-Cal	Various stakeholders, including the California Latino Legislative Caucus and AFSCME, requests $15 million for interpreters in the Medi-Cal program.	$15 million
3. AIDS Medi-Cal Waiver Program Rates	The California HIV Alliance proposes a rate increase for the AIDS Medi-Cal Waiver program. It notes that provider reimbursement rates for this program are lower than Medi-Cal rates for the same services. This increase would equalize case management and case management administrative expenses for the AIDS Medi-Cal waiver to other Home and Community-Based Waiver Services programs.	$4.9 million

Department of Public Health		
4. Drug Overdose Prevention (Naloxone)	The Drug Policy Alliance (DPA) requests to establish a grant program for local agencies and community-based organizations in order to reduce the rate of fatal drug overdose caused by prescription analgesics and other drugs. DPA estimates this investment would save an estimated 1,200 lives. Furthermore, hospitalization rates for treatment of effects of non-fatal but debilitating overdoses would also be reduced.	$3 million
5. Hepatitis Initiatives	Stakeholders, such as CalHEP and Project Inform, request: 1) $100,000 for DPH to purchase and distribute hepatitis B (HBV) vaccine to local health jurisdictions to vaccinate high risk adults; 2) $600,000 for DPH to purchase hepatitis C (HCV) rapid test kits to distribute to community-based testing programs; 3) $500,000 for DPH to certify non-medical personnel to perform rapid HCV and HIV testing in community-based settings; and 4) $200,000 to the DPH Office of AIDS for technical assistance to local governments and to increase the number of syringe exchange and disposal programs throughout California and the number of jurisdictions in which syringe exchange and disposal programs are authorized.	$1.4 million
6. Children's Dental Disease Prevention Program (DDPP)	Advocates propose to restore funding for DDPP. From 1980 to 2009, the DDPP provided school-based oral health prevention services to approximately 300,000 low-income school children in 32 counties in California. Participating sites provided fluoride supplementation, dental sealants, plaque control, and oral health education.	$3.2 million
7. Early Detection and Diagnosis of Alzheimer Disease	Various stakeholders, including the Alzheimer's Association, request funds for the California Alzheimer Disease Centers for early detection and diagnosis of Alzheimer disease. Funds would be used to determine the standard of care in early and accurate diagnosis, provide professional outreach and education, and evaluate the educational effectiveness of these efforts.	$2.5 million (one-time)
8. Biomonitoring Program	Various advocates, including the Natural Resources Defense Council and the Breast Cancer Fund, request an augmentation for the biomonitoring program to increase and support the scientific work of this program. This funding would be split between DPH, the Department of Toxic Control, and the Office of Environmental Health Hazard Assessment.	$1 million
9. End of Life Option Act - Telephone Line (SB 1002)	Senator Monning requests funds ($150,000) to establish a telephone line for answering End of Life Option Act inquiries and require that the individuals answering be bilingual. SB 1002 (Monning) would implement this request.	$150,000
Office of Statewide Health Planning and Development		
10. Primary Care Workforce Development	Various stakeholders request funding ($82.5 million) for Song Brown Program to increase residency programs for primary care physicians and funding ($17.5 million) to establish new teaching health center sites offering additional primary care residencies, and other efforts related to graduate medical education.	$100 million over three years ($33 million/year)

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Interagency Task Force on HIV, Hepatitis C, Sexually Transmitted Diseases, and Drug User Health

Issue. The California HIV Alliance, Project Inform, and CalHEP request $500,000 General Fund to establish an interagency task force to address HIV, HCV, sexually-transmitted infections, and drug user health.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to modify this advocate proposal and only adopt placeholder trailer bill language to establish this task force (i.e., not include a General Fund augmentation for this purpose, as these activities are consistent with the role of the agency).

0530 CALIFORNIA OFFICE OF HEALTH INFORMATION INTEGRITY (CALOHII)

Issue 1: Restructure the California Office of Health Information Integrity

Budget Issue. CalOHII requests a reduction of five positions and operating expenses for a net reduction of $1.4 million ($1.3 million General Fund). Based on a zero base budget analysis, CalOHII requests to reduce its staffing and amend its statutory obligations. CalOHII will continue to serve as the state's authority on the Health Insurance Portability and Accountability Act (HIPAA) matters, but will reduce the scope of its activities to updating statewide HIPAA policy and monitoring progress of HIPAA impacted and covered departments.

The Administration also proposes trailer bill language to implement these changes.

This issue was discussed at the March 3, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Administration's proposed placeholder trailer bill language.

0530 OFFICE OF SYSTEMS INTEGRATION (OSI)

Issue 1: MEDS Modernization Multi-Departmental Planning Team

Budget Issue. OSI requests 18.0 positions and $3.7 million to provide dedicated staffing and resources required for the agency-wide planning effort for Medi-Cal Eligibility Data System (MEDS) Modernization. See table below for details on the funding components of this request.

This issue was discussed at the March 3, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the request from OSI and the corresponding budget request from the Department of Health Care Services to support this effort.

Issue 2: eWIC Management Information System Project

Budget Issue. OSI requests $4.1 million in expenditure authority and 19.5 permanent positions for the new Women, Infants and Children (WIC) Management Information Systems (eWIC MIS) project. The California Department of Public Health (DPH), as the single state entity responsible for the federally-funded WIC Program, is proposing to contract with the OSI to assume management of the eWIC MIS Project including completing the system acquisition and managing the project through successful completion of statewide implementation. DPH will fund the project with 100 percent federal funding and has submitting a separate BCP to request the necessary appropriation authority.

This issue was discussed at the March 3, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: CalHEERS

Budget Issue. OSI requests an increase of $8 million in expenditure authority and two permanent positions in 2016-17 related to the transfer of 58 California Healthcare Eligibility, Enrollment and Retention (CalHEERS) staff to OSI from Covered California. The costs will continue to be reimbursed by Covered California and the Department of Health Care Services (DHCS). OSI proposes to increase its full day-to-day Project Management (PM) of the staff and activities and continue to provide oversight services for the design, development, implementation and operation and maintenance of the project.

This issue was discussed at the March 17, 2016 Subcommittee No. 3 hearing.

In addition, the May Revision proposes a technical adjustment and a change to provisional budget bill language (Issue 401-MR) to decrease funding by $1,641,000 to align OSI's expenditure authority with the revised CalHEERS project cost for 2016-17.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Budget Bill Language.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Expansion of State Loan and Allied Health Repayment Programs for CMSP Counties

Issue. The County Medical Services Program (CMSP) requests to expand the State Loan Repayment Program and the Allied Health Loan Repayment Program in CMSP counties using CMSP funds. The CMSP Governing Board would provide funding for this purpose over a three year period, with an estimated cost of $4.85 million, including $350,000 for OSHPD to administer.

Subcommittee Staff Comment—Approve and Adopt Budget Bill Language. It is recommend to increase OSHPD's reimbursement authority and adopt placeholder budget bill language to implement this proposal.

4150 DEPARTMENT OF MANAGED HEALTH CARE

The following issues were discussed at the March 17, 2016 Subcommittee No. 3 hearing.

Issue 1: Infrastructure and Support Services

Budget Issue. DMHC requests two permanent positions and $247,000 for 2016-17 and $234,000 for 2017-18 and ongoing to ensure the DMHC can address the critical administrative workload resulting from program expansions resulting from the implementation of the Affordable Care Act (ACA) and conforming state legislation.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: End of Life Option Act (AB 15 X2, 2015)

Budget Issue. DMHC requests two-year limited-term expenditure authority of $244,000 for 2016-17 and 2017-18 to meet the department's operational needs in order to address the short-term workload resulting from the implementation of AB 15 X2 (Eggman), Chapter 1, Statutes of 2015, the End of Life Option Act.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: Federal Mental Health Parity Ongoing Compliance Review

Oversight and Budget Issue. DMHC requests $529,000 for 2016-17 and 2017-18 for clinical consulting services to design new compliance filing instructions and forms, conduct review of plans' classification of benefits and nonquantitative treatment limits (NQTLs), and for resolving clinical issues arising in compliance filings associated with performing ongoing oversight of compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

(MHPAEA) and its Final Rules. These resources would be used for the initial front-end compliance reviews for new plans and new products.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: Large Group Rate Review (SB 546, 2015)

Budget Issue. DMHC requests four permanent positions and $682,000 for 2016-17 and $644,000 for 2017-18 and ongoing to address the increased workload resulting from the implementation of SB 546 (Leno), Chapter 801, Statutes of 2015.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 5: Limitations on Cost-Sharing: Family Coverage (AB 1305, 2015)

Budget Issue. DMHC requests limited-term expenditure authority of $196,000 for 2016-17 and $188,000 for 2017-18 to meet the department's operational needs to implement AB 1305 (Bonta), Chapter 641, Statutes of 2015.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 6: Outpatient Prescription Drug Formularies (AB 339, 2015)

Budget Issue. DMHC requests limited-term resources of $733,000 for 2016-17; $700,000 for 2017-18; $558,000 for 2018-19; and $558,000 for 2019-20 to meet the department's operational needs in order to address the short-term workload resulting from the implementation of AB 339 (Gordon) Chapter 619, Statutes of 2015.

This request includes $196,000 in contracted consulting costs for 2016-17, 2017-18, 2018-19, and 2019-20 to assist DMHC offices with developing implementation standards and identifying health plan clinical standard deficiencies during the survey process.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 7: Provider Directories (SB 137, 2015)

Budget Issue. DMHC requests eight permanent positions and $1,436,000 for 2016-17; $1,366,000 for 2017-18; and $1,181,000 for 2018-19 and ongoing to address the increased workload resulting from the implementation of SB 137 (Hernandez) Chapter 649, Statutes of 2015.

This request includes $153,000 for 2016-17; $153,000 for 2017-18; and $77,000 for 2018-19 and ongoing for the Office of Enforcement's (OE) expert witness and deposition costs for enforcement trials. This request also includes limited-term expenditure authority of $89,000 for 2016-17 and 2017-18, enabling DMHC's Office of Technology and Innovation (OTI) to address short-term IT-related setup activities.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 8: Vision Services (AB 684, 2015)

Budget Issue. DMHC requests two permanent positions and $308,000 for 2016-17 and $292,000 for 2017-18 and ongoing to address the increased workload resulting from the implementation of AB 684 (Alejo) Chapter 405, Statutes of 2015.

Subcommittee Staff Comment and Recommendation—Approve.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: County Eligibility Administration Funding and Trailer Bill

Budget Issue. The budget continues to provide an additional $169.9 million ($57 million General Fund) in 2016-17 and 2017-18 to counties to administer the Medi-Cal program. According to the Administration, this augmentation provides the funding to address the ongoing increased workload as a result of the significant caseload growth since the federal Affordable Care Act (ACA) implementation.

Additionally, the Administration proposes trailer bill language to suspend the cost-of-living adjustment (COLA) provided to the counties as part of the annual state budget allocation for county administration in 2016-17. The Administration finds that the COLA is not necessary given the augmentations (discussed above) provided in response to ACA implementation. The proposed trailer bill language also deletes outdated language referencing the Healthy Families Program which transitioned to Medi-Cal in 2013-14.

This issue was discussed at the March 17, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve and adopt Administration's proposed placeholder trailer bill language.

Issue 2: Health Insurance Portability and Accountability Act Compliance and Monitoring

Budget Issue. DHCS requests the conversion of eight limited-term positions to permanent effective July 1, 2016. The requested expenditure authority for this conversion is $1,202,000 ($240,000 General Fund). The positions are necessary to continue existing efforts, maintain compliance with current federal and state regulations, address new Health Insurance Portability and Accountability Act (HIPAA) rules, provide support for growth in the Capitation Payment Management System (CAPMAN), and continue to strengthen oversight of privacy and security protections for members served by DHCS programs.

This issue was discussed at the March 17, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: Specialty Mental Health Services Oversight and Monitoring

Budget Issue. DHCS requests 13 full-time, permanent positions and expenditure authority of $1,925,000 ($866,000 General Fund) for 2016-17 and $2,128,000 ($972,000 General Fund) on-going. The permanent resources requested, included $400,000 for contracted clinicians, who will work to meet the Special Terms and Conditions (STCs) required by the Centers for Medicare and Medicaid Services (CMS). CMS placed this as a condition of the renewal of DHCS Medi-Cal Specialty Mental Health Services (SMHS) Waiver authorized under Section 1915(b) of the Social Security Act.

This issue was discussed at the April 21, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: Performance Outcomes System for Medi-Cal Specialty Mental Health Services

Budget Issue. The budget includes $23.7 million ($11.9 million General Fund) for implementation of the performance outcomes system (POS) for Medi-Cal specialty 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.

These funds would be used to fund county personnel costs and for training for county clinicians on how to use the tools for data collection. County mental health plans will collect, manage, use, and report additional functional assessment data as part of the POS.

This issue was discussed at the April 21, 2016 Subcommittee No. 3 hearing.

May Revision. The May Revision requests a decrease of $5,055,000 (in both General Fund and Federal Fund) to reflect the revised implementation timeline (and a delay in hiring county staff) and technology costs associated with the functional assessment tool that will be selected as part of Performance Outcomes System. The functional assessment tool will measure the functional impairment of a child receiving mental health services through Medi-Cal to better report on participant outcomes. (DOF Issue 551-MR)

Subcommittee Staff Recommendation—Approve.

Issue 5: Mental Health Services Act (Proposition 63) Reappropriation

Budget Issue. Through a Spring Finance Letter, DHCS requests reappropriation of $1.9 million in unexpended Mental Health Services Act (MHSA) funding from 2013-14, 2014-15, and 2015-16. The reappropriated funds will support costs to procure contracts for 1) MHSA data quality assurance, 2) MHSA data collection, and 3) MHSD Web re-design. Currently, the department indicates it is unable

to provide timely and accurate information for data queries from stakeholders or legislative staff. This proposal requests the following budget bill language to reappropriate unexpended prior year funding:

> **4260-490—Reappropriation, Department of Health Care Services. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2018:**
> **3085—Mental Health Services Fund**
> **(1) Item 4260-001-3085, Budget Act of 2013 (Chs. 20 and 354, Stats. of 2013),**
> **(2) Item 4260-001-3085, Budget Act of 2014 (Ch. 25, Stats. of 2014),**
> **(3) Item 4260-001-3085, Budget Act of 2015 (Ch. 10, Stats. of 2015)**

Of the $1.9 million in funds to be reappropriated, $250,000 per year for 2013-14, 2014-15, and 2015-16 is from unused contract funds and the remaining unexpended funds are due to salary savings in 2013-14, 2014-15, and 2015-16.

This issue was discussed at the April 21, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 6: Drug Medi-Cal Waiver Program Resources

Budget Issue. Through a Spring Finance Letter, the Administration requests eight permanent full-time positions to support fiscal oversight and programmatic monitoring requirements 1115 Demonstration Waiver Amendment for the Drug Medi-Cal Organized Delivery System (DMC-ODS).

These resources would be phased in over two years, five positions in 2016-17, for a cost of $624,000 ($312,000 General Fund), and three more positions in 2017-18 for a cost of $322,000 ($161,000 General Fund) given the uncertainty related to how many counties will be ready to file implementation plans and how many will be approved by the federal Centers for Medicare and Medicaid Services (CMS).

This issue was discussed at the April 21, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 7: Drug Medi-Cal – Residential Treatment Services

Budget Issue. The May Revision requests a decrease of $20,144,000 General Fund and $31,689,000 Federal Fund to reflect the updated implementation timeframe for the expansion of residential treatment services to non-perinatal beneficiaries. DHCS has received nine county implementation plans to date; however, only one county implementation plan has been approved by DHCS. Prior to implementation, these local plans require approval by participating county boards of supervisors as well as the federal Centers for Medicaid and Medicare Services. (DOF Issue 556-MR)

Subcommittee Staff Comment and Recommendation—Approve.

Issue 8: Home and Community-Based Services (HCBS) Federal Requirements

Budget Issue. DHCS requests limited-term resources of $1,112,000 ($491,000 General Fund) to fund the following:

1. **HCBS Federal Requirements.** Three-year limited-term resources to comply with the Centers for Medicare and Medicaid Services (CMS) Federal Regulations (2249-F and 2296-F) on Home and Community-Based Settings Final Rule for existing Home and Community-Based Services (HCBS) providers and beneficiaries promulgated on March 17, 2014.

2. **Statewide Transition Plan (STP).** Four-year limited-term resources to work on the CMS approved Assisted Living Waiver (ALW) program, coordinate activities with the STP and ensure ongoing compliance of ALW providers with the HCBS final rule. Resources will also address continued work to meet existing Community-Based Adult Services (CBAS) workload, coordinate activities with the STP and ensure ongoing compliance of CBAS providers with the HCB Final Rule. The resources will address work done currently by limited-term positions that are set to expire 6/30/16.

This issue was discussed at the May 5, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 9: Office of Family Planning Contract Conversion

Budget Issue. DHCS requests ten permanent, full-time state civil service positions and $1,458,000 ($637,000 General Fund) for 2016-17 and $1,368,000 ($596,000 General Fund) on-going to replace existing contracted staff. The requested positions will ensure adequate staffing levels to meet state Office of Family Planning (OFP) requirements and comply with Government Code Section 19130, which prohibits contracting out for services that can be performed by state civil servants.

The current contract funding is built within the Medi-Cal Local Assistance Estimate. DHCS proposes to discontinue the policy change in order to build the expenditure authority in the state operations budget. The current contract is annually budgeted at $2,861,000 ($1,430,000 General Fund). With the contract conversion to state civil service positions, there is an anticipated cost savings of approximately $1,403,000 ($793,000 General Fund) in year one and $1,493,000 ($834,000 General Fund) in year two and on-going.

This issue was discussed at the May 5, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 10: Medi-Cal Estimate May Revision Adjustments

Budget Issue. The May Revision requests that the technical adjustments noted below be made to the following budget bill items to reflect a variety of caseload and cost changes not highlighted in the other Medi-Cal proposals:

- Item 4260-101-0001 be decreased by $647,158,000 and reimbursements be increased by $749,916,000
- Item 4260-101-0890 be increased by $1,491,171,000
- Item 4260-101-0080 be increased by $11,000
- Item 4260-101-0232 be increased by $4,929,000
- Item 4260-101-0233 be increased by $1,408,000
- Item 4260-101-0236 be increased by $6,673,000
- Item 4260-101-3168 be increased by $482,000
- Item 4260-101-3213 be increased by $41,402,000
- Item 4260-106-0890 be increased by $1,298,000
- Item 4260-113-0001 be increased by $184,022,000
- Item 4260-113-0890 be increased by $558,591,000
- Item 4260-117-0001 be increased by $145,000
- Item 4260-117-0890 be increased by $685,000

(DOF Issues 501-MR and 531-MR)

Subcommittee Staff Recommendation—Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken. This is a technical adjustment.

Issue 11: Medi-Cal May Revision Adjustments to January Budget

Budget Issue. The May Revision requests these adjustments to the January Budget:

1. **May 2016 Workload Adjustments (Issues 552, 553, 554, 555-MR)—**It is requested that General Fund be increased by $73,724,000, and Federal Fund be increased by $2,001,673,000 to reflect workload changes related to End of Life Services (Issue 552-MR), Palliative Care (Issue 553-MR), Scaling and Root Planning Prior Authorization and Preventive Dental Services (Issue 554-MR), and Affordable Care Act Optional Expansion (Issue 555-MR).
2. **Managed Care Enrollee Tax (Issue 557-MR)—**It is requested that General Fund be decreased by $1,106,739,000 to reflect the approval of SB 2 X2 (Hernandez), Chapter 2, Statutes of 2016, which authorized a tiered, enrollment based tax on health care service plans in order to provide a stable funding mechanism for the Medi-Cal program. The revenue received from the tax funds the non-federal share of capitation payments to managed care plans that provide health care services to Medi-Cal beneficiaries; and, consequently General Fund expenditures can be reduced.
3. **Medi-Cal Fiscal Intermediary Adjustments (Issue 559-MR)—**It is requested that General Fund be decreased by $2,555,000, Federal Fund be decreased by $26,766,000, Item

4260-117-0001 be increased by $315,000, and Item 4260-117-0890 be increased by $3,031,000. These changes reflect the stoppage of DHCS' efforts to replace the California Medicaid Management Information System, partially offset by increases associated with close-out activities, transitioning project management to the state, and the reprocurement of new vendors for the operation of the legacy system and system replacement.

4. **Minimum Wage Impact (Issue 562-MR)—**It is requested that General fund be increased by $7,067,000 and Federal Fund be increased by $5,086,000 to implement SB 3 (Leno), Chapter 4, Statutes of 2016. This request accounts for increased costs in Home and Community-Based Services waiver programs and Long-Term Care facilities rate add-ons as well as savings in the Medi-Cal program due to decreases in eligibility.
5. **BHT Transition (Issue 563-MR)—**It is requested that General Fund be increased by $87,894,000 and Federal Fund be increased by $115,789,000. These changes reflect costs associated with the transition of Medi-Cal beneficiaries who are existing Department of Developmental Services regional center consumers to Medi-Cal for their BHT services.

   It is also requested that provisional language in Item 4260-101-0001 be amended to allow the transfer of funding between the Department of Developmental Services to support the transition of current Medi-Cal eligible regional center clients receiving BHT services upon completion of the statewide transition plan. Proposed amended budget bill language:

   > "13. The Department of Finance may authorize the transfer of expenditure authority ~~from~~ between Schedule (2) of item 4300-101-0001 ~~to~~ and Schedule (3) of this item to support the transition of current Medi-Cal eligible regional center clients receiving behavioral health treatment services pursuant to Section 14132.56 of the Welfare and Institutions Code upon completion of the statewide transition plan.
   >
   > The Director of Finance shall provide notification to the Joint Legislative Budget Committee of any transfer of expenditure authority approved under this provision not less than 30 days prior to the effective date of the approval. The 30-day notification shall include a description of the transfer, including the number of children per regional center affected, the average cost of behavioral health treatment services for a regional center consumer, and the average cost of behavioral health treatment services for a Medi-Cal enrollee, and assumptions used in calculating the amount of expenditure authority to be transferred."

Subcommittee Staff Recommendation—Approve

Issue 12: Hospital Quality Assurance Fee Extension

Issue. The California Hospital Association (CHA) requests that the Subcommittee consider trailer bill language to extend the sunset date of the hospital quality assurance fee (QAF); the current QAF sunsets January 1, 2017. CHA requests the sunset date be extended one year to January 1, 2018. The existing hospital QAF is estimated to provide, annually, approximately $800 million in savings to the General Fund, with a certain portion of the fee revenue offsetting General Fund costs for providing children's health care coverage.

The budget assumes that the QAF sunsets and; consequently, only includes about $150 million in General Fund savings.

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt placeholder trailer bill language to extend the hospital QAF until January 1, 2018. It is also recommended to account for the approximately $950 General Fund savings as a result of the extension of this QAF. According to the Legislative Analyst's Office, depending on the timing of federal approval, $700 million General Fund savings could be scored in 2017-18 and $250 million General Fund savings could be scored in 2018-19.

Issue 13: Medi-Cal Electronic Health Records Staffing

Budget Issue. DHCS requests three-year limited-term resources of $403,000 ($41,000 General Fund) for the Medi-Cal Electronic Health Record (EHR) Incentive Program to provide extensive data analysis, policy analysis, enrollment and eligibility support, and pre- and post-payment audits and investigations for program eligible managed care and fee-for-service providers. The federal Centers for Medicare and Medicaid Services (CMS) has approved 90 percent federal funding participation (FFP) for these requested resources.

Subcommittee Staff Recommendation—Approve

Issue 14: Family Health May Revision Estimate

Budget Issue. The May Revision requests adjustments to the California Children's Services (CCS), Child Health and Disability Prevention Program (CHDP), the Genetically Handicapped Person's Program (GHPP), and the Every Woman Counts (EWC) program. See tables below for details. These changes reflect revised expenditure estimates in the four Family Health programs based on: (1) revised caseload estimates, (2) a decrease in Orkambi pharmaceutical costs in the California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP), (3) a decrease in average annual cost per case in GHPP, (4) an increase in therapy service costs in the CCS program, and (5) other miscellaneous adjustments. (DOF Issues 502 and 532-MR)

Table: Family Health Estimate May Revision Summary

Program	Budget Act 2015-16	May Revision Projected 2015-16	January Budget Proposed 2016-17	May Revision Proposed 2016-17
CCS	$85,682,000	$81,911,000	$78,164,000	$79,732,000
CHDP	1,375,000	836,000	467,000	115,000
GHPP	128,467,000	134,885,000	183,545,000	167,532,000
EWC	42,140,000	28,887,000	32,215,000	28,592,000
TOTAL	**$257,664,000**	**$246,519,000**	**$294,391,000**	**$275,971,000**

Subcommittee Staff Recommendation—Approve.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Licensing and Certification (L&C): Program Quality Improvement Projects

Budget Issue. DPH requests expenditure authority of $2 million from the Internal Departmental Quality Improvement Account to execute two contracts to implement program improvement recommendations. DPH will allocate $1.5 million to the redesign of the Centralized Applications Unit (CAU) IT systems, and $500,000 to the Health Facilities Consumer Information System (HFCIS) redesign.

DPH proposes to redesign the Central Applications Unit IT systems. This project would entail replacing substantially paper-based processes with information technology solutions that will allow recording and tracking of multi-level facility ownership structures, as well as on-line applications and reporting features. This redesign will also enable the center to be compliant with Affordable Care Act requirements, while also improving the quality and timeliness of services provided to facilities. Once complete, the redesign will enable the center to provide more accurate and timely information on facility ownership and compliance history. Further, the redesign will enable the Central Applications Unit to achieve greater staff efficiencies by fully centralizing all ownership tracking activities that currently take place in the Central Applications Unit, district offices, and Los Angeles County.

DPH also proposes to redesign the Health Facilities Consumer Information System. Established in 2008, the Health Facilities Consumer Information System provides consumers and patients access to information about the DPH's licensed long-term care facilities and hospitals throughout the state. The website provides profile information for each facility, as well as performance history including complaints, facility self-reported incidents, state enforcement actions, and deficiencies identified by Public Health staff; the system also allows consumers to submit complaints to Public Health electronically. According to DPH, the current system is outdated and not as user-friendly or accessible as many other public-facing consumer-centric websites.

This issue was discussed at the March 3, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: L&C: Timely Investigations of Caregivers

Budget Issue. DPH requests an additional $2.5 million in expenditure authority from the State Department of Public Health Licensing and Certification Program Fund to convert 18.0 existing two-year limited-term positions to permanent positions, and fund two additional positions for the Office of Legal Services, for a total of 20.0 positions to improve the timeliness of investigations of complaints against caregivers.

This issue was discussed at the March 3, 2016 Subcommittee No. 3 hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: L&C: State Citation Penalty Account and Long-Term Care Ombudsman

Budget Issue. Last year's budget included a one-time $1 million augmentation to the Long-Term Care (LTC) Ombudsman Program using funds from the State Health Facilities Citation Account. This account still maintains a $7 million fund balance.

Subcommittee Staff Comment and Recommendation—Augment Funding for LTC Ombudsman Program. It is recommended to augment the LTC Ombudsman Program with $1 million in ongoing funds from the State Health Facilities Citation Account. As previously discussed, it is reasonable to assume that the ombudsman program's presence and advocacy on behalf of skilled nursing facility (SNF) residents improves quality of life for these residents and improves a SNF's compliance with state and federal laws.

Issue 4: Women, Infants, and Children Program

Budget Issue. The budget requests the following:

a. **Increase Enrollment of Children.** Four permanent positions and $513,000 in federal fund expenditure authority to WIC Division's outreach activities and improve data-sharing with the California Department of Social Services' (CDSS) CalFresh Program to increase child enrollment in both programs.

b. **eWIC.** To redirect three permanent positions to the Office of Systems Integration (OSI) and increase federal fund expenditure authority by $5.78 million for fiscal year 2016-17 to replace WIC paper checks with an electronic debit card, and replace the current WIC Management Information System (WIC MIS) with a United States Department of Agriculture (USDA) approved, Electronic Benefits Transfer (EBT)-ready Management Information System (MIS). The total request for the project is $39 million ($7.9 million for EBT and $31.1 million for the MIS) over five years. (This issue was also discussed at the March 3, 2016 Subcommittee No. 3 hearing under the Office of Systems Integration.)

This issue was discussed at the May 5, 2016 Subcommittee No. 3 hearing.

May Revision. The May Revision also reflects updated expenditures of $1.075 billion for WIC, an approximately $18 million reduction from the Governor's budget, to reflect updated caseload and food expenditure projections. (DOF Issue 435-MR)

Subcommittee Staff Comment and Recommendation—Approve.

Issue 5: Office of AIDS – Advocate Proposals

Issue. The California HIV Alliance requests:

a. To eliminate cost-sharing for individuals enrolled in the AIDS Drug Assistance Program with annual incomes between 400 percent and 500 percent of the Federal Poverty Level. DPH estimates that 112 ADAP clients paid an ADAP share of cost

(SOC). By eliminating the ADAP SOC obligation for these 112 ADAP SOC clients, ADAP would have saved $67,705 in calendar year 2015.

b. To develop a Pre-Exposure Prophylaxis (PrEP) Affordability Program affordability program to cover PrEP-related copays, coinsurance, and deductibles incurred by all individuals accessing PrEP in California with annual incomes below 500 percent of the federal poverty level. The cost of this program would be capped at $1 million from the Ryan White Supplemental Drug Rebate Fund.

c. That the Office of AIDS' Health Insurance Premium Payment (OA-HIPP) Program cover premiums, copays, coinsurance, and deductibles incurred by all eligible people living with HIV/AIDS in California. DPH estimates that 5,966 private insurance ADAP clients did not receive premium payment assistance from OA-HIPP Program. Consequently, this proposal would result in expenditures of $8.6 million in 2016-17 (based on calendar year 2015 data).

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language. It is recommended to approve these proposals and adopt placeholder trailer bill language to implement these changes.

Issue 6: Protecting Children from the Effects of Lead Exposure – May Revision Adjustment

Budget Issue. DPH requests an increase of $8.2 million annually ($1.4 million in state operations and $6.8 million in local assistance) for four years from the Childhood Lead Poisoning Prevention Special Fund and to establish seven positions to extend services to children who have been exposed to lead as now defined by a lower blood lead level by the Centers for Disease Control and Prevention (CDC). The Subcommittee approved this proposal on May 5, 2016.

The May Revision requests to amend this request by augmenting the request by $180,000 in 2016-17 and $320,000 in 2017-18 to add Geographical Information System (GIS) functionality to the Response and Surveillance System for Childhood Lead Exposure. This GIS capability will provide the Department of Public Health (Public Health) with more timely and accurate data regarding childhood lead contamination. (DOF Issue 421-MR)

Subcommittee Staff Recommendation—Approve May Revision Adjustment.

Issue 7: May Revision Technical Adjustments

The following technical adjustments are requested in the May Revision:

1. **Ebola Emergency Preparedness: Federal Funding Technical Correction (Issue 401-MR).** It is requested that Item 4265-001-0890 be increased by $3,860,000 and Item 4265-111-0890 be increased by $11,340,000 to correct federal funding spending levels. These funds were inadvertently reduced during the development of the 2016-17 Governor's Budget. The funding reflects 2015 federal grant award amounts received by Public Health related to the health preparedness planning and operational readiness efforts to respond to the threat of the Ebola virus.

2. **Lease Revenue Bond Adjustments (Issue 403-MR).** It is requested that Items 4265-003-0070, 4265-003-0098, and 4265-003-3098 be decreased by $1,000; Item 4265-003-0080 be decreased by $3,000; and Item 4265-003-0203 be decreased by $5,000 to amend amounts incorrectly reflected in the 2016-17 Governor's Budget.
3. **Lease Revenue Bond Adjustments for General Fund (Issues 407-MR and 408-MR).** It is requested that Item 4265-003-0001 and reimbursements be decreased by $976,000 to correct amounts reflected in the 2016-17 Governor's Budget.
4. **Proposition 99 Adjustment: Health Education Account (Issue 411-MR).** It is requested that Item 4265-001-0231 be increased by $2,060,000 and Item 4265-111-0231 be increased by $40,000, to reflect a projected increase in Proposition 99 revenues. These increases will be used for additional Proposition 99 related media campaign expenditures, competitive grants, and program evaluation activities.
5. **Proposition 99 Adjustment: Research Account (Issue 411-MR).** It is requested that Item 4265-001-0234 be increased by $226,000, to reflect a projected increase in Proposition 99 revenues. Funds will be used for external research contracts.
6. **Proposition 99 Adjustment: Unallocated Account (Issue 411-MR).** It is requested that Item 4265-001-0236 be increased by $119,000 to reflect a projected increase in Proposition 99 revenues. The funds will be used for the California Health Interview Survey and external contracts.
7. **May Revision 2016 Estimate: AIDS Drug Assistance Program (ADAP) (Issue 431-MR).** It is requested that Item 4265-111-0890 be increased by $32,921,000 and the ADAP Rebate Fund be decreased by $39,206,000. These adjustments reflect: ADAP clients continuing to transition from ADAP to Medi-Cal, clients enrolling directly in Medi-Cal, a delay in the implementation of providing payment of out-of-pocket medical expense services from spring 2016 to July 1, 2016, and the federal Health Resources and Services Administration requirement to spend mandatory rebate funds prior to federal funds.

Subcommittee Staff Recommendation—Approve.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

The following issues were discussed at the April 7, 2016 Subcommittee No. 3 hearing.

Issue 1: Porterville Developmental Center – Upgrade Fire Alarm System

Budget Issue. The budget requests $6.5 million General Fund for the construction phase of a project to purchase and install a new fire alarm system (FAS) in 10 buildings (nine consumer utilized and one administrative building) at the Porterville Developmental Center in Tulare County.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: Fiscal and Program Research Unit

Budget Issue. DDS requests $923,000 ($630,000 General Fund) for seven new permanent positions and the redirection of one vacant position to establish a Fiscal and Program Research Unit. This unit will provide fiscal and programmatic analyses to assist the department's response to external requests for data and information related to the regional center and developmental center programs, as well as inform accurate, reliable, data-driven decisions.

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Trailer Bill Language. It is recommended to approve this proposal. Also, given the Subcommittee discussion on improving transparency and oversight of the community-based developmental services system, it is also recommended:

1. To adopt placeholder trailer bill language to:
   a. Require DDS to annually report and post on its website supplemental budget information. This information would be reported by February 1 and includes:
      i. Budget estimates for each developmental center, including a break out of funding for Porterville Developmental Center's general treatment area and secured treatment area
      ii. For each regional center: Current year estimates for operations funding, purchase of service (POS) funding, caseload, per capita for operations, per capita for POS
      iii. By regional center, information on staff (number of various classifications, e.g., number of case managers)
      iv. For Community Placement Program (CPP) funding: For each regional center, past year and current year information by component of CPP.

   b. Specify analysis and deliverables for the new research unit. These would include an:
      i. Assessment of disparities data reported by regional centers.
      ii. Assessment of caseload ratio requirements by regional center.
      iii. Assessment of performance dashboard (see below) data as it becomes available.

   c. Establish a performance dashboard, require DDS to work with stakeholders on the development of this dashboard, and require this dashboard to be published annually. Metrics included in this dashboard would include, but not be limited to:
      i. Recognized quality and access measures
      ii. Measures to indicate compliance with and movement toward compliance with new federal Home and Community Based Services waiver rules
      iii. Measures to evaluate the changes in the number of consumers who work in competitive integrated employment
      iv. Consumer complaints, timeliness of responses to complaints, number of administrative hearings

2. Augment DDS state operations budget by $300,000 General Fund (available over three years) for contracting services to assist in the development of this performance dashboard.

Issue 3: Four-bed Alternative Residential Model Homes

Budget Issue. The budget includes:

1. $46 million ($26 million General Fund) to help transition and establish smaller alternative residential model (ARM) four-bed homes for regional center consumers living outside their family. Originally, this model was based on six-bed homes.

2. Provisional budget bill language requiring regional centers to report annually to the department the number of facilities receiving these rates.

3. Trailer bill language to establish a rate schedule for residential community care facilities vendored to provide services to a maximum of four persons with developmental disabilities. This trailer bill language also prohibits regional centers from authorizing any residential service-level changes, if the change would increase state costs.

DDS indicates that there are 4,233 ARM community care facilities (CCFs), serving 21,118 consumers. Of these, 1,618 operate four beds or less and would be eligible for this funding.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: Consumer Program Coordinators Funding

Budget Issue. The budget includes $17 million ($12 million General Fund) to fund additional regional center (RC) consumer program coordinator positions to reduce caseload ratios and improve case management functions. Regional center case management services are eligible for federal funding participation for consumers enrolled under the Home and Community-Based (HCBS) waiver. It is estimated that this proposed funding would support the addition of about 200 coordinator positions, about one-third of what is estimated to meet federal caseload ratio requirements.

The budget also includes provisional budget bill language requiring regional centers to report annually to the department the number of staff hired with these additional funds and the effectiveness of these funds in reducing average caseload ratios.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to approve the funding and to modify the budget bill language to require regional centers not only report the number of staff hired with the additional funds and the effectiveness of these funds in reducing average caseload ratios, but also information justifying why a regional center, if it chooses, uses this funding for non-HCBS coordinators.

Issue 5: Increased Vendor Audit Coverage

Budget Issue. DDS requests $952,000 ($650,000 General Fund) to permanently establish and retain the funding for seven full-time positions previously established as limited-term for the Vendor Audit

Section. According to DDS, retaining these positions will enable the department to continue audit coverage and oversight of the more than $4.6 billion in vendor payments that are disbursed each fiscal year within the developmental services system.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 6: Repeal Prevention Resources and Referral Services Program Statute

Budget Issue. The Governor proposes trailer bill language to repeal obsolete authority for the Prevention Resources and Referral Services (PRRS) program as eligibility for the Early Start program was restored in effective January 1, 2015.

Subcommittee Staff Comment and Recommendation—Adopt Administration's proposed placeholder trailer bill language.

Issue 7: Standards Authorizing Medical Services by Regional Centers

Issue. The Lanterman Act currently requires regional centers to use generic services when available. Medical and dental services covered by generic resources, such as Medi-Cal, health plan(s) or private insurance, cannot be purchased by regional centers for consumers enrolled in these insurance plans without proof of denial from the insurance provider and the regional center determines that an appeal by the consumer or family of the denial does not have merit. Regional centers may pay for medical or dental services pending a final administrative decision on the appeal if the family provides verification that an appeal is being pursued.

This policy was implemented in the 2009-10 budget in order to achieve General Fund savings and address the state's budget crisis. At the time, it was estimated that $18.4 million ($17 million General Fund) would be saved through this policy as consumers would use generic services. Estimates and methodology to evaluate if these cost savings were realized are not available.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt placeholder trailer bill language to eliminate the requirement to pursue a Medi-Cal appeal. The costs to implement this change are negligible, as the savings estimated in 2009-10 were a result of requiring consumers to use generic services.

Issue 8: May Revision Technical Adjustments

The following technical adjustments are requested in the May Revision:

1. **Office of Protective Services Record Management System (Issues 402-MR and 502-MR).** It is requested that General Fund be decreased by $249,000 and reimbursements be decreased by $158,000 to eliminate the augmentation requested in the Governor's budget to purchase a record management system for the Office of Protective Services. DDS will absorb the purchase of this database software within its fiscal year 2015-16 resources.
2. **Developmental Center Audit Findings (Issue 406-MR).** It is requested that Item General Fund be decreased by $3,800,000 to eliminate the augmentation requested in the Governor's

budget for audit repayments to the federal Centers for Medicare and Medicaid Services (CMS) for 2011-12. The overall amount owed to CMS has decreased as a result of audit appeals and sufficient authority is available in the current year to make payments for amounts owed from 2008-09 through 2011-12.

3. **Caseload Adjustments (Issues 404-MR, 407-MR, 503-MR and 507-MR).** It is requested that General Fund be decreased by $1,485,000 and reimbursements be increased by $2,994,000. These changes reflect updated expenditures in caseload-driven operations and purchase of services costs.
4. **Fair Labor Standards Act Implementation (Issues 408-MR and 508-MR).** It is requested that General Fund be decreased by $19,266,000 and reimbursements be decreased by $16,463,000 to reflect the updated expenditure data used to estimate the impact of changes to the federal Fair Labor Standards Act.
5. **Behavioral Health Treatment (BHT).** It is requested that the General Fund be adjusted as follows:
    a. Increased by $352,000 and reimbursements increased by $352,000 to reflect the updated estimates of children receiving BHT services (Issues 409-MR and 509-MR).
    b. Decreased by $69,720,000 and reimbursements decreased by $71,497,000 to reflect reduced costs for regional centers as consumers transition to Medi-Cal managed care plans for BHT services (Issues 410-MR and 510-MR).
    c. Decreased by $6,085,000 and reimbursements increased by $12,171,000 to reflect costs for regional centers as consumers transition to Medi-Cal fee-for-service for BHT services (Issues 416-MR and 516-MR).

    The Department of Health Care Services (DHCS) will reimburse DDS for BHT services for approximately 1,300 consumers that have transitioned to Medi-Cal fee-for-service. Additionally, a technical amendment to budget bill provisional language is requested to permit the transfer of funds between DDS and DHCS to provide flexibility during the transition.
6. **AB 1522 (Gonzalez), Chapter 317, Statutes of 2014: Paid Sick Leave (Issues 411-MR, and 511-MR).** It is requested that General Fund be decreased by $3,571,000 and reimbursements be decreased by $2,746,000 to reflect updated expenditure data for costs associated with AB 1522, which requires employers to provide up to three sick leave days per year.
7. **SB 3 (Leno), Chapter 4, Statutes of 2016: Minimum Wage Increase (Issues 415-MR and 515-MR).** It is requested that General Fund be increased by $12,001,000 and reimbursements be increased by $9,244,000 to provide funding for the minimum wage increase beginning January 1, 2017 to $10.50 per hour. SB 3 provides for a series of scheduled increases to the state's minimum wage such that, depending on economic and budgetary conditions, the minimum wage would reach $15.00 per hour by January 1, 2022, after which it would be indexed to inflation.
8. **Technical Adjustment: Home and Community-Based Services, New Regulations Workload (Issues 417-MR and 517-MR).** It is requested that $1.6 million be transferred from the purchase of services program to the operations program. This correctly reflects the schedule of funding proposed at Governor's budget for new positions at regional centers to oversee the Home and Community-Based Services waiver implementation in the operations program.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken.

Issue 9: Home and Community-Based Services (HCBS) Federal Requirements

Budget Issue. DDS requests the following to comply with new federal Home and Community-Based Services regulations:

1. Headquarters - $483,000 ($330,000 General Fund) and four positions to support the immediate workload associated with the state's transition plan and direct regional center and service provider efforts to comply with the Centers for Medicare and Medicaid Services' (CMS) new regulations for Medicaid-eligible home and community-based settings. The new, comprehensive regulations create additional workload for planning, training, assessing, and reporting activities to demonstrate compliance by March 2019 in order for the state to maintain the current level of $1.7 billion annually in federal financial participation reimbursements for purchase of services (POS) expenditures.

2. Regional Center Operations - $1.6 million ($0.9 million General Fund) to fund 21 program evaluator positions within the regional centers to ensure HCBS program settings are integrated into the community.

3. Purchase of Services (POS) - $15 million ($11 million General Fund) to fund modifications to some service providers' programs that will be necessary for compliance with HCBS regulations.

4. Budget Bill Language – Provisional budget bill language requiring regional centers to report annually to the department the number of providers receiving these funds.

5. Trailer Bill Language – Trailer bill language expressing the Legislature's intent to enact Legislation to implement changes necessary to comply with the HCBS regulations. The proposed language is:

> It is the intent of the Legislature to enact legislation that would authorize the State Department of Developmental Services to timely implement changes necessary to comply with the federal Medicaid home- and community-based settings requirements established pursuant to the Centers for Medicare and Medicaid Services' (CMS) final rules…, effective March 17, 2014, to maintain or increase federal funding pending the issuance of regulations.

Subcommittee Staff Recommendation—Approve Funding Proposals, Adopt Placeholder Budget Bill Language, Reject Proposed Placeholder Trailer Bill Language. It is recommended to approve all items listed above except the proposed trailer bill language as it only expresses the Legislature's intent to enact legislation, it is recommended to reject this language.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

The following issues were discussed at the April 21, 2016 Subcommittee No. 3 hearing.

Issue 1: Investment in Mental Health Wellness Act of 2013 – Triage Personnel Grants

Budget Issue. The commission requests reappropriation of $3.8 million in funds from 2013-14 ($2.2 million), 2014-15 ($939,276), and 2015-16 ($585,214), to support triage personnel grants until 2017-18, allowing counties to spend the Triage Grant funding until the end of the current grant cycle.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: Innovation Plan Reviews

Budget Issue. The OAC requests three permanent, full-time positions, for $396,000 from the Mental Health Services Fund (MHSF), to support administration of regulatory authority to perform a review of innovation plans under AB 82 (Committee on Budget), Chapter 23, Statutes of 2013.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: Advocacy Contracts

Budget Issue. Through a Spring Finance Letter, the OAC requests $200,000 Mental Health Services Fund (MHSF) ongoing funds beginning in 2016-17 to support mental health advocacy for lesbian, gay, bisexual, transgender, questioning (LGBT) populations, and $1 million MHSF ongoing to support advocacy contracts for youth, veterans, and racial and ethnic minorities.

Subcommittee Staff Comment and Recommendation—Modify. As discussed at the April 21, 2016 Subcommittee hearing, it has been requested that all consumer advocacy contracts be supported at the same level. Consequently, it is recommended to augment this request by $1.536 million MHSA State Administration funds. (With this action, all consumer advocacy contracts will be funded at approximately $670,000.)

Issue 4: Reappropriation of Mental Health Services Fund

Budget Issue. Through a Spring Finance Letter, the OAC requests a reappropriation of $2.5 million Mental Health Services Fund (MHSF) from 2015-16 to continue support of the Evaluation Master Plan and $315,000 MHSF from 2013-14 to permit the completion of consensus guidelines and best practices for involuntary commitment care and provide applicable training. In addition, the Administration proposes amending the budget bill, as specified below:

> "4560-491—Reappropriation, Mental Health Services Oversight and Accountability Commission. The balances of the appropriations

provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2018:
3085—Mental Health Services Fund
(1) Item 4560-001-3085, Budget Act of 2013 (Chs. 20 and 354, Stats. 2013), as reappropriated by Item 4560-491, Budget Act of 2014 (Ch. 25, Stats. 2014)
(2) Item 4560-001-3085, Budget Act of 2014 (Ch. 25, Stats. 2014)
(3) Item 4560-001-3085, Budget Act of 2015 (Ch. 10, Stats. 2015)
~~Provisions:~~
~~1. T~~
~~he funds reappropriated in this item are available to continue funding triage personnel grants approved by the Mental Health Services Oversight and Accountability Commission.~~"

Subcommittee Staff Comment and Recommendation—Approve.

0877 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Children's Crisis Services Capacity Development Grant Program

Issue. As discussed at the April 21, 2016 Subcommittee No. 3 hearing, reports have called to attention a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited mental health services for individuals, children in particular, in psychological distress and acute psychiatric crisis. Nearly 40,000 California children ages 5-19 (or five of every 1,000) were hospitalized for mental health issues in 2014.

According to a draft Mental Health Services Oversight and Accountability Commission (OAC) report, "no county has successfully built out the full continuum of services required to fully meet the needs of children and families in crisis." The OAC has issued draft recommendations to "support the continued buildout" of a comprehensive continuum of crisis services and ensure access for all children and youth.

The continuum of children's crisis services includes:

- Crisis Residential – Crisis residential programs are a community-based treatment option in home-like settings that offer safe, trauma informed alternatives to psychiatric emergency units or other locked facilities.
- Crisis Stabilization – Crisis stabilization services are those lasting less than 24 hours for individuals who are in psychiatric crisis. The goal of crisis stabilization is to avoid the need for inpatient services. These services must be provided on a site at licensed 24-hour health care facility.
- Mobile Crisis Support Teams – Mobile crisis support teams can provide crisis intervention and family support.
- Family Support Services – Family support services help families participate in the planning process, access services, and navigate programs.

May Revision. The May Revision projects $26.4 million in available Mental Health Services Act (MHSA) state administration funding available. This reflects a reduction due to a declining MHSA revenue projection and minor adjustments related to Spring Finance Letters.

Subcommittee Staff Comment and Recommendations. It is recommended to adopt placeholder trailer bill language to establish a one-time grant program for the development of children's crisis services capacity. It is also recommended to allocate $18 million from the MHSA state administrative funding for this purpose to the OAC and the California Health Facilities Financing Authority (CHFFA).

Additionally, CHFFA anticipates that approximately $6 million General Fund related to the SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013 will go unspent. It is recommended to reappropriate these funds to CHFFA for grants to develop children's crisis services capacity.

ITEMS FOR DISCUSSION

0530 CALIFORNIA OFFICE OF HEALTH INFORMATION INTEGRITY (CALOHII)

Issue 1: Use, Disclosure, and Protection of Specially Protected Health Information

Budget Issue. The May Revision proposes $800,000 in spending authority for subject matter expert consultants on a one-year limited-term basis to develop non-mandatory guidance to non-state organization, local governments, providers, health information exchange (HIE) entities, and other stakeholders on compliance with federal and state laws, pertaining to the use, disclosure, and protection of specially protected health information including mental health, substance abuse, HIV/AIDS, and behavioral health. This guidance will facilitate the exchange of sensitive information and better inform conversations about care coordination and data sharing both within and outside of government.

Budget bill language is also requested for this proposal. The funding is being provided by the California HealthCare Foundation.

Background. While CalOHII has developed guidance for state departments around the use and exchange of sensitive health information, the state has not produced guidance for non-state organizations, local governments, providers, health information exchange (HIE) entities, and other stakeholders. There are unclear areas in state law surrounding sensitive health information due to inconsistent language, outdated laws adopted before current technologies existed, lack of case law, high liability, lack of regulation, and no formalized policy or guidance from the state clearly explaining how the state interprets its laws. These non-state entities need guidance that clarifies state policy on sensitive health information to eliminate confusion and perceived barriers that serve as obstacles to exchanging this type of information. Most types of health information can be exchanged between providers for treatment purposes without consent from the patient. There are greater consent restrictions for substance abuse and other sensitive categories of information. State guidance synthesizing all the federal and state requirements with a unified interpretation of those laws and patient protections around sensitive health information will aid in the exchange of this information.

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Budget Bill Language.

Questions.

1. Please provide an overview of this request.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Sonoma Developmental Center – Decertification of ICF/IDD

Issue. On May 13, 2016, the federal Centers for Medicare and Medicaid Services (CMS) provided notice to the state of its determination that the state "failed to substantially comply with the Settlement Agreement" for the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) at the Sonoma Developmental Center (SDC). Consequently, federal financial participation (FFP), of approximately $26.4 million in 2016-17, for these units will be discontinued effective July 1, 2016.

CMS notes that the state failed to substantially meet the standards specified in the "Conditions of Participation" and references the finding of deficiencies that posed immediate jeopardy to the health and safety of SDC clients.

DDS indicates that there are approximately 136 residents in the ICF/IDD and that it has identified a provider and begun transition activities for 36 of these residents.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill and Budget Bill Language. Assurances had been provided to stakeholders and the Legislature that the state had been meeting the conditions of the settlement agreement and ensuring the safety and wellbeing of the SDC residents. This recent development is alarming and puts in doubt the department's oversight of the DCs and highlights the importance of a timely closure of the developmental centers. Additionally, given the timing of this notification, the loss of FFP in the budget year has not been accounted for by the Administration in the 2016-17 budget.

It is recommended to adopt (1) placeholder trailer bill language requiring DSS to report the monthly General Fund backfill costs as a result of the loss of FFP, since this General Fund backfill should go down as SDC residents transition into the community and (2) provisional budget bill language prohibiting the use of the General Fund backfill (as a result of the loss of FFP) for any other purposes.

Questions.

1. Please provide an update on this issue.

2. Please describe steps DDS has taken to ensure the health and safety of individuals at SDC since the February 2016 survey?

3. Does DDS expect this recent notification to impact settlement agreements related to the Fairview Developmental Center and Porterville Developmental Center, which expire on June 3, 2016?

4. Is DDS prioritizing the identification of providers/placements for the 100 ICF/IDD residents that still do not have an identified provider?

Issue 2: Developmental Centers Closures

Budget Issue. The May Revision proposes the following related to the proposed closures of the developmental centers:

1. **Independent Monitoring Contract for Fairview and Porterville Developmental Centers (Issues 401-MR and 501-MR).** It is requested that Item 4300-003-0001 be increased by $1,164,000 and reimbursements be increased by $736,000 to fund an independent monitoring contract as part of the anticipated settlement agreements with the federal Centers for Medicare and Medicaid Services (CMS) for Fairview Developmental Center and the General Treatment Area of Porterville Developmental Center. Independent monitoring is required by the settlement agreement currently in place for Sonoma Developmental Center and the Department of Developmental Disabilities (DDS) expects a similar requirement for Fairview and Porterville**.**

2. **Exemption from Public Contract Code to Become a Regional Center Vendor.** Trailer bill language (TBL) is requested to allow developmental center employees working at facilities slated for closure to become service providers prior to termination of their state employment. Currently, state employment must be terminated prior to becoming a vendor, resulting in a loss of income during the start-up period, which can take up to one year. The goal of this proposal is to encourage well-trained and experienced developmental center employees to become community providers and assist with continuity of care for consumers transitioning out of developmental centers.

3. **Special Managed Care Provisions for Developmental Center Closures**. TBL is requested to extend managed care provisions for Medi-Cal eligible individuals at the developmental centers that transition to the community and need coordinated medical and specialty care as documented in their individual program plan. The provisions of existing law were originally enacted during the Agnews and Lanterman Developmental Center closures. These specified managed care provisions include access to specialized medical care, enhanced case management, and expedited enrollment services.

4. **Provisional Language: Retention Stipends for Developmental Center Staff (Issue 418-MR).** It is requested that provisional budget bill language be added to Item 4300-003-0001 to authorize an extended encumbrance period for the payment of retention stipends available to developmental center employees during the closure process. Under Item 9800 in the state budget (as CalHR will negotiate this with the union), the May Revise provides $18.1 million ($14.3 million General Fund for retention incentives for DDS DC "rank and file" employees and $2 million ($1.6 million General Fund) for "excluded classification" employees at Sonoma, Fairview, and Porterville. As part of this funding, beginning July 1, 2016, new and current employees at Sonoma, Fairview, and Porterville will be eligible to accrue a quarterly retention stipend. For each full quarter worked during 2016-16, employees will accrue $250 per full quarter worked. Beginning July 1, 2017, each employee will accrue $500 per full quarter worked. The maximum accrual per employee is $6,000. Employees would forfeit amounts accrued if they separate from DDS prior to these milestones. This is a one-time

retention incentive for DDS employees that remain working at facilities that are slated for closure until December 2017, or until resident population levels decrease to 50 percent of current levels. Provisional language is included to clarify that these funds would be available for encumbrance until June 30, 2021 and available for liquidation until December 31, 2021. DDS would also be required to report annually on the number of employees receiving payments and the amount of payments made from this appropriation. It should be noted that these figures are subject to negotiation, are spread over multiple budget years (through 2021), and could change depending on the impact of the Sonoma DC decertification.

The May Revision continues to assume that in the current year 202 consumers would transition out of developmental centers. As of March 2016, only 109 consumers had transitioned. DDS indicates that it projects that 150 individuals would transition by June 30, 2016. The budget projects that 240 residents will transition from developmental centers to community based services in 2016-17.

The January budget included the following proposals related to the closure of the developmental centers:

1. **Headquarters Resources for Developmental Center Closures.** DDS requests $2.1 million ($1.8 million General Fund), eight new positions, and the redirection of five vacant positions for staffing and contract resources needed to support the continued efforts for the closure of the Sonoma Developmental Center and the initial closure efforts for the Fairview Developmental Center and the Porterville Developmental Center -General Treatment Area (GTA).

2. **Development of Community Resources.** The budget includes $146.6 million ($127.2 million General Fund) to assist in the development of community resources for placement of current developmental center residents. This includes $24.5 million for Sonoma Developmental Center, $29.7 million for Fairview Developmental Center, and $24.6 million for Porterville Developmental Center.

3. **Closure Activities.** The budget includes $18 million ($12 million General Fund) to resolve open workers' compensation claims, inventory and archive clinical and historical records, execute an independent monitoring contract as stipulated by the federal government, and relocate residents and their personal belongs.

4. **Developmental Center Staffing Adjustments.** The budget includes an $8.8 million ($4.9 million General Fund) decrease and a total reduction of 129.2 positions (63.1 level-of-care and 66.1 non-level of care) based on an estimated population decline of 188 developmental center residents transitioning into the community. This reduction reflects adjustments to staffing for specialized support and closure activities.

5. **Assessment of Sonoma DC Property.** Through an April Spring Finance Letter, the Administration requests $2.2 million General Fund to contract with the Department of General Services for an assessment of the Sonoma DC property, buildings, and clinical records. These funds would be used to complete the second and third phase of an environmental site assessment and architectural historical evaluation of Sonoma DC. DDS proposes to use current year funds of $190,000 to complete the first phase initial site assessments. According to the

Administration, these assessments will help determine: (1) the property value, (2) restrictions on land use, and (3) the potential cost of future investments on the property.

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

The 2015-16 budget includes funds for the initial development of community residential and non-residential resources to serve residents of Sonoma, as well as regional center and headquarters funding to support the activities related to the safe closure of Sonoma by the end of 2018. More specifically, the 2015-16 budget provides $49.3 million ($46.9 million General Fund) for additional Community Placement Plan (CPP) funding to begin developing community resources to support the transition of Sonoma DC residents, as well as to contract with an independent risk management company to conduct data analysis, training, and technical assistance in mitigating consumer risks.

The budget includes $146.6 million ($127.2 million General Fund) to assist in the development of community resources for placement of current developmental center residents. This includes $24.5 million for Sonoma Developmental Center, $29.7 million for Fairview Developmental Center, and $24.6 million for Porterville Developmental Center.

Cal-Mortgage and California Health Facilities Financing Authority Loans. Concerns have been raised by stakeholders that it is difficult to secure financing to develop residential facilities. However, the state operates loan programs for these types of facilities. For example, the Cal-Mortgage Loan Insurance Program, operated by the Office of Statewide Health Planning and Development (OSHPD), provides credit enhancement for eligible health care facilities and facilities licensed by the Department of Social Services when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of the State of California. This guarantee permits borrowers to obtain lower interest rates, similar to the rates received by the State of California. According to OSHPD, the program's total authorization to insure facility construction, improvement, and expansion loans is limited to a total of not more than $3 billion. Currently the program insures just over $1.7 billion

Additionally, the California Health Facilities Financing Authority (CHFFA) administers the Bond Financing Program and the Tax-Exempt Equipment Financing Program. CHFFA also provides direct loans to small and rural health facilities through the Healthcare Expansion Loan Program (HELP) II Financing Program and the Medi-Cal Bridge Loan Program. By borrowing through CHFFA, health facilities can likely obtain lower interest rates than they would through conventional bonds. Generally, nonprofit, licensed health facilities in California, including adult day health centers, community clinics, skilled nursing facilities, developmentally disabled centers, hospitals, community care facilities, and drug and alcohol rehabilitation centers are eligible for CHFFA financing. According to the Treasure, there is no limit on the total amount of bonds that CHFFA can issue.

CHFFA indicates that it has been in discussions with DDS on approaches to streamline this process for nonprofit entities working on residential capacity development for persons with developmental

disabilities. Currently, the HELP II program has a limit of a $1.5 million loan per borrower. CHFFA notes that it is exploring other limit options, such as a limit per facility location. CHFFA plans to have this item on its June board agenda, as an informational item, with possible actions occurring at the July meeting.

Subcommittee Staff Comment and Recommendation. The transition of SDC residents into the community is behind schedule, as discussed above only 109 of the projected 202 individuals have transition in the current year. Yet the department assures that sufficient progress is being made and that it is on track to meet the proposed closure schedule for SDC. It is not clear how this will be accomplished. Ongoing and robust monitoring of community resource development and resident transition planning will be critical to ensuring a successful and timely closure of these centers. Consequently, the following is recommended:

1. Approve, with the modifications noted below, the January budget and May Revision proposals discussed above and adopt placeholder trailer bill and budget bill language to implement these proposals. The following modifications are recommended:

    a. Modify the request for funding for an independent monitoring contract for Fairview and Porterville Developmental Centers by adding provisional budget bill language authorizing this expenditure only if CMS approves settlement agreements for these DCs through the budget year.

    b. Specify a timeline by which the transition plan regarding special managed care provisions related to individuals transitioning out the DCs, developed by DDS and the Department of Health Care Services, should be developed regarding the processes for individuals assigned to a Medi-Cal managed care plan which promote coordination of care during and following the transition, identification of providers prior to a transition occurring; and the continuation of medically necessary covered services.

2. Additionally, as part of the Legislature's approval of these DC closure plans, it is recommended to adopt the following placeholder trailer bill language to:

    a. Require the department to develop a plan to be submitted to the Legislature no later than January 10, 2017 regarding how the department will ensure access to crisis services post developmental closure and how the state will maintain its role in providing residential services to those whom private sector vendors cannot or will not serve. As part of this plan, the department should assess the option of expanding the Community State Staff Program to assign state staff to serve as regional crisis management teams to provide assessment, consultation and resolution for persons with DD in crisis in the community.

    b. Require that reports of injuries, death, restraint usage, and incidents of seclusion, for example, at community facilities be reported to the federally mandated protection and advocacy agency.

    c. Limit the use of seclusion and restraints in community facilities licensed by the Department of Social Services.

d. Require that crisis services and specialized health care/clinic services at these DCs through the transition process and until closure.

e. Require the closure of the DC upon the successful transition of all residents into the community.

f. Require regular public posting (on the department's website) of progress being made to develop residential capacity by regional center. Including information on monthly targets for movers based on transition activities and community resource development activities) by regional center. This monthly reporting would also include information on why targets are not met.

3. It is also recommended to augment DDS's budget by $5 million General Fund in the budget year and $10 million in future years for the Community State Staff Program. As has noted by multiple stakeholders, advocates, and DC resident family members, to ensure a successful transition of DC residents into the community, it is critical to retain the experience and expertise of the DC employees and the services they provide. It is recommended to adopt placeholder trailer bill language to implement this change.

Questions.

1. Please provide an overview of these May Revision proposals.

2. Is the department on track to close the Sonoma Developmental Center by December 31, 2018? What is at risk if the department and regional centers do not meet this deadline? Given the decertification of the ICF/IDD at SDC, should DDS prioritize the transition of ICF/IDD residents?

3. How is the department ensuring that regional centers are on track to developing residential capacity and are engaged in transition planning? Are there consequences for regional centers if they do not meet their targets and do not have a valid reason for the delays? Should there be?

4. How is DDS working with the California Health Facilities Financing Authority on options for long-term financing for residential facilities for the developmentally disabled?

Issue 3: Deferred Maintenance Projects

Budget Issue. Control Section 6.10 of the Governor's budget proposes that the Department of Finance (DOF) may allocate $500 million General Fund to various state departments to address a portion of deferred maintenance needs, including $18 million General Fund to DDS for the Porterville Developmental Center (PDC). DOF must provide their approve list of projects to be funded through the authority granted in this Control Section to the Joint Legislative Budget Committee (JLBC) 30 days prior to the allocation of these funds. Additionally, any change to the list must be approved by DOF, subject to a 30 day review by the JLBC.

On April 29, 2016, the Legislature was supplied with an initial list of projects proposed for funding pursuant to Control Section 6.10. The chart below lists the proposed projects and the Administration's rationale for why these projects should be funded.

Project	Estimated Cost	GTA, STA, or Both*?	If General Treatment or Both*, why should the state make this investment when the part of PDC is closing?	Health & Safety Issue?
P DC Boiler Replacement	$10,089,000	Both	The current boiler system is oversized, inefficient, and requires costly repairs to pipes and accessories. Investing in new boilers will maximize efficiency, lower pollution, and meet all emissions requirements. This project will have ongoing benefits through increased energy savings, reduced pollution, and operational efficiencies for the Secure Treatment Area that will remain open beyond the closure of the GTA.	Yes. The boilers operate all steam used for heating buildings, cooking, cleaning, and sanitizing. Failure in the boiler system would cause deficiencies in steam and hot water temperature used for sanitizing dishes and for resident showers/cleanliness, and also prevent proper heating of buildings. The current heat exchangers in the hot water tanks throughout the campus are single-walled exchangers that have the potential to contaminate the potable water system. Installing double-walled heat exchangers will reduce the risk of contamination.

Fiber Optic Panel, and Connective Wiring Project	$450,000	Both	The Central control System is part of the network infrastructure that supports the entire facility; the Fiber Optics panel and controls for the Fire Alarm System are in the Administration building which is not closing.	Yes, this is part of the network system that will support the fire alarm system.
Hazardous Material Removal/Disposal for Environmental Compliance	$30,000	GTA	Compliance with Hazmat removal and disposal regulations of approximately 800 neon exit signs that were removed and replaced, and will need to be resolved regardless of closure.	Yes. Retention of hazardous materials is a health risk to both clients and employees.
Road Repair for Service and Food Accessibility	$1,200,000	Both	This is the main access-road into the facility and roads to key delivery areas. They will be utilized throughout the area of campus that will remain open beyond the closure of the GTA.	Yes. The roads enable delivery of food, medical supplies, and medicine, as well as safe transportation of clients and staff.
Replace Privacy Windows (Secure Treatment Area)	$1,200,000	STP		Yes. The privacy glass is designed to regulate building temperature and provide client privacy.
Building Duct Cleaning: All Resident Units and Administration Building	$600,000	Both	This project is needed to maintain compliance with licensing requirements to address current air quality in residences and will be needed while the GTA is still open--including the nursing areas where some individuals with more significant respiratory issues reside.	Yes. This project ensures clean air in the living areas, which lessens respiratory illnesses.
Replace Wireless Keycard (Secure Treatment Area)	$1,200,000	STP		Yes. The project is designed to provide higher security for the clients and safety for staff.

Upgrade Electrical - Camp Vandalia and Well Field	$850,000	Both	This area is part of the infrastructure that supports the entire facility as well as the filtration systems for the water wells. The electrical system and wells will need to be maintained as long as the facility is open.	Yes. Potable drinking water and consistent availability of electricity is necessary for the ongoing safety and security of clients and staff.
Replace Roof (Residences 13-14)	$650,000	STP		Yes. Damage to the roof exposes the buildings to leaks and poor temperatures.
Replace Rain Gutters	$180,000	Both	Maintenance of the gutters prevents water damage to the buildings, including the foundations and roofing systems. These buildings will continue to be used beyond closure.	Yes. Damage to the building is a safety risk to clients resulting from falls, building damage, or mold growth.
Landscape Restoration (Woodchip project)	$20,000	GTA	This project relates to B-18-12 water reduction due to California drought and is ongoing deferred maintenance of the facility while the GTA is open.	Yes, prevents injury/property damage risk from falling tree branches.
Upgrade Exterior and Interior Lighting	$250,000	STP		Yes. Adequate lighting reduces the risk of trips and falls.
Day Training Activity Center - Classroom Upgrades	$1,506,000	STP		No.
Total	**$18,225,000**			

* Both--includes areas and buildings in the non-secure area that will continue to be used for Administration and facility operations even after the GTA closure. GTA: General Treatment Area; STA: Secured Treatment Area.

The boiler replacement/retrofit project at Porterville was previously proposed at an estimated cost of $5.4 million. According to DDS, this was an estimate that was prepared several years ago, and was based on a boiler project that envisioned that the internal steam and condensate distribution system could continue to be utilized in its existing condition. A detailed study of the project conducted by an outside consultant, and managed by DGS, concluded that in order for the new boilers to be effective,

much of the internal system would need to be either repaired or replaced. Deficiencies identified in the current system, which is over 60 years old, include the following:

- Significant leakage in the mechanical systems – in joints, flanges, and valves.
- Because of the leakage, the asbestos containing thermal wrap on the steam pipes is starting to deteriorate and crumble.
- Many pipes are completely exposed, with no thermal wrap in place.
- Over 60 percent of the steam traps are defective and are releasing significant amounts of steam.

Based on these deficiencies and the recommended solution, DGS prepared an estimate for the project that included $7.2 million in construction costs, with another $2.8 million for other project costs, including architectural and engineering services, construction inspection, state fire marshal review, project management, materials testing, and special consultants related to asbestos removal. Total project costs are now estimated at $10 million. Additionally, the updated cost estimate is also affected by the need to update seven mechanical rooms at a cost of $1.5 million and an increase cost of approximately $1 million for DGS architectural and engineering fees.

Legislative Analyst's Office (LAO). The LAO notes that the Legislature has expressed concerns with this proposal in the past, particularly given the slated closure of the general treatment area at Porterville. Accordingly, the LAO recommends DDS to further justify the need to fund this proposal at this time, particularly in light of the General Fund deficiency created by the loss of federal funding at Sonoma DC mentioned above. Specifically, we recommend DDS further justify the increased costs, explain the health and safety considerations, and explain exactly how this proposal takes closure of the general treatment area into account.

Subcommittee Staff Recommendation—Modify. It is recommended to reject the proposal to replace the PDC boiler in order to continue discussions on this topic. It is recommended to approve all other projects.

Questions.

1. Please provide an overview of this request.

Issue 4: Special Session Resources and Technical Clean-up Trailer Bill Language

Budget Issue. The May Revision requests the following to implement the provisions of AB 1 X2 (Thurmond), Chapter 3, Statutes of 2016:

1. **Headquarters Resources (Issues 400-MR and 500-MR).** It is requested that Item 4300-001-0001 be increased by $513,000 and five positions, and reimbursements be increased by $239,000, to provide state-level oversight of recent augmentations to community-based services, develop guidelines to implement the Competitive Integrated Employment program, and provide additional support and oversight of the provider rate study required by AB 1 X2.

2. **Administrative and Community-Based Resources (Issues 412-MR, 413-MR, 414-MR, 512-MR, 513-MR and 514-MR).** It is requested that Item 4300-101-0001 be increased by $6,063,000 and reimbursements be increased by $1,441,000 to provide funding for a provider rate study and 42 positions at regional centers to oversee the implementation of programs to reduce cultural disparities and provide competitive integrated employment opportunities for individuals with developmental disabilities. Effective July 1, 2016, AB 1 X2 appropriated $287 million General Fund to support specified rate adjustments for community-based providers serving individuals with developmental disabilities, establish a competitive integrated employment program, and implement recommendations related to cultural disparities. DDS and regional center administrative costs were recognized at the time of the development of AB 1 X2, but were not included in the appropriation. It is also requested that reimbursements of $14 million to reflect increased funding for regional center operations and $172.2 million to reflect increased funding for community-based services provided through regional centers, be included in a non-Budget Act item associated with the AB1 X2 appropriations.

3. **Clean-up Trailer Bill Language (TBL).** TBL is requested to clarify that the rate increase provided by AB 1 X2 applies to out-of-home respite services, and clarify the provisions of competitive integrated employment (CIE) to expand participation in the workforce by providing an incentive payment separate from supported employment services for regional center providers that place individuals in CIE.

Background. AB 1 X2 appropriated $20 million General Fund (and anticipated matching funds for $29 million total funds) to DDS for CIE incentive payments for providers that place individuals with developmental disabilities. The bill also appropriated $10 million General Fund (and anticipated matching funds for $16.4 million total funds) to provide a rate increase for respite providers. DDS and regional center administrative costs associated with implementation of CIE placements are included in the Regional Center May Revision Estimate.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language.

Questions.

1. Please provide an overview of these requests and the proposed TBL.

Issue 5: Provider Rate Adjustments to Address State Minimum Wage Increase Trailer Bill Language

Budget Issue. The May Revision proposes trailer bill language to implement provider rate adjustments to address the state minimum wage increase.

Background. SB 3 (Leno), Chapter 4, Statutes of 2016, provides for a series of scheduled increases to the state's minimum wage such that, depending on economic and budgetary conditions, the minimum wage would reach $15.00 per hour by January 1, 2022, after which it would be indexed to inflation.

California provides community-based services to approximately 300,000 individuals with developmental disabilities and their families through a statewide system of 21 regional centers. Regional centers are private, nonprofit agencies under contract with the department for the provision of services and supports to people with developmental disabilities.

Regional centers fund services such as residential facilities, respite, community-based day programs, work activity programs, and supported living. There are several different methods used to set reimbursement rates for providers of community-based services for regional center consumers, depending on the type of service. These rate setting methodologies include but are not limited to:

- Rates set by the department based on cost statements;
- Rates established in either statute or regulation; and
- Rates established by negotiation between the regional center and the provider.

Current provisions, effective July 1, 2008, in the Welfare and Institutions Code have frozen rates for many providers, requiring a statutory change to make rate adjustments due to the new minimum wage provisions. As a result, trailer bill legislation is necessary to allow for rate adjustments for impacted service providers.

The proposed language will amend Welfare and Institutions Code Sections 4681.6, 4691.6 and 4691.9, effective January 1, 2017, to allow the department and regional centers to adjust specified provider rates for the state minimum wage adjustments. For services with rates set either by the department based on cost statements, or by the regional centers through negotiation with vendors, the proposed change allows providers to request rate adjustments only for the purpose of funding the state minimum wage increase, and associated payroll costs if the provider can demonstrate the adjustment is necessary and not already provided.

Subcommittee Staff Recommendation—Adopt Proposed Placeholder Trailer Bill Language.

Questions.

1. Please provide an overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: L&C: Los Angeles County Contract

Budget Issue. DPH requests an increase in expenditure authority of $2.1 million from the State Department of Public Health Licensing and Certification Program Fund to augment the Los Angeles (LA) County contract to account for two, 3 percent salary increases effective October 2015 and October 2016, an increase to the employee benefit rate from 55.1 to 57.8 percent, and a decrease in the indirect cost rate from 33.2 to 31.4 percent. (DOF Issue 425-MR)

This funding will augment the existing contract to reflect employee compensation and benefit rates approved by the Los Angeles County Board of Supervisors. Public Health has contracted with Los Angeles County for the past 30 years to license and certify health care facilities in the County on behalf of the state.

Background. For over 30 years, DPH has contracted with LA County to perform federal certification and state licensing surveys and investigate complaints and entity-reported incidents for approximately 2,500 health care facilities in the LA County area. The 2015 Budget Act authorized an additional $14.8 million dollars in expenditure authority to fully fund LA County to conduct tier 1 and tier 2 federal workload, long-term care complaints and entity-reported incidents, and pending complaints and entity-reported incidents. In July 2015, DPH and LA County renewed the contract for a three-year term (ending June 30, 2018), for an annual budget of $41.8 million to fund 225 positions. Roughly one third of licensed and certified health care facilities in California are located in LA County, and 18.7 percent of the long term care complaints and entity-reported incidents received statewide each year are generated in LA County.

According to DPH, due to the timing of LA County's approval of salary increases, these costs were unforeseen and not included in the current contract, nor in the 2016-17 Governor's Budget. Consequently, the current contract is now underfunded. If this request is not approved, the LA County contract will not be fully funded and the county will not be able to pay for the staff necessary to complete the contracted workload. This will result in increased vacancies to offset the insufficient funding, fewer complaints being addressed timely, greater backlogs of open complaints, and the potential loss of future CMS grant awards due to lack of compliance. This proposal includes $2.1 million to fund the current contract positions at the current LA County salary rates, which will increase the total annual budget of the contract to $43.9 million.

Subcommittee Staff Recommendation—Approve.

Questions.

1. Please provide an overview of this proposal.

2. Has LA County met workload and performance requirements set forth in the contract?

Issue 2: Marijuana Study

Budget Issue. DPH requests $500,000 General Fund for 2016-17 to help support a study analyzing the health risks associated with the use of marijuana. DPH will participate in decision making regarding the direction and scope of the study organized by the Centers for Disease Control and Prevention (CDC) Foundation on the impacts of medical marijuana to provide information that can guide the state's regulatory process to ensure patient safety. (DOF Issue 427-MR)

Background. Marijuana is classified as a Schedule 1 drug by the U.S. Drug Enforcement Administration. Schedule I substances are defined as having high potential for abuse and no currently accepted medical use in treatment. Marijuana is the most commonly-used illicit drug, with 22.2 million past-month users according to a 2014 National Survey on Drug Use and Health.

Over the past 19 years, 40 states have legalized marijuana for medical or recreational use (four states have legalized retail marijuana sales, the District of Columbia has legalized possession, 23 states and the District of Columbia have legalized medical marijuana use, and 17 states have legalized cannabidiol use). Recent reports suggest there has been a doubling of marijuana use both in adults and adolescents over the past 15 years, with 30 percent of adult users meeting the criteria for a marijuana disorder.

The CDC and other federal and state public health agencies do not yet have a clear picture of how these changing patterns of marijuana use might impact youth and adult health. To date, there has not been a national-level systematic synthesis of available evidence on marijuana health effects comparable to those conducted for alcohol and tobacco. As a result, less is known about the health consequences of marijuana use than is known about other psycho-active drugs available for legal purchase, such as alcohol, caffeine and nicotine. To address this need, the CDC Foundation has sought financial contributions from a variety of federal agencies, states, philanthropies, and a national nonprofit. This BCP would provide $500,000 in one-time funding from California towards this effort for the Institute of Medicine (IOM) to perform a comprehensive review of existing scientific evidence about the health consequences of marijuana use. The IOM is a well-respected institution with a long history of generating reports and research agendas that have successfully helped advance both science and policy on a wide variety of issues.

The scientific review project is expected to focus on the following categories: 1) patterns of marijuana initiation and use among United States youth and adults, 2) potential and proven health risks of marijuana use, 3) potential therapeutic uses of marijuana, and 4) public health research gaps and recommendations. The project will include both medical and recreational marijuana usage and effects. This study is expected to be completed in 2017.

Subcommittee Staff Recommendation—Approve.

Questions.

1. Please provide an overview of this proposal

Issue 3: Medical Cannabis Trailer Bill Language

Budget Issue. The May Revision proposes changes to the Medical Marijuana Regulation and Safety Act. The changes impacting DPH include:

a. Requires DPH to establish minimum security requirements for the storage of medical cannabis products at the manufacturing site.
b. Shifts the authority to license laboratories from DPH to the Bureau of Medical Cannabis Regulation.
c. Provide DPH with cite and fine authority.
d. Gives DPH the authority to conduct mandatory recalls when a medical cannabis product creates or poses an immediate or serious threat to human life.
e. Allows DPH to embargo manufactured medical cannabis product that violates the law to prevent its distribution and sale to protect the public health and safety.

In the January budget, DPH requested 37 positions and $12 million in funding from the Medical Marijuana Regulation and Safety Act Fund to be phased-in between fiscal years 2015-16 to 2018-19 to begin the implementation of the mandated provisions specified in AB 266 (Bonta), Chapter 689, Statutes of 2015, AB 243 (Wood), Chapter 688, Statutes of 2015, and SB 643 (McGuire), Chapter 719, Statutes of 2015. DPH requests to phase-in these positions, as follows: six positions and $457,000 in reimbursement authority for 2015-16; eight additional positions and $3,438,000 in 2016-17; two additional positions and $2,520,000 in 2017-18; and the final 21 additional positions and $5,658,000 in 2018-19.

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt the Administration's placeholder trailer bill language.

Questions.

1. Please provide an overview of the proposed changes. Why is the Administration proposing to move the authority to license testing laboratories to the Bureau of Medical Cannabis Regulation?

2. How does this proposal impact the department's request for resources?

Issue 4: Genetic Disease Screening Program

Budget Issue. The May Revision requests $133.7 million for the Genetic Disease Screening Program (GDSP), a $15.1 million increase compared to the January budget. DPH proposes to use this funding increase to purchase equipment to test for adrenoleukodystrophy, as recommended by the federal Recommended Uniform Screening Panel and required by AB 1559 (Pan), Chapter 565, Statutes of 2014. GDSP will also: (1) contract with a third-party to provide medical billing services for the Prenatal Screening program; (2) transition the Screening Information System from the Department of Health Care Services to DPH; (3) contract for services, including billing support, and secure payment services (lock box); and (4) address increased specimen shipping costs. (DOF Issue 433-MR)

The budget proposes to increase the prenatal screening fee by $14.60 to $221.60 and to increase the newborn screening fee by $17.55 to $130.25.

The revised program estimate is based on the following three new assumptions that have a significant impact on the costs of the program:

1. **Operational Support for Enhancements and Maintenance and Operations (M&O) for Screening Information System (SIS) and Accounts Receivable (AR) System; Data Center Transition; Accounts Receivable Vendor Transition.** GDSP requests $3.6 million in 2015-16 and $10.7 million in 2016-17 for the Deloitte Consulting Contract amendments, lockbox payment services, and specimen shipping costs from collection sites to labs. GDSP is in the process of amending Deloitte's contract to add services needed for the migration and support of the AR system. Deloitte will work with the DPH Information Technology Services Division (ITSD) to move SIS from DHCS to DPH. The contract also will include 2 years of M&O support for the AR system and training support.
2. **Transition In-House Patient Billing to an Outsourcing Vendor.** GDSP requests $340,000 in 2015-16 and $2.9 million in 2016-17 for the transition to an outsourcing vendor. GDSP hopes to accelerate revenue collection, reducing uncollectable accounts, and reducing the overall risk and cost to collect.
3. **GS $Mart Loan Repayment.** GDSP requests a GS $Mart Loan from the Department of General Services of $7.3 million to cover the software and hardware needs for transitioning SIS from the Department of Health Care Services to DPH ($26 million) and equipment to perform statewide screening of newborns for adrenoleukodystrophy (ALD) ($4.7 million).

Background. GDSP 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 to patients. The programs are self-supporting by fees collected from screening participants through the hospital of birth, third party payers, or private parties.

Subcommittee Staff Recommendation—Approve.

Questions.

1. Please provide an overview of this issue.

Issue 5: Special Session Legislation Related to e-Cigarettes and Tobacco

Issue. Various pieces of legislation, including SB 5 X2 (Leno), Chapter 7, Statutes of 2016, were past as part of the recent special session.

According to the Senate Appropriations Committee analysis, for SB 5 X2, the following costs have been identified:

1. One-time costs of about $180,000 to revise regulations and educational materials relating to the prohibition on the sale of tobacco products to minors by the DPH (General Fund or tobacco tax funds).

2. Ongoing costs in the tens of thousands to low hundreds of thousands per year for additional survey activities at retail stores selling electronic cigarettes (General Fund or tobacco tax funds).

3. Ongoing costs in the hundreds of thousands per year for enforcement actions relating to illegal sales of electronic cigarettes to minors (General Fund or tobacco tax funds).

4. Ongoing licensing costs of about $300,000 for the BOE to license retailers who sell electronic cigarettes but are not currently licensed because they do not sell tobacco products (Compliance Fund). These costs would be offset by an increase in the licensing fee, from the current one-time $100 to an annual licensing fee of $265. No anticipated change in tobacco tax revenue (General Fund and special fund). This bill does not change the definition of "tobacco product" in the Revenue and Taxation Code to include electronic cigarettes. Thus, this bill does not extend the state's existing tax on those products to electronic cigarettes.

Subcommittee Staff Comment and Recommendation—Hold Open. Staff has requested technical assistance on the resources needed to implement the various pieces of special session legislation impacting DPH.

Questions.

1. Please provide an overview of the special session legislation impacting DPH. What are the effective dates of these changes?

2. Given that the May Revision does not include resources to implement the legislation, how does DPH plan to address the increased workload?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Caseload and Estimate

May Revision. The May Revision proposes $90.2 billion ($17.7 billion General Fund) for the Medi-Cal program. See table below for program budget summary.

Medi-Cal Budget Summary (dollars in millions)

	2016-17 January	2016-17 May	Amount Change	Percent Change
General Fund	$19,084.10	$17,661.30	($1,422.80)	-7.50%
Federal Funds	$54,046.50	$57,668.20	$3,621.60	6.70%
Other Funds	$11,907.70	$14,823.10	$2,915.40	24.50%
Total Local Assistance	**$85,038.50**	**$90,152.50**	**$5,114.00**	**6.00%**
Medical Care Services	$80,481.30	$85,627.20	$5,145.90	6.40%
County Administration	$4,100.40	$4,158.10	$57.70	1.40%
Fiscal Intermediary	$456.70	$367.10	($89.60)	-19.60%

Caseload. DHCS estimates baseline caseload to be approximately 14.1 million average monthly enrollees in 2016-17 as compared to 13.5 million in 2015-16, a 4.8 percent increase.

Legislative Analyst's Office (LAO). The LAO finds that the Administration's Medi-Cal caseload estimates for 2016-17 appear reasonable. Medi-Cal caseload has continued to grow and by December 2015 (the most recently available month of complete data) caseload had reached 13.3 million. The Administration assumes 15-16 to 16-17 year-over-year growth of 2.8 percent for families and children, 11.1 percent for the optional expansion population, and 3.0 percent for seniors and persons with disability. Based on the most recently available data on Medi-Cal enrollment, these assumptions appear reasonable. Additionally, the LAO notes that the estimate no longer separately accounts for redetermination delays. Up until the May 2016 estimate, DHCS has included a separate policy change to estimate the impact of the delay in annual Medi-Cal redeterminations that resulted from the increased workload for county eligibility workers associated with the ACA. The Administration states they no longer included this policy change as of the May 2016 estimate because they believe the base caseload trends now accurately reflect any impact of redeterminations. At this time, the LAO finds that the base caseload assumptions are moderate enough to capture any potential impacts of any ongoing redetermination delays.

Subcommittee Recommendation—Approve.

Questions.
1. Please provide a high-level overview of the May Revision changes.

Issue 2: Medi-Cal: Federal Managed Care Regulations Staffing Resources

Budget Issue. The May Revision requests the establishment of 38.0 permanent positions and expenditure authority, and two-year limited-term funding for staff resources and contractual services to implement new federal Medicaid regulations. (DOF Issue 402-MR)

The request supports the implementation of Medicaid and CHIP Managed Care Final Rule CMS-2390-P and Fee-for-Service Final Rule CMS-2328-NC. The total funding requested is $10,411,000 ($4,984,000 General Fund and $5,427,000 Federal Fund).

The following positions are requested to be established:

- **Managed Care Quality and Monitoring Division – 18.0 Staff Resources**
  1.0 Research Manager I (RM I)
  2.0 Research Program Specialist II (RPS II) – 1.0 2-year LT equivalent
  2.0 Research Program Specialist I (RPS I)
  9.0 Associate Governmental Program Analyst (AGPA) – 5.0 2-year LT equivalent
  1.0 Health Program Specialist II (HPS II) – 2-year LT equivalent
  1.0 Research Analyst II (RA II)
  1.0 Medical Consultant I (MC I)
  1.0 Office Technician (OT)

  These resources would be used to extend new monitoring requirements to all populations/ components of the Medi-Cal Managed Care program. Additionally, the new staff resources will promulgate the corresponding state regulations to align with the federal regulations, establish and publish provider network adequacy standards for beneficiaries and stakeholders, establish and publish cultural sensitivity standards for all populations of beneficiaries, and ensure full participation in State Fair Hearing procedures and follow-up.

  This division is also requesting $3 million in contract authority to support data auditing and validation by an external quality review organization (EQRO) which is necessary to ensuring the department has appropriate resources to evaluate and publicly report managed care plan health outcomes and utilization factors experienced by Medi-Cal members accessing services in the managed care delivery system

- **Managed Care Operations Division – 4.0 Staff Resources**
  3.0 Associate Governmental Program Analyst (AGPA) – 1.0 2-year LT equivalent
  1.0 Associate Information System Analyst (AISA) – 2-year LT equivalent

  These resources would be used to add the requirement for plan and provider training as this is not a current function of program; develop a formal complaint process to track and resolve beneficiary issues through the Medi-Cal enrollment broker; add the requirement for updating provider directories on a monthly basis instead of the current standard of every six months.

- **Capitated Rates Development Division – 8.0 Positions**

2.0 Research Program Specialist I (RPS I)
2.0 Research Analyst II
1.0 Staff Services Manager I (SSM I)
2.0 Associate Governmental Program Analyst (AGPA)
1.0 2-year LT equivalent

These resources would be used to address the new federal rules regarding requirements, practices, and procedures related to capitation rate setting; address the requirement to provide that actuarial certification at the individual rate cell level, rather than certifying to a rate range; reinforce a more stringent federal focus on developing rates on a prospective rather than retrospective basis; implement new federal rules to provide for a nationally determined uniform medical loss ratio (MLR) standard no less than 85 percent as well as minimum standards for the MLR calculation methodology.

- **Long Term Care Division – 4.0 Staff Resources (2-year LT equivalent)**
  1.0 Research Program Specialist II (RPS II)
  2.0 Research Analyst II (RA II)
  1.0 Associate Government Program Analyst (AGPA)

  These resources would be used to update Medi-Cal's managed long-term supports and services managed care delivery system to include metrics for evaluating the soundness of actuarial payment provisions, promote accountability of Medicaid managed care plans, promote enhanced quality of care provisions, and strengthen delivery systems that serve Medicaid beneficiaries.

- **Office of Legal Services – 6.0 Staff Resources**
  3.0 Attorney III – 1.0 2-year LT equivalent
  3.0 Attorney – 2.0 2-year LT equivalent

  These resources will assist in the legal component of each division's workload, as well as any litigation of any other legal issues that arise as a result of the final rule.

- **Mental Health Services Division – 2.0 Staff Resources**
  4.0 Associate Governmental Program Analyst (AGPA)

  These resources will promulgate the corresponding state regulations to align with the federal regulations; establish and publish provider network adequacy standards for beneficiaries and stakeholders; establish and publish cultural sensitivity standards for all populations of beneficiaries; ensure full participation in State Fair Hearing procedures; provide technical assistance to the county mental health plans; provide oversight on provider networks, cultural and language standards, and quality improvement projects.

- **Audits & Investigations Division – 8.0 Staff Resources**
  1.0 Health Program Auditor III (HPA III)
  2.0 Health Program Auditor IV (HPA IV)
  5.0 Nurse Evaluator II (NE II)

These resources will address the increased audit and investigation workload related to (1) administration and management, (2) appeal and grievance systems, (3) claims management, (4) enrollee materials and customer services, (5) finance, including medical loss ratio reporting, (6) information systems, including encounter data reporting, (7) marketing, (8) medical management, including utilization management and case management, (9) program integrity, (10) provider network management, (11) availability and accessibility of services, (12) quality improvement, and (13) areas related to the delivery of long term services.

- **Research and Analytic Studies Division – 4.0 Staff Resources**
  1.0 Research Program Specialist I (RPS I) – 2-year LT equivalent
  2.0 Research Program Specialist II (RPS II)
  1.0 Research Scientist II (RS II) – 2-year LT equivalent

  These positions would be used to increase fee-for-service access monitoring activities; research current literature relating to patient access to care, and identify national benchmarks for health outcomes, health care utilization, and health system capacity measurement. These benchmarks will be incorporated into numerous reports to evaluate Medi-Cal program policies and initiatives with specific goals aimed at beneficiary subgroups.

- **Administration Division – 3.0 Positions**
  1.0 Personnel Specialist (PS)
  1.0 Associate Personnel Analyst (APA)
  1.0 Associate Governmental Program Analyst (AGPA)

  These positions would be used to address the increase administrative and contracting workload associated with implementation of these new federal requirements.

Additionally, the May Revision notes that these new federal managed care regulations could negatively impact California and result in General Fund costs in the hundreds of millions annually. The Administration's multi-year project assumes costs related to these regulations of $150 million General Fund in 2017-18, $175 million General Fund in 2018-19, and $200 million General Fund in 2019-20.

Background. Final Rule 2390-P changes the Medicaid managed care regulations to reflect the increased utilization of managed care as a delivery system. It aligns the rules governing Medicaid managed care with those of other major sources of coverage, including Qualified Health Plans and Medicare Advantage Plans; implements statutory provisions; changes actuarial payment provisions; and promotes the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also strengthens beneficiary protections and policies related to program integrity. This rule also requires states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries.

Final Rule 2328-NC requires states to develop and implement a transparent, data-driven process to evaluate provider payments, in regards to covered care and services consistent with section 1902(a)(30)(A) of the Social Security Act.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language. Given that the final rule was just issued on May 6, 2016, it is difficult at this point to assess the impact these regulations have on DHCS's workload and the state budget. It is recommended to approve this proposal to allow DHCS the flexibility to recruit and hire the needed staff to implement these new regulations.

It is also recommended to adopt placeholder trailer bill language to implement the following:

a. A transition of care policy that ensures continued access to services during a transition from FFS to managed care or from one MCO to another for all populations to ensure the enrollees do not suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
b. A beneficiary support system that performs outreach and assistance in understanding managed care.

Questions.

1. Please provide an overview of this proposal.

2. Please provide an overview on why there is out-year costs associated with these new federal regulations.

3. Has DHCS identified the regulations and statutory provisions that need changing as a result of these new regulations? If so, can DHCS please share this list with the Subcommittee. If not, can DHCS please follow-up with this information when it is available.

Issue 3: Medi-Cal: Managed Care Enrollment Tax Workload

Budget Issue. The May Revision requests three-year limited-term expenditure authority of $240,000 ($120,000 GF/$120,000 FF) to support the implementation and oversight of the managed care enrollment tax established by SB 2 X2 (Hernandez), Chapter 2, Statutes of 2016. (DOF Issue 401-MR)

According to DHCS, this funding would provide the resources necessary to facilitate the tax and complete the necessary administrative duties to ensure payment, collection, and use of the tax.

Background. SB 2 X2 implements a tax reform proposal to restructure the taxes paid by managed care plans (MCPs) in response to the Governor's call for a special session of the Legislature to consider and act upon legislation necessary to enact permanent and sustainable funding from a new managed care organization (MCO) tax and/or alternative funding sources. SB 2 X2 includes a replacement managed care enrollment tax for the tax expiring at the end of June 2016 and other taxes currently paid by the health plan industry.

Administrative staffing costs related to implementation and operationalization of the tax would include three-year limited term authority to develop, implement and oversee policies and procedures required for tax assessment and collection, provide financial analysis, management reports and policy analysis, plan reporting, providing customer service to providers and stakeholders, and work with the actuarial consultants to ensure rates to Medi-Cal MCPs accurately reflect the tax amount.

On May 17, 2016 the federal Centers for Medicare and Medicaid Services (CMS) approved a slightly revised version of the MCO Provider Tax enacted in SB2 X2. The revised MCO provider tax includes a change to expand the definition of excluded plans, this change only affected a single health plan, Community Health Group. No other health plan is impacted. CMS' approval of the revised tax will support approximately $3.74 billion in funding for the state's Medi-Cal program over the next three years.

Subcommittee Staff Comment and Recommendation—Approve. No concerns have been raised regarding this proposal. However, Health Net points out that existing law requires insurers to make four prepayments each equal to 25 percent of their annual Gross Premiums Tax (GPT) liability based on the amount owed in the preceding calendar year. SB2 X2 did not amend this Rev and Tax section. So even though Health Net may have a zero GPT liability with the new MCO tax, it would still have to make these quarterly pre-payments, for four quarters which presents a cash flow issue for the plan. Health Net requests trailer bill language to amend SB 2 X2 to change the prepayment obligation of insurers that qualify for the 0% gross premiums tax rate so that each prepayment obligation for such insurers is 25% of what their annual insurance tax liability for the preceding year would have been if SB 2 X2 had been operative from July 1, 2015 through June 30, 2016.

Questions.

1. Please provide an overview of this request.

2. Does the Administration support the proposed trailer bill language proposed by HealthNet?

Issue 4: Electronic Health Records Incentive Program

Budget Issue. The May Revision request trailer bill language to increase the existing General Fund annual limit, from $200,000 to $450,000, for state administrative costs associated with the implementation of the Medi-Cal Electronic Health Records Incentive Program. This program assists California health care providers transform their practices from paper-based environments to one that leverages electronic health record technology and promotes health information exchange.

There is no associated request for increased General Fund expenditures as existing staff will be redirected to this program/

Subcommittee Staff Recommendation—Adopt placeholder trailer bill language.

Questions.

1. Please provide an overview of this issue.

Issue 5: Covered Outpatient Drugs Final Federal Rule

Budget Issue. The May Revision includes $327.8 million ($130 million General Fund) in savings as a result of changes to the Medi-Cal fee-for-service pharmacy program's implementation of updated federal maximum reimbursements, federal upper limits (FUL), for some generically equivalent drugs dispensed by pharmacies. The May Revision also proposes trailer bill language (TBL) to provide DHCS authority to comply with the final federal rule related to Medicaid reimbursement for covered outpatient drugs. The final rule, issued on February 1, 2016, requires states to align pharmacy reimbursements with the actual acquisition cost of drugs and to pay an appropriate professional dispensing fee.

The budget also includes $645,000 ($322,000 General Fund) to support two contractors; one for project management services and another to survey drug prince information from pharmacies and to develop a new professional dispensing fee.

Background. On February 1, 2016, CMS published the Final Rule for Covered Outpatient Drugs, effective April 1, 2016. The Final Rule requires states to (1) reimburse pharmacies based on the Actual Acquisition Cost (AAC) of outpatient drugs, effective April 1, 2016; and (2) establish a dispensing fee, effective no later than April 1, 2017.

In order to comply with the Final Rule by April 1, 2017, the department must complete a survey on pharmacy acquisition costs and a study for the dispensing fee. (The current dispensing fee is $7.25.) The department will need to make State Plan Amendment (SPA) and legislative changes to adjust the existing pharmacy reimbursement and dispensing fee methodology. The department anticipates a fiscal impact from this change; however, the net impact is currently unknown.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language. Concerns have been raised by the pharmacy industry that implementation of the first part of this rule and the resulting reduction to their payments of $327.8 million will have a negative impact on this industry and may impact access to these services. It is anticipated that the implementation of the second component of this rule (the dispensing fee) will likely compensate for the payment reduction as a result of FULs; however, given the staggered implementation of these rules (a year apart) the pharmacy industry is requesting supplemental payments until the dispensing fee is revised. The California Pharmacists Association request a $3.56 supplement to the dispensing fees, with an estimated costs of $149 million (total funds) for a 12-month period.

Questions.

1. Please provide an overview of this issue.

2. What is DHCS's response to the concerns raised by the pharmacy industry?

Issue 6: Managed Care Fine and Penalty Revenue to Medi-Cal

Budget Issue. The May Revision requests trailer bill language (TBL) to allow the use of managed care administrative fines and penalties revenue over $1 million for the purpose of funding health care services for children, seniors, persons with disabilities, and dual eligibles in the Medi-Cal program. Currently, any administrative fines and penalties over $1 million are used to support the Managed Risk Medical Insurance Program (MRMIP). It is also requested to decrease General Fund support of the Medi-Cal program by $2 million as the managed care fines and penalties would offset this amount General Fund expenditure. (DOF Issue 564-MR)

Background. AB 60 (Isenberg), Chapter 1168, Statutes of 1989, established MRMIP. Since 1991, MRMIP has provided health insurance to Californians who are unable to obtain coverage, or charged unaffordable premiums, in the individual health insurance market due to a pre-existing condition. Californians who qualify for MRMIP contribute to the cost of their health care coverage by paying monthly premiums equal to 100 percent of the average market cost of premiums (based on the Silver level coverage through the Exchange), an annual deductible and copayments. These monthly premiums are subsidized through the Cigarette and Tobacco Products Surtax Fund (Proposition 99). MRMIP has an annual benefit cap of $75,000, and a lifetime benefit cap of $750,000. MRMIP is not an income-based eligibility program. MRMIP was originally established as a state high-risk pool; however, the need for high-risk pools has been greatly reduced as a result of the passage of the federal Affordable Care Act (ACA). Projected enrollment figures support the expected decline, with figures estimated at: 1,579 individuals in 2016; 1,485 in 2017; and 1,441 in 2018 (enrollment in January 2013 was 5,737).

Subcommittee Staff Comment and Recommendation—Modify. Under current law, MRMIP is a program where a person can purchase health coverage throughout the year if they missed the open enrollment period for commercial coverage or do not qualify for Medi-Cal. With this proposal the only ongoing revenue source for MRMIP would be eliminated and; consequently, it is unclear how this safety net coverage option would be supported. A comprehensive review of this program and the needed funding levels would be appropriate once the department has completed it reconciliation of actual plan expenditures and claims already paid.

Consequently, it is recommended to modify this proposal to only shift these funds to the Medi-Cal program if there are sufficient resources available to support the MRMIP program.

Questions.

1. Please provide a review of this proposal.

Issue 7: Long-Term Care Quality Assurance Fund

Budget Issue. The May Revision requests trailer bill language (TBL) that would make the Long-Term Care Quality (LTC) Assurance Fund continuously appropriated without regard to fiscal year. This change will align the expenditure authority of programs supported by the Long-Term Care Quality Assurance Fund with available fee revenues. Expenditures from the fund are used to offset General Fund expenditures for long term care provider reimbursements.

The 2016 May Revision also includes an unanticipated current year shortage in spending authority for fund in the amount of $40,336,000. The shortage in authority is attributable to increased revenues to the fund from the long-term care quality assurance fee and the intermediate care facility for the developmentally disabled fee. (Issue 565-MR)

Background. AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, established the Long-Term Care Quality Assurance Fund. AB 1467 requires that all long-term care quality assurance fees be deposited into this fund.

Subcommittee Staff Recommendation—Adopt placeholder trailer bill language. This fund, similar to the managed care organization tax and hospital quality assurance fee (which are continuously appropriated), is used to offset General Fund expenditures; consequently, it is recommended to approve this proposal.

Concerns have been raised by the California Association of Health Facilities (CAHF) that the May Revision does not include required "add-ons" to the rates paid to skilled-nursing facilities and intermediate care facilities for the developmentally disabled. CAHF notes that federal requirements on "The Payroll Based Journal" should be included for a cost of $37.6 million General Fund, and $12.7 million General Fund for requirements related to antimicrobial stewardship.

Questions.

1. Please provide an overview of this proposal.

2. What is the reason for the current year shortfall?

3. What is the department's response regarding the required "add-ons" the LTC rates? Why weren't these add-ons included?

Issue 8: Institutionally Deemed Behavioral Health Treatment Population Case Management

Budget Issue. The May Revision requests $2.2 million ($1.1 million General Fund) for case management for current participants (an estimated 433) of the Home and Community Based Services (HCBS) for the Developmentally Disabled Waiver who will lose their Medi-Cal eligibility in March 2017. These beneficiaries are currently receiving behavioral health services (BHT) services through the waiver and are eligible for Medi-Cal through institutional deeming, which requires beneficiaries needing nursing facility level of care, be under the age of 21, live at home, receive at least one HCBS, and are not otherwise eligible for Medi-Cal without a share of cost. With the transition of this benefit from the HCBS waiver to the Medi-Cal program, these individuals no longer qualify for Medi-Cal under institutional deeming.

The requested funding will allow case managers to help transition the affected beneficiaries into comprehensive health care coverage by March 2017 to avoid gaps in coverage. Trailer bill language is also requested to enable procurement of contractors. (DOF Issue 560-MR)

Background. SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014 requires DHCS to add behavioral health treatment (BHT) services, such as applied behavioral analysis (ABA), as a covered benefit in Medi-Cal to the extent required by federal law. Subsequent to the enactment of the 2014 budget, the federal government issued guidance indicating that BHT should be a covered Medicaid benefit for eligible children and adolescents with autism spectrum disorder (ASD). In response to the guidance, DHCS submitted State Plan Amendment (SPA) 14–026 to the Centers for Medicare & Medicaid Services (CMS) on September 30, 2014 to seek the necessary approval to include BHT as a covered Medi-Cal service for individuals under 21 years of age with ASD. On January 21, 2016, CMS approved this SPA. BHT services are approved retroactively to July 2014.

On November 20, 2015, DHCS and Department of Developmental Services (DDS) jointly issued a transition plan that describes the transition of Behavioral Health Treatment (BHT) services from the regional centers to the Medi-Cal managed care and fee-for-service delivery systems. This transition began in February 2016 and will occur over a period of six months. Approximately, 5,000 individuals (of the estimated 13,000) have transitioned with 92 percent receiving automatic continuity of care with the same provider. The remaining eight percent have transitioned to a new provider.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language.

Questions.

1. Please provide an overview of this proposal.

2. Please explain how these case manager services would work? Who would provide these case management services?

Issue 9: New Qualified Immigrant Affordability and Benefit Program

Budget Issue. The May Revision includes an increase of $31.8 million General Fund to reflect a delay of one year (from January 1, 2017 to January 1, 2018) in shifting newly eligible New Qualified Immigrants (NQI) populations to Covered California pursuant to SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013.

The May Revision also requests trailer bill language (TBL) to adjust the income eligibility requirements for the New Qualified Immigrant Affordability and Benefit program to no more than 150 percent of the federal poverty level, based on the applicant's eligibility for Advanced Premium Tax Credit, a health insurance federal subsidy. Additionally, the proposed TBL will extend the date for DHCS to promulgate program regulations.

Background. The federal Personal Responsibility and Work Opportunity Act (PRWORA) specified that federal financial participation (FFP) is not available for full-scope Medi-Cal services for most qualified nonexempt immigrants during the first five years they are in the country. Currently, FFP is only available for emergency and pregnancy services. California law requires that legal immigrants receive the same services as citizens and pays for other services with 100 percent General Fund.

Effective January 1, 2014, the federal Affordable Care Act (ACA) allow states to expand Medicaid coverage to previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level (FPL), referred to as the optional expansion group. Additionally, the ACA established online health insurance exchanges. Covered California, California's health insurance exchange, determines an applicant's eligibility for federally subsidized health coverage. Individuals with incomes below 400 percent FPL are eligible for federal subsidies to help offset the monthly premium costs.

Effective for January 1, 2018 (under the May Revision proposal), DHCS will begin transitioning optional expansion childless adult NQIs who have been in the country less than five years from Medi-Cal into Covered California. DHCS will pay for all out-of-pocket expenditures and will provide Medi-Cal fee-for-services for services that are not covered by Covered California (such as dental care).

Subcommittee Staff Comment and Recommendation. It is recommended to approve the May Revision proposal to delay the NQI wrap program. It is also recommended to reject the proposed trailer biller bill language. Concerns have been raised by stakeholders that this proposal presents significant policy questions that should be addressed in a policy bill.

Questions.

1. Please provide an overview of this proposal.

2. What is the intent of the trailer bill language.

Issue 10: Emergency Medical Air Transportation Act Cleanup

Budget Issue. The May Revision requests trailer bill language to remove a provision of SB 326 (Beall), Chapter 797, Statutes of 2015 regarding emergency medial air transportation funding from penalty assessments for Vehicle Code violations. The specific provision requested to be eliminated is:

> **Welfare and Institutions Code (WIC) 10752.** The department shall, by March 1, 2017, in coordination with the Department of Finance, develop a funding plan that ensures adequate reimbursement to emergency medical air transportation providers following the termination of penalty assessments pursuant to subdivision (f) of Section 76000.10 of the Government Code on January 1, 2018.

Background. SB 326 extended the sunset date of the $4 penalty assessment for Vehicle Code violations, other than parking offenses, and related funding provisions, from January 1, 2016 to January 1, 2018, to continue raising revenues to augment funding for emergency medical air transportation Medi-Cal providers.

An amendment by the Assembly Appropriations Committee added WIC 10752 in an effort to establish a permanent funding source for this service.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to modify this language to be:

> The department shall, by March 1, 2017, in coordination with the Department of Finance, ~~develop a funding plan that ensures adequate reimbursement to~~ ***report to the Legislature on the fiscal impact to Medi-Cal of, and the planned reimbursement methodology for emergency medical air transportation services after,*** ~~to emergency medical air transportation providers following~~ the termination of penalty assessments pursuant to subdivision (f) of Section 76000.10 of the Government Code on January 1, 2018.

This change reflects discussions with the Assembly Appropriations Committee to ensure the intent of its amendment to the bill.

Questions.

1. Please provide an overview of this request and explain why the department is seeking this change.

Issue 11: Drug Medi-Cal Rate Setting Process

Budget Issue. The May Revision requests trailer bill language (TBL) to permit rate adjustments by way of bulletin authority or similar instructions to improve administrative efficiencies. Under existing law, Drug Medi-Cal rates are updated annually through regulations based on the cumulative growth in the implicit price deflator for the costs of goods and services to governmental agencies. The annual rates are based either on the developed rates for use in the next fiscal year or the 2009-10 Budget Act rates adjusted for the deflator, whichever is lower.

Drug Medi-Cal Organized Delivery System. At the beginning of 2014, DHCS began a stakeholder engagement process to solicit input to improve the DMC system and purse a DMC-ODS federal waiver to provide an organized delivery system of substance use disorder services and demonstrate how this organized system of care would increase successful outcomes for DMC beneficiaries. The DMC-ODS waiver, an amendment to DHCS' Bridge to Reform Waiver, was approved by CMS on August 13, 2015 for five and a half years.

According to DHCS, the continuum of care model enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance use disorder treatment, and coordinates with other systems of health care.

Subcommittee Staff Comment and Recommendation—Reject. This May Revision proposal has no budget implications; consequently, it is recommended to reject this proposal.

Questions.

1. Please provide an overview of this proposal.

Issue 12: Continuum of Care Reform: Short-Term Residential Treatment Center Licensing (AB 403, 2015)

Budget Issue. DHCS requests the following resources to implement the Continuum of Care Reform (CCR) pursuant to AB 403 (Stone), Chapter 773, Statutes of 2015:

- One permanent position and expenditure authority of $118,000 for one associate governmental program analyst (AGPA).
- Three-year funding (phased-in) of $251,000 for staffing resources equivalent to one staff services manager I and one AGPA.
- $416,000 ($208,000 General Fund) to reimburse counties for participating in a child and family team and providing assessments for seriously emotionally disturbed children.

This issue was discussed at the April 21, 2016 Subcommittee No. 3 hearing.

May Revision. In addition, the May Revision requests a $12 million ($6.8 million General Fund and $5.2 million Federal Fund) augmentation to fund county mental health costs to improve assessments of foster youth placements, and increase transparency and accountability for child outcomes. These funds cover half year costs. These adjustments reflect increased county mental health costs to participate in child and family teams and training for county mental health staff. (DOF Issue 561-MR)

Subcommittee Staff Comment and Recommendation—Approve. The County Behavioral Health Directors Association raises concerns with the May Revision estimates and finds that the Administration underestimates the new costs to the counties.

Questions.

1. Please provide an overview of these costs.
2. Why are there differences between DHCS's estimated costs and the estimated costs provided by the counties?

Issue 13: Medi-Cal: PACE Modernization

Budget Issue. DHCS proposes trailer bill language to enable modernization of the Program for All-Inclusive Care for the Elderly (PACE). The proposed legislative changes would:

- **Rate Setting**: Standardize rate-setting to DHCS to determine comparability of cost and experience between PACE and like population subsets served through Long-Term Services and Supports (LTSS) integration into managed care health plans under the Coordinated Care Initiative. Statutory change is necessary as DHCS is currently required to use a Fee-for-Service (FFS) equivalent cost/upper payment limit methodology to set capitation rates for PACE Organizations.
- **Remove Cap on the Number of PACE Organizations**: Remove existing statutory language that caps the number of PACE Organizations with which DHCS can contract.
- **Remove Not-for-Profit Requirement**: Remove existing statutory language to align with updated PACE federal rules and regulations.
- **PACE Flexibilities**: Add new statutory language enabling DHCS to seek flexibility from the Centers for Medicare and Medicaid Services (CMS) on several issues including the composition of the PACE interdisciplinary team (IDT), the frequency of IDT meetings, use of alternative care settings, use of community-based physicians, marketing practices, and development of a streamlined PACE waiver process.

This issue was discussed at the May 5, 2016 Subcommittee No. 3 hearing.

May Revision. The May Revision proposes changes to this trailer bill language. These changes incorporate stakeholder feedback and include:

1. The specific rate methodology applied to PACE organizations shall address features of PACE that differentiate it from other managed care plan models.
2. Consistent with actuarial methods, the primary source of data used to develop rates for each PACE organization shall be its Medi-Cal cost and utilization data, or other data sources as deemed necessary by the department.
3. The rate methodology developed shall contain a mechanism to account for the costs of high-cost drugs and treatments.
4. Rates developed shall be actuarially certified prior to implementation.
5. Consistent with the requirements of federal law, the department shall calculate an upper payment limit for payments to PACE organizations. In calculating an upper payment limit, the department may correct the applicable data as necessary. In calculating an upper payment limit, the department shall consider the risk of nursing home placement for the comparable population when estimating the level of care and risk of PACE participants.
6. During the first year in which a new PACE organization or existing PACE organization enters a previously unserved area the department may, in its sole discretion, pay at any rate within the certified actuarially sound rate range developed with respect to that entity, to the extent consistent with federal requirements.

Subcommittee Staff Comment and Recommendation—Adopt May Revision Placeholder Trailer Bill Language.

Questions.

1. Please provide an overview of the proposed changes.

Issue 14: Budget Control Section 4.13

Budget Issue. The May Revision requests that Control Section 4.13 be added to the budget bill to facilitate repayments to counties pursuant to AB 85 (Committee on Budget), Chapter 24, Statutes of 2013. AB 85 modified the 1991 Realignment Local Revenue Fund distributions to capture and redirect county savings from the implementation of federal health care reform. These savings are reallocated to counties to pay an increased county contribution towards the costs of California Work Opportunity and Responsibility to Kids grants, also known as CalWORKs, which reduces state General Fund expenditures. The state redirected $300 million in 2013-14; however, actual county savings in 2013-14 are lower than previously estimated and the May Revision assumes repayment of $177.4 million to counties in 2016-17.

Repayments to a county shall be authorized by the Department of Finance once final redirection determinations and appeals are completed for each county. Control Section 4.13 is proposed to be added as follows:

> SEC. 4.13. Notwithstanding any other provision of law, items of appropriation in this act may be adjusted, as determined by the Department of Finance, to reflect changes to General Fund expenditures resulting from the final redirection calculation and appeals pursuant to Chapter 24, Statutes of 2013 (AB 85). Upon order of the Department of Finance, any payment to a county based on the AB 85 final reconciliation shall be transferred by the Controller to the health account within the county's local health and welfare trust fund.

Subcommittee Staff Recommendation—Adopt Placeholder Budget Bill Language.

Questions.

1. Please provide an overview of this request.

2. Why were the actual county savings in 2013-14 lower than previously estimated given the substantial growth in Medi-Cal?

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Wednesday, May 18, 2016
9:30 a.m.
State Capitol - Room 4203

Consultant: Michelle Baass

OUTCOMES

VOTE ONLY

MULTIPLE DEPARTMENTS

Issue 1: Health-Related General Fund Investments

As discussed at the May 12th hearing, the Subcommittee has received multiple requests for General Fund augmentations for health-related programs.

Subcommittee Staff Recommendation—Approve. Given the state's fiscal situation, it is recommended to approve the following General Fund augmentations and to adopt any needed placeholder trailer bill language to effectuate these proposals:

Proposal	Description	Annual General Fund Amount (unless otherwise noted)
Department of Health Care Services		
1. Medi-Cal Estate Recovery	Multiple stakeholders, including Western Center on Law and Poverty, Health Access, CPEN, and Consumers Union, request to limit estate recovery in the Medi-Cal program by requiring collection for only those health care services required to be collected under federal law, to make it easier for individuals to pass on their assets by using a narrower definition of "estate" in	$26 million

	federal Medicaid law, and to allow a hardship exemption from estate recovery for a home of modest value. • **Motion – Approve** • **Vote – 2-1 (Stone)**	
2. Interpreters for Medi-Cal	Various stakeholders, including the California Latino Legislative Caucus and AFSCME, requests $15 million for interpreters in the Medi-Cal program. • **Motion – Approve** • **Vote – 3-0**	$15 million
3. AIDS Medi-Cal Waiver Program Rates	The California HIV Alliance proposes a rate increase for the AIDS Medi-Cal Waiver program. It notes that provider reimbursement rates for this program are lower than Medi-Cal rates for the same services. This increase would equalize case management and case management administrative expenses for the AIDS Medi-Cal waiver to other Home and Community-Based Waiver Services programs. • **Motion – Approve** • **Vote – 3-0**	$4.9 million
Department of Public Health		
4. Drug Overdose Prevention (Naloxone)	The Drug Policy Alliance (DPA) requests to establish a grant program for local agencies and community-based organizations in order to reduce the rate of fatal drug overdose caused by prescription analgesics and other drugs. DPA estimates this investment would save an estimated 1,200 lives. Furthermore, hospitalization rates for treatment of effects of non-fatal but debilitating overdoses would also be reduced. • **Motion – Approve** • **Vote – 3-0**	$3 million
5. Hepatitis Initiatives	Stakeholders, such as CalHEP and Project Inform, request: 1) $100,000 for DPH to purchase and distribute hepatitis B (HBV) vaccine to local health jurisdictions to vaccinate high risk adults; 2) $600,000 for DPH to purchase hepatitis C (HCV) rapid test kits to distribute to community-based testing programs; 3) $500,000 for DPH to certify non-medical personnel to perform rapid HCV and HIV testing in community-based settings; and 4) $200,000 to the DPH Office of AIDS for technical assistance to local governments and to increase the number of syringe exchange and disposal programs throughout California and the number of jurisdictions in which syringe exchange and disposal programs are authorized. • **Motion – Approve** • **Vote – 3-0**	$1.4 million

6. Children's Dental Disease Prevention Program (DDPP)	Advocates propose to restore funding for DDPP. From 1980 to 2009, the DDPP provided school-based oral health prevention services to approximately 300,000 low-income school children in 32 counties in California. Participating sites provided fluoride supplementation, dental sealants, plaque control, and oral health education. • **Motion – Approve** • **Vote – 3-0**	$3.2 million
7. Early Detection and Diagnosis of Alzheimer Disease	Various stakeholders, including the Alzheimer's Association, request funds for the California Alzheimer Disease Centers for early detection and diagnosis of Alzheimer disease. Funds would be used to determine the standard of care in early and accurate diagnosis, provide professional outreach and education, and evaluate the educational effectiveness of these efforts. • **Motion – Approve** • **Vote – 3-0**	$2.5 million (one-time)
8. Biomonitoring Program	Various advocates, including the Natural Resources Defense Council and the Breast Cancer Fund, request an augmentation for the biomonitoring program to increase and support the scientific work of this program. This funding would be split between DPH, the Department of Toxic Control, and the Office of Environmental Health Hazard Assessment. • **Motion – Approve** • **Vote – 3-0**	$1 million
9. End of Life Option Act - Telephone Line (SB 1002)	Senator Monning requests funds ($150,000) to establish a telephone line for answering End of Life Option Act inquiries and require that the individuals answering be bilingual. SB 1002 (Monning) would implement this request. • **Motion – Approve** • **Vote – 2-1 (Stone)**	$150,000
Office of Statewide Health Planning and Development		
10. Primary Care Workforce Development	Various stakeholders request funding ($82.5 million) for Song Brown Program to increase residency programs for primary care physicians and funding ($17.5 million) to establish new teaching health center sites offering additional primary care residencies, and other efforts related to graduate medical education. • **Motion – Approve** • **Vote – 3-0**	$100 million over three years ($33 million/year)

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Interagency Task Force on HIV, Hepatitis C, Sexually Transmitted Diseases, and Drug User Health

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

0530 CALIFORNIA OFFICE OF HEALTH INFORMATION INTEGRITY (CALOHII)

Issue 1: Restructure the California Office of Health Information Integrity

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to modify this advocate proposal and only adopt placeholder trailer bill language to establish this task force (i.e., not include a General Fund augmentation for this purpose, as these activities are consistent with the role of the agency).

0530 OFFICE OF SYSTEMS INTEGRATION (OSI)

Issue 1: MEDS Modernization Multi-Departmental Planning Team

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the request from OSI and the corresponding budget request from the Department of Health Care Services to support this effort.

Issue 2: eWIC Management Information System Project

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: CalHEERS

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Budget Bill Language.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Expansion of State Loan and Allied Health Repayment Programs for CMSP Counties

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment—Approve and Adopt Budget Bill Language. It is recommend to increase OSHPD's reimbursement authority and adopt placeholder budget bill language to implement this proposal.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Infrastructure and Support Services

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: End of Life Option Act (AB 15 X2, 2015)

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: Federal Mental Health Parity Ongoing Compliance Review

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: Large Group Rate Review (SB 546, 2015)

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 5: Limitations on Cost-Sharing: Family Coverage (AB 1305, 2015)

- **Motion – Approve staff recommendation**

- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 6: Outpatient Prescription Drug Formularies (AB 339, 2015)

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 7: Provider Directories (SB 137, 2015)

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 8: Vision Services (AB 684, 2015)

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: County Eligibility Administration Funding and Trailer Bill

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Approve and adopt Administration's proposed placeholder trailer bill language.

Issue 2: Health Insurance Portability and Accountability Act Compliance and Monitoring

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: Specialty Mental Health Services Oversight and Monitoring

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: Performance Outcomes System for Medi-Cal Specialty Mental Health Services

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Approve.

Issue 5: Mental Health Services Act (Proposition 63) Reappropriation

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 6: Drug Medi-Cal Waiver Program Resources

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 7: Drug Medi-Cal – Residential Treatment Services

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 8: Home and Community-Based Services (HCBS) Federal Requirements

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 9: Office of Family Planning Contract Conversion

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 10: Medi-Cal Estimate May Revision Adjustments

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Recommendation—Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken. This is a technical adjustment.

Issue 11: Medi-Cal May Revision Adjustments to January Budget

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Recommendation—Approve

Issue 12: Hospital Quality Assurance Fee Extension

- **Motion – Approve staff recommendation**
- **Vote – 2-0 (Stone not voting)**

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt placeholder trailer bill language to extend the hospital QAF until January 1, 2018. It is also recommended to account for the approximately $950 General Fund savings as a result of the extension of this QAF. According to the Legislative Analyst's Office, depending on the timing of federal approval, $700 million General Fund savings could be scored in 2017-18 and $250 million General Fund savings could be scored in 2018-19.

Issue 13: Medi-Cal Electronic Health Records Staffing

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Approve

Issue 14: Family Health May Revision Estimate

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Approve.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Licensing and Certification (L&C): Program Quality Improvement Projects

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: L&C: Timely Investigations of Caregivers

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: L&C: State Citation Penalty Account and Long-Term Care Ombudsman

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Augment Funding for LTC Ombudsman Program. It is recommended to augment the LTC Ombudsman Program with $1 million in ongoing funds from the State Health Facilities Citation Account. As previously discussed, it is reasonable to assume that the ombudsman program's presence and advocacy on behalf of skilled nursing facility (SNF) residents improves quality of life for these residents and improves a SNF's compliance with state and federal laws.

Issue 4: Women, Infants, and Children Program

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 5: Office of AIDS – Advocate Proposals

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language. It is recommended to approve these proposals and adopt placeholder trailer bill language to implement these changes.

Issue 6: Protecting Children from the Effects of Lead Exposure – May Revision Adjustment

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Approve May Revision Adjustment.

Issue 7: May Revision Technical Adjustments

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Approve.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Porterville Developmental Center – Upgrade Fire Alarm System

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: Fiscal and Program Research Unit

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Trailer Bill Language. It is recommended to approve this proposal. Also, given the Subcommittee discussion on improving transparency and oversight of the community-based developmental services system, it is also recommended:

1. To adopt placeholder trailer bill language to:
   a. Require DDS to annually report and post on its website supplemental budget information. This information would be reported by February 1 and includes:
      i. Budget estimates for each developmental center, including a break out of funding for Porterville Development Center's general treatment area and secured treatment area
      ii. For each regional center: Current year estimates for operations funding, purchase of service (POS) funding, caseload, per capita for operations, per capita for POS

iii. By regional center, information on staff (number of various classifications, e.g., number of case managers)
iv. For Community Placement Program (CPP) funding: For each regional center, past year and current year information by component of CPP.

b. Specify analysis and deliverables for the new research unit. These would include an:
i. Assessment of disparities data reported by regional centers.
ii. Assessment of caseload ratio requirements by regional center.
iii. Assessment of performance dashboard (see below) data as it becomes available.

c. Establish a performance dashboard, require DDS to work with stakeholders on the development of this dashboard, and require this dashboard to be published annually. Metrics included in this dashboard would include, but not be limited to:
i. Recognized quality and access measures
ii. Measures to indicate compliance with and movement toward compliance with new federal Home and Community Based Services waiver rules
iii. Measures to evaluate the changes in the number of consumers who work in competitive integrated employment
iv. Consumer complaints, timeliness of responses to complaints, number of administrative hearings

2. Augment DDS state operations budget by $300,000 General Fund (available over three years) for contracting services to assist in the development of this performance dashboard.

Issue 3: Four-bed Alternative Residential Model Homes

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: Consumer Program Coordinators Funding

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to approve the funding and to modify the budget bill language to require regional centers not only report the number of staff hired with the additional funds and the effectiveness of these funds in reducing average caseload ratios, but also information justifying why a regional center, if it chooses, uses this funding for non-HCBS coordinators.

Issue 5: Increased Vendor Audit Coverage

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 6: Repeal Prevention Resources and Referral Services Program Statute

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Adopt Administration's proposed placeholder trailer bill language.

Issue 7: Standards Authorizing Medical Services by Regional Centers

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt placeholder trailer bill language to eliminate the requirement to pursue a Medi-Cal appeal. The costs to implement this change are negligible, as the savings estimated in 2009-10 were a result of requiring consumers to use generic services.

Issue 8: May Revision Technical Adjustments

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the above adjustments, with any changes to conform as appropriate to other actions that have been, or will be, taken.

Issue 9: Home and Community-Based Services (HCBS) Federal Requirements

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Approve Funding Proposals, Adopt Placeholder Budget Bill Language, Reject Proposed Placeholder Trailer Bill Language. It is recommended to approve all items listed above except the proposed trailer bill language as it only expresses the Legislature's intent to enact legislation, it is recommended to reject this language.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Investment in Mental Health Wellness Act of 2013 – Triage Personnel Grants

- **Motion – Approve staff recommendation**

- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: Innovation Plan Reviews

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: Advocacy Contracts

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Modify. As discussed at the April 21, 2016 Subcommittee hearing, it has been requested that all consumer advocacy contracts be supported at the same level. Consequently, it is recommended to augment this request by $1.536 million MHSA State Administration funds. (With this action, all consumer advocacy contracts will be funded at approximately $670,000.)

Issue 4: Reappropriation of Mental Health Services Fund

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve.

0877 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Children's Crisis Services Capacity Development Grant Program

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendations. It is recommended to adopt placeholder trailer bill language to establish a one-time grant program for the development of children's crisis services capacity. It is also recommended to allocate $18 million from the MHSA state administrative funding for this purpose to the OAC and the California Health Facilities Financing Authority (CHFFA).

Additionally, CHFFA anticipates that approximately $6 million General Fund related to the SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013 will go unspent. It is recommended to reappropriate these funds to CHFFA for grants to develop children's crisis services capacity.

ITEMS FOR DISCUSSION

0530 CALIFORNIA OFFICE OF HEALTH INFORMATION INTEGRITY (CALOHII)

Issue 1: Use, Disclosure, and Protection of Specially Protected Health Information

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Recommendation—Approve and Adopt Placeholder Budget Bill Language.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Sonoma Developmental Center – Decertification of ICF/IDD

- **Motion – Approve staff recommendation noted below**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill. It is recommended to adopt placeholder trailer bill language requiring DSS to report the monthly General Fund backfill costs as a result of the loss of FFP.

Issue 2: Developmental Centers Closures

- **Motion – Approve all Governor's Budget and May Revision proposals except the May Revision proposal for Retention Stipends for Developmental Center Staff (Item 1 below)**
- **Vote – 3-0**

- **Motion – Approve May Revision Retention Stipends for Developmental Center Staff**
- **Vote – 2-1 (Stone)**

- **Motion – Approve staff recommended placeholder trailer bill language regarding closure of the developmental centers (Item 2 below)**
- **Vote – 2-0 (Stone not voting)**

- **Motion – Approve staff recommended for an augmentation related to Community State Staff Program funding (Item 3 below)**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Recommendation. The following is recommended:

1. Approve, with the modifications noted below, the January budget and May Revision proposals discussed above and adopt placeholder trailer bill and budget bill language to implement these proposals. The following modifications are recommended:

    a. Modify the request for funding for an independent monitoring contract for Fairview and Porterville Developmental Centers by adding provisional budget bill language authorizing this expenditure only if CMS approves settlement agreements for these DCs through the budget year.

    b. Specify a timeline by which the transition plan regarding special managed care provisions related to individuals transitioning out the DCs, developed by DDS and the Department of Health Care Services, should be developed regarding the processes for individuals assigned to a Medi-Cal managed care plan which promote coordination of care during and following the transition, identification of providers prior to a transition occurring; and the continuation of medically necessary covered services.

2. Additionally, as part of the Legislature's approval of these DC closure plans, it is recommended to adopt the following placeholder trailer bill language to:

    a. Require the department to develop a plan to be submitted to the Legislature no later than January 10, 2017 regarding how the department will ensure access to crisis services post developmental closure and how the state will maintain its role in providing residential services to those whom private sector vendors cannot or will not serve. As part of this plan, the department should assess the option of expanding the Community State Staff Program to assign state staff to serve as regional crisis management teams to provide assessment, consultation and resolution for persons with DD in crisis in the community.

    b. Require that reports of injuries, death, restraint usage, and incidents of seclusion, for example, at community facilities be reported to the federally mandated protection and advocacy agency.

    c. Limit the use of seclusion and restraints in community facilities licensed by the Department of Social Services.

    d. Require that crisis services and specialized health care/clinic services at these DCs through the transition process and until closure.

    e. Require the closure of the DC upon the successful transition of all residents into the community.

    f. Require regular public posting (on the department's website) of progress being made to develop residential capacity by regional center. Including information on monthly targets for movers based on transition activities and community resource development

activities) by regional center. This monthly reporting would also include information on why targets are not met.

3. It is also recommended to augment DDS's budget by $5 million General Fund in the budget year and $10 million in future years for the Community State Staff Program. As has noted by multiple stakeholders, advocates, and DC resident family members, to ensure a successful transition of DC residents into the community, it is critical to retain the experience and expertise of the DC employees and the services they provide. It is recommended to adopt placeholder trailer bill language to implement this change.

Issue 3: Deferred Maintenance Projects

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Modify. It is recommended to reject the proposal to replace the PDC boiler in order to continue discussions on this topic. It is recommended to approve all other projects.

Issue 4: Special Session Resources and Technical Clean-up Trailer Bill Language

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language.

Issue 5: Provider Rate Adjustments to Address State Minimum Wage Increase Trailer Bill Language

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Adopt Proposed Placeholder Trailer Bill Language.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: L&C: Los Angeles County Contract

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Recommendation—Approve.

Issue 2: Marijuana Study

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Approve.

Issue 3: Medical Cannabis Trailer Bill Language

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended to adopt the Administration's placeholder trailer bill language.

Issue 4: Genetic Disease Screening Program

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Approve.

Issue 5: Special Session Legislation Related to e-Cigarettes and Tobacco

- **Held open**

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Caseload and Estimate

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Recommendation—Approve.

Issue 2: Medi-Cal: Federal Managed Care Regulations Staffing Resources

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language. Given that the final rule was just issued on May 6, 2016, it is difficult at this point to assess the impact these regulations have on DHCS's workload and the state budget. It is recommended

to approve this proposal to allow DHCS the flexibility to recruit and hire the needed staff to implement these new regulations.

It is also recommended to adopt placeholder trailer bill language to implement the following:

a. A transition of care policy that ensures continued access to services during a transition from FFS to managed care or from one MCO to another for all populations to ensure the enrollees do not suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
b. A beneficiary support system that performs outreach and assistance in understanding managed care.

Issue 3: Medi-Cal: Managed Care Enrollment Tax Workload

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Issue 4: Electronic Health Records Incentive Program

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Adopt placeholder trailer bill language.

Issue 5: Covered Outpatient Drugs Final Federal Rule

- **Motion – Approve staff recommendation noted below**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language. Augment DHCS's budget by $1 million General Fund for a dispensing fee supplemental payment.

Issue 6: Managed Care Fine and Penalty Revenue to Medi-Cal

- **Motion – Approve staff recommendation noted below**
- **Vote – 2-0 (Stone not voting)**

Subcommittee Staff Comment and Recommendation. It is recommended to reject the proposed trailer bill language and redirect $2 million from the Major Risk Medical Insurance Fund balance to the Medi-Cal program.

Issue 7: Long-Term Care Quality Assurance Fund

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Adopt placeholder trailer bill language. This fund, similar to the managed care organization tax and hospital quality assurance fee (which are continuously appropriated), is used to offset General Fund expenditures; consequently, it is recommended to approve this proposal.

Issue 8: Institutionally Deemed Behavioral Health Treatment Population Case Management

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language.

Issue 9: New Qualified Immigrant Affordability and Benefit Program

- **Motion – Approve staff recommendation**
- **Vote – 2-1 (Stone)**

Subcommittee Staff Comment and Recommendation. It is recommended to approve the May Revision proposal to delay the NQI wrap program. It is also recommended to reject the proposed trailer biller bill language. Concerns have been raised by stakeholders that this proposal presents significant policy questions that should be addressed in a policy bill.

Issue 10: Emergency Medical Air Transportation Act Cleanup

- **Motion – Approve staff recommendation noted below**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to modify this language to be:

> The department shall, by March 1, 2017, in coordination with the Department of Finance, ~~develop a funding plan that ensures adequate reimbursement to~~ ***notify to the Legislature on the fiscal impact to Medi-Cal of, and the planned reimbursement methodology for emergency medical air transportation services after,*** ~~to emergency medical air transportation providers following~~ the termination of penalty assessments pursuant to subdivision (f) of Section 76000.10 of the Government Code on January 1, 2018.

This change reflects discussions with the Assembly Appropriations Committee to ensure the intent of its amendment to the bill.

Issue 11: Drug Medi-Cal Rate Setting Process

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Reject. This May Revision proposal has no budget implications; consequently, it is recommended to reject this proposal.

Issue 12: Continuum of Care Reform: Short-Term Residential Treatment Center Licensing (AB 403, 2015)

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Approve. The County Behavioral Health Directors Association raises concerns with the May Revision estimates and finds that the Administration underestimates the new costs to the counties.

Issue 13: Medi-Cal: PACE Modernization

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Comment and Recommendation—Adopt May Revision Placeholder Trailer Bill Language.

Issue 14: Budget Control Section 4.13

- **Motion – Approve staff recommendation**
- **Vote – 3-0**

Subcommittee Staff Recommendation—Adopt Placeholder Budget Bill Language.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

May 19, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

Consultants: Theresa Pena and Michelle Baass

ISSUES RECOMMENDED FOR VOTE ONLY

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

5180 DEPARTMENT OF SOCIAL SERVICES – CALWORKS

Issue 1: Trailer Bill Language: Approved Relative Caregiver (ARC) Program Parity

May Revision. The Administration proposes to clarify that a relative who has been approved under the resource family approval (RFA) process and who is federally ineligible for Aid to Families with Dependent Children-Foster Care (AFDC-FC) is authorized to receive a CalWORKs grant and a supplement amount equal to the resource family basic amount paid to children who are federally eligible for AFDC-FC.

Background. The ARC program allows counties that opt in to provide payments to federally ineligible relative caregivers an amount equal to the foster care basic rate received by federally eligible relative caregivers of dependent children. Approved relatives in these counties would receive a grant payment which would consist of funds from CalWORKs, General Fund, and county, if necessary.

Advocate Concerns. The Alliance for Children's Rights has strong concerns about the proposed TBL. They feel that the TBL as currently drafted does the opposite of what it intends, and actually builds inequities into resource family approval process by making it clear that relatives are not included when caring for non-federally eligible children, except at the counties' option and through an entirely different program.

Staff Comment and Recommendation. This subcommittee heard and discussed this item during its May 17, 2016 hearing. Approve proposed trailer bill language as placeholder with the understanding that the department will work with stakeholders on concerns. Trailer bill language should ultimately reflect the stated goal to provide for program parity.

Issue 2: Trailer Bill Language: Subsidized Employment

Budget Proposal. CWDA is proposing trailer bill language to streamline the two CalWORKs subsidized employment programs, AB 98 and Expanded Subsidized Employment, to reduce the administrative burden of two separate programs and to help maximize utilization of the programs.

Staff Recommendation. This subcommittee heard and discussed this item during its March 10, 2016 hearing. Approve trailer bill language as placeholder. No concerns have been raised.

Issue 3: California Farm to Food Bank Tax Credit Proposal

Budget Proposal. The California Association of Food Banks and others are requesting to extend California's current tax credit for farm donations to food banks from 2017 to 2022, increase the credit from 10 percent to 15 percent, expand the list of qualified donation items, and value items at wholesale cost.

Background. AB 152 (Fuentes), Chapter 503, Statues of 2011, created the existing 10 percent tax credit for donations of fresh fruits and vegetables to a qualified nonprofit entity and required DSS to establish and administer a State Emergency Food Assistance Program. This proposal is also included in a bill, AB 1577 (Eggman), currently on the Assembly Appropriations Committee suspense calendar, and is similar AB 515 (Eggman), which was vetoed last year with a host of other tax credit bills. The Governor's veto message stated that tax credits needed to be considered comprehensively as part of the budget process.

Advocates argue that extending the credit would increase access to healthy foods for low-income Californians.

Staff Recommendation. This subcommittee heard and discussed this item during its May 12, 2016 hearing. Approve as requested.

Issue 4: State Emergency Food Assistance Program (SEFAP)

Budget Proposal. The California Association of Food Banks requests a $10 million General Fund appropriation for the SEFAP. Currently, there is no on-going General Fund dedicated for this use. The $10 million SEFAP request would be distributed to all counties based on the established formula for the distribution of Emergency Food Assistance Program, currently funded with federal dollars.

Background. The SEFAP funds provide additional flexibility to food banks, as they can purchase the items that they need to complement the types of foods that are currently available to them.

Staff Recommendation. This subcommittee heard and discussed this item during its March 10, 2016 hearing. Approve a $2 million on-going appropriation for the SEFAP.

5180 DEPARTMENT OF SOCIAL SERVICES – IMMIGRATIONS BRANCH

Issue 5: Immigration Services Funding Augmentation

Budget Proposal. The One California coalition, joined by the Latino Legislative Caucus and the Asian Pacific Islander Legislative Caucus, request an increase of $25 million to the Immigration Services Program for a total of $40 million in FY 2016-17. They state that the current level of investment does not reflect the need for services in the state or the demonstrated capacity to meet those needs.

Background. The Immigration Services Program was established in the 2015-16 budget to provide services for California's immigrant communities that may be eligible for deferred action protection programs or citizenship. Advocates claim that under the current $15 million investment, less than 1 percent of the immigrant community that is eligible to apply for naturalized citizenship is being reached. They also point out that despite the emphasis on DACA, the funding will only reach 2.8 percent of the total eligible population in the state.

Staff Recommendation. This subcommittee heard and discussed this item during its April 28, 2016 hearing. Approve a $10 million augmentation to the Immigration Services Program.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 6: Continuum of Care Reform (Issue 407-MR)

May Revision. The Administration requests an additional $59.9 million General Fund in 2016-17 to fund the implementation of the Continuum of Care Reform (CCR) enacted by AB 403 (Stone), Chapter 773, Statutes of 2015, and to implement revisions to the state's current rate-setting system, services and programs serving children and families in the continuum of Aid to Families with Dependent Children - Foster Care (AFDC-FC) eligible placement settings.

Background. Last year, the Legislature passed AB 403 (Stone), Chapter 773, Statutes of 2015 to implement the Continuum of Care Reform (CCR), which seeks to improve the assessment of child and families, emphasize home-based family care, support placement with available services, and increase transparency for child outcomes. The Governor's budget included approximately $61 million General Fund to implement the various components of the CCR.

Advocate Concerns. Advocates have expressed strong concern with the proposed rate structure, given that there has not been sufficient time to review the new rates and assess their impact on the CCR effort. They also feel there is not enough information on details surrounding the levels of care and the assessment tool, which will be instrumental in how children are placed into homes and how the rate structure works within the larger goals of CCR.

Staff Comment and Recommendation. This subcommittee heard and discussed this item during its May 17, 2016 hearing. Staff remains concerned that there has not been sufficient time to review the new rates, and that there is a lack of information concerning the levels of care and assessment tool. Staff recommends approval of the May Revision proposal, but with the addition of supplemental reporting language that at minimum, requires the department to meet with stakeholders to discuss their concerns around the rates, and that, as a starting point for this continued dialogue, a meeting take place with legislative staff, the department, and advocates in July of 2016 to further assess the proposed rate structure intended to inform future rate discussions. Additionally, staff requests that the department schedule monthly briefings to update legislative staff on the progress of CCR implementation and the rate structure to begin after the passage of the 2016 budget and ongoing through the 2016-17 fiscal year. Staff recommends that the Committee request for the LAO to provide an initial draft of supplemental reporting language to staff that is consistent with the description above and any additional details recommended by the LAO.

Issue 7: Trailer Bill Language: Child Near Fatalities and Fatality Reporting and Disclosure

May Revision. The Administration proposes trailer bill language to comply with federal requirements to establish requirements regarding the disclosure of findings and information in child near fatality incidents resulting from abuse and neglect. The proposed language requires the county welfare services agency to provide a written description of findings related to the child near fatality, including a summary of reports received and actions taken by the county welfare services agency, upon request within 30 days of either the request or the disposition of the investigation. The trailer bill language also allows counties the option to establish their own policy to release actual, redacted documents in place of the summary. The language also makes some changes to current statute on fatality reporting and disclosure, including extending the amount of time the county welfare services agency has to respond to a request from 10 days to 30 days.

Background. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states receiving funds under CAPTA must disclose to the public findings and information about child abuse and neglect cases that result in fatalities or near fatalities. On December 8, 2015, the federal Administration for Children, Youth, and Families (ACYF) notified DSS of non-compliance with federal guidelines regarding public disclosure procedures in cases where a child dies or nearly dies as the result of abuse or neglect. If the state is unable to comply with federal reporting requirements, California could lose up to a total of $4.8 million in CAPTA funds. A number of approaches would satisfy the federal requirement, including the current Administration proposal, which the Administration has vetted with the federal AYCF.

Advocate Concerns. The California Newspaper Publishers Association and some children's advocates have raised concerns with the writing a summary of certain events in the case, and prefer to be able to have the original documents with redacting. They have also expressed concerns with the proposed changes to the amount of time for responding to a request, among other provisions.

Staff Comment and Recommendation. This subcommittee heard and discussed this item during its May 17, 2016 hearing. Staff recommends rejecting the Administration's proposal and instead conforming to federal law by approving placeholder trailer bill language that uses existing law with respect to fatalities as a starting point to craft language that will comply with the federal requirements on near fatality disclosures and makes federally required changes to fatality disclosures.

Issue 8: Meeting the Requirements of Commercially Sexually Exploited Children (CSEC) Mandates

Budget Proposal. CWDA requests a total of $19.7 million GF increase for the CSEC program to aid child welfare agencies in meeting their mandate to serve children who are commercially sexually exploited. Specifically, CWDA requests $16.2 million GF to bring Tier I counties up to Tier II level funding, and to fully fund all Tier II counties. CWDA also requests $3.5 million GF for on-going training of child welfare staff to help CSEC youth.

Background. In 2014, SB 855 clarified that children who are commercially sexually exploited must be served as dependents under the child welfare system. Shortly after SB 855 was signed into law, federal mandates created additional imperative for child welfare agencies to serve this population. In 2015-16, $10.75 million GF was made available for counties. Eighteen counties received Tier I funding to support local protocol development and twenty-two counties with established protocols received Tier II funding to implement those protocols.

Staff Comment and Recommendation. This subcommittee heard and discussed this item during its April 21, 2016 hearing. Approve proposal as requested.

Issue 9: Public Health Nursing and Monitoring of Psychotropic Medication

Budget Proposal. The National Center for Youth Law and various other organizations request $1.65 million GF (with an assumed federal match of $4.95 million) to provide additional staffing to ensure that there is appropriate medication case management within the Health Care Program for Children in Foster Care (HCPCFC) and to meet the requirements of recently passed legislation. This funding would enable the hiring of additional Public Health Nurses (PHNs) to review and monitor psychotropic medication and treatment, assist in scheduling and monitoring appointments, and support court review of treatments.

Staff Comment and Recommendation. This subcommittee heard and discussed this item during its April 21, 2016 hearing. Approve proposal as requested.

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

Issue 10: Trailer Bill Language: IHSS MOE

Governor's Budget. The Administration proposes to clarify in existing law that counties are responsible for paying the entire nonfederal share of any IHSS cost increase exceeding the maximum amount of the state's participation, and that the counties' share of these expenditures are included in the county IHSS MOE.

Background. Beginning July 1, 2012, all counties in California were required to have a county IHSS MOE, which would be in-lieu of paying the nonfederal share of IHSS costs. Statute specified that the county's IHSS MOE would be based on expenditures from FY 2011-12 and would be adjusted by an inflation factor of 3.5 percent annually, beginning July 1, 2014. In addition, the county IHSS MOE would be adjusted for the annualized costs of increases in provider wages and/or health benefits that were locally negotiated, mediated, or imposed prior to the Statewide Authority assumption of its responsibilities. If the department approved a rate or benefit increase, the state would be responsible for 65 percent of the nonfederal share of the costs while the county would be responsible for the remaining 35 percent with a limit for the state up to $12.10 per hour for wages and health benefits.

The department notes that this proposal clarifies and affirms the intent of existing law that the increased costs to the contract mode are shared by the counties, consistent with the IHSS MOE.

Advocate concerns. The California State Associate of Counties (CSAC), the County Welfare Directors Association of California (CWDA), and the California Association of Public Authorities (CAPA) have concerns with the current way the TBL is drafted. They are not opposed to TBL that would clarify that the county IHSS MOE's should be increased for the county's share of contract provider wage or health benefit increases resulting from local negotiations, but feel that the proposed language is too broad.

Staff Recommendation. This subcommittee heard and discussed this item during its April 28, 2016 and May 17, 2016 hearings. The department and CWDA indicate that they are still working together to address concerns. Approve placeholder trailer bill language provided by CWDA with the understanding that it will only move forward if consensus is reached.

Issue 11: IHSS Overtime Restriction Exemptions (Issues 417-MR and 418-MR)

May Revision. The Administration requests an increase of $22,277,000 General Fund and reimbursements to be increased by $25,122,000 to reflect costs associated with exempting providers who meet specified criteria from IHSS overtime restrictions contained in SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014.

Background. Exemptions will be available for live-in family care providers who, as of January 31, 2016, reside in the home of two or more disabled minor or adult children or grandchildren for whom they provide services. A second type of exemption will be considered for recipients with extraordinary circumstances and granted on a case-by-case basis. Under either exemption, the maximum number of hours for a provider may work cannot exceed 360 hours per month.

Staff Comment and Recommendation. This subcommittee heard and discussed this item during its May 17, 2016 hearing. Approve as requested.

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

Issue 1: Spring Finance Letter: CWS-NS

Governor's Budget. The Administration requests an augmentation of $32.1 million in combined state and federal funding for DSS local assistance costs, as well as $28.66 million in expenditure authority for OSI to develop and implement CWS-NS. This funding will be available until project completion and reviewed on an annual basis. Budget bill language is also being requested which will allow for increased project funding beyond the appropriation authority, funds to be transferred to state operations for project-related activities, and provides various reporting requirements.

Background. In November 2015, the state changed its typical procurement approach from a monolithic, multi-year Request for Proposal to pursue an agile development aproach for numerous smaller modules of functionality reflecting the same ultimate scope as the prior efforts.

The department notes that it requests additional resources for the CWS-NS project in light of uncertainty in the Agile development process, and the need to be flexible in administrative processes and contracting, and uncertainty in vendor competition and performance.

Staff Comment and Recommendation. This subcommittee heard and discussed this item during its April 21, 2016 and May 17, 2016 hearings. Approve augmentation of $32.1 million in combined state and federal funding for DSS local assistance costs and $28.66 million in expenditure authority for OSI to develop and implement CWS-NS. Approve budget bill language LAO drafted at Staff's request that clarifies that the flexibility should not increase total project costs, and that the Legislature have adequate notification before funds are increased, and staff will continue refining language with the department. Below is the language that the LAO has provided:

Of the funds appropriated in Schedule (1) of this item, $29,179,000 is for the support of activities related to the Child Welfare Services-New System (CWS-NS) project. Expenditure of these funds is contingent upon approval of project documents by the Department of Finance and the Department of Technology. This amount may be increased by the Department of Finance, up to a maximum of $5,000,000 during the 2016-17 fiscal year, upon approval of revised project documents. Such an increase shall only be used to support an acceleration of planned project activities, and shall not be used to increase total project costs. Any such increase shall be authorized no less than 30 calendar days following written notification to the Chairperson of the Joint Legislative Budget Committee, or a lesser period if requested by the department and approved by the Chairperson of the Joint Legislative Budget Committee or his or her designee.

Issue 2: Trailer Bill Language: Child Welfare Services Automation

Budget Issue. CWDA proposes trailer bill language that would codify the new Agile approach to CWS automation by (1) requiring DSS, OSI and CWDA to jointly seek resources to enable the necessary level of engagement by counties in the Agile development and maintenance process; (2) require that counties have a voting seat on all governance bodies; (3) require that existing CWS/CMS operations functionality be maintained and not decommissioned until the full statewide implementation of the CWS-NS in all counties; and (4) requires the continuation of existing monthly updates to the Legislature and stakeholders on efforts to develop and implement CWS-NS and regularly scheduled quarterly forums offered to provide project updates to stakeholders and legislative staff.

Staff Comment and Recommendation. This subcommittee heard and discussed this item during its April 21, 2016 hearing. Approve trailer bill language as placeholder.

4170 DEPARTMENT OF AGING

Issue 1: Senior Nutrition Program

Budget Proposal. The California Commission on Aging, the California Association of Area Agencies on Aging, and the Congress of California Seniors request $5.4 million General Fund to augment existing senior nutrition programs. Area Agencies on Aging operate these programs, including Congregate Mealsites and Home-delivered Meals (known as Meals on Wheels).

Staff Comment and Recommendation. This subcommittee heard and discussed this item during its April 28, 2016 hearing. Approve $2 million General Fund to augment existing senior nutrition programs.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Special Session Legislation Related to e-Cigarettes and Tobacco

Issue. Various pieces of legislation regarding e-cigarettes and tobacco, including SB 5 X2 (Leno), Chapter 7, Statutes of 2016, SB 7 X2 (Hernandez), Chapter 8, Statutes of 2016, and AB 7 X2 (Stone), Chapter 4, Statutes of 2016 were past as part of the recent special session and result in increased workload for the department. The May Revision does not include resources to implement the legislation. As discussed at the May 18th hearing, Subcommittee staff requested technical assistance from the department on the resources needed to implement this legislation.

Subcommittee Staff Comment and Recommendation. It is recommended to augment the department's budget by $1 million General Fund in 2016-17 and $1.95 million General Fund in 2017-18 and ongoing for enforcement activities and $1.36 million in Proposition 99 funds in 2016-17 for outreach and media campaigns. These funds would support:

- **For Enforcement Activities: 10 permanent positions (phased-in beginning in 2016-17) for inspections conducted by the Food and Drug Branch (FDB):**
    - FDB conducts inspections working with undercover decoys and investigators who travel statewide conducting undercover buys to ensure compliance with the federal STAKE Act. The undercover inspections involve purchasing the evidence (i.e. combustible or e-cigarettes), recording the evidence (video surveillance), and documenting the transaction. FDB will enforce both electronic cigarettes and the increase in the legal smoking age during 2016/17, utilizing a phased-in approach. Positions required and start dates are as follows:
        - Supervising Investigator 1.0 – September 1, 2016
        - AGPA 2.0 – October 1, 2016
        - Investigator 2.0 – October 1, 2016
        - Investigator 4.0 – February 1, 2017
        - Attorney 1.0 – May 1, 2017
    - Contract dollars will be used to fund decoys that work with investigators to conduct statewide undercover buys to ensure compliance with the federal STAKE Act.

- **For Outreach/Media/Education:** $1.36 million in Proposition 99 funding will be used to develop and conduct an education and outreach campaign focused on the Tobacco 21 law.
    - The Education and Outreach Effort will consist of the following:
        - Retailer Letters to 37,000 licensed tobacco retailers and about 1,200 vape shops. Mailing will include signs, window cling, fact sheet, FAQ, Tip Sheets on valid ID for CA and active duty military and products covered by the expanded tobacco products definition.
        - Paid point-of-sale educational signs at gas stations and convenience stores to raise awareness that the minimum age of tobacco sales is 21.
        - Ads in Retailer Trade Publications.
        - Updated federal STAKE Act mandated age-of-sale warning signs, which will include the military exemption language.

- Window Clings, "We check IDs".

- The Education and Outreach Effort will begin in June 2016 with mailing and signage using existing Prop 99 funds. The paid point-of-sale media campaign will run July-August 2016 and January-March 2017.
- The costs of these efforts in 2017-18 and beyond will be reviewed as part of the Proposition 99 evaluation during the 2017-18 budget development cycle.

Issue 2: School-Based Health Centers Request

Issue. As discussed at the May 5th Subcommittee hearing, Assembly Member Ridley-Thomas requests to fund two limited-term positions (24 months) to provide technical assistance to assist in the development and expansion of school-based health centers.

Subcommittee Staff Comment and Recommendation. It is recommended to augment the department's budget by $600,000 from the Tobacco Settlement Account to support two two-year limited term resources as described above.

0877 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY
4265 DEPARTMENT OF PUBLIC HEALTH
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Jail Construction Funding

Issue. The Governor's budget includes $250 million General Fund for jail construction funding. This proposal was rejected in Subcommittee No. 5 on May 18th and instead, Subcommittee No. 5 took action to approve the following General Fund augmentations and necessary budget bill and trailer bill language for investments designed to reduce people's involvement in the criminal justice system. The following General Fund augmentations relate to health and human services programs:

a. $80 million to build capacity for the continuum of children's mental health crisis services.
b. $10 million for sexually transmitted disease prevention
c. $10 million for teen pregnancy prevention (focusing on Foster Care teens)
d. $6 million for the Adolescent Family Life Program
e. $2 million for prevention and treatment efforts related to hepatitis B and hepatitis C

Subcommittee Staff Recommendation. It is recommended to conform to Subcommittee No. 5's action.

Senate Budget and Fiscal Review—Mark Leno, Chair

SUBCOMMITTEE NO. 3 Agenda

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

May 19, 2016
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

Consultants: Theresa Pena and Michelle Baass

OUTCOMES

Item	Department	Action
5180	**Department of Social Services – CalWORKs**	
Issue 1	TBL: ARC Program Parity	Approve (3-0)
Issue 2	TBL: Subsidized Employment	Approve (2-1)
Issue 3	California Farm to Food Bank Tax Credit Proposal	Approve (3-0)
Issue 4	State Emergency Food Assistance Program proposal	Approve (3-0)
5180	**Department of Social Services – Immigrations Branch**	
Issue 5	Immigration Services Funding	Approve (2-1)
5180	**Department of Social Services – Child Welfare Services**	
Issue 6	TBL: Child Near Fatalities Reporting and Disclosure	Approve (3-0)
Issue 7	Continuum of Care Reform (Issue 407-MR)	Approve (3-0)
Issue 8	Meeting the Requirements of Commercially Sexually Exploited Children Mandates	Approve (3-0)
Issue 9	Public Health Nursing and Monitoring of Psychotropic Medication	Approve (3-0)
5180	**Department of Social Services – In-Home Supportive Services (IHSS)**	
Issue 10	TBL: IHSS MOE	Approve (3-0)
Issue 11	IHSS Overtime Restriction Exemptions (Issues 417-MR and 418-MR)	Approve (2-1)
0530	**Health and Human Services Agency/Office of Systems Integration**	
5180	**Department of Social Services**	
Issue 1	BCP: Case Management, Information and Payrolling System (CMPIS II)	Approve (3-0)
Issue 2	SFL: CWS-NS	Approve (3-0)
Issue 3	TBL: Child Welfare Services Automation	Approve (2-1)

4170	**Department of Aging**	
Issue 1	Senior Nutrition Programs	Approve (3-0)
4265	**Department of Public Health**	
Issue 1	Special Session Legislation Related to e-Cigarettes and Tobacco	Approve (3-0)
Issue 2	School-Based Health Centers Requirements	Approve (3-0)
0877	**California Health Facility Financing Authority**	
4265	**Department of Public Health**	
4560	**Mental Health Services Oversight and Accountability Commission**	
Issue 1	Jail Construction Funding	Approve (2-0)

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California Legislature

SENATE COMMITTEE ON HUMAN SERVICES

MIKE McGUIRE
CHAIR

Senate Human Services Committee &
Senate Budget and Fiscal Review, Subcommittee #3 on Health and Human Services

State Capitol, Room 3191
Sacramento, California
September 26, 2016, 1:00 p.m.

AGENDA

A Failure of Oversight: Misuse of Psychotropic Medications on California's Foster Children

I. Welcome

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

II. Report: California's Foster Care System, the State and Counties Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care

- Elaine M. Howle, California State Auditor

III. Oversight Mechanisms for Use Psychotropic Medication in Foster Care

- Will Lightbourne, Director, Department of Social Services
- Jennifer Kent, Director, Department of Health Care Services
- Frank Mecca, Executive Director, County Welfare Directors Association
- Barry Zimmerman, Director, Ventura County Human Services Agency
- Mary Adèr, Deputy Director, County Behavioral Health Directors Association of California
- Dr. William Arroyo, Medical Director, Children's System of Care, Los Angeles County Department of Mental Health

IV. Statewide Perspective

- Bill Grimm, Senior Attorney, National Center for Youth Law
- Carroll Schroeder, Executive Director, California Alliance of Children and Family Services
- Tisha Ortiz, former foster youth
- Mariah, former foster youth
- Dr. Lynn Thull, Mental Health Policy and Practice Improvement Consultant, California Alliance of Child and Family Services

V. State response

- Jennifer Kent, Department of Health Care Services
- Will Lightbourne, Department of Social Services

A Failure of Oversight: Misuse of Psychotropic Medications on California's Foster Children

A Joint Oversight Hearing of the Senate Human Services Committee and Senate Budget Subcommittee #3 on Health and Human Services

Senator Mike McGuire, Chair, Senate Human Services Committee
Senator Holly Mitchell, Chair, Senate Budget Subcommittee #3

September 26, 2016
1:00 p.m. - 4:00 p.m.
Room 3191

Ten years ago, the Legislature identified a growing concern within California's foster care system: increasingly, children in foster care were being prescribed psychotropic medications. Today, those concerns remain, although the numbers have grown significantly, from 1 percent of all foster youth in 2000 to 12 percent today. In August 2014, the San Jose Mercury News published a series of stories, "Drugging Our Kids," which found that youth in foster care were being prescribed psychotropic medications at heightened rates and in unsafe dosages as a means of controlling behavior. It cited data showing that one-quarter of all adolescents in California's foster care system were prescribed at least one psychotropic medication – more than three times the national rate for teens. The series led to Legislative hearings, bills and a request to the state Auditor to evaluate the state's tracking and oversight of psychotropic medication.

This hearing, which follows two Senate hearings in 2015 on psychotropic medication of foster children, is intended to look at the findings of the Bureau of State Audits, which recently released a report criticizing both the state and counties for allowing fragmented oversight to imperil foster children.

The auditor found that about 1 in 8 foster youth in California is prescribed psychotropic medication, or nearly 9,500 of the 79,000 foster youth in the study. In reviews of 80 individual case files in four counties, the auditor found nearly one-third of children prescribed psychotropic medications did not receive recommended follow-up visits and a significant number did not appear to have received appropriate mental health services. Nearly a quarter of the children whose files were reviewed were authorized to take medication in dosages that exceeded the state's recommended maximum and one in three did not have evidence of required court authorization for the medications, among other findings.

Additionally, the auditor criticized the state's fragmented oversight system for creating larger oversight deficiencies "leaving us unable to identify a comprehensive plan that coordinates the various mechanisms currently in place to ensure that the foster children's health care providers prescribe these medications appropriately." The report identified the California Department of Social Services (CDSS) as the state agency that should be providing oversight and faulted the Administration for exerting little system-effort to ensure that systems collaborate to ensure appropriate care for children. It found that combined data from CDSS and the Department of Health Care Services (DHCS) contains inaccurate and incomplete information and that neither department can identify which foster children are prescribed medication and in what dosages.

The auditor acknowledges that various recent efforts are in early stages of implementation to improve oversight of the use of psychotropic medications on foster youth, however, the report still finds significant gaps in oversight. Substantial criticism was levied at the counties' poor administration of the Health and Education Passports, which are supposed to be handed to each foster parent when the child is placed, and, if updated, should include information about current prescriptions. As the foster parent or group home staff are frequently the adults interacting with the doctor on the child's behalf, the lack of such information could lead to poor decision-making. The auditor identifies a lack of communication among departments– and specifically between county social services and mental health departments– as a significant gap in the system.

Background

Child welfare

Approximately 55,000 children and youth in California were in foster care as of April 1, 2016, or roughly 1 in 7 foster children nationwide.[1] About 85 percent of children in care were removed from their families due to neglect, 8 percent due to physical abuse, and 2 percent due to sexual abuse. The median length of time California children spent in foster care was about 15 months, as of 2012.

As of January 2015, 48 percent of youth placed in group homes in California through the child welfare services system had been there more than two years, and 23 percent had been there more than five years. The child welfare system is overseen by CDSS.

Mental health

Medi-Cal Mental Health. Three systems provide mental health services to Medi-Cal beneficiaries, and are overseen by DHCS:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal "specialty" mental health services under a waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, and psychologists, as well as psychiatric inpatient hospital services. County

[1] http://cssr.berkeley.edu/cwscmsreports/dashboard/

mental health plans are the responsible entity for ensuring specialty mental health services are provided. Medi-Cal enrollees must obtain their specialty mental health services through the county.

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. Generally, EPDST requires services be provided to correct or ameliorate physical and mental illnesses and conditions discovered through screening.

2. **Managed Care Plans (MCPs) -** Effective January 1, 2014, SB1 X1 (Hernandez), Chapter 4, Statutes of 2013-14 of the First Extraordinary Session expanded the scope of Medi-Cal mental health benefits and required these services to be provided by the Medi-Cal Managed Care Plans excluding those benefits provided by county mental health plans under the state's specialty mental health waiver. Generally these are mental health services for those with mild to moderate levels of impairment. Mental health services provided by the MCPs include:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

3. **Fee-For-Service Provider System (FFS system) -** The mental health services listed below are also available through the Fee-For-Service/Medi-Cal provider system:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

In 2014, mild to moderate mental health benefits were added to coverage requirements for managed care plans and fee for service providers. The law made no change to specialty mental health services provided by county mental health plans. For children, the addition of these benefits to managed care provided an alternative channel to access "basic" mental health services, which they already were entitled to receive. (These benefits were not provided to adults prior to 2014.) Consequently, if a child meets the medical necessity criteria for any specialty mental health services, they are entitled to these services through the county mental health plan, regardless of impairment level (mild, moderate, or severe).

According to data provided by DHCS, in 2014-15, 42,260 foster children – or 47.8 percent of children in foster care – were receiving specialty mental health or psychosocial services. Of these, 44.2 percent of foster children, or 39,109 children were receiving specialty mental health services through county mental health plans. (See Attachment A)

Approximately 34 percent of foster children are enrolled in Medi-Cal managed care for their health care coverage. Most of the remaining foster children receive health services through the Medi-Cal fee-for-service system.

Mental Health Services Act. The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. These tax receipts are used 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. 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.

According to a 2016 report by the National Alliance on Mental Illness of California, various counties use MHSA funds to provide mental health services to children in foster care.

Prior hearings

In August 2015, the Senate Human Services and Senate Health committees held a joint oversight hearing entitled, "Psychotropic Medication and Mental Health Services for Foster Youth: Seeking Solutions for a Broken System." The hearing focused on system-wide standards and oversight tools used by state and local agencies in evaluating the effectiveness of county mental health plans, county child welfare agencies, contracted providers, and individual prescribers in providing access to a broad spectrum of timely, effective, trauma-informed psychosocial services that minimize the need for psychotropic medication.

In February 2015, the Senate Human Services Committee and the Select Committee on Mental Health held an informational hearing entitled, "Misuse of Psychotropic Medication in Foster Care: Improving Child Welfare Oversight and Outcomes within the Continuum of Care" that highlighted concerns about a statewide trend toward increased prescribing of psychotropic medications. The hearing included testimony indicating that California's child welfare and children's mental health systems are over-reliant on psychotropic medication among foster youth and do not effectively manage the provision of such medication leading to unnecessary prescribing, inappropriately high dosages of medication for children, and inappropriate use of multiple medications, and usage occurring at longer durations than appropriate. In response to these concerns, the hearing focused on oversight of individual cases, including court authorization procedures which informed the development of several bills.

Additionally, both hearings highlighted concerns that breakdowns in the provision of effective trauma-informed psychosocial services has led to system-wide failures in treating children and youth who later suffer from trauma-related behavioral health challenges, for which medication is seen as the only available treatment option.

Recent reforms

A series of bills and other reforms followed last year's Legislative hearings and related media reports about the overuse of psychotropic medications on foster youth.

SB 238 (Mitchell, Chapter 534, Statutes of 2015) requires data sharing agreements between DHCS and the CDSS as well as between the state and county placing agencies to provide information about children and foster youth taking psychotropic medication. It requires CDSS, in consultation with DHCS and stakeholders, to develop and distribute a monthly report to each county placing agency, which must include information on what psychotropic medication have been authorized for a child and pharmacy data based on paid claims and managed care encounters, including the name of the psychotropic medication, quantity, and dose prescribed for the child. Additionally, the monthly reports must include information about psychosocial interventions and incidents of polypharmacy.

Additionally, SB 238 required a system to flag social workers about situations that may warrant additional follow-up. The indicators may include, but need not be limited to, an indicator that identifies each child under five years of age for whom one or more psychotropic medications is prescribed and an indicator that identifies each child of any age for whom three or more psychotropic medications are prescribed.

SB 238 requires robust data sharing agreements between DHCS and CDSS and county placing agencies in a three-way arrangement known as the Global Interagency Agreement (GIA). Under the GIA, DHCS will provide DSS with both medical and pharmacy claims level detail, with which DSS will match with their foster care specific data. This combined, matched data will then be provided to each county's foster care placing agency. As of September 2016, 22 of the 59 counties had data sharing agreements, and two others had separate data use agreements:

Alameda	**Butte**	**Contra Costa**	**El Dorado**	**Humboldt**	**Kern**	**Lake**
Madera	**Mendocino**	**Modoc**	**Placer**	**Sacramento**	**San Diego**	**San Francisco**
San Luis Obispo	**San Mateo**	**Santa Clara**	**Santa Cruz**	**Sonoma**	**Ventura**	**Yolo**
Yuba						

*Los Angeles and Riverside counties have separate data use agreements

SB 484 (Beall, Chapter 540, Statutes of 2015) mandates additional review and increased standards of psychotropic medication usage in group homes, and creates new

data collection and notification requirements for the Community Care Licensing Division (CCLD) within CDSS in order to identify and mitigate inappropriate levels of psychotropic medication use by children in foster care residing in group homes.

SB 319 (Beall, Chapter 535, Statutes of 2015) authorizes a foster care public health nurse to monitor and oversee the child's use of psychotropic medications, and authorizes the release of health information, as specified. It also requires a foster care public health nurse to assist a nonminor dependent to make informed decisions about health care.

2016 Budget includes $1.65 million General Fund (with an assumed federal match of $4.95 million) to fund the hiring of additional public health nurses to improve the monitoring of psychotropic drug use in foster care. The 2016 Budget also includes the addition of one full-time permanent research position at DHCS and $134,000 ($67,000 General Fund) in 2016-17 and $125,000 ($63,000 GF) ongoing, to implement the requirements of SB 238; and for CDSS includes $149,000 ($100,000 General Fund) in contract funding to develop monthly, county-specific reports for children in foster care who are prescribed psychotropic medications through Medi-Cal, and two-year limited-term funding of $833,000 ($684,000 General Fund) to support approximately five positions (three licensing program analysts (LPA), 0.5 licensing program manager I, 0.5 office assistant, and one associate governmental program analyst), both to implement the requirements of SB 238 and SB 484.

Additionally, the following bills are currently enrolled, and awaiting the Governor's signature to be enacted:

SB 253 (Monning, 2016) requires that an order for administration of a psychotropic medication to a foster child be granted only upon a court's finding that it is in the best interest of the child. Mandates that a court determine lab screenings and other requirements have been met and imposes other court oversight mechanisms. Requires a pre-authorization review under certain circumstances

SB 1291 (Beall, 2016) requires annual mental health plan reviews to be conducted by an external quality review organization (EQRO) and, commencing July 1, 2018, and would require those reviews to include specific data for Medi-Cal eligible minor and nonminor dependents in foster care, including the number of Medi-Cal eligible minor and nonminor dependents in foster care served each year. The bill would require the DHCS to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics, as specified. It requires any corrective action plan to be posted on the county's website.

SB 1466 (Mitchell, 2016) requires**,** consistent with federal law, that screening services under the EPSDT program include screening for trauma, as specified. It requires DHCS, in consultation with CDSS and others, to adopt, employ, and develop, as appropriate, tools and protocols for screening children for trauma.

SB 1174 (McGuire, 2016) requires DHCS and CDSS under a specified data-sharing agreement, to provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for specified children and minors placed in foster care using data provided by the two state agencies.

AB 741 (Williams, 2016) expands the definition of a short-term residential treatment center to include a children's crisis residential center to be used as a diversion from psychiatric hospitalization, and limits the stay to 10 consecutive days and no more than 20 total days within a six-month period.

Continuum of Care Reform (CCR) effort

In 2012, CDSS convened a working group to recommend changes to the current rate-setting system, services, and programs serving children and families in the continuum of foster care settings. The three- year effort came in response to statutory requirements in budget trailer bill *(SB 1013, Senate Budget Committee, Chapter 25, Statutes of 2012)*, which mandated the workgroup consider, at a minimum, reforms to programs provided by Foster Family Agencies and group homes, and how to ensure the provision of services in family-like settings, including after care services, when appropriate. In January 2015, the CDSS published the "California's Child Welfare Continuum of Care Reform" report. It outlined an interdependent approach to improving California's child welfare system by improving assessments of children and families, and centering support services for children in home-based family care settings rather than in group care.

Two subsequent CDSS-sponsored bills, *AB 403 (Stone, Chapter 773, Statutes of 2015*) and *AB 1997 (Stone, 2016*), which is awaiting the Governor's signature, enacted the reforms. These bills focus delivery of appropriate treatment and services on the child regardless of living arrangement, rather than using the placement setting to drive decisions about services which historically has caused a child to "fail upwards" into higher levels of care. Overall, CCR emphasized the creation of supports for resource families to decrease group care. Short term treatment facilities are required to have mental health approval and oversight from the county mental health plan. CCR has required increased coordination between child welfare and mental health services.

State Guidelines for Use of Psychotropic Medication

In April 2015, CDSS and DHCS jointly released "Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care," which outlines parameters for safe prescribing, identifies situations which should flag further review and underscores the concept that psychotropic medications should be used in conjunction with other strategies to help a foster child. The guidelines were an outcome of the state's Quality Improvement Project, convened jointly by DHCS and CDSS in October 2012 to identify effective strategies to oversee and monitor the use of psychotropic medications of children and youth in the foster care system.

EPSDT Performance Outcome System (POS)

SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012 and AB 82 (Committee on Budget), Chapter 34, Statutes of 2013 required DHCS to establish a Performance Outcome System to better understand the statewide outcomes of specialty mental health services provided, and to ensure compliance with federal EPSDT requirements. The EPSDT Performance Outcomes System is intended to establish outcome measurements for clients receiving specialty mental health services. It also required the development of measures for screening and referring Medi-Cal beneficiaries to mental health services. DHCS released the first EPSDT POS reports in February 2015.

In August 2016, DHCS released four population-based reports (large, medium, small and rural county) and the first ever county specific POS reports. Among the key findings of these population-based reports is that for all four-population categories, the number of children being served through the specialty mental health system (county mental health plans) has increased from 2010-11 through 2013-14; however, the penetration rate for these services has declined.

Additionally, earlier this month, the state released its first Foster Care EPSDT POS report, which similarly indicates that the number of Foster Care children being served through the specialty mental health system (county mental health plans) has increased from 2011-12 through 2013-14 from 38,961 to 41,005; however, the penetration rates for these services has declined by nearly 2 percent.

This report also shows that in 2014-15, 25.3 percent of the Foster Care children receiving specialty mental health services were age 0-5, 31.1 percent were age 6-11, 35.7 percent were age 12-17, and 7.9 percent were age 18-20. In contrast, for all children, in 2014-15, 12.4 percent of children receiving specialty mental health services were age 0-5, 33.7 percent were age 6-11, 41.7 percent were age 12-17, and 12.2 percent were age 18-20.

Katie A. implementation

In July 2002, plaintiffs filed a class action suit alleging violations of federal Medicaid laws, the American with Disabilities Act, and other state and federal statutes because the state failed to provide mental health services for foster youth. Nine years later a federal district judge approved a settlement agreement that would provide intensive home- and community-based mental health services for children in foster care or at risk of removal from their families.

As part of the agreement, the state agreed to pay for therapeutic foster care and to seek federal matching dollars for that treatment. The settlement was followed by monitoring by a Special Master appointed by the judge to ensure DHCS and CDSS could come to agreement about provision of mental health services to foster youth. Other elements of the core practice model adopted by DHCS and CDSS included a promise to continue working collaboratively to provide foster children with mental health services, data

collection and mental health screening and assessment for foster youth. In 2013, the court discontinued monitoring, and the state continues to host implementation updates.

Child Welfare Services – New System (CWS-NS) Project

The Child Welfare Services – New System (CWS-NS) Project will replace the aging Child Welfare Services/Case Management System (CWS/CMS). The CWS-NS Project is intended to make the system easier to use for CWS workers, result in enhanced data reliability and availability, allow user mobility, and automate system interfaces with other state partners to enable data sharing. This represents an opportunity to better update and share information contained in a foster youth's Health and Education Passport.

The CWS-NS Project is not expected to implement fully until later in 2020. Various system releases will begin to roll out beginning in July of 2017, starting with intake components. Currently, other pending releases include licensing, case management, resource management/court processing, and eligibility/financial management.

Ongoing concerns

California's county-based child welfare system serves as the de-facto parent for approximately 55,000 children at any given time who have been removed from home based on allegations of abuse or neglect. Various studies have indicated that the type of abuse or neglect that warrants a child's removal, compounded by the child's removal from their home of origin, creates a level of trauma that merits a mental health evaluation and treatment. However, competing local priorities between child welfare, mental health and education create obstacles to effectively serving children. As the Auditor highlighted, significant gaps in record keeping at the county level mean the state is unable to identify whether many foster youth are receiving mental health treatment, what medications they are taking and whether those medications are taken at dangerous levels or for off-label purposes. Data and access problems are compounded by a severe shortage of child and adolescent psychiatrists to treat children in foster care

While recent legislation intended to close some of those gaps, the Auditor's report highlights a fragmented oversight system in which the state, as foster childrens' de-facto parent, has been ineffective. In addition, the following are key issues that should be considered when evaluating next steps to improve the provision of services and quality of life of foster children.

State's inadequate oversight of county mental health plans and absence of timely access standards for specialty mental health services

Concerns have been raised not only by stakeholders, but also by the federal Centers for Medicare and Medicaid Services (CMS), about DHCS's oversight of county mental health plans and in particular violations by county mental health plans that significantly impede a beneficiaries' access to care, such as not maintaining a 24-hour hotline with appropriate language access, not maintaining a beneficiary grievance and appeal log and

not monitoring timeliness of care. Thirteen new positions at DHCS were added in the 2016 budget to improve the state's oversight of county mental health plans and meet the terms and conditions of the specialty mental health waiver extension. Seven positions were added in the 2014 budget to address similar concerns by CMS. One of the key functions of these positions will be to improve tracking, monitoring and improvement of timeliness of care, access to care, and MHP and subcontractor grievances and appeals.

In response to concerns raised by CMS, an effort was launched to establish statewide timely access standards for specialty mental health services provided by county mental health plans. The effort has been put on hold given new federal managed care regulations, which will require county mental health plans to move toward a managed care model. Without such standards, there is no system in place to track and enforce timely access to services.

Mental health services penetration rates going down

As noted above, while the number of Foster Care children being served by county mental health plans has increased over the last few years, the penetration rate has decreased. DHCS is not able to provide information as to why the penetration rate has decreased and indicates that since these reports are still relatively new, it plans to work with stakeholders on determining a framework to assess the findings of the data. Even though these Foster Care specific-reports are new, the statewide aggregated EPSDT POS reports, first published in February 2015 show the same trend. Consequently, DHCS has had over 18 months to look at these trends and draw conclusions and make recommendations, but nothing has been done.

"Mild to Moderate" impairment level distinction has created confusion

As discussed earlier, in 2014, mild to moderate mental health benefits were added to Medi-Cal managed care and fee-for-services. For children, that distinction does not apply: All children in Medi-Cal are entitled to specialty mental health services, provided by county mental health plans, under EPSDT services regardless of impairment level, as long at the child meets medical necessity criteria.

However, the distinction on the adult side has created significant confusion about whether children should be referred to managed care or fee-for-service if a mental health assessment determines they have "mild or moderate" mental health needs. At recent CCR workgroup meetings and the Medi-Cal Managed Care Advisory Committee, DHCS has not been direct in its communication on this issue. This has intensified the confusion and creates opportunities for children to be shuffled back and forth between systems.

Successful implementation of CCR will require collaboration between child welfare and mental health

The Auditor identified a system of oversight so fragmented that neither CDSS nor DHCS can identify which children are taking psychotropic medications or in what quantity.

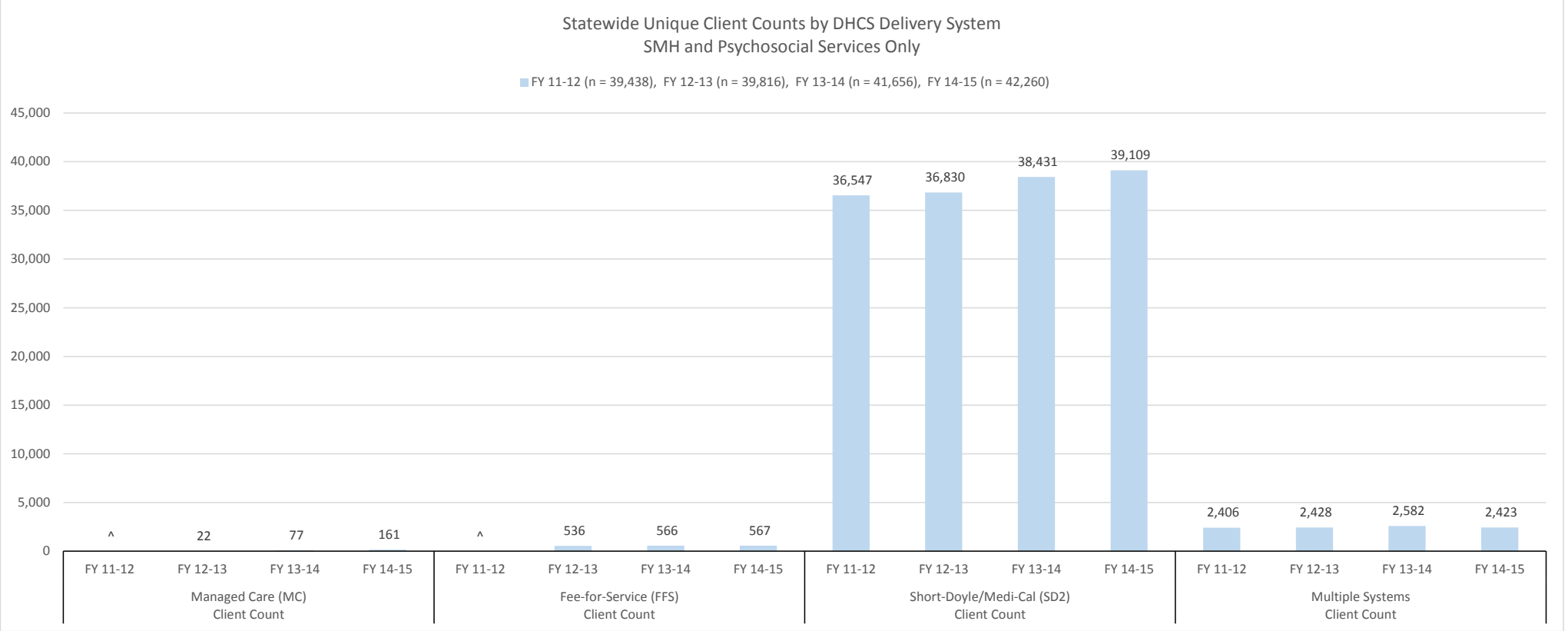
Collaboration between these state agencies is essential not only in overseeing the care of foster youth taking these medications, but in the state's CCR efforts, which are intended to roll out beginning January 1, 2017. Leadership by CDSS and cooperation from its state and county partners are essential for the successful implementation of the reform efforts. The concurrent effort to properly oversee the use of psychotropic medications on foster youth provides an opportunity to integrate both efforts. However, it also creates a challenge for CDSS to remain focused on key reforms in each effort while implementing major statewide change.

Technology

A key finding of the Auditor was that the Health and Education Passports used by count child welfare agencies to inform caregivers about a child's health is woefully inadequate. Data is missing or incorrect in a significant number of cases, including the type and dosage of psychotropic medications. Inputting information into the passport relies on a foster parent or group home provider carrying a paper copy of the document into a psychiatrist's office, having the doctor record visit information, and then having the foster parent or group home provider hand that document to the social worker for entry into the county's system. CDSS's plans for its CWS/New System project may provide an opportunity for third parties to access health, education and child welfare records in a single place, when it rolls out the case management component in several years, if the state and counties can agree how to address privacy concerns in the various systems. However, ongoing disputes over privacy issues continue to prevent most of the counties from sharing this information.

CDSS Foster Care Clients by DHCS Delivery System
Specialty Mental Health (SMH) or Psychosocial Services Only

	FY 11-12			FY 12-13			FY 13-14			FY 14-15		
	Foster Care Youth with SMH or Psychosocial Services	Certified Eligible Foster Care Youth	Percentage of Eligibles Receiving SMH or Psychosocial Services	Foster Care Youth with SMH or Psychosocial Services	Certified Eligible Foster Care Youth	Percentage of Eligibles Receiving SMH or Psychosocial Services	Foster Care Youth with SMH or Psychosocial Services	Certified Eligible Foster Care Youth	Percentage of Eligibles Receiving SMH or Psychosocial Services	Foster Care Youth with SMH or Psychosocial Services	Certified Eligible Foster Care Youth	Percentage of Eligibles Receiving SMH or Psychosocial Services
MC	^	79,145	^	22	81,109	0.0%	77	86,084	0.1%	161	88,477	0.2%
FFS	^	79,145	^	536	81,109	0.7%	566	86,084	0.7%	567	88,477	0.6%
SD2	36,547	79,145	46.2%	36,830	81,109	45.4%	38,431	86,084	44.6%	39,109	88,477	44.2%
Multiple	2,406	79,145	3.0%	2,428	81,109	3.0%	2,582	86,084	3.0%	2,423	88,477	2.7%
Total	**39,438**	**79,145**	**49.8%**	**39,816**	**81,109**	**49.1%**	**41,656**	**86,084**	**48.4%**	**42,260**	**88,477**	**47.8%**



Please note -

- Foster Care clients presented in this report are identified by having an Out-of-Home Foster Care Placement from a matched data set provided by the California Department of Social Services, Child Welfare Services/Case Management System (CWS/CMS) as of September 13, 2016.
- Mental Health Services were expanded in Managed Care through the ACA Optional Benefits Expansion effective January 1, 2014.

^Data suppressed to protect patient privacy.