Senate Budget and Fiscal Review

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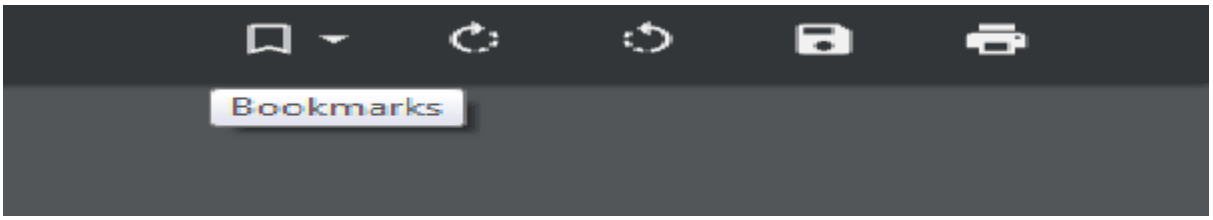

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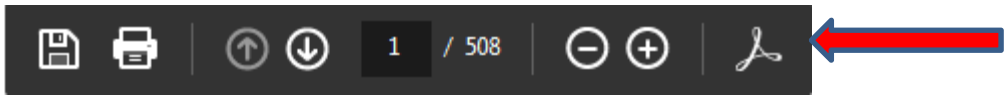

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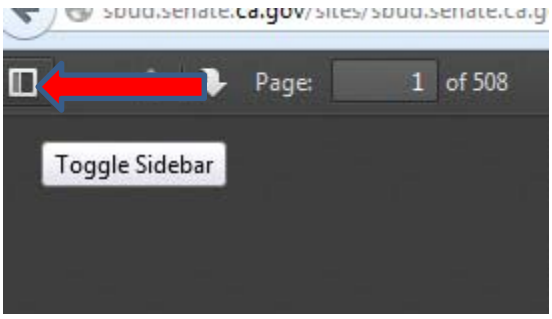

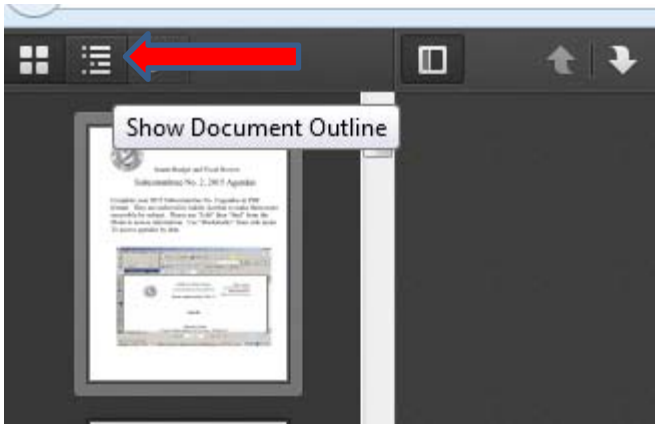

Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Melissa Hurtado
Vacancy

INFORMATIONAL HEARING
"Update: Rate Study and Reform in the Developmental Services System"
Wednesday, January 22, 2020
9 am
State Capitol - Room 4203

Consultant: Renita Polk

I. OPENING REMARKS – SENATOR RICHARD PAN, M.D., CHAIR

II. RATE STUDY HISTORY
Sonja Petek, Legislative Analyst's Office

III. OVERVIEW OF RATE STUDY METHODOLOGY
Nancy Bargmann, Director, Department of Developmental Services
Stephen Pawlowski, Burns and Associates

IV. SERVICE PROVIDERS
Michele Rogers, Ph.D., Executive Director, Early Learning Institute
Lori Anderson, President and CEO, United Cerebral Palsy of Los Angeles, Ventura, and Santa Barbara Counties
Kevin Rath, Executive Director, Manos Home Care

V. OVERVIEW OF RESPONSE TO PUBLIC COMMENTS AND NEXT STEPS
Nancy Bargmann, Director, Department of Developmental Services
Stephen Pawlowski, Burns and Associates
Jay Kapoor, Department of Finance
Brent Houser, Department of Finance

VI. PUBLIC COMMENT

VII. CONCLUDING REMARKS – SENATOR RICHARD PAN, M.D., CHAIR

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Informational Hearing

Update: Rate Study and Reform in the Developmental Services System

BACKGROUND

INTRODUCTION

In California, the Lanterman Developmental Disabilities Services Act entitles persons with a developmental disability, as defined in law, access to services and supports. California has a uniquely designed community-based system of services and supports for persons with developmental disabilities. The Department of Developmental Services (DDS) oversees delivery of a variety of services to more than 330,000 children and adults. Home and community-based services (HCBS) are primarily delivered through 21 nonprofit Regional Centers (RCs) that, in turn, contract with several thousand nonprofit and for-profit service providers (vendors). RCs coordinate the delivery of more than 150 services to support people with developmental disabilities. RCs 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.

Over the years, since its enactment, the Lanterman Act has 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). Additionally, new residential models have been developed to provide more intensive medical and behavioral supports in a home-setting.

2015-16 EXTRAORDINARY SESSION

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Ultimately, the California Legislature passed AB 1 X2 (Thurmond, Beall, Bonta, Cannella, and Maienschein), Chapter 3, Statues of 2015-16 Second Extraordinary Session. The legislation appropriated additional funding for vendor rate increases and RC operations, required RCs to provide specified information to the DDS, and focused on addressing disparities within the system. $244.9 million (General Fund) was appropriated for DDS vendor rate increases. Including federal funds, rates were increased by more than $400 million in total. The legislation targeted these

increases to a number of areas, including direct care workers, agency administrative expenses, and targeted increases for supportive and independent living services, respite, supported employment, and transportation. AB 1 X2 also required the DDS to submit a rate study to the appropriate committees of the Legislature "addressing the sustainability, quality, and transparency of community-based services…"

OVERVIEW - CURRENT RATE SYSTEM

The state's system for establishing payment rates for the services delivered by providers is complex, encompassing several different methodologies depending on the service provided. Rates are often inconsistent, with providers delivering the same service in the same area being paid different rates. Service providers, consumers, and other stakeholders have all expressed confusion and disillusionment with the current rate-setting system. Further, between 2003 and 2015, these payment rates were subject to various reductions, freezes, and other constraints, particularly during economic downturns. These changes are detailed in the table below.

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The methodology to establish rates for services is based on the type of service vendors have been approved to provide. Below is an explanation of the various rate setting methodologies and the applicable services for each methodology.

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- Rates established by Medi-Cal[1]. If a service is also provided under the Medi-Cal program, then the RC may pay no more than the rate established by Medi-Cal for the same service. This methodology primarily applies to medical service providers, such as nurses, home health aides, and therapists.

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- Rates set by regional center mileage reimbursement. Some transportation services have rates that can be set based on what the RC reimburses its own employees for travel.

- Rates set through negotiation between the regional center and the provider. If none of the other methods for establishing a service rate apply, then the service rate is determined through negotiation between the RC and the provider. Examples of services subject to negotiated rates include supported living, specialized residential facilities, and behavior analysts.

For some services, multiple methodologies may be applicable. In these instances, the rate is based on the provider's already established rate or the rate established by DDS. Otherwise, the rate is established through negotiation between the RC and provider. As is evident by the various methodologies listed above, the current rate-setting system is complex and at times confusing.

RATE STUDY

During the 2015-16 Extraordinary Session, legislation was passed that required DDS to submit a rate study addressing the sustainability, quality, and transparency of community-based services for

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individuals with developmental disabilities to the Legislature. The Legislature approved $3 million (General Fund) for the study, and DDS contracted with Burns & Associates, Inc. to conduct the study. The study was submitted to the Legislature on March 15, 2019.

W&IC Section 4519.8

On or before March 1, 2019, the Department shall submit a rate study to the appropriate fiscal and policy committees of the Legislature, addressing the sustainability, quality, and transparency of community-based services for individuals with developmental disabilities. The Department shall consult with stakeholders, through the developmental services task force process, in developing the study. The study shall include, but not be limited to, all of the following:

(a) An assessment of the effectiveness of the methods used to pay each category of community service provider. This assessment shall include consideration of the following factors for each category of service provider:

(1) Whether the current method of rate-setting for a service category provides an adequate supply of providers in that category, including, but not limited to, whether there is a sufficient supply of providers to enable consumers throughout the state to have a choice of providers, depending upon the nature of the service.

(2) A comparison of the estimated fiscal effects of alternative rate methodologies for each service provider category.

(3) How different rate methodologies can incentivize outcomes for consumers.

(b) An evaluation of the number and type of service codes for regional center services, including, but not limited to, recommendations for simplifying and making service codes more reflective of the level and types of services provided.

Development of Rate Models. The development of the rate models began with a detailed review of service requirements. With Burns & Associates assistance, DDS undertook a comprehensive review of service definitions. This process also included a review of California-specific laws – such as labor related requirements – that impact providers' costs. From this review, DDS is compiling a list of potential statutory and regulatory changes that would be needed should the rate models be implemented. The rate models are built on detailed assumptions regarding a number of factors, including the wages, benefits, and productivity of the direct care worker; the agency's program operation and administrative costs; staffing ratios and staffing levels, attendance/absence factors, travel-related expenses, facility costs, and program supplies. Providers' costs generally reflect current rates rather than market-based conditions. For this reason, other data sources are used. These sources include California-specific, cross-industry wage data from the U.S. Department of Labor's Bureau of Labor Statistics, several sources that provide estimates of health insurance costs, and the Internal Revenue Services' mileage rate. Further, various analyses were undertaken to understand regional variability in costs associated with wages, travel, and real estate.

The draft rate models developed as a result of the rate study are intended to reflect assumptions on five key cost drivers: (1) the wage for the direct care worker, (2) the benefits package for the direct care worker, (3) the 'productivity' of the direct care worker (that is, the ratio of their billable hours to their work hours), (4) program operation costs, and (5) agency administration. Other cost drivers vary by service or location and may include staffing ratios, mileage, supervision, and facility costs. Key assumptions that broadly affect the draft rate models include state minimum wage requirements, a comprehensive benefits package for direct care workers, and the rate for administrative costs.

For each service and rate variant, a 'base' rate model is established. Then, to account for differences in wage, travel, and real estate costs across California, a draft rate model is established for each RC by applying a 'multiplier' for these three cost factors, as applicable, that reflects the cost in that RC in relation to the statewide value.

Stakeholder Engagement. The DDS and Burns & Associates engaged with the department's Developmental Services task force to gather input for the study. The DDS also conducted stakeholder meetings throughout the state to further engage the community. Surveys for both service providers and consumers and their families were also administered to inform the study. The provider survey was distributed on May 15, 2018, and was conducted to gather data from providers regarding the manner in which they deliver services and their costs. 1,100 organizations out of 4,500 vendors responded to the survey. The DDS distributed the consumer and family survey on October 3, 2018, and received over 1,700 responses.

Public Comment Process. DDS began briefing sessions on the release of the rate study on February 25, 2019. Comments on the rate models were accepted up to April 5, 2019. At the time of the rate study's release, DDS and Burns & Associates expressed intent to review the provided comments and make modifications to the draft rate models as appropriate. The DDS requested parties wishing to provide comment share comments with a rates workgroup representative. The rates workgroup members were expected to aggregate comments and submit a consolidated response. Trailer bill language in the 2019-20 Budget required the DDS to post a summary of public comments and departmental responses to the rate study by October 1, 2019. That summary and the departmental responses were made available on January 10, 2020, with the release of the 2020-21 Governor's Budget. More information on those responses are detailed below.

Stakeholder Response. Upon release of the rate study on March 15, 2019, numerous stakeholders provided comment in public meetings and hearings, as well as in writing. Many acknowledged the significant amount of work that went into developing the rate models, and commended how the models established a framework for estimating costs of services, allowed for rates that vary based on staff qualifications and other differences, and recommended professionalizing the direct care workforce. Conversely, providers expressed concerns about some of the assumptions used by Burns &Associates, and that the implementation of the rate models as developed would eliminate some services categories, collapse some services into a few categories, and create a homogenization of different programs. Others wondered how the rate models would incorporate various policy initiatives (such as Employment First and Self-Determination).

Response to Public Comments. As described above, the DDS released responses to public comments along with the department's budget on January 10, 2020. In total, approximately 3,600 pages of comments were received. The released document summarized and categorized the comments, and contained detailed replies to hundreds of stakeholder comments. Commenters provided feedback on the rate study, as well as issues not within the scope of the study, such as the implementation of the rate models. A sample of shared comments submitted by multiple stakeholders include:

- Rate study does not address requirement to assess whether current rate-setting methods provide an adequate supply of providers.

- No vendor rates should be reduced, and negotiated rates should be grandfathered.

- Some commenters expressed support for standardizing service codes and definitions, while others objected to the proposed consolidations of service codes, concerned that the consolidations may limit options.

- Some commenters expressed support for standardized rates, where all vendors are paid the same rate for providing the same service in the same area. However, others objected to standardized rates, stating that they are not equitable or consumer driven.

- Commenters protested the recommendation that all services be converted to hourly billing, stating that it impairs the ability of vendors to meet individual needs.

- Rates should be tied to quality and outcomes for individuals. Commenters recommended that the DDS should track consumer satisfaction.

- Commenters expressed support for efforts made to differentiate rates by geography, but also objected to various aspects of the regional adjustment factors.

- Commenters objected to the use of Bureau of Labor Statistics data to set wage assumptions, arguing that the data was outdated, among other things.

- Commenters challenged the use of a 12 percent rate for administrative expenses, suggesting that the rate models should include a higher percentage.

Updated Rate Models. Several changes to the original rate models were made in January 2020 which fell into three different categories: technical adjustments, methodological changes, and changes in response to public comments.

In general, these changes related to specific assumptions in rate models for individual services rather than fundamental assumptions that impacted all rate models. Changes were made to many service categories including personal support and training; residential; day, employment, and transportation; and professional. Changes affecting services in multiple categories were also made. Notable changes to the rate models in response to public comments include, but are not limited to the following:

- Incorporation of more current wage, workers' compensation, and mileage rate data published after release of the draft rate models.

- Increased wage assumptions for various services, including Supported Employment, Independent Living, Community-Based Day Programs, and registered behavior technicians.

- Withdrew the methodology to align rates for certain services with Medi-Cal rates and establishing rate models for these services (most notably affecting Specialized Therapeutic Services and certain professionals in Infant Development programs).

- Withdrew the methodology establishing separate short-term and long-term encounter rates for various in-home services.

- Added overtime to rate models for Supported Living and certain residential services.

- Withdrew the methodology to require Respite vendors supporting employer of record models to become financial management services agencies.

- Reduced assumed attendance in day programs from 90 percent to 88 percent.

Fiscal Impact. In total, the estimated cost of fully implementing the study remains at $1.8 billion total funds. The estimate continues to be based on 2019-20 spending projections. The estimated cost does not account for the rate increases included in the 2019-20 budget or the increases for additional service codes proposed in the 2020-21 budget. Note that all of the rate models mentioned here are proposed, and none have been implemented. However, supplemental rate increases included in the 2019-20 budget and proposed in the 2020-21 budget were determined using input from the rate models.

THE 2019-20 BUDGET ACT

The 2019-20 Budget Act contained several provisions relating to the rate study, and more broadly, fiscal reform within the developmental services system. The budget provided for $206.7 million ($125 million General Fund) to provide rate increases of up to 8.2 percent for specified service providers, effective January 1, 2020. Details on specific increases are detailed in the table below.

Service Code	Rate Increase
017 - Crisis Team - Evaluation & Behavior Modification	8.20%
025 - Tutor Services – Group	8.20%
028 - Socialization Training Program	8.20%
048 - Client/Parent Support Behavior Intervention Training	8.20%
055 - Community Integration Training Program	8.20%
062 - Personal Assistance	8.20%
063 - Community Activities Support Services	8.20%
073 - Parent Coordinator Supported Living Prog	6.30%
091 - In-Home/Mobile Day Program	8.20%
093 - Parent-Coordinated Personal Assist Service	8.20%
094 - Creative Arts Program	8.20%
108 - Parenting Support Services	8.20%
109 - Program Support Group-Residential	8.20%
110 - Program Support Group-Day Service	8.20%
111 - Program Support Group-Other Services	8.20%
113 - DSS Licensed-Specialized Residential Facility	8.20%
420 - Voucher Respite	8.20%
465 - Participant-Directed Respite Services	8.20%
475 - Participant Directed Community-Based Training Services/ Adults	8.20%
510 - Adult Development Center	8.20%
515 - Behavior Management Program	8.20%
605 - Adaptive Skills Trainer	3.90%
612 - Behavior Analyst	8.20%
613 - Associate Behavior Analyst	8.20%
615 - Behavior Management Assistant	8.20%
616 - Behavior Technician - Paraprofessional	8.20%
635 - Independent Living Specialist	2.40%
645 - Mobility Training Services Agency	8.20%
650 - Mobility Training Service Specialist	8.20%
860 - Homemaker Services	8.20%
862 - In-Home Respite Services Agency	8.20%
864 - In-Home Respite Worker	8.20%
875 - Transportation Company	8.20%
880 - Transportation-Additional Component	8.20%
882 - Transportation-Assistant	8.20%
896 - Supported Living Services	8.20%
904 - Family Home Agency	8.20%
905 - Residential Facility Serving Adults-Owner Operated	8.20%
910 - Residential Facility Serving Children - Owner Operated	8.20%
915 - Residential Facility Serving Adults - Staff Operated	8.20%
920 - Residential Facility Serving Children-Staff Operated	8.20%
950 - Supported Employment-Group	8.20%
952 - Supported Employment-Individual	7.60%

SB 81 (Committee on Budget and Fiscal Review), Chapter 28, Statutes of 2019, required the DDS, beginning in the summer of 2019, to hold workgroups with stakeholders to discuss how to "create a sustainable, innovative, cost-effective, consumer focused, and outcomes-based delivery system." The first meeting of this workgroup occurred on January 15, 2020. The DDS will report on the progress and any outcomes of these workgroups during the 2020-21 budget process.

ISSUES FOR CONSIDERATION

While this document has examined the various challenges, concerns, and considerations associated with the rate study itself and its implementation, there is no plan to implement the study at this time. Proposals in both the 2019-20 budget and the proposed 2020-21 budget have made efforts to improve the financial situations of service providers and improve the overall system by proposing rate increases for various service codes. Additionally, the DDS has developed a stakeholder workgroup to discuss creating a sustainable and cost-effective system. Advocates express concern that no plan for implementation has been put forth in the DDS's budget proposals.

Implementation of the proposed rate models would involve significant and consequential adjustment at every level of the system. Specific considerations include:

- Enacting required policy changes. Implementing the rate models will require changes to statute and/or regulations. The DDS has not identified policy changes that would be needed in order to implement the proposed rate models.

- Update of the rate models. The proposed rate models are developed from 2016-17 data. If redone using more recent data, it is likely that recommended rates would change. If implemented, the rate models would need to be updated on a frequent basis to keep up to date with current data.

- Day-to-day operational changes. Numerous changes would be needed at the DDS, RC, service provider, and consumer levels to successfully implement the rate models. For example, the study recommends a conversion to hourly billing for most services. Most day services are currently reimbursed on a daily basis so the adoption of hourly billing would require changes to these vendors' monitoring and billing practices.

Questions for DDS.

1. *What does the DDS see as the next reasonable and realistic step in rate reform within the DDS system? Would those next steps include any of the issues for consideration listed above? If so, how would the DDS proceed on the considerations listed above?*

2. *Please provide an update on the goals and progress of the system and fiscal reform workgroup required by Senate Bill 81 (Committee on Budget and Fiscal Review), Chapter 28, Statutes of 2019.*

Questions for DDS and Burns and Associates.

3. *Were various policy initiatives, such as Employment First and Self Determination, considered in the development of the rate models?*

4. *Was the concept of value based budgeting/payments considered when developing the rate models?*

5. *Please explain how the fiscal impact of the study, after updating several rate models in January 2020, remains at $1.8 billion.*

6. *Please provide an overview of the department's responses to public comments on the rate study that were made public on January 10, 2020.*

Informational Hearing

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individuals with developmental disabilities to the Legislature. The Legislature approved $3 million (General Fund) for the study, and DDS contracted with Burns & Associates, Inc. to conduct the study. The study was submitted to the Legislature on March 15, 2019.

W&IC Section 4519.8

On or before March 1, 2019, the Department shall submit a rate study to the appropriate fiscal and policy committees of the Legislature, addressing the sustainability, quality, and transparency of community-based services for individuals with developmental disabilities. The Department shall consult with stakeholders, through the developmental services task force process, in developing the study. The study shall include, but not be limited to, all of the following:

(a) An assessment of the effectiveness of the methods used to pay each category of community service provider. This assessment shall include consideration of the following factors for each category of service provider:

(1) Whether the current method of rate-setting for a service category provides an adequate supply of providers in that category, including, but not limited to, whether there is a sufficient supply of providers to enable consumers throughout the state to have a choice of providers, depending upon the nature of the service.

(2) A comparison of the estimated fiscal effects of alternative rate methodologies for each service provider category.

(3) How different rate methodologies can incentivize outcomes for consumers.

(b) An evaluation of the number and type of service codes for regional center services, including, but not limited to, recommendations for simplifying and making service codes more reflective of the level and types of services provided.

Development of Rate Models. The development of the rate models began with a detailed review of service requirements. With Burns & Associates assistance, DDS undertook a comprehensive review of service definitions. This process also included a review of California-specific laws – such as labor related requirements – that impact providers' costs. From this review, DDS is compiling a list of potential statutory and regulatory changes that would be needed should the rate models be implemented. The rate models are built on detailed assumptions regarding a number of factors, including the wages, benefits, and productivity of the direct care worker; the agency's program operation and administrative costs; staffing ratios and staffing levels, attendance/absence factors, travel-related expenses, facility costs, and program supplies. Providers' costs generally reflect current rates rather than market-based conditions. For this reason, other data sources are used. These sources include California-specific, cross-industry wage data from the U.S. Department of Labor's Bureau of Labor Statistics, several sources that provide estimates of health insurance costs, and the Internal Revenue Services' mileage rate. Further, various analyses were undertaken to understand regional variability in costs associated with wages, travel, and real estate.

The draft rate models developed as a result of the rate study are intended to reflect assumptions on five key cost drivers: (1) the wage for the direct care worker, (2) the benefits package for the direct care worker, (3) the 'productivity' of the direct care worker (that is, the ratio of their billable hours to their work hours), (4) program operation costs, and (5) agency administration. Other cost drivers vary by service or location and may include staffing ratios, mileage, supervision, and facility costs. Key assumptions that broadly affect the draft rate models include state minimum wage requirements, a comprehensive benefits package for direct care workers, and the rate for administrative costs.

For each service and rate variant, a 'base' rate model is established. Then, to account for differences in wage, travel, and real estate costs across California, a draft rate model is established for each RC by applying a 'multiplier' for these three cost factors, as applicable, that reflects the cost in that RC in relation to the statewide value.

Stakeholder Engagement. The DDS and Burns & Associates engaged with the department's Developmental Services task force to gather input for the study. The DDS also conducted stakeholder meetings throughout the state to further engage the community. Surveys for both service providers and consumers and their families were also administered to inform the study. The provider survey was distributed on May 15, 2018, and was conducted to gather data from providers regarding the manner in which they deliver services and their costs. 1,100 organizations out of 4,500 vendors responded to the survey. The DDS distributed the consumer and family survey on October 3, 2018, and received over 1,700 responses.

Public Comment Process. DDS began briefing sessions on the release of the rate study on February 25, 2019. Comments on the rate models were accepted up to April 5, 2019. At the time of the rate study's release, DDS and Burns & Associates expressed intent to review the provided comments and make modifications to the draft rate models as appropriate. The DDS requested parties wishing to provide comment share comments with a rates workgroup representative. The rates workgroup members were expected to aggregate comments and submit a consolidated response. Trailer bill language in the 2019-20 Budget required the DDS to post a summary of public comments and departmental responses to the rate study by October 1, 2019. That summary and the departmental responses were made available on January 10, 2020, with the release of the 2020-21 Governor's Budget. More information on those responses are detailed below.

Stakeholder Response. Upon release of the rate study on March 15, 2019, numerous stakeholders provided comment in public meetings and hearings, as well as in writing. Many acknowledged the significant amount of work that went into developing the rate models, and commended how the models established a framework for estimating costs of services, allowed for rates that vary based on staff qualifications and other differences, and recommended professionalizing the direct care workforce. Conversely, providers expressed concerns about some of the assumptions used by Burns &Associates, and that the implementation of the rate models as developed would eliminate some services categories, collapse some services into a few categories, and create a homogenization of different programs. Others wondered how the rate models would incorporate various policy initiatives (such as Employment First and Self-Determination).

Response to Public Comments. As described above, the DDS released responses to public comments along with the department's budget on January 10, 2020. In total, approximately 3,600 pages of comments were received. The released document summarized and categorized the comments, and contained detailed replies to hundreds of stakeholder comments. Commenters provided feedback on the rate study, as well as issues not within the scope of the study, such as the implementation of the rate models. A sample of shared comments submitted by multiple stakeholders include:

- Rate study does not address requirement to assess whether current rate-setting methods provide an adequate supply of providers.

- No vendor rates should be reduced, and negotiated rates should be grandfathered.

- Some commenters expressed support for standardizing service codes and definitions, while others objected to the proposed consolidations of service codes, concerned that the consolidations may limit options.

- Some commenters expressed support for standardized rates, where all vendors are paid the same rate for providing the same service in the same area. However, others objected to standardized rates, stating that they are not equitable or consumer driven.

- Commenters protested the recommendation that all services be converted to hourly billing, stating that it impairs the ability of vendors to meet individual needs.

- Rates should be tied to quality and outcomes for individuals. Commenters recommended that the DDS should track consumer satisfaction.

- Commenters expressed support for efforts made to differentiate rates by geography, but also objected to various aspects of the regional adjustment factors.

- Commenters objected to the use of Bureau of Labor Statistics data to set wage assumptions, arguing that the data was outdated, among other things.

- Commenters challenged the use of a 12 percent rate for administrative expenses, suggesting that the rate models should include a higher percentage.

Updated Rate Models. Several changes to the original rate models were made in January 2020 which fell into three different categories: technical adjustments, methodological changes, and changes in response to public comments.

In general, these changes related to specific assumptions in rate models for individual services rather than fundamental assumptions that impacted all rate models. Changes were made to many service categories including personal support and training; residential; day, employment, and transportation; and professional. Changes affecting services in multiple categories were also made. Notable changes to the rate models in response to public comments include, but are not limited to the following:

- Incorporation of more current wage, workers' compensation, and mileage rate data published after release of the draft rate models.

- Increased wage assumptions for various services, including Supported Employment, Independent Living, Community-Based Day Programs, and registered behavior technicians.

- Withdrew the methodology to align rates for certain services with Medi-Cal rates and establishing rate models for these services (most notably affecting Specialized Therapeutic Services and certain professionals in Infant Development programs).

- Withdrew the methodology establishing separate short-term and long-term encounter rates for various in-home services.

- Added overtime to rate models for Supported Living and certain residential services.

- Withdrew the methodology to require Respite vendors supporting employer of record models to become financial management services agencies.

- Reduced assumed attendance in day programs from 90 percent to 88 percent.

Fiscal Impact. In total, the estimated cost of fully implementing the study remains at $1.8 billion total funds. The estimate continues to be based on 2019-20 spending projections. The estimated cost does not account for the rate increases included in the 2019-20 budget or the increases for additional service codes proposed in the 2020-21 budget. Note that all of the rate models mentioned here are proposed, and none have been implemented. However, supplemental rate increases included in the 2019-20 budget and proposed in the 2020-21 budget were determined using input from the rate models.

THE 2019-20 BUDGET ACT

The 2019-20 Budget Act contained several provisions relating to the rate study, and more broadly, fiscal reform within the developmental services system. The budget provided for $206.7 million ($125 million General Fund) to provide rate increases of up to 8.2 percent for specified service providers, effective January 1, 2020. Details on specific increases are detailed in the table below.

Service Code	Rate Increase
017 - Crisis Team - Evaluation & Behavior Modification	8.20%
025 - Tutor Services – Group	8.20%
028 - Socialization Training Program	8.20%
048 - Client/Parent Support Behavior Intervention Training	8.20%
055 - Community Integration Training Program	8.20%
062 - Personal Assistance	8.20%
063 - Community Activities Support Services	8.20%
073 - Parent Coordinator Supported Living Prog	6.30%
091 - In-Home/Mobile Day Program	8.20%
093 - Parent-Coordinated Personal Assist Service	8.20%
094 - Creative Arts Program	8.20%
108 - Parenting Support Services	8.20%
109 - Program Support Group-Residential	8.20%
110 - Program Support Group-Day Service	8.20%
111 - Program Support Group-Other Services	8.20%
113 - DSS Licensed-Specialized Residential Facility	8.20%
420 - Voucher Respite	8.20%
465 - Participant-Directed Respite Services	8.20%
475 - Participant Directed Community-Based Training Services/ Adults	8.20%
510 - Adult Development Center	8.20%
515 - Behavior Management Program	8.20%
605 - Adaptive Skills Trainer	3.90%
612 - Behavior Analyst	8.20%
613 - Associate Behavior Analyst	8.20%
615 - Behavior Management Assistant	8.20%
616 - Behavior Technician - Paraprofessional	8.20%
635 - Independent Living Specialist	2.40%
645 - Mobility Training Services Agency	8.20%
650 - Mobility Training Service Specialist	8.20%
860 - Homemaker Services	8.20%
862 - In-Home Respite Services Agency	8.20%
864 - In-Home Respite Worker	8.20%
875 - Transportation Company	8.20%
880 - Transportation-Additional Component	8.20%
882 - Transportation-Assistant	8.20%
896 - Supported Living Services	8.20%
904 - Family Home Agency	8.20%
905 - Residential Facility Serving Adults-Owner Operated	8.20%
910 - Residential Facility Serving Children - Owner Operated	8.20%
915 - Residential Facility Serving Adults - Staff Operated	8.20%
920 - Residential Facility Serving Children-Staff Operated	8.20%
950 - Supported Employment-Group	8.20%
952 - Supported Employment-Individual	7.60%

SB 81 (Committee on Budget and Fiscal Review), Chapter 28, Statutes of 2019, required the DDS, beginning in the summer of 2019, to hold workgroups with stakeholders to discuss how to "create a sustainable, innovative, cost-effective, consumer focused, and outcomes-based delivery system." The first meeting of this workgroup occurred on January 15, 2020. The DDS will report on the progress and any outcomes of these workgroups during the 2020-21 budget process.

ISSUES FOR CONSIDERATION

While this document has examined the various challenges, concerns, and considerations associated with the rate study itself and its implementation, there is no plan to implement the study at this time. Proposals in both the 2019-20 budget and the proposed 2020-21 budget have made efforts to improve the financial situations of service providers and improve the overall system by proposing rate increases for various service codes. Additionally, the DDS has developed a stakeholder workgroup to discuss creating a sustainable and cost-effective system. Advocates express concern that no plan for implementation has been put forth in the DDS's budget proposals.

Implementation of the proposed rate models would involve significant and consequential adjustment at every level of the system. Specific considerations include:

- Enacting required policy changes. Implementing the rate models will require changes to statute and/or regulations. The DDS has not identified policy changes that would be needed in order to implement the proposed rate models.

- Update of the rate models. The proposed rate models are developed from 2016-17 data. If redone using more recent data, it is likely that recommended rates would change. If implemented, the rate models would need to be updated on a frequent basis to keep up to date with current data.

- Day-to-day operational changes. Numerous changes would be needed at the DDS, RC, service provider, and consumer levels to successfully implement the rate models. For example, the study recommends a conversion to hourly billing for most services. Most day services are currently reimbursed on a daily basis so the adoption of hourly billing would require changes to these vendors' monitoring and billing practices.

Questions for DDS.

1. *What does the DDS see as the next reasonable and realistic step in rate reform within the DDS system? Would those next steps include any of the issues for consideration listed above? If so, how would the DDS proceed on the considerations listed above?*

2. *Please provide an update on the goals and progress of the system and fiscal reform workgroup required by Senate Bill 81 (Committee on Budget and Fiscal Review), Chapter 28, Statutes of 2019.*

Questions for DDS and Burns and Associates.

3. *Were various policy initiatives, such as Employment First and Self Determination, considered in the development of the rate models?*

4. *Was the concept of value based budgeting/payments considered when developing the rate models?*

5. *Please explain how the fiscal impact of the study, after updating several rate models in January 2020, remains at $1.8 billion.*

6. *Please provide an overview of the department's responses to public comments on the rate study that were made public on January 10, 2020.*

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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Melissa Hurtado
Senator Melissa Melendez

Sunday, May 24, 2020

2:00 PM

State Capitol - Room 4203

Part B – Human Services

Consultant: Renita Polk

VOTE ONLY CALENDAR

(Attachment)

Sustained and Withdrawn January Governor's Budget Proposals

Modifications to January Governor's Budget Proposals

New May Revision Proposals

ISSUES FOR DISCUSSION

ISSUES FOR DISCUSSION

4170 DEPARTMENT OF AGING (CDA)

Issue 1: Major May Revision Changes

Requests. The May Revision includes the following reductions within the Department of Aging budget that would be triggered off if the federal government provides sufficient funding to restore them.

- $2 million ongoing reduction in the Long-Term Care Ombudsman program.
- $23.9 million ($22.2 million General Fund) reduction for the elimination of the Multipurpose Senior Services Program (MSSP)
- $3 million ($1.6 million General Fund) reduction for the elimination of the Community Based Adult Services (CBAS) Program

The May Revision also includes a one-time reduction of $8.5 million GF for the department's nutrition programs and a one-time reduction of $3 million for Aging and Disability Resource Centers. These two reductions are not subject to the federal "trigger."

Background. The 2019 Budget Act increased funding for local Ombudsman programs by $5.2 million annually. The Ombudsman program also received $2 million in federal CARES Act funding in response to the coronavirus epidemic. Note that the program will ultimately see a net reduction of $1 million as the May Revision also includes the transfer of $1 million to the program from the Department of Public Health, pursuant to the Budget Act of 2019. The 2019 Budget Act also included a one-time increase of $29.6 million ($14.8 million General Fund) to provide supplemental payments to MSSP providers. The increased funding for the local Ombudsman programs and the increase in supplemental payments to MSSP providers in the 2019 Budget Act was part of an Aging package of legislative investments. At the same time, the Governor established a task force to create a state Master Plan for Aging, to address projected growth in California's over-65 population for state government, local communities, private organizations and philanthropy to build environments that promote an age friendly California. Each of these programs was identified as a key component of that effort.

The 2019 Budget Act increased funding for both senior nutrition programs and ADRCs by $17.5 million and $5 million, respectively. These funds were subject to suspension on December 31, 2021, and the January Governor's budget proposed to delay those suspensions

out to take effect on July 1, 2023. The ADRC funding was meant to provide grants to ADRCs to utilize the "No Wrong Door" model. Note that the reduction in funding would continue past 2020-21 until the suspension takes effect.

Questions.

1. MSSP provides social and health case management services for frail, elderly clients who wish to remain in their own homes and communities but are certified (or certifiable) as eligible to enter into a nursing home. Given that older adults in nursing homes have a higher risk of contracting COVID-19 please explain the reasoning behind the proposed elimination of the MSSP.

2. A May 2020 study by the UC Berkeley Goldman School of Public Policy found that the need for food delivery among adults 65 and older increased from 306,223 individuals pre-COVID-19 to about a million individuals in April 2020 during the COVID-19 pandemic. Given these numbers, please explain the reasoning for the decision to reduce funding for nutrition programs.

3. What will the reduction in funding for nutrition programs equate to in terms of meals no longer received and individuals affected?

Staff Recommendation:

- $2 million reduction in the Long-Term Care Ombudsman program. **Hold open.**

- $23.9 million ($22.2 million General Fund) reduction for the elimination of the Multipurpose Senior Services Program (MSSP). **Hold open.**

- $3 million ($1.6 million General Fund) reduction for the elimination of the Community Based Adult Services (CBAS) Program. **Hold open.**

- One-time reduction of $8.5 million GF for the department's nutrition programs. **Reject May Revision proposal and approve $8.5 million GF in support of CDA Nutrition programs.**

- One-time reduction of $3 million for Aging and Disability Resource Centers. **Reject May Revision proposal and approve $3 million GF for Aging and Disability Resource Centers.**

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

Issue 1: Major May Revision Changes

Request. The May Revision includes the following reductions and modifications within the DDS budget that would be triggered off if the federal government provides sufficient funding to restore them.

- Establishment of a cost-sharing program for higher-income families resulting in $2 million General Fund (GF) savings in 2020-21. Trailer bill language is associated with this proposal.

- One-time reduction to provider rates and review of expenditure trends resulting in $300 million GF savings in 2020-21. $270 million GF savings is estimated due to adjustment of provider rates and $30 million GF savings is estimated due to the review of expenditure trends. Trailer bill language is associated with this proposal.

- Implementation of the uniform holiday schedule resulting in about $31.3 million GF savings in 2020-21. Trailer bill language is associated with this proposal.

- One-time reduction to the operations budget for Regional Centers resulting in $30 million GF savings in 2020-21. Trailer bill language is associated with this proposal.

The May Revision also includes the following proposals to maximize federal funding:

- Maximize federal funding for eligible services by including additional individuals with developmental disabilities eligible for and enrolled in Medi-Cal and new waiver eligible services. The proposal would result in approximately $27 million GF savings in 2020-21. Trailer bill language is associated with this proposal.

- Maximize federal funding by adding a service delivery alternative focused on the provision of service and case coordination via teleservices, videoconferencing, or other such technologies. Trailer bill language is associated with this proposal.

Background. Currently, DDS has three different cost-sharing programs for families. This proposal would restructure those three programs into two. The purpose of the proposed changes is to consolidate and streamline the process for collection of parental fees, be more equitable across varying family incomes, and increase funding to support regional center services. According to DDS, the new fee

schedule is more equitable to lower income families and requires higher fees be paid by families with higher income levels. Six months after the fee changes have been implemented, DDS will review the billing and collection of the new fees for reevaluation of revenues.

The department proposes payment reductions based on a three-tiered schedule informed by the January 2020 rate study update. This proposal is estimated to result in savings assuming federal approval and a November 1, 2020 implementation start date. The department will engage its stakeholders in 2020-21 to evaluate this payment reduction and determine potential alternative methodologies to achieve required budgetary savings in future years should the fiscal crisis persist. The trailer bill language also requires regional centers to conduct expenditure and utilization reviews based on guidelines developed by DDS in collaboration with stakeholders.

As part of a package of budget solutions passed in 2009 in response to the significant state budget deficit, the state enacted a policy prohibiting regional centers from paying service providers on 14 set holidays per year. This meant that service providers either did not provide services on those days or absorbed the cost without payment. The policy also required that the 14 holidays be uniform statewide (in other words, it could not be any 14 days throughout the year). The 2019 Budget Act delayed implementation of the 14 day Uniform Holiday Schedule.

While individuals under the age of eighteen may initially fail to qualify for Medi-Cal based on family income, a program known as Institutional Deeming is available through the Medi-Cal Home and Community Based Services Waiver for those individuals who qualify. Under this program, family income is not counted against the income requirements associated with Medi-Cal, and instead only the individual's, in this case the child's, income is considered. The department estimates that roughly 44,000 individuals currently without Medi-Cal could qualify through Institutional Deeming. The department proposes to require individuals to apply for Medi-Cal, including pursuing Institutional Deeming, when the regional center identifies that the individual is eligible for regional center services. Furthermore, if the family chooses to not pursue Medi-Cal enrollment (or Institutional Deeming), the department proposes that the regional center seek reimbursement from individuals and families for that portion of services that would have been eligible for federal funding.

Questions.

1. In the 2019 Budget Act, various service providers received rate increases of up to 8.2 percent. The 2019 budget suspended those rate increases on December 31, 2021. The 2020 Governor's budget proposes to push the effective date of that suspension to July 1, 2023. Will providers that received a rate increase in the 2019 budget effectively see their rates reduced twice?

2. The proposed language on the review of expenditure trends requires regional centers to submit revised expenditure plans by July 1, 2021. If plans are submitted on July 1, 2021, what is the source of the estimated 2020-21 savings?

3. The proposed language on the one-time reduction of provider rates allows the department to implement additional payment reductions to achieve budgeted savings if the savings are not realized in 2020-21. What process will the department use to vet additional payment reductions? Will a stakeholder process be used?

4. How will the department ensure that reductions in regional center operations budgets have minimal impact on consumers? Does the department expect that some regional centers will need to reduce service coordinator positions to account for the reduction?

5. Please respond to advocate concerns that the proposal to maximize federal funding would place federal costs on consumers and families without due process protections including notice or hearing rights.

Staff Comment. Staff has concerns that the proposed language requiring consumers to apply for Medi-Cal does not appear to include due process protections. The subcommittee may want to consider modifying language to address this concern.

Staff Recommendation: Hold open**.**

Issue 2: January Governor's Budget Proposal (Sustained) – Incompetent to Stand Trial Capacity

Request. The May Revision sustains the January proposal to temporarily increase bed capacity at the Porterville Developmental Center (PDC) Secure Treatment Program (STP) to decrease current admission wait times. The DDS proposes to increase the current 211 bed capacity limit to 231 through June 30, 2024. The bed capacity would return to 211 by July 1, 2024, at which point additional community capacity for WIC 6500 commitments is projected to be developed and operational. The proposal would result in $16.6 million GF costs.

The May Revision also sustains the January proposal to increase the capacity of Enhanced Behavioral Support Homes (EBSH) with delayed egress, secure perimeters from six to eleven, and remove the January 1, 2021 sunset provision on the pilot program.

Background. PDC STP is currently serving individuals who are either court-ordered to PDC due to being a danger to self or others (WIC 6500 commitments) or individuals who have been deemed incompetent to stand trial (IST) and require competency training. The STP is the only DDS facility that serves the IST population. Some of these individuals could be served in a less restrictive but secure setting in the community. Pursuant to SB 856 (Committee on Budget and Fiscal Review) Chapter 30, Statues of 2014, the DDS developed the EBSH pilot program to serve individuals with challenging behavioral needs in the community. A subset of this program has aimed at serving WIC 6500 commitments in EBSH's with delayed egress and secured perimeters. Statute currently limits EBSH's

with delayed egress secured perimeter (DESP) to six homes throughout the state and the state may not authorize more than 150 beds in facilities with secured perimeters. Current statute sunsets the EBSH pilot on January 1, 2021. The reasons for this limitation is that these settings are considered more restrictive and are not eligible for federal matching funds. However, the DDS has found the EBSH model to be a successful addition to the array of service options necessary in California to move away from the institution model of care. DDS has the authority to serve the IST population in the community and is allowed to place a maximum of 50 IST placements in the community. However, DDS has not developed that service and currently there are not any IST placements in the community.

Questions.

1. Why has the department not developed any IST treatment options in the community? How long will it take DDS to establish additional suitable community placements for individuals moving out of PDC?

2. How many individuals are currently ready to move as soon as a suitable placement is developed?

Staff Comment. As the system has moved away from institutional models of care, the DDS and RCs have endeavored to place individuals in the least restrictive settings possible. It seems that expanding capacity at Porterville's STP may conflict with that goal. Note that the DDS has had the ability since 2014 to serve individuals that have been declared IST in the community, which would be less restrictive than placing them at PDC. Currently, the DDS is not serving any of these individuals in the community. The committee should consider if there is a way to reduce the IST wait list, while also serving individuals in the community. Staff recommends the Legislature approach this proposal with caution given that it expands the use of restrictive settings – a model that the system as a whole is trying to move away from.

Staff Recommendation. Hold open**.**

5175 DEPARTMENT OF CHILD SUPPORT SERVICES (DCSS)

Issue 1: Major May Revision Changes

Requests. The May Revision includes the following reductions and modifications within the DCSS budget that would be triggered off if the federal government provides sufficient funding to restore them.

- Revert Local Child Support Agency (LCSA) funding methodology to 2018 levels, resulting in a General Fund savings of $38 million. Note that $19 million was proposed in the 2020 Governor's budget, and the other $19 million was included in the 2019 budget.

- Temporarily reduce state operations and contracts, resulting in a General Fund savings of $8.3 million General Fund.

Background. The 2019 Budget Act included funding for the department to implement an interim funding methodology for LCSA administrative costs. The budget also included trailer bill language requiring the department to convene a series of stakeholder working sessions to develop an ongoing funding methodology and to provide a written update to the Legislature describing recommended changes to the funding methodology by February 1, 2020.

Questions.

1. Please explain the impacts of (1) withdrawing the proposed 2020-21 funding augmentation, and (2) reducing current base funding on LCSAs. Please describe the methodology of proposed reductions to various LCSAs.

2. The report submitted to the Legislature in February 2020 detailed program efficiencies that could be implemented. Please speak to the possibility of implementing some of those efficiencies in the coming fiscal year to offset cost pressures created by the recent pandemic.

Staff Comment. Due to the COVID-19 pandemic, the Subcommittee did not have the opportunity to meet and discuss the report referenced above and potential adjustments to the funding methodology. The subcommittee submitted follow up questions to the department that were not able to be addressed due to the pandemic. Due to this, the subcommittee may want to consider having the department present potential updates to the funding methodology in the 2021 Governor's budget, per the February 2020 report.
Staff Recommendation: Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES (DSS)

Issue 1: Major May Revision Changes - Child Welfare Services and Continuum of Care Reform (CCR)

Requests. The May Revision proposes the following new proposals related to child welfare services and CCR. Note there are additional proposals related to child welfare services in the vote only calendar that are not discussed here.

- Eliminate Foster Family Agency social worker rate increase for a one-time savings of $4.7 million GF. This one-time proposal is subject to federal "off trigger."

- Reduce Short-term Residential Treatment Program (STRTP) rates by five percent for a savings of $13.3 million GF. This is an ongoing proposal subject to federal "off trigger."

- Revert and eliminate Family Urgent Response System (FURS) for a one-time savings of $30 million. This proposal is subject to federal "off trigger."

- Suspend Level of Care (LOC) rates two through four for a savings of $15.5 million GF. This is an ongoing proposal subject to federal "off trigger."

- CCR Reconciliation: Child and Family Teams (CFTs) for fiscal years 2016-17 and 2017-18 at a cost of $2.6 million GF.

Background. The 2019 Budget Act included $6.5 million General Fund for a Cost of Living Adjustment (COLA) for the rates paid to foster family agencies (FFAs). These funds were subject to suspension on December 31, 2021, and the January Governor's budget proposed to delay those suspensions to take effect on July 1, 2023.

Under CCR, the state has begun to eliminate group homes and replace them with STRTPs. STRTPs are intended to provide care, supervision, and expanded services and supports on a short-term basis. Both FFAs and STRTPs are required to ensure access to specialty mental health services.

The 2019 Budget Act included $15 million General Fund in 2019-20 and annual funding thereafter to implement FURS. These funds were subject to suspension on December 31, 2021, and the January Governor's budget proposed to delay those suspensions to take effect on July 1, 2023.

To implement a new rate structure under CCR, a LOC tool was developed to aid in assessing foster youth and placing them in the appropriate LOC. All new FFA entries into foster care are being assessed with a LOC tool.

Proposition 30 requires that the state fund the net costs to each county of any new state child welfare requirements or programs enacted after 2011, and provides that counties only have to implement those new state requirements or programs to the extent of the state funding provided. CCR legislation, enacted in 2016, contained new and expanded administrative requirements. Counties have been fronting additional costs for the administrative provisions of CCR without reimbursement. The May Revision includes $2.6 million GF to reimburse counties for the net costs associated with CFTs for 2016-17 and 2017-18, based on a methodology developed by CWDA and CDSS. The Administration will not be providing reimbursement for the net new costs associated with the Resource Family Approval (RFA) process.

Questions.

1. The May Revision includes an ongoing five percent reduction to STRTP rates and an ongoing suspension to level of care rates. Please describe the reasoning behind making these reductions ongoing, as opposed to making them time-limited to coincide with future economic recovery.

2. Would the proposed suspension of the level of care rates affect those currently receiving those rates? Is this a prospective suspension?

3. Please describe the process used to develop the CCR reconciliation methodology.

4. Why is FURS proposed for elimination and if eliminated, how much federal funding will be required to administratively resume the program? How will programs like FURS be prioritized for federal funding if there is insufficient federal funds to support all of the proposed "off triggers"?

Staff Recommendation. Hold open**.**

Issue 2: Major May Revision Changes - Supplemental Security Income/State Supplemental Payment (SSI/SSP)

Request. The May Revision proposes an ongoing withholding of the federal January 2021 COLA to SSI/SSP Recipients for a cost savings of $33.7 million GF. This proposal is subject to the federal "off trigger." Note there are additional proposals related to SSI/SSP on the vote only calendar that are not discussed here.

Background. The SSI/SSP programs provide cash assistance to around 1.2 million Californians, who are aged 65 or older (29 percent), are blind (one percent), or have disabilities (70 percent), and in each case meet federal income and resource limits. A qualified SSI recipient is automatically qualified for SSP. SSI grants are 100 percent federally funded. The state pays SSP, which augments the federal benefit. The federal government, which funds the SSI portion of the grant, is statutorily required to provide an annual COLA each January. The state COLA for the SSP was permanently repealed in 2011 through statute. The 2016 budget included a one-time SSP COLA of 2.76 percent. The 2018 Budget Act included trailer bill language that codified COLAs to SSP grants beginning in 2022-23, subject to funding in the annual Budget Act. The Governor's budget estimates SSI/SSP monthly maximum grant levels will reach $957.72 for individuals and $1,602.14 for couples.

Questions.

1. The proposed withholding of the SSI COLA is proposed to be ongoing. Please explain the reasoning behind making this an ongoing proposal instead of one-time.

Staff Comment. Those receiving SSI/SSP grants are some of California's most vulnerable residents. Due to the vulnerable nature of SSI/SSP recipients, the Subcommittee may wish to make this a one-time withholding. Additionally, if approved, the subcommittee may wish to require the state to restore the withheld amount after a set amount of time when the economy is recovered.

Staff Recommendation. Hold open.

Issue 3: Major May Revision Changes – In-Home Supportive Services (IHSS)

Request. The May Revision proposes the following new proposals related to the IHSS program. Note there are additional proposals related to IHSS that are not discussed here.

- Seven Percent Reduction to recipients' service hours resulting in approximately $205 million GF savings. This proposal is subject to the federal "off trigger."

- Hold county administration and Public Authority funding to 2019 Budget Act level resulting in $12.1 million GF savings. This proposal is subject to the federal "off trigger."

- Transfer payroll functions from counties to a vendor resulting in a $9.2 million GF savings.

Background. The IHSS program provides personal care services to approximately 610,457 qualified low-income individuals who are blind (1.5 percent), over 65 (36.8 percent), or who have disabilities (61.7 percent). 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. 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.

Questions.

1. Does linking reductions to restoring IHSS service levels reduce the likelihood of the state receiving federal relief, given that the federal government has already provided an enhanced federal medical assistance percentage?

2. Access to IHSS services reduces institutionalization and is less costly. How much of the projected savings from reduction of IHSS service hours will be offset by higher costs of nursing home care covered by Medi-Cal?

3. Please provide a brief description of the specific payroll functions proposed for transfer from counties. Describe the potential impact to county staff.

Staff Recommendation. Hold open.

Issue 4: Major May Revision Changes - CalWORKs

Requests. The May Revision proposes the following new proposals related to the CalWORKs program. All proposals listed below are subject to the federal "off trigger." Note there are additional proposals related to CalWORKs in the vote only calendar that are not discussed here.

- Revised CalWORKs Employment Services and Child Care assumptions for an estimated savings of $67.5 million GF.
- Ongoing suspension of CalWORKs Expanded Subsidized Employment for an estimated savings of $134 million.
- Reduction in the CalWORKs Home Visiting program for an estimated savings of $30 million.
- Suspension of CalWORKs Outcomes and Accountability Review (Cal-OAR) for an estimated savings of $21 million.
- CalWORKs Child Care Regional Market Rate reduction for an estimated savings of $32.9 million.

Background. The projections for CalWORKs Employment Services and Child Care costs related to COVID-19 caseload increases assume that both take up and cost per case will be lower than average, resulting in a $665 million ($67.5 million GF) proposed decrease to CalWORKs Employment Services and Child Care, compared with what would have been budgeted under the existing methodology.

Under subsidized employment, counties form partnerships with employers, non-profits, and public agencies to match CalWORKs recipients with jobs. Wages are fully or partially subsidized for six months to a year.

The CalWORKs Home Visiting Program began in 2018. It pairs new parents with a nurse or other trained professional who makes regular visits to the participant's home to provide guidance, coaching, access to prenatal and postnatal care, and other health and social services.

Cal-OAR is a framework for a new performance measurement system for CalWORKs. Under Cal-OAR, data on various performance indicators are collected and published, and counties will regularly undergo self-assessment and develop system improvement plans with targets for the performance indicators.

Questions.

1. Please describe the rationale behind the assumption that take up and cost per case related to COVID-19 caseload will be lower than average.

2. Please discuss the rationale behind the reduction in subsidized employment. Please respond to advocate assertions that this program is a likely path to employment during an economic downturn.

3. How will CalWORKs recipients currently enrolled in the subsidized employment program be affected by this proposal? Will these participants remain employed on July 1, 2020, if this proposal is approved?

4. How will families currently participating in the CalWORKs Home Visiting Program be affected by the reduction in funding for the program?

Staff Recommendation. Hold open.

Subcommittee No. 3 on Health and Human Services
Part B – Human Services
Consultant: Renita Polk

Attachment: Vote-Only Calendar

January Governor's Budget Sustained and Withdrawn Issues

Issue	BU	Department	BR Title	General Fund BY	Other Funds BY	Positions BY	Staff Comments	Staff Recommendation
1	0530	HHS	Electronic Visit Verification for In-Home Supportive Services (Phase I)	--	20,684,000	--	The May Revision sustains the Administration's January proposal for $20.7 million.	Approve as budgeted.
2	4170	CDA	Electronic Visit Verification Penalty Backfill	31,000	--	--	The May Revision sustains the Administration's January proposal for $31,000.	Approve as budgeted.
3	4300	DDS	Southern California Headquarters Office	1,600,000	400,000	--	The May Revision sustains the Administration's January proposal for $2 million ($1.6 million General Fund).	Approve as budgeted.
4	4300	DDS	Community State Staff Program - Reimbursement	--	9,700,000	--	The May Revision sustains the Administration's January proposal for $9.7 million.	Approve as budgeted.
5	4300	DDS	Developmental Centers - Regional Resources Developmental Program for Southern California	1,078,000	--	8.0	The May Revision sustains the Administration's January proposal for $1 million.	Approve as budgeted.
6	4300	DDS	Developmental Centers - Fairview Warm Shutdown	11,954,000	--	54.0	The May Revision sustains the Administration's January proposal for $11.9 million General Fund.	Approve as budgeted.

7	4300	DDS	Regional Centers - Electronic Visit Verification Phase II Penalties	5,089,000	--	--	The May Revision sustains the Administration's January proposal for $5 million General Fund to pay EVV Phase II penalties	Approve as budgeted.
8	4300	DDS	Developmental Centers - Community State Staff Program Lump Sum	1,495,000	--	--	The May Revision sustains the Administration January proposal for $1.5 million General.	Approve as budgeted.
9	4300	DDS	Developmental Center Retention Stipend Carryover	15,689,000	--	--	This issue is not a request for new funding. It reflects already appropriated funds from the 2016 Budget Act to retain development center employees at closing developmental centers. These stipend funds are still being paid out. The 2016 Budget Act had provisional language stating the funds are available until June 30, 2021 and available for liquidation until December 31, 2021.	Approve as budgeted
10	4300	DDS	Information Security Office	234,000	59,000	2	The May Revision sustains the Administration's January proposal for $293,000 ($234,000 General Fund).	Approve as budgeted.
11	4300	DDS	Uniform Fiscal System (UFS) Modernization Withdrawal	-1,344,000	-67,000	-2.0	The May Revision withdraws the Administration's January proposal for $1.4 million ($1.3 million General Fund) to plan for the replacement of the UFS.	Adopt the May Revision.
12	4300	DDS	Cooperative Electronic Document Management System Withdrawal	-531,000	-183,000	-4.6	The May Revision withdraws the Administration's January proposal for $714,000 ($531,000 General Fund) for a cooperative electronic document management system.	Adopt the May Revision proposal.

13	4300	DDS	Information Technology and Data Planning Withdrawal	-1,927,000	-272,000	-7.0	The May Revision withdraws the Administration's January proposal for $2.2 million ($1.9 million General Fund) for IT data planning.	Adopt the May Revision proposal.
14	4300	DDS	Withdraw Additional Supplemental Provider Rate Adjustments	-10,778,000	-7,185,000	--	The May Revision withdraws the January proposal for $18 million ($10.8 million General Fund)	Hold open.
15	4300	DDS	Enhanced Caseload Ratios for Young Children Withdrawn	-11,808,000	-5,557,000	--	The May Revision withdraws the Administration's January proposal for $17.4 million ($11.8 million General Fund) for enhanced caseload ratios for children aged three to five.	Adopt the May Revision proposal.
16	4300	DDS	Enhanced Performance Incentive Program Withdrawn	-60,000,000	-18,000,000	--	The May Revision withdraws the Administration's January proposal for $78 million ($60 million General Fund) for a regional center performance incentive program.	Adopt the May Revision proposal.
17	4300	DDS	Systemic, Therapeutic, Assessment, Resources, and Treatment Training Withdrawn	-2,555,000	-1,985,000	--	The May Revision withdraws the Administration's January proposal for $4.5 million ($2.6 million General Fund) for START training. The committee may want to consider delaying implementation of the program for two years instead of withdrawing the proposal	Hold open.
18	4700	CSD	Reimbursements for California Earned Income Tax Credit Program and VITA	--	10,000,000	--	The May Revision withdraws the Administration’s January proposal for $10 million in reimbursement authority.	Adopt the May Revision proposal.
19	5160	DOR	Extension of Reimbursement Authority for the	--	2,000,000	2.7	The May Revision sustains the Administration’s January proposal for $2 million and 2.7 positions.	Approve as budgeted.

			Deaf and Disabled Telecommunications Program					
20	5160	DOR	Systems and Privacy Protections	670,000	0	4.0	The May Revision sustains the Administration's January proposal for $670,000 for systems and privacy protections.	Approve as budgeted.
21	5165	DYCR	Transition of the Division of Juvenile Justice	-25,352,000	--	-112.0	The May Revision withdraws the Administration's January proposal to transition the DJJ to a standalone department within the California Health and Human Services Agency.	Adopt the May Revision proposal.
22	5165	DYCR	Transition of the Division of Juvenile Justice	-250,775,000	-5,408,000	-1,250.9		
23	5165	DYCR	Transition of the Division of Juvenile Justice	-8,115,000	--	-53.0		
24	5170	State ILC	Reversal of 2018 Removal of CFS Funding	--	116,000	--	The May Revision sustains the Administration's January proposal for $116,000.	Approve as budgeted.
25	5175	DCSS	Automation Changes for Child Support Disregards	-300,000	-500,000	--	The Governor's January budget proposed to increase the amount of monthly child support a CalWORKs family could retain from $50 to $100 for a family with one child and to $200 for a family with two or more children effective January 1, 2021. As a result of withdrawing this proposal, CalWORKs families will continue to retain only $50 of monthly child support payments. The May Revision withdraws the Administration's January proposal for $800,00 ($300,000 General Fund)	Hold open.

							forautomation changes relating to child support payments.	
26	5175	DCSS	Local Assistance Estimate	1,052,000	705,000	--	The May Revision sustains the Administration's January proposal for $1.7 million ($1 million General Fund) for local assistance.	Approve as budgeted.
27	5180	DSS	Immigration Services Operation Support	551,000	--	3.0	The May Revision sustains the Administration's January proposal for $551,000 General Fund and three positions for immigration services and support.	Approve as budgeted.
28	5180	DSS	Protecting Data and Systems	1,043,000	--	6.0	The May Revision sustains the Administration's January proposal for $1 million to protect data and systems.	Approve as budgeted.
29	5180	DSS	Caregiver Background Check Bureau: Criminal Record Exemption Case Processing	733,000	165,000	7.0	The May Revision sustains the Administration's January proposal for $898,000 ($733,000 General Fund)	Approve as budgeted.
30	5180	DSS	Community Care Licensing: Quality Oversight Staffing Resources	342,000	158,000	3.0	The May Revision sustains the Administration's January proposal for $500,000 ($342,000 General Fund).	Approve as budgeted.
31	5180	DSS	Housing and Homelessness Operations Support	1,280,000	--	8.0	The May Revision sustains the Administration's January proposal for $1.3 million General Fund.	Approve as budgeted.
32	5180	DSS	Information Technology Systems Improvements and Federal Compliance	673,000	--	4.0	The May Revision sustains the Administration's January proposal for $673,000 General Fund.	Approve as budgeted.
33	5180	DSS	Increased State Hearings Workload	630,000	1,070,000	8.0	The May Revision sustains the Administration's January proposal for $1.7 million ($630,000 General Fund).	Approve as budgeted.

34	5180	DSS	Expansion of Housing Providers (AB 960)	196,000	337,000	--	The May Revision sustains the January proposal for $533,000 ($196,000 General Fund) to implement AB 960.	Approve as budgeted.
35	5180	DSS	CalWORKs Income Exemptions (AB 807)	--	500,000	--	The May Revision sustains the January proposal for $500,000 to implement AB 807.	Approve as budgeted.
36	5180	DSS	Civil Rights Unit Support	196,000	234,000	3.0	The May Revision sustains the January proposal for $430,000 ($196,000 General Fund) and three positions.	Approve as budgeted.
37	5180	DSS	California Newcomer Education and Well-Being Project	15,000,000	--	--	The May Revision sustains the Administration's proposal for trailer bill language and $15 million for the CalNEW project.	Approve and adopt placeholder trailer bill language.
38	5180	DSS	In-Home Supportive Services: Mandatory Training for County Social Workers and Managers	1,858,000	1,829,000	--	The May Revision sustains the Administration's proposal for $3.7 million ($1.6 million General Fund) for IHSS mandatory training.	Approve as budgeted and adopt placeholder trailer bill language.
39	5180	DSS	CalFresh Application Assistance	5,000,000	--	--	The May Revision sustains the January proposal for $5 million for CalFresh application assistance.	Approve as budgeted.
40	5180	DSS	Commercially Sexually Exploited Children 2018 Budget Act Reappropriation (Pending 2020 Budget Act)	8,424,000	--	--	The May Revision sustains the January proposal for $8.4 million General Fund.	Approve as budgeted.
41	5180	DSS	AB 85 FY 2017-18 County Repayment	-325,662,000	--	--		Approve as budgeted.
42	5180	DSS	Subsidized Childcare Provider Collective Bargaining Activities (AB 378)	290,000	20,000	2.0	The May Revision sustains the January proposal for $310,000 ($290,000 General Fund) to implement AB 378.	Approve as budgeted.

43	5180	DSS	Restaurant Meal Program (AB 942 and AB 612)	-413,000	-413,000	-6.0	The May Revision withdraws the January proposal for $826,000 ($413,000 General Fund) to implement the Restaurant Meal Program.	Reject the May Revision and approve the funding.
44	5180	DSS	Establish the CA Access to Housing and Services Fund	-750,000,000	5,577,000	--	The May Revision withdraws the January proposal to establish the Access to Housing and Services Fund.	Adopt the May Revision.
45	5180	DSS	Establish the CA Access to Housing and Services Fund	--	-5,577,000	-10.0		
46	5180	DSS	In-Home Supportive Services: Medi-Cal Expansion for Undocumented Immigrants Age 65 and Older	-6,812,000	--	--	The May Revision withdraws the January proposal to expand Medi-Cal for undocumented immigrants age 65 and older.	Hold open.
47	5180	DSS	EBT Fraud and Theft Prevention	-201,000	-364,000	-4.0	The May Revision withdraws the Administration's January proposal for $565,000 ($201,000 General Fund) for resources to detect EBT fraud.	Adopt the May Revision.
48	5180	DSS	Continued Oversight of Psychotropic Medication in Foster Care	-622,000	-287,000	--	The May Revision withdraws the Administration's January proposal for $909,000 ($622,000 General Fund) for continued oversight of psychotropic medication in foster care.	Reject the May Revision and approve $909,000 for continued oversight of psychotropic medication in foster care.
49	5180	DSS	Foster Care Audits and Rates Branch: Eligibility Program Development and Monitoring	-319,000	-369,000	--	The May Revision withdraws the Administration’s January proposal for $688,000 ($369,000 General Fund) for eligibility program development and monitoring.	Adopt the May Revision proposal.

50	5180	DSS	Office of Tribal Affairs: Increased Workload and Training Contract Resources	-136,000	-85,000	--	The May Revision withdraws the Administration's January proposal for $221,000 ($136,000 General Fund) for increased resources within the Office of Tribal Affairs.	Adopt the May Revision proposal.
51	5180	DSS	Federal Title IV-E Well-Being Project Evaluation Contract	-600,000	--	--	The May Revision withdraws the proposal for $600,000 General Fund for the evaluation of the federal Title IV-E Well-Being contract.	Adopt the May Revision.
52	5180	DSS	Child Welfare Workforce Development	-5,903,000	-4,145,000	--	The May Revision withdraws the Administration's proposal for $10 million ($5.9 million General Fund) for child welfare workforce development.	Adopt the May Revision.
53	5180	DSS	Child Support Disregard	-600,000	--	--	The Governor's January budget proposed to increase the amount of monthly child support a CalWORKs family could retain from $50 to $100 for a family with one child and to $200 for a family with two or more children effective January 1, 2021. As a result of withdrawing this proposal, CalWORKs families will continue to retain only $50 of monthly child support payments. The May Revision withdraws the Administration's proposal for $600,000 associated with child support payments.	Hold open.
54	5180	DSS	Foster Youth Bill of Rights (AB 175)	-100,000	-46,000	--	The May Revision withdraws the Administration's proposal for $146,000 ($100,000 General Fund) to implement AB 175.	Reject May Revision and approve $146,000 ($100,000 General Fund)

								toimplement AB 175.
55	5180	DSS	Documents for Dependent Children (AB 718)	-80,000	-34,000	--	The May Revision withdraws the Administration's proposal for $114,000 ($80,000 General Fund) to implement AB 718.	Reject May Revision and approve $114,000 ($80,000 General Fund) to implement AB 718.
56	5180	DSS	Resource Family Caregiver Training: Commercially Sexually Exploited Children (AB 865)	-39,000	-31,000	--	The May Revision withdraws the Administration's January proposal for $70,000 ($39,000 General Fund) to implement AB 865.	Reject May Revision and approve $70,000 ($39,000 General Fund) to implement AB 865.

January Governor's Budget Modified Issues

Item	BU	Department	BR Title	General Fund BY	Other Funds BY	Positions BY	Staff Comments	Staff Recommendation
57	4170	CDA	Headquarters Relocation Funding	743,000	--	--	The January Governor's Budget included a proposal for $2.3 million for headquarters relocation for CDA. The May Revision increases the original proposal by $743,000. The increased costs are attributable to revised one-time tenant improvement costs.	Hold open.
58	4300	DDS	Relocation to Allenby Building Update	-860,000	--	--	The January Governor's Budget included a joint proposal with HHS, DDS, and the Department of State Hospitals for $8.2 million General Fund. The May Revision reduces the original proposal by $860,000. The department's relocation will be evaluated to make government more efficient through workforce telework opportunities.	Adopt the May Revision.
59	5180	DSS	Increased State Hearings Workload	950,000	1,600,000	10.0	The January Governor's Budget included a proposal for $1.7 million ($630,000 GF) for increased state hearings workload.	Adopt the May Revision.

							The May Revision increases the original proposal by $2.55 million to support 10 positions in fiscal year 2020-21 and 20 positions ongoing necessary to address increased workload and reduce federal penalties associated with the state hearings backlog.	
60	5180	DSS	Food Banks	30,000,000	--	--	The January Governor's Budget included a proposal for $20 million GF for increased support of food banks. The May Revision requests that Item 5180-151-0001 be increased by $30 million to support food banks response to COVID-19. It is also requested that Provision 15 of Item 5180-151-0001 be amended.	Adopt May Revision.
61	5180	DSS	Increasing Support for CalWORKs and CalFresh Program Improvement	-1,302,000	-1,690,000	-20.0	The January Governor's Budget included a proposal for $3 million ($1.3 million GF) for increased support for CalWORKs and CalFresh. The May Revision reduces the original proposal by a total of $3 million and 20 positions consistent with a workload budget.	Adopt May Revision.

New May Revision Issues

Issue	BU	Department	BR Title	General Fund BY	Other Funds BY	Positions BY	Staff Comments	Staff Recommendation
62	4170	CDA	MIPPA - Technical Adjustment for Expenditure Authority	--	2,214,000	--	The May Revision includes an ongoing augmentation of $2,214,000 in Federal Trust Fund authority ($180,000 in State Operations and $2,034,000 in Local Assistance) as a result of the MIPPA federal grant funding becoming ongoing.	Adopt the May Revision.
63	4170	CDA	Transfer of Funds from the Department of Public Health to CDA)Adjustment per Item 4265-002-0942, Provision 3, Budget Act of 2019)	--		--	The May Revision includes a request that Item 4170-102-0942 be increased by $1 million to reflect the transfer of funds from the Department of Public Health, pursuant the Budget Act of 2019, which allows fund balance in excess of $6 million to go toward the local long-term care ombudsman program under the CDA.	Adopt the May Revision.
64	4170	CDA	Loan from HICAP Fund to General Fund	5,000,000	-5,000,000	--	The May Revision requests that Item 4170-011-0289 be added to include loan authority of $5 million to support the General Fund in response to the coronavirus pandemic. It is also requested that the following language be added to Item 4170-101-0289: The Department of Finance may	Adopt May Revision.

							transfer up to $5,000,000 as a loan to the General Fund. The Department of Finance shall order the repayment of all or a portion of the loan if it determines that either of the following circumstances exists: (a) the fund or account from which the loan was made has a need for the moneys, or (b) there is no longer a need for the moneys in the fund or account that received the loan. This loan shall be repaid with interest calculated at the rate earned by the Pooled Money Investment Account at the time of transfer.	
65	4300	DDS	Self-Determination Program Implementation Funding Alignment	3,130,000	1,315,000	--	The May Revision requests that Item 4300-001-0001 be increased by $279,000, and reimbursements be increased by $93,000. It is also requested that Item 4300-101-0001 be increased by $2,851,000, and reimbursements be increased by $1,222,000. This additional funding is necessary to address administrative costs and workload related to expanding the Self-Determination Program. It is further requested that Provision 3 of Item 4300-001-0001 and Provision 6 of	Adopt May Revision.

							Item 4300-101-0001 be eliminated, as the flexibility is no longer required given the requested augmentation.	
66	4300	DDS	Regional Center May Revision	415,137,000	-11,814,000	--	The May Revision requests that Item 4300-101-0001 be increased by $415,137,000 and reimbursements be decreased by $12,541,000, and Item 4300-101-0890 be increased by $727,000 for adjustments made in regional center caseload, utilization, and operations. The General Fund increase is primarily attributed to an adjustment to the claiming of federal funds for state-only populations.	Adopt May Revision.
67	4300	DDS	Federal Medical Assistance Percentage Increase	-370,789,000	370,789,000	--	The May Revision requests that Item 4300-101-0001 be decreased by $370.8 million and reimbursements be increased by $370.8 million due to the enhanced Federal Medical Assistance Percentage, which is assumed to be effective until June 30, 2021.	Adopt May Revision.
68	4300	DDS	COVID-19 Impacts	237,507,000	99,222,000	--	The May Revision requests that Item 4300-101-0001 be increased by $254.1 million ($170.8 million GF) be increased by $83.3 million and item 4300-001-0001 be increased by 82.6 million ($66.7 million GF) to	Adopt the May Revision.

							reflect impacts of COVID-19 on the developmental services system. These changes reflect increased costs associated with increased utilization in purchase of services specific to residential settings, respite, and personal attendants. These costs also reflect surge development at the developmental centers and in the community.	
69	4300	DDS	Reversion of Prior Year Funds	--	0	--	The May Revision requests that Item 4300-495 be added to revert funding from Item 4300-101-0001, Budget Act of 2017 and Items 4300-001-001 and 4300-101-0001, Budget Act of 2018 related to purchase of services and state operated facilities.	Adopt May Revision.
70	4700	CSD	Reappropriation and Extension of Liquidation of Greenhouse Gas Reduction Funds for the Low Income Weatherization Program	--	0	--	The May Revision requests that Item 4700-490 be added to reappropriate the unencumbered amount from Item 4700-101-3228, Budget Act of 2017 to Item 4700-101-3228. Of the reappropriated balance, it is requested that $750,000 be transferred to Item 4700-001-3228 to allow the Department of Community Services and Development to meet its contractual and programmatic obligations. It is also requested	Adopt May Revision.

							that Item 4700-491 be added to extend the liquidation period to June 30, 2022 for Item 4700-101-3228, Budget Act of 2016 due to projects delayed as a result of COVID-19	
71	5160	Department of Rehabilitation	Increase of Reimbursement Authority for CalFresh	--	1,200,000	--	The May Revision requests that is requested that Item 5160-001-0001 be amended by increasing reimbursements by $1.2 million to continue the CalFresh outreach and application assistance to Supplemental Security Income (SSI) recipients who are newly-eligible for CalFresh benefits as part of the reversal of the SSI cash-out policy.	Adopt May Revision.
72	5160	Department of Rehabilitation	Reductions in Independent Living Centers	-2,120,000	--	--	The May Revision requests that Item 5160-101-0001 be decreased by $2,120,000 to reduce the Independent Living Centers funding as part of the statewide budget reduction efforts in response to the coronavirus pandemic.	Hold open
73	5175	Department of Child Support Services	May Revision Local Assistance Estimate	-1,000,000	-1,410,000	--	The May Revision requests that Item 5175-101-0001 be decreased by $1 million, Item 5175-101-0890 be increased by $10,169,000, and Item 5175-101-8004 be decreased by $11,579,000 to reflect revised	Adopt May Revision.

							forecasts of child support collections.	
74	5180	DSS	Legal Services Supporting Immigration and Refugee Programs	245,000	--	--	The May Revision requests Item 5180-001-0001 be increased by $245,000 to convert a limited-term position to permanent to provide legal support to the Immigration and Refugee programs.	Adopt May Revision.
75	5180	DSS	State Emergency Food Operations Support	639,000	--	4.0	The May Revision requests Item 5180-001-0001 be increased by $639,000 and 4 permanent positions to address workload related to administering state-funded emergency food programs.	Adopt May Revision.
76	5180	DSS	IHSS Maintenance-of-Effort and Wage Negotiation Workload	240,000	239,000	3.0	The May Revision requests Item 5180-001-0001 be increased by $240,000 and 3 positions, and reimbursements be increased by $239,000 to convert 3 limited-term positions to permanent to address workload associated with IHSS county maintenance-of-efforts and provider wage negotiations.	Adopt May Revision.
77	5180	DSS	Community Care Licensing: New Facility Management System for Certification Approval and Licensing	6,821,000	--	--	The May Revision requests that Item 5180-001-0001 be increased by $6,821,000 to procure, configure, and deploy a Platform as a Service solution to support Community Care Licensing programs.	Adopt May Revision

78	5180	DSS	Medi-Cal Eligibility Data System Modernization Reduction	-60,000	-541,000	--	The May Revision requests Item 5180-001-0001 be decreased by $60,000 and reimbursements be decreased by $541,000 to reflect a shift in focus from the Medi-Cal Eligibility Data System modernization project to an enterprise-wide modernization approach.	Adopt May Revision.
79	5180	DSS	CalFresh Able Bodied Adult without Dependents Management Evaluations	0	0	--	The May Revision requests provisional language be added to Item 5180-001-0001 and Item 5180-001-0890 to allow the Department of Social Services to expend up to $1 million to comply with the federal Able Bodied Adult without Dependents rule, contingent on the Department of Finance's approval	Adopt May Revision.
80	5180	DSS	Supplemental Security Income/State Supplemental Payment Estimate	43,735,000	--	--	*See Table 1 The May Revision provides $2.7 billion from the General Fund for SSI/SSP in 2020-21, which is slightly lower than the revised estimates of 2019-20 expenditures—by about 2 percent. However, relative to the Governor's January budget, the May Revision proposes slightly higher SSI/SSP General Fund costs in 2020-21 and 2019-20—by about 1 percent. This is	Hold open.

							primarily due to May Revision including slightly higher SSI/SSP caseload estimates than the Governor's January budget.	
81	5180	DSS	Other Social Services Programs Local Assistance Adjustments	14,375,000	396,015,000	--	*See Table 1	Hold open.
82	5180	DSS	Able-Bodied Without Dependents Final Rule	0	--	--	The May Revision requests provisional language be added to Item 5180-141-0001 to allow the Department of Social Services to expend up to $8 million to comply with the federal Able Bodied Adult without Dependents rule, contingent on the Department of Finance's approval. (	Adopt May Revision.
83	5180	DSS	In-Home Support Services Estimate	131,391,000	106,189,000	--	*See Table 1	Hold open.
84	5180	DSS	CalWORKs Estimate	3,514,401,000	19,308,000		*See Table 1	Hold open.
85	5180	DSS	In-Home Supportive Services: Eliminate Proration of Protective Supervision Hours for Recipients in the Same Residence	15,833,000	20,070,000	--	The May Revision requests that Item 5180-111-0001 be increased by $15,833,000 and reimbursements be increased by $20,070,000 to eliminate prorating protective supervision hours for IHSS recipients who are in the same household.	Hold open.

86	5180	DSS	Sick Leave Expansion for IHSS Providers per H.R. 6201	26,932,000	36,203,000	--	The May Revision requests Item 5180-111-0001 be increased by $26,932,000 and reimbursements be increased by $36,203,000 to expand paid sick leave to IHSS providers per H.R. 6201, establish a provider back-up system for IHSS recipients whose provider is sick, and provide pay differential to back-up providers. The expanded paid sick leave benefit, provider back-up system, and pay differential are effective until January 1, 2021.	Adopt May Revision.
87	5180	DSS	Statewide Verification Hub	295,000	479,000	5.0	The May Revision requests Item 5180-001-0001 be increased by $295,000 and 2 positions, and reimbursements be increased by $35,000, and Item 5180-001-0890 be increased by $444,000 and 3 positions to reflect positions and resources, and the redirection of one limited-term position and associated resources from the Office of Systems Integration to the Department of Social Services for the planning and development of the Statewide Verification Hub	Adopt May Revision
88	5180	DSS	In-Home Supportive Services: Conform	-72,558,000	72,558,000	--	The May Revision requests Item 5180-111-0001 be decreased by $72,558,000 and	Hold open.

			Residual Program to timing of Medi-Cal Coverage				reimbursements be increased by $72,558,000 to conform the IHSS Residual Program to timing of Medi-Cal coverage. When Medi-Cal is terminated, clients are moved to the Residual Program, which is 100 percent General Fund. If their Medi-Cal status is restored retroactively to the termination date, the Residual Program is not adjusted to account for this change. This conformity saves General Fund because federal funding will be applied.	
89	5180	DSS	Transfer of Federal Temporary Assistance for Needy Families Fund from California Student Aid Commission to CalWORKs	-600,000,000	600,000,000	--	The May Revision requests Item 5180-101-0001 be decreased by $600 million and Item 5180-101-0890 be increased by $600 million to reflect a decrease in the amount of federal TANF block grant funds available to offset General Fund costs in the Cal Grant program.	Adopt May Revision.
90	5180	DSS	CalWORKs County Administration Funding	1,906,000	80,408,000	--	The May Revision requests Item 5180-101-0001 be increased by $1.9 million and Item 5180-101-0890 be increased by $80.4 million to reflect revised CalWORKs county administration funding.	Adopt May Revision.
91	5180	DSS	CalFresh County Administration Funding	74,242,000	104,418,000	--	The May Revision requests Item 5180-141-0001 be increased by $74,242,000 and	Adopt May Revision.

							Item 5180-141-0890 be increased by $104,418,000 to reflect revised CalFresh county administration funding,	
92	5180	DSS	In-Home Supportive Services: Savings due to Enhanced Federal Medical Assistance Percentage	-825,788,000	825,788,000	--	The May Revision requests that Item 5180-111-0001 be decreased by $825,788,000 and reimbursements be increased by $825,788,000 due to the enhanced Federal Medical Assistance Percentage, which is assumed to be effective until June 30, 2021.	Adopt May Revision.
93	5180	DSS	County Medical Services Program Board Reserve Redirection	-50,000,000	--	--	The May Revision requests that Item 5180-101-0001 be decreased by $50 million to reflect the County Medical Services Program Board reserve redirection to offset General Fund costs in the CalWORKs program.	Adopt May Revision.
94	5180	DSS	Increased AB 85 Savings	-38,051,000	--	--	The May Revision requests that Item 5180-101-0001 be decreased by $38,051,000 to reflect increased AB 85 savings.	Adopt May Revision.
95	5180	DSS	Transition Child Care Programs from Department of Education to DSS	2,000,000	--	--	The May Revision that Item 5180-001-0001 be increased by $2 million to support resources for the transition of Child Care Programs from the Department of Education to the Department of Social Services.	Defer without prejudice.

96	5180	DSS	1991 Realignment Adjustments	232,970,000	--	--	The May Revision requests Item 5180-101-0001 be increased by $232.9 million to reflect updated 1991 realignment projected revenues	Hold open.
97	5180	DSS	Housing and Disability Advocacy Program Reappropriation	0	0	--	The May Revision requests provisional language to allow the reappropriation of unexpended funds for the Housing and Disability Advocacy Program	Adopt May Revision.
98	5180	DSS	Reversion of Funding from Various Programs				The May Revision requests Item 5180-495 be added to revert funding from the 2019 Budget Act for the Family Urgent Response System, Immigration Justice Fellowship Program, Youth Civic Engagement Initiative, and Public Health Nursing Early Intervention Program in Los Angeles County.	Hold open.
99	5180	DSS	Suspension Language	0	0	--	The May Revision requests suspension language associated with Family Urgent Response System, Foster Family Agencies Rate and Public Health Nursing Early Intervention Program in Los Angeles County be eliminated	Hold open
100	5180	DSS	Technical Change related to Child Welfare Services-California Automated				The May Revision requests that technical changes be made to Provision 11(a) of Item 5180-151-0001.	Adopt May Revision.

			Response and Engagement System					

Table 1. May Revision Caseload Adjustments (Issues 78, 79, 81, 82)—The May Revision proposes a net increase of $4,225,414,000 (increases of $3,703,902,000 General Fund, $438,386,000 Federal Trust Fund, $83,266,000 reimbursements, and $60,000 School Supplies for Homeless Children Fund, partially offset by decreases of $200,000 State Children's Trust Fund) primarily resulting from updated caseload estimates since the Governor's Budget. Caseload and workload changes since the Governor's Budget are displayed in the following table:

Program	Item	Change from Governor's Budget
California Work Opportunity and Responsibility to Kids (CalWORKs)	5180-101-0001 5180-101-0890	$3,514,685,000 $19,308,000
Kinship Guardianship Assistance Payment	5180-101-0001	-$284,000
Supplemental Security Income/ State Supplementary Payment (SSI/SSP)	5180-111-0001	$43,735,000
In-Home Supportive Services (IHSS)	5180-111-0001 Reimbursements	$131,391,000 $106,189,000
Other Assistance Payments	5180-101-0001	$27,203,000

	5180-101-0890 5180-101-8075	$14,027,000 $60,000
County Administration and Automation Projects	5180-141-0001 5180-141-0890 Reimbursements	$19,271,000 $14,047,000 $2,802,000
Community Care Licensing	5180-151-0890	-$11,000
Special Programs	5180-151-0001	-$26,000
Realigned Programs		
Adoption	5180-101-0001 5180-101-0890	-$1,036,000 $65,318,000
Foster Care	5180-101-0001 5180-101-0890 5180-141-0890	-$49,940,000 $176,382,000 -$5,901,000
Child Welfare Services (CWS)	5180-151-0001 5180-151-0803 5180-151-0890 Reimbursements	$18,903,000 -$200,000 $155,007,000 -$31,834,000
Adult Protective Services	5180-151-0890 Reimbursements	$209,000 $6,109,000

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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Andreas Borgeas
Senator Melissa Hurtado

Thursday, March 5, 2020
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Renita Polk

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

4170 DEPARTMENT OF AGING (CDA)

DEPARTMENT OVERVIEW

Budget Summary. With a proposed 2020-21 budget of $254.9 million ($67.3 million General Fund), the CDA administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the state. As the federally designated State Unit on Aging, the department administers federal Older Americans Act (OAA) programs and the Health Insurance Counseling and Advocacy Program.

California Department of Aging
Expenditures by Fund Source
* Dollars in thousands

Grand Total By Fund	Fiscal Year	
	2019-20	2020-21 (Proposed Budget)
General Fund	$84,276	$67,282
State HICAP Fund	$2,506	$2,506
Federal Funds	$188,660	$168,731
Special Deposit Fund	$2,213	$1,213
Reimbursements	$14,892	$12,883
Department of Public Health Licensing and Certification Program Fund	$400	$400
Skilled Nursing Facility Quality and Accountability Fund	$1,900	$1,900
Total All Funds	$294,847	$254,915

2019 Budget Actions. The 2019 Budget Act provided significant investments in various programs at CDA, including:

- **Long-Term Care Ombudsman.** The 2019 budget increased funding for local Long-Term Care Ombudsman offices by $5.2 million annually. Additionally, the budget included trailer bill language requiring quarterly visits to Skilled Nursing Facilities and Residential Care Facilities for the Elderly by Long-Term Care Ombudsman staff. In 2019, local Ombudsman programs received an approximately 125 percent increase in General Fund support. Local Ombudsman programs reported being able to hire 36 new full-time equivalents, 20 new part-time staff, nine existing staff went from part-time to full-time and 12 existing part-time staff had an increase in hours.

- **Senior Nutrition.** The budget increased funding for senior nutrition programs by $17.5 million General Fund annually. The 2020-21 budget proposes to suspend this funding on July 1, 2023, unless there is sufficient General Fund revenue to support all programs proposed for suspension in the subsequent two fiscal years, as determined by the Department of Finance. Each Area

Agency on Aging (AAA) received a base of $150,00 for start-up and equipment costs. The remaining funding was allocated to each AAA using an interstate funding formula

- **Multipurpose Senior Services Program (MSSP).** The 2019 budget included a one-time increase of $29.6 million ($14.8 million General Fund) to be expended over three years to provide supplemental payments to MSSP providers. This resulted in a 25 percent supplemental payment increase for each MSSP site. The $4,285 per slot per year payment was increased to $5,356)

- **"No Wrong Door" Model**. The 2019 budget included $5 million General Fund annually to provide grants to local Area Agencies on Aging and Independent Living Centers to utilize the "No Wrong Door" model. The 2020-21 budget proposes to suspend this funding on July 1, 2023, unless there is sufficient General Fund revenue to support all programs proposed for suspension in the subsequent two fiscal years, as determined by the Department of Finance. Six local partnerships (jointly referred to as Aging and Disability Resource Centers (ADRCs)) have been approved as "State Designated ADRCs" and qualified for funding. Another ten local partnerships have been approved as "Emerging ADRCs" and also qualified for funding. Each designated ADRC will receive $180,000 base funding for each fiscal year. The table below shows funding allocations for 2019-20 and 2020-21. Each emerging ADRC will receive $90,000 in base funding. The remaining funding for both designated and emerging ADRCs will be allocated based on county population, county square mileage, and county geographic isolation.

Designated ADRCs	SFY 2019-20 Allocation[a]	SFY 2020-21 Allocation[b]
Marin County ADRC	$262,755	$239,380
Nevada County ADRC	$243,542	$225,594
Orange County ADRC[c]	$400,000	$781,322
Riverside County ADRC	$907,588	$702,073
San Francisco County ADRC	$410,632	$345,488
Ventura County ADRC	$425,483	$356,143
Total	$2,650,000	$2,650,000

Emerging ADRCs	SFY 2019-20 Allocation[a]	SFY 2020-21 Allocation[b]
Alameda County	$215,272	$215,272
Kern County	$180,824	$180,824
Monterey County	$133,919	$133,919
Amador, Calavera, Mariposa and Tuolumne Counties	$128,564	$128,564
Placer County	$131,596	$131,596
San Benito County	$98,172	$98,172
San Bernardino County	$279,757	$279,757

- **Dignity at Home Fall Prevention Program.** The budget includes $5 million General Fund one-time to provide grants to local Area Agencies on Aging for injury prevention education and

home modifications for seniors at risk of falling or institutionalization. The CDA allocated the funding equally among the 32 participating AAAs.

Overview of Programs.

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

MSSP provides social and health case management services for frail, elderly clients who wish to remain in their own homes and communities. Clients must be aged 65 or older, eligible for Medi-Cal, and certified (or certifiable) as eligible to enter into a nursing home. Teams of health and social service professionals assess each client to determine needed services and work with the clients, their physicians, families, and others to develop an individualized care plan. CDA implements MSSP under the supervision of the Department of Health Care Services (DHCS) through an interagency agreement.

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

Supportive Services. The Supportive Services Program assists older individuals to help them live as independently as possible and access services available to them. Services include information and assistance, transportation services, senior centers, in-home and case management, and legal services for frail older persons.

Senior Legal Services. The Senior Legal Services Program assesses legal service needs and assists older adults with disabilities in their community with a variety of legal problems. This is a priority service under Title IIIB and each AAA must include it as one of their funded programs. There are 39 legal services projects in California.

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

Long-Term Care Ombudsman (LTCO). The LTCO identifies, investigates, and resolves community complaints made by, or on behalf of, individual residents in long-term care facilities. These facilities include nursing homes, residential care facilities for the elderly, and assisted living facilities. The LTCO Program is a community-supported program, of which volunteers are an integral part. Approximately, 167 staff and 717 volunteers advocate on behalf of residents of long-term care facilities. These include 1,230 skilled nursing and intermediate care facilities and 7,300 residential care facilities for the elderly. The office also maintains a 24-hour, seven days a week crisis line to receive complaints by, and on behalf of, long-term care residents.

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

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

Senior Community Service Employment Program (SCSEP). The SCSEP Program provides part-time, subsidized work-based training and employment in community service agencies for low-income persons, 55 years of age and older, who have limited employment prospects.

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

Issue 1: Master Plan on Aging Update

Background. In June 2019, Governor Newsom issued an executive order calling for the creation of a Master Plan for Aging (MPA). This plan was spurred, in large part, by the projected growth of California's over-65 population to 8.6 million by 2030. This plan will serve as an outline for state and local governments, the private sector, and philanthropic organizations to promote health aging and prepare for demographic changes. The MPA will include key data indicators to support implementation and recommendations to better coordinate programs and services to older adults, families, and caregivers. The ultimate goal is to provide a person-centered, data-driven, ten-year California Master Plan for Aging by October 1, 2020. This includes a state plan, data dashboard, and best practice toolkit. The CDA has taken a lead role in developing the MPA.

As part of the MPA, the California Health and Human Services Agency (CHHS) convened a cabinet workgroup for aging. A stakeholder advisory committee and two subcommittees – research and long-term services and supports (LTSS) were also convened by CHSS. CHHS also convened an equity workgroup to provide advice on the MPA through an equity lens. The equity workgroup convened in February and is projected to meet four times between

Legislative/Budget Actions Advancing the MPA and Aging Issues. Within the past year, the Legislature has approved several measures to advance the MPA and to address other aging issues. These measures include:

- AB 1118 (Rubio), Chapter 820, Statutes of 2019. Requires the Secretary of CHHS to consider applying to join the AARP Network of Age-Friendly States and Communities on behalf of California.

- AB 1287 (Nazarian), Chapter 825, Statues of 2019. Requires the MPA to consider the efficacy of utilizing a "No Wrong Door" system and the use of a universal tool and process that is capable of assessing individual need and determining initial eligibility for programs and services available in the long-term services and supports delivery network.

- SB 228 (Jackson), Chapter 742, Statutes of 2019. Requires the director of the CDA to lead the development and implementation of the MPA.

- SB 453 (Hurtado), Chapter 850, Statutes of 2019. Requires the CDA to develop a core model of ADRC best practices and to develop a plan for and oversee implementation of the "No Wrong Door" system.

- 2019 Budget Act Investments. The 2019 Budget Act included several actions to advance the MPA and other aging issues.

    - "No Wrong Door" model. The 2019 budget provided $5 million to provide grants to local AAAs and Independent Living Center to utilize this model.

    - Dignity at Home Fall Prevention Program. The 2019 budget included $5 million to provide grants to local AAAs for injury prevention education and home modifications for seniors.

- Senior Nutrition programs. The budget provided $17.5 million ongoing for the expansion of Senior Nutrition programs at the CDA.

- Multipurpose Senior Services Program (MSSP). The 2019 budget included $29.6 million ($14.8 million General Fund) for supplemental payments to MSSP providers.

- Long-Term Care Ombudsman (LTCO). The 2019 budget included $5.2 million annually to aid in conducting quarterly visits to Skilled Nursing Facilities and Residential Care Facilities for the Elderly by LTCO staff.

- LTSS Actuarial Study. The 2019 budget included $1 million for the Department of Health Care Services to fund a feasibility study and actuarial analysis of LTSS financing and benefit options to meet the growing need for those services.

Update on Development. The CDA, as well as other departments and agencies with roles in the MPA, have provided consistent updates on the plan throughout its development. The CHHS agency has been releasing progress reports on the MPA every quarter. The agency has begun organizing "Webinar Wednesdays" where stakeholders can learn about and discuss various policy issues and their effects on seniors, as well as ways the MPA may address those issues. Final work is being conducted on the LTSS Subcommittee report from its stakeholder advisory committee. That report is due to the Governor in March 2020. During the winter and spring, recommendations for the MPA will continue to be gathered through the various processes mentioned above, with draft deliverables to be reviewed by the stakeholder advisory committee in the summer of 2020. The final MPA will be issued by the Administration no later than October 2020.

Next Steps. The LTSS subcommittee will submit a report to the Governor by March 2020. The research subcommittee will release a data dashboard in the spring/summer of 2020. During the rest of the year, recommendations for the MPA will continue to be gathered through the various processes mentioned above, with draft deliverables to be reviewed by the stakeholder advisory committee in the summer of 2020. The final MPA will be issued by the Administration no later than October 2020. CDA is also working on a new strategic plan that will be launched in July 2020.

Staff Comment and Recommendation. Informational item. No action is necessary.

Questions.

1. Please provide an update on the Master Plan for Aging.

2. One of the components of the Master Plan for Aging described in the most recent update is a transformation of the CDA. Please provide more information on what this entails.

Issue 2: BCP – Headquarters Relocation Funding

Governor's Proposal. The Administration requests $2.3 million General Fund in 2020-21 and $619,000 ongoing General Fund to relocate the department's offices. One-time costs include moving expenses, informational technology equipment and set-up, and furniture. Ongoing costs would be for facilities operations costs.

Background. Currently, the CDA and COA offices are located in the Natomas community of Sacramento. The departments have been in their current locations for the past 15 years. Recently, the building has had continuous ceiling leaks and problems with its heating, ventilation, and air conditioning system (HVAC), causing health and safety concerns for employees. The lessor of the building made modifications to the HVAC system in the spring of 2018, but problems with the system have persisted.

In addition to these concerns, the departments have outgrown the building's current capacity. As part of the Legislature's aging package in the Budget Act of 2019, the CDA was granted a total of approximately $65 million in additional investments to serve older Californians. With that additional funding came a need for expansion within the department. The CDA is also integrally involved in the development of the California Master Plan on Aging, creating additional growth at the CDA. With all these additional responsibilities and investments, the CDA has outgrown its current space.

The CDA has already identified a new location. The new building is much easier to access with public transit, contains spaces for large stakeholder meetings, and has space to allow for future growth within the CDA.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 3: Proposals for Investment

1. Statewide expansion of the Aging and Disability Resource Connections

Budget Issue. The California Association of Area Agencies on Aging requests $19 million in 2020-22, $30.1 million in 2021-22, and $51 million in 2022-23 for the expansion of the ADRC network. This request would expand the network from six designated ADRCs to 58. The proposal is intended to address the difficulty older Californians and people with disabilities faces accessing the services and supports they need. Getting timely, accurate information is critical to avoiding costly institutional care, preventing health and safety emergencies, or seeking aid during disasters. The California Association of Area Agencies on Aging proposes a three-year phased in approach where in year 1 designated and emerging ADRC's in the system would be funded, year 2 additional ADRCs would be established, and in year three the network would be extended to cover all counties.

Staff Comment and Recommendation. Hold open.

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

Issue 1: Overview

The In-Home Supportive Services (IHSS) program provides personal care services to approximately 610,457 qualified low-income individuals who are blind (1.5 percent), over 65 (36.8 percent), or who have disabilities (61.7 percent). 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.

As of November 2019, 15.2 percent of IHSS consumers are 85 years of age or older, 40.3 percent are ages 65-84, 36.9 percent are ages 18-64, and 7.5 percent are 17 years of age or younger. There are approximately 522,500 IHSS providers. Close to 54 percent of providers are live-in.

Budget Summary. The budget proposes $14.9 billion ($5.2 billion General Fund) for services and administration in 2020-21. 2019-20 funding includes $13.2 billion ($4.5 billion General Fund) for the program. 2020-21 funding is about 13 percent above estimated 2019-20 expenditures.

Service delivery. County social workers determine IHSS eligibility and perform case management after conducting a standardized in-home assessment of an individual's ability to perform activities of daily living. In general, most social workers annually reassess recipients' need for services. Based on authorized hours and services, IHSS recipients are responsible for hiring, firing, and directing their IHSS provider(s). If an IHSS recipient disagrees with the hours authorized by a social worker, the recipient can request a reassessment, or appeal their hour allotment by submitting a request for a state hearing to DSS. The average number of service hours provided to IHSS recipients in 2020-21 is estimated to be 114 hours per month.

Program Funding. The program is funded with federal, state, and county resources. Federal funding is provided by Title XIX of the Social Security Act. About 98 percent of the IHSS caseload receives federal funding. The IHSS program predominately is delivered as a benefit of the Medi-Cal program. According to the Legislative Analyst's Office (LAO), IHSS is subject to federal Medicaid rules, including the federal reimbursement rate of 50 percent of costs for most Medi-Cal recipients. The state receives an enhanced federal reimbursement rate—93 percent in calendar year 2019 and 90 percent in calendar year 2020 and beyond—for individuals that became eligible for IHSS as a result of the Patient Protection and Affordable Care Act (about three percent of IHSS recipients). The federal government provides a 56 percent match for about 45 percent of recipients based on their higher assessed level of need. This higher reimbursement rate is referred to as the Community First Choice Option.

When the state transferred various programs from the state to county control during 1991 Realignment, it altered program cost-sharing ratios and provided counties with dedicated tax revenues from the sales tax and vehicle license fee to pay for these changes. Beginning in 2011, an IHSS county maintenance-of-effort (MOE) was put into place, meaning county costs would reflect a set amount of nonfederal IHSS costs. Historically, counties paid 35 percent of the nonfederal share of costs.

Major Drivers of Increasing Costs. Primary drivers of the increased costs are caseload growth, an increasing number of paid hours per case, and wage increases for IHSS providers.

- Caseload growth. According to the LAO, the average monthly caseload for IHSS increased 30 percent over the past ten years from 430,000 in 2009-10 to an estimated 560,000 in 2019-20. The average year-to-year caseload growth is about five percent, and is estimated to continue to grow at that rate in 2020-21.

- Increasing paid hours per case. Over the past ten years, the average number of monthly hours per case for IHSS has increased by 29 percent, from about 87 paid hours in 2009-10 to an estimated 112-paid hours in 2019-20. Just between 2013-14 and 2018-19 average paid hours per case increased by 22 percent. Note that this increase is in part due to policy changes within the program. For example, in 2015-16, the state implemented requirements that providers be compensated for previously unpaid tasks, such as waiting during their recipient's medical appointments.

- State and Local Wage Increases. The LAO estimates that about 40 percent of the increase in wage costs ($220 million General Fund) are due to recent state minimum wage increases from $12 per hour to $13 per hour, and the scheduled increase to $14 per hour on January 1, 2021. The LAO estimates that the remainder of the increase in wage costs ($305 million General Fund) is due to local wage increases above the state minimum wage, largely because of collective bargaining agreements.

Recent and Proposed Policy Changes. In addition to the policies listed above, several other proposed and recently enacted policies impact the IHSS program – both fiscally and programmatically, including:

- **IHSS Maintenance of Effort (MOE).** The enactment of the 2019 Budget Act legislated several changes to the state IHSS MOE. The 2019 budget established the statewide MOE at $1.6 billion. The new MOE created a more sustainable fiscal structure for counties to manage costs by increasing the General Fund commitment for those costs. Specific changes to the MOE are discussed in detail in the next item.

- **Restoration of the seven percent reduction in service hours.** A legal settlement in *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*, resulted in an eight percent reduction to authorized IHSS hours, effective July 1, 2013. Beginning in July 1, 2014, the reduction in authorized service hours was changed to seven percent. The 2015 Budget Act approved one-time General Fund resources, and related budget bill language, to offset the seven-percent across-the-board reduction in service hours. Starting in 2016, the seven percent restoration was funded for the duration of the Managed Care Organization (MCO) tax. The MCO tax expired on July 1, 2019. The 2019 budget restored the seven percent reduction, but with a potential suspension date of December 31, 2021. The proposed 2020 budget proposes $894.5 million ($402.4 million General Fund) to continue to fund the restoration with a later suspension date of July 1, 2023.

- **Undocumented 65 and Older Full-Scope Expansion.** Currently, California provides full scope Medi-Cal coverage to the undocumented population up through 25 years of age. The proposed 2020 budget expands full-scope Medi-Cal to undocumented residents of California who are 65

years of age or older, regardless of immigration status, effective January 1, 2021. Estimated costs associated with the proposed expansion equal $5.9 million General Fund in 2020-21, increasing to $120 million in 2021-22. An additional $1 million is included in the budget for automation updates within the Department of Health Care Services budget.

- **Paid sick leave.** SB 3 (Leno), Chapter 4, Statutes of 2016, provided eight hours of paid sick leave to IHSS providers who work over 100 hours beginning July 1, 2018. Beginning January 1, 2020, IHSS providers will accrue 16 hours, and when the state minimum wage reaches $15, providers will receive 24 hours of sick leave. The proposed budget includes $52 million ($24 million General Fund) in 2019-20 for this purpose and $116.4 million ($53.3 million General Fund) in 2020-21. The budget assumes that about 80 percent of providers will use the maximum amount of paid sick leave. However, the LAO notes that costs could come in lower than estimated if fewer providers utilize paid sick leave or if providers use a lower than estimated amount.

- **Electronic Visit Verification.** H.R. 2646 was signed in December of 2016, and contains provisions related to Electronic Visit Verification, or "EVV." These provisions would require states to implement EVV systems for Medicaid-funded personal care and home health care services, such as IHSS. The bill stipulates that the electronic system must verify (1) the service performed, (2) the date and time of service, (3) the location of the service, and (4) the identities of the provider and consumer. California has until January 2021 to comply for personal care services, and until January 2023 for home care services, or escalating penalties will be incurred.

  In October 2018, the department submitted a request for $8 million ($800,000 General Fund and $7.2 million federal funds) to the Department of Finance (DOF) in order to comply with the federal mandate to implement EVV. The department used the funds to modify its existing Case Management, Information, and Payrolling System (CMIPS). The department has leveraged its existing Electronic Services Portal and Telephonic Timesheet System to meet EVV requirements. The EVV was piloted in Los Angeles County from July-December 2019. EVV will be implemented statewide during 2020. The proposed 2020 budget includes county administration funds to implement the remaining cases. $2.6 million is included for implementation in 2020-21, and $3.2 million is included for ongoing maintenance. Additional EVV funding is discussed in a later item.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of caseload and funding levels for the IHSS program.

2. The Governor's budget estimates that average hours per case in 2019-20 will be maintained at the same level as they were in 2018-19. Additionally, the budget estimates only a slight increase in 2020-21. Based on recent growth trends, the average hours per case will likely be higher in 2019-20. How does the DOF plan to adjust if average hours do turn out to be higher than estimated?

Issue 2: Update on IHSS MOE

Background. The 2019 budget enacted many changes to the IHSS county MOE. The most significant of which was lowering the county MOE and increasing the state's General Fund commitment. Beginning in 2019-20, the county MOE was rebased to $1.56 million. The 2020-21 budget updates the MOE to $1.59 billion in 2019-20 and $1.67 billion in 2020-21. This reflects a slight decrease in 2019-20 due to lower projected hours based on recent actual data and an increase in 2020-21 due to anticipated adjustments to the MOE calculation. While total IHSS county MOE costs increase from 2019-20 to 2020-21, the IHSS county MOE is projected to offset a decreasing share of the nonfederal IHSS costs—26 percent and 24 percent, respectively.

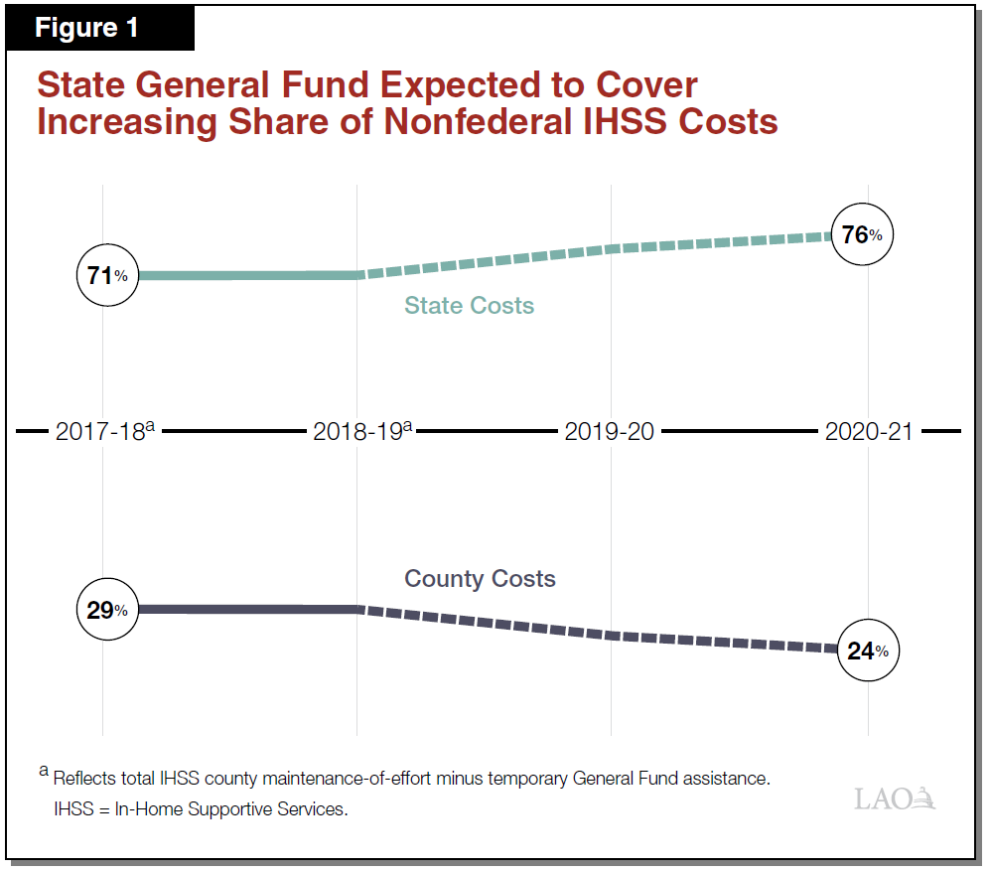
1991 Realignment. In 1991, the Legislature shifted significant fiscal and programmatic responsibility for many health and human services programs from the state to counties—referred to as 1991 realignment. The 1991 realignment package: (1) transferred several programs and responsibilities from the state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

IHSS County Costs. Historically, counties paid 35 percent of the nonfederal—state and county—share of IHSS service costs and 30 percent of the nonfederal share of IHSS administrative costs. Beginning in 2012-13, however, the historical county share of cost model was replaced with an IHSS county maintenance-of-effort (MOE), meaning county costs would reflect a set amount of nonfederal IHSS costs as opposed to a certain percent of nonfederal IHSS costs. In 2017-18, the initial IHSS MOE was eliminated and replaced with a new county MOE financing structure—referred to as the 2017 IHSS MOE. Under this MOE, counties were responsible for paying based on 2017-18 actual expenditures, which is adjusted for locally negotiated, mediated, imposed, or adopted by ordinance increases to wages and/or benefits and an annual inflation factor. The county MOE was scheduled to increase by an inflation factor – five percent for 2018-19, and seven percent for the following fiscal years.

Senate Bill 90 – 1991 Realignment Report. The Budget Act of 2017 included a requirement for the DOF to submit a report to the Legislature that would review the funding structure of the 1991 realignment. The DOF released the report with the Governor's 2019-20 budget. The report acknowledged that the revenue sources for 1991 Realignment are not sufficient to cover increased program costs due to several changes in the structure of 1991 Realignment including collective bargaining, minimum wage increases, and federal overtime rules. IHSS has been one of the fastest growing programs within the state budget with mostly double-digit growth rates each year, with the exception of years where reductions were made in order to balance the budget. The 2017 MOE included an inflation factor of seven percent annually, which is below the average annual growth rate of eleven percent. The report proposed a number of recommendations that were reflected in the 2019 budget.

2019 MOE Changes. The 2019 changes to the MOE provided a supportable financial structure for counties. In addition to providing that sustainable arrangement, the annual inflation factor for counties will be lowered from seven percent to four percent, beginning in 2020-21. The county MOE will only increase by the inflation factor and the county share of locally negotiated wage and benefit

increases. Once the state minimum wage reaches $15 per hour, county negotiated increases for IHSS wages and benefits will shift to a non-federal sharing ratio of 35 percent state and 65 percent county of the non-federal share of the increases with no state participation cap. The MOE no longer consists of four separate components for services, county administration, public authority administration and now contains only one component for services. Administrative costs will now be funded through a General Fund allocation and counties will be responsible for administrative costs above the General Fund allocation. Overall, these changes shifted about $300 million of what otherwise would have been county costs to the state in 2019-20, increasing to about $550 million in 2022-23. With the changes to the MOE, state IHSS costs are expected to increase more over time. The figure below, provided by the LAO, shows how the state share of nonfederal costs will increase over time, while county costs will decrease.



Collective Bargaining. The 2019 budget also made changes to IHSS collective bargaining provisions. Budget language requires a specified mediation process, including a fact-finding panel and recommended settlement terms, to be held if a public authority or nonprofit consortium and the employee organization fails to reach agreement on a bargaining contract with IHSS workers on or after October 1, 2019. The mediation process also includes the county board of supervisors holding a public hearing after the fact-finding panel's public release of its findings and recommended settlement terms. Counties would be subject to withholding of a specified amount of realignment funds if, after completion of the mediation process, the fact-finding panel issues recommendations more favorable to the employee organization, the parties do not reach an agreement within 90 days after release, and the collective bargaining agreement has expired. These provisions will expire on January 1, 2021.

The subcommittee has requested the following panelist, in addition to DSS, DOF, and the LAO, to provide comment on the implementation of changes made to the IHSS MOE in the 2019 budget:

- Justin Garrett, Legislative Representative, California State Association of Counties

Staff Comment and Recommendation. Informational item. No action necessary.

Questions.

1. Please provide an update on how the implementation of the 2019 changes to the IHSS MOE is going.

2. Please provide an update on the status of collective bargaining.

3. How is the state planning for the increase in state costs given the 2019 MOE changes, as well as the inevitable increase to the IHSS caseload due to changing state demographics?

For Justin Garrett, CSAC:

4. Please detail the counties' perspectives on the 2019 changes to the IHSS MOE.

5. Please provide an update on the status of collective bargaining from the county perspective.

Issue 3: Mandatory IHSS Social Worker Training TBL

Governor's Proposal. The Administration proposes language that would mandate new IHSS caseworkers, caseworker supervisors, quality assurance and program integrity staff, and program managers receive training within the first six months of employment to ensure compliance with IHSS statues, policies, and regulations on service assessment and authorization. The language would further require existing staff that did not have training before July 1, 2019, to complete a one-day refresher training on service assessment and the hourly task guide during 2020-21. The Governor's budget includes $3.7 million ($1.9 million General Fund) for the refresher training.

Background. Since 2005, the DSS, in partnership with the California State University of Sacramento's Office of Continuing Education, has offered year-round IHSS training to all 58 counties through the IHSS Training Academy. In December 2017, an All-County Information Notice provided clarification regarding the IHSS assessment process, transmitting new and/or updated assessment tools, and ensuring appropriate case documentation. However, IHSSTA training is not mandatory and a refresher was not required for current IHSS caseworkers, supervisors, quality assurance and program integrity staff, or program managers. Therefore, even with this guidance, annual state quality assurance reviews and technical assistance continue to find that counties are not correctly trained on provisions of supportive services.

Mandating all IHSS caseworkers and case supervisors, quality assurance and program integrity staff and program managers regardless of years of experience, to participate in the training would ensure uniformity and decrease errors when administrating the IHSS program. The academy will ramp up core competency training for new staff and facilitate 70 new one-day modules for experienced social workers and social worker supervisors, to refresh the use of functional ranks and hourly task guidelines to assess and authorize IHSS. The training will be provided to 3,306 new and existing social workers and managers.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposed language.

Issue 4: Proposals for Investment

1. Proposals related to collective bargaining

Budget Issue. UDW/AFSCME Local 3930 submits the following proposals related to collective bargaining issues.

- Increase penalty for counties to seven percent annually. The average wage for IHSS providers across UDW's 21 counties is just above minimum wage, $13.23 per hour, and less than ten percent of providers receive county-sponsored health benefits. In fiscal year 2019-20, the state enacted a one-time fiscal penalty (equal to one percent of a county's IHSS MOE) against counties that fail to reach collective bargaining agreements in a reasonable amount of time. According to UDW, this penalty has not been enough to incentivize counties to reach an agreement. UDW requests the Legislature increase the penalty for counties who refuse to bargain in good faith from one percent to seven percent of the county's IHSS MOE and from a one-time penalty to an annual penalty so long as the contract remains at an impasse.

- Require transparency in spending of taxpayer dollars. According to UDW, some counties contract with anti-union law firms to represent them in IHSS contract negotiations. This results in counties spending millions of taxpayer dollars for outside contractors when that money could be better used to fund wage and benefit increases for IHSS providers. UDW requests the Legislature ensure transparency in taxpayer funding for IHSS collective bargaining by mandating public disclosure of costs paid by counties for vendor contracts for IHSS negotiations. In addition, UDW requests that the state ensure these costs do not exceed 80 percent of the total cost of the wage and benefit increase proposed by the union.

- Reverse 2019 change to state/county cost sharing in IHSS wage and benefit increases. Currently, the non-federal share of cost for negotiated wage and benefit increases in IHSS is 65 percent paid by the state and 35 percent paid by county. In the 2019-20 budget, the state reversed this formula to become 65 percent county/35 percent state, beginning on January 1, 2022. Local collective bargaining in IHSS has always been very difficult. According to UDW, this will only get worse once the new formula goes into effect. UDW requests that the Legislature rescind the changes enacted in last year's budget and to retain the current share of cost formula of 35 percent county – 65 percent state.

Staff Comment and Recommendation. Hold open.

2. Reinstate accelerated caseload growth allocations in 1991 realignment

Budget Issue. In 2019-20, the state returned to the pre-2017 methodology for calculating IHSS caseload growth, which is a comparison to prior years, instead of using the accelerated approach to allocating funds, which uses current estimate of caseload and cost estimates. According to UDW, the accelerated approach was adopted in 2017-18 because of longstanding complaints by counties in collective bargaining that they could not afford to fund wage and benefit increases because of the lag in time before they would receive caseload growth allocations.

UDW requests the Legislature reinstate accelerated caseload growth in order to incentivize wage and benefit increases for IHSS providers.

Staff Comment and Recommendation. Hold open.

3. Allow Waiver Personal Care Service (WPCS) Providers the ability to receive paid sick leave

Budget Issue. SEIU California requests a General Fund appropriation of $223,000 annually for 965 WPCS---only providers to gain the ability to receive paid sick leave, mirroring the statute that gives sick leave to IHSS providers. On July 1, 2020, IHSS providers will receive 16 hours and on July 1, 2022, providers will gain 24 hours of paid sick leave. Unfortunately, WPCS---only providers, that do the exact same work as IHSS providers, do not have the ability to receive paid sick leave. SEIU requests state law be amended to entitle WPCS--- only providers the ability to receive paid sick leave.

Staff Comment and Recommendation. Hold open.

4. Permanent Restoration of the seven percent cut to IHSS hours

Budget Issue. SEIU Local 2015, representing 385,000 IHSS providers in 37 counties, continues to advocate for the permanent restoration of the seven percent across-the-board cut to IHSS service hours; a cut that was made in 2014 and has been restored through subsequent budget actions since 2015. In 2019, the General Fund ($342.3 million) restored the cut through December 31, 2021. The proposed 2020-21 budget proposes to extend the restoration an additional 18 months, through June 30, 2023. Estimated 2020-21 costs are $402.4 million General Fund. SEIU continues to urge rescinding WIC section 12301.01 through section 12301.05 to permanently restore the seven percent cut.

UDW is also in support of this request.

Staff Comment and Recommendation. Hold open.

0530 HEALTH AND HUMAN SERVICES AGENCY OFFICE OF SYSTEMS INTEGRATION (OSI)
5180 DEPARTMENT OF SOCIAL SERVICES (DSS)

Issue 1: BCP – Electronic Visit Verification (EVV) for In-Home Supportive Services (Phase I)

Governor's Proposal. The Administration requests a total of $20.7 million in 2020-21 and $19.4 million ongoing for local assistance and EVV implementation, outreach, and help desk, training, and system refinements. The tables below provide detailed cost breakdowns of 2020-21 and ongoing funding for Phase I of the EVV project.

CMIPS Budget Display

Activity	2020-21 Beginning Baseline	2020-21 Proposed Budget	2020-21 Budget Year Request
OSI Staff	$4,547,775	$4,547,775	-
Other	2,622,546	$2,622,546	-
CMIPS II Prime Contract	$40,736,996	$61,420,948	$20,683,952
State Support Contracts	$7,620,281	$7,620,281	-
Interfaces	$1,662,490	$1,662,490	-
Facilities	$413,000	$413,000	-
OSI Cost	**$57,603,088**	**$78,287,040**	**$20,683,952**
County Travel	$120,240	$120,240	-
Data Center Services	$19,800,000	$19,800,000	-
CDSS Cost	**$19,920,240**	**$19,920,240**	**-**
Total Local Assistance	**$77,523,328**	**$98,207,280**	**$20,683,952**
Local Assistance General Fund	$39,184,536	$45,296,521	$6,111,985
Local Assistance Other Funds	$38,338,792	$52,910,759	$14,571,967
State Operations Cost	**$1,400,049**	**$1,400,049**	**-**
Total CMIPS II Budget	**$78,923,377**	**$99,607,329**	**$20,683,952**

Activity	FY 2020-21	FY 2021-22	FY 2022-23	Total
EVV Implementation	$1,269,638	$0	$0	**$1,269,638**
EVV Cloud Infrastructure	$234,051	$160,674	$160,674	**$555,399**
EVV Telephone Transaction	$3,047,983	$3,230,862	$3,230,862	**$9,509,707**
EVV Application Maintenance	$3,253,592	$3,266,197	$3,266,197	**$9,785,986**
EVV Help Desk	$12,878,688	$13,073,474	$13,073,474	**$39,025,636**
Total Costs	**$20,683,952**	**$19,731,207**	**$19,731,207**	**$60,146,366**

Cloud infrastructure costs include vendor staff to support expansion of the web portal and additional cloud software licenses. The telephone transactions costs refer to costs associated with the anticipated increase in call volume. Application maintenance costs are for ongoing system development to fix defects found in testing and continually refine the system based on user feedback and program needs. Help desk costs relate to staff and infrastructure needed to support EVV.

Background. The federal 21st Century Cures Act was signed in December of 2016, and contains provisions related to EVV. These provisions require states to implement EVV systems for Medicaid-funded personal care and home health care services, such as IHSS. The bill stipulates that the electronic system must verify (1) the service performed, (2) the date and time of service, (3) the location of the service, and (4) the identities of the provider and consumer. California has until January 2021 to comply for personal care services, and until January 2024 for home care services, or escalating penalties will be incurred. Penalties would progressively increase, estimated to start at $29.4 million in 2019-20 and going up to $180 million by 2023-24.

The Administration will implement this project in two phases. Phase I will implement EVV requirements for personal care services in the IHSS and Waiver Personal Care Services (WPCS) programs. This phase will be implemented by making changes to the already existing Case Management, Information, and Payrolling System (CMIPS) and the Telephonic Timesheet System. Phase II includes planning, identifying, developing, implementing and/or modifying a system to implement EVV for non-IHSS/WPCS providers and agencies that provide home health care services to eligible Medi-Cal beneficiaries. Phase II will consists of a new project comprising the efforts of multiple state departments. Note that a discussion of Phase II implementation will take place during the subcommittee's March 12, 2020 hearing.

EVV Implementation. The EVV application pilot on the IHSS web portal begin in the Lancaster district office in Los Angeles County in July 2019. Other LA district offices were added throughout the rest of 2019. As of November 2019, 85 percent of all LA providers were enrolled in the EVV system. The remaining counties will be added in waves throughout 2020 to achieve compliance by January 1, 2021. After the pilot, the state will be divided into five multi-county waves, with the last wave going live in September 2020. Each wave will be a two-month roll-out, with providers and recipients currently using electronic timesheets going live in the first month, and the remaining population going live in the second month. The second month would include any providers/recipients selecting the EVV telephonic option. The table below depicts the EVV implementation schedule.

EVV Implementation Timeline

Group	Timeline	Counties
Pilot	July 2019-December 2019	Los Angeles
1	January 2020-February 2020	Orange, Lake, Napa, Placer, Sacramento, San Luis Obispo, Solano
2	March 2020-April 2020	San Bernardino, Riverside, Fresno, Kern, Tulare, Kings
3	May 2020-June 2020	Alameda, Contra Costa, Marin, Mendocino, Monterey, San Francisco, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sonoma
4	July 2020-August 2020	Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Lassen, Mariposa, Merced, Modoc, Mono, Nevada, Plumas, San Benito, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba
5	September 2020-October 2020	Butte, Imperial, Madera, San Diego, Ventura

Federal Financial Participation (FFP). During design, development, and implementation of EVV, the state receives 90 percent FFP. Once the project enters maintenance and operations, the state receives 75 percent FFP. The federal Centers for Medicare and Medicaid Services (CMS) requires a single certification process for the two EVV phases that are on separate implementation tracks and timelines. Because CMS requires a single certification process for both phases, EVV phase I will initially receive 50 percent FFP for the first three years of maintenance and operations, starting in January 2021. Once EVV phase II completes the certification process in 2024, CMS will retroactively reimburse the state for the additional 25 percent FFP for those first three years.

On December 20, 2019, the Department of Health Care Services (DHCS) received a letter from the CMS regarding the state's EVV system. The letter stated that the state's electronic timesheet system is not sufficient in and of itself to meet the EVV requirements. CMS does not believe that California's EVV system complies with the requirement that specified data elements be "electronically verified." The DHCS and the CMS continue to engage in discussions on this. However, note that the CMS did approve California's initial plan for its EVV system, and has not deviated from that plan since its approval. The Administration believes that its EVV system is still in compliance with the electronic verification requirement. Note that if the state is not fully compliant by January 1, 2021, FFP will be affected beginning in the first quarter of 2021. For the 2020-21 budget year, a 0.25 percentage point reduction in the FFP would be imposed if the state were not compliant. This would result in a loss of roughly $20 million in federal funds for the budget year.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. Given the letter the state has received from the CMS on its adherence to the electronic verification component, would the resources requested in this proposal change if the state was considered to not be in compliance with the electronic verification requirement?

5180 DEPARTMENT OF SOCIAL SERVICES – SSI/SSP

Issue 1: Overview

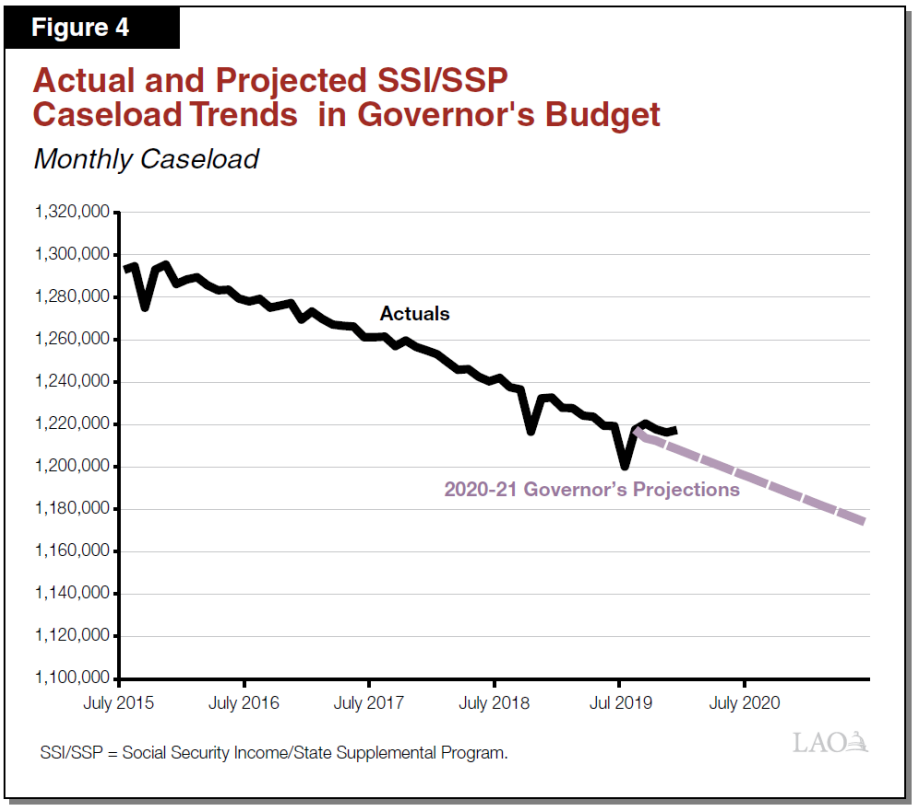
The Supplemental Security Income/State Supplemental Payment (SSI/SSP) programs provide cash assistance to around 1.2 million Californians, who are aged 65 or older (29 percent), are blind (one percent), or have disabilities (70 percent), and in each case meet federal income and resource limits. A qualified SSI recipient is automatically qualified for SSP. SSI grants are 100 percent federally funded. The state pays SSP, which augments the federal benefit.

Budget. The budget proposes $9.7 billion ($2.7 billion General Fund) in 2020-21 for SSI/SSP. The revised 2019-20 budget provides the same amount for the program. The flat funding level is largely due to estimated caseload decline being offset by increased federal expenditures. This increase in federally administered funds is due to the impacts of the 2020 and 2021 federal Cost-of-Living Adjustments (COLA) on the federal SSI version of the grant. The Governor's 2020-21 budget proposal does not include an increase to the SSP portion of the grant. The state pays administration costs to the Social Security Administration (SSA) to distribute SSP, around $183.3 million for the budget year. Costs for SSI/SSP include the Cash Assistance Program for Immigrants and the California Veterans Case Benefit Program.

Cash Assistance Program for Immigrants (CAPI). In 1998, the Cash Assistance Program for Immigrants (CAPI) was established as a state-only program to serve legal non-citizens who were aged, blind, or had disabilities. After 1996 federal law changes, most entering immigrants were ineligible for SSI, although those with refugee status are allowed seven years of SSI. The CAPI recipients in the base program include 1) immigrants who entered the United States prior to August 22, 1996, and are not eligible for SSI/SSP benefits solely due to their immigration status; and 2) those who entered the U.S. on or after August 22, 1996, but meet special sponsor restrictions (have a sponsor who is disabled, deceased, or abusive). The extended CAPI caseload, which is separate from the base CAPI caseload, includes immigrants who entered the U.S. on or after August 22, 1996, who do not have a sponsor or have a sponsor who does not meet the sponsor restrictions of the base program. In 2020-21, the estimated monthly average caseload is 13,511 for extended CAPI.

California Veterans Cash Benefit Program (CVCB) Program. The California Veterans Cash Benefit Program (CVCB) program is linked to the federal Special Veterans Benefit (SVB) Program, which was signed into law in 1999 and provides benefits for certain World War II veterans. The SVB application also serves as the CVCB application, and payments for both programs are combined and issued by the SSA. CVCB program benefits are specifically for certain Filipino veterans of World War II who were eligible for CA SSP in 1999, who are eligible for the SVB program, and who have returned to live in the Republic of the Philippines. Grant levels are identical to the SSP portion for individuals.

Caseload. Since 2014-15, caseloads have shown a steady decline. The Governor's budget projects that the caseload will decrease by 1.8 in percent in 2019-20 and 2020-21. The graph on the next page, provided by the LAO, shows actual and projected caseload trends for SSI/SSP.



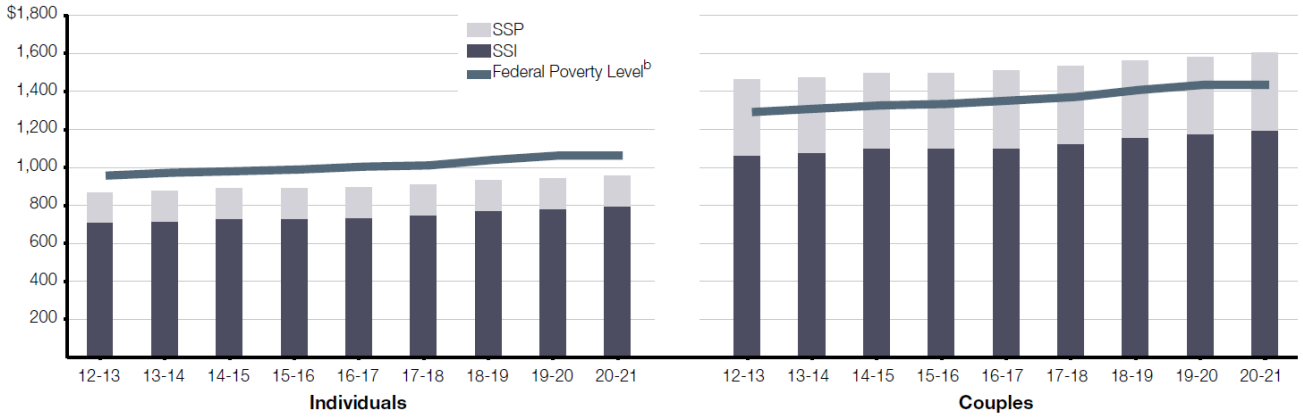
Grant Levels. The federal government, which funds the SSI portion of the grant, is statutorily required to provide an annual COLA each January. The state COLA for the SSP grant was suspended periodically throughout the 1990s and into the 2000s and was permanently repealed in 2011 through statute. The 2016 budget included a one-time SSP COLA of 2.76 percent.

The 2020-21 Governor's budget does not include an increase to the SSP grant, however the 2018 Budget Act included trailer bill language that codified COLAs to SSP grants beginning in 2022-23, subject to funding in the annual Budget Act. The LAO estimates the cost of providing the SSP COLA in 2022-23 (based on an estimated California Necessities Index of 2.8 percent) would cost about $70 million.

The Governor's budget estimates SSI/SSP monthly maximum grant levels will reach $957.72 for individuals and $1,602.14 for couples. The maximum grants for individuals and couples have gradually increased since 2011-12. Even with these increases, current maximum SSI/SSP grants for individuals are below the federal poverty level (FPL), and grants for couples are just above the FPL. As of January 2020, the federal poverty level for individuals is $1,063 per month and $1,436 per month for couples. The graph on the next page, provided by the LAO, shows SSI/SSP grant levels for both couples and individuals compared to the FPL.

Figure 3

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



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

[b] Federal poverty guidelines as established by U.S. Department of Health and Human Services, effective as of January 1 of the respective budget year up to 2019-20.

LAO

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of caseload and funding levels for the SSI/SSP program.

2. What are the reasons for the declining caseload for SSI/SSP?

Issue 2: Housing and Homelessness Programs - Update on Housing and Disability Advocacy Program (HDAP)

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

HDAP programs are operated at the county level. The DSS collects data from grantees on a monthly and quarterly basis and analyzes the data to provide targeted technical assistance. Grantees that receive HDAP funds are required to offer four components to all eligible participants. Those components include:

- Outreach. Active outreach is critical to ensuring the most vulnerable are engaged and served. Active outreach may include establishing and utilizing partnerships with local Homeless Outreach Teams within the community, or other engagement teams trained in seeking out and engaging with vulnerable individuals experiencing homelessness.

- Case Management. Activities associated with the role of the HDAP care coordination case management function may include general adult daily living skill development, case coordination and linkage to disability advocacy services, behavioral health services, medical care, and housing assistance, including housing navigation and housing specific case management.

- Disability Benefits Advocacy. Grantees provide benefits advocacy services for a variety of disability benefit programs, as appropriate. As part of a thorough disability benefit application, HDAP grantees seek out any and all entitlement benefits the client may be eligible to receive. Disability benefits advocacy services are provided through legal representation (at no cost to program participants) or through disability advocacy case managers with benefits assistance training.

- Housing Assistance. Housing assistance entails financial assistance for housing costs provided in coordination with both housing navigation and housing specific case management services. Housing specific case management provides support to HDAP clients specific to their housing needs.

Funding and Budget Actions. In 2016-17, the Senate "No Place Like Home" package of homelessness initiatives included a one-time investment to incentivize local governments to boost outreach efforts and advocacy to get more eligible people enrolled in the SSI/SSP program. $45 million General Fund was approved, and the HDAP was established. $513,000 was reserved for staffing the program and to make it operational as soon as possible. Implementation of HDAP was included in the 2017-18 budget, and funds are now available through June 30, 2020.

The 2019 budget provided $25 million General Fund ongoing for the program. SB 80 (Committee on Budget and Fiscal Review), Chapter 27, Statutes of 2019, required the DSS to submit an annual report on the implementation progress of HDAP. DSS submitted that report to the Legislature in February 2020. SB 80 also expanded eligible grantees to tribes, tribal consortiums, or tribal organizations. A dollar for dollar grantee match is required for the program.

Program Data. The tables below, found in the DSS annual HDAP report, show select program data.

Select Data Elements	Count
Enrollees	2568
Disability applications submitted	1536
Disability applications approved	341
Enrollees with a housing intervention (interim or permanent)	1302
Enrollees permanently housed	831

HDAP Target Population	Count	Percent
General Assistance (GA)/ General Relief (GR)	1647	50%
CalWORKs	38	1%
Diverted from Jail/ Prison	57	2%
Low Income Veteran	601	18%
Discharged from Institution	46	1%
Other Low/ No Income	938	28%
Total	3327	

Note: There is duplication in the above table. For example, a low-income veteran may also be on GA/GR.

Number of Submitted Applications by Type

Disability Benefit Type	Count	Percent
SSI	1487	75%
SSDI	487	24%
CAPI, Veteran's Benefits, or Other*	18	<1%
Total	1992	

Note: There is duplication in the above table. In some instances, a given HDAP enrollee is potentially eligible for more than one disability benefit program. *Note: These categories are combined to ensure that any personal identifying information in the data cannot be used to identify an individual.

Staff Comment and Recommendation. Informational item. No action necessary.

Questions.

1. Please provide an update on HDAP implementation.

Issue 3: Proposals for Investment

1. Restoring SSI grants above the Federal Poverty Level (FPL)

Budget Issue. 1.2 million aged and disabled Californians rely entirely or partly on the federal/state SSI/SSP program for their income for housing, food, utilities, and transportation. In 2009, the state reduced the state contribution to the grant from $223 a month to $156. With the exception of a single cost-of-living adjustment, these recession era grants have never been restored. With housing costs and availability at crisis levels, SSI grants are simply inadequate to afford housing and there is a rising number of SSI recipients that are homeless.

Restoring the cuts to SSI will reduce the housing cost burdens of SSI recipients. This means they will be less vulnerable to rent increases or losing their housing if an unexpected bill causes them to fall behind in their rent. Additionally, increased grants allow recipients to eat more and better food which will lead to better health outcomes.

Californians 4 SSI requests SSI/SSP grants be increased to restore them to the FPL. Restoring these grants is estimated to cost $1.2 billion General Fund annually.

Staff Comment and Recommendation. As mentioned earlier in this agenda, the Governor's budget estimates SSI/SSP monthly maximum grant levels will reach $957.72 for individuals and $1,602.14 for couples in 2020. As of January 2020, the federal poverty level for individuals is $1,063 per month and $1,436 per month for couples. Even with these proposed 2020-21 budget increases, maximum SSI/SSP grants for individuals would still be below the federal poverty level (FPL), and grants for couples would be right above the FPL. **Hold open**.

5180 DEPARTMENT OF SOCIAL SERVICES – COMMUNITY CARE LICENSING (CCL)

CCL OVERVIEW

Background. The Community Care Licensing (CCL) Division in the Department of Social Services (DSS) oversees the licensure or certification of 74,693 licensed facilities that include childcare centers; family child care homes; adult day care facilities; foster family homes; children, adult, and senior residential facilities; and certified family homes and home care organizations. CCL is responsible for protecting the health and safety of individuals served by those facilities. Licensing program analysts investigate any complaints lodged, and conduct inspections of the facilities. The CCL division has a total authorized position count of 1,486.8 positions.

To fulfill these objectives CCL focuses on three priorities:

- Prevention – provide licensees with technical support, online resources, and training to assure that facilities have the necessary tools to meet the standards for the health and safety of everyone they serve.

- Enforcement – provide CCL staff who conduct inspections with the necessary tools and training to ensure that inspections are thorough and consistent and take administrative actions when licensing standards are not met.

- Compliance – creating clear and consistent expectations for licensees in meeting licensing regulations and striving to address issues in real time to ensure the health and safety of the individuals that are served.

Total CCL Licensed Facilities in 2020-21

State Licensed Day Care Facilities	State Licensed 24-Hour Care Facilities	County Licensed 24-Hour Care Facilities	Certified Family Home Facilities[1]	Home Care Organization Facilities	Total
44,298	27,701	977	10	1,707	74,693

Funding. Licensed facilities must pay an application fee and an annual fee, which is set in statute. The revenue from these fees is deposited into the Technical Assistance Fund (TAF) and is expended by the department to fund administrative and other activities in support of the licensing program. In addition to these annual fees, facilities are assessed civil penalties if they are found to have committed a licensing violation. Civil penalties assessed on licensed facilities are also deposited into

[1] A certified family home is a foster home that is certified by a Foster Family Agency. DSS does not license certified family homes. However, DSS is responsible for investigating any complaint of certified family homes.

the TAF, and are required to be used by the department for technical assistance, training, and education of licensees.

Recent budget actions for program improvement. In 2014-15, the budget included $7.5 million ($5.8 million General Fund) and 71.5 positions for quality enhancement and program improvement measures. The additional positions and resources seek to improve the timeliness of investigations; help to ensure the CCL division inspects all licensed residential facilities as statutorily required; increase staff training; establish clear fiscal, program, and corporate accountability; develop resources for populations with medical and mental health needs; and update facility fees.

In 2015-16, the budget included an increase of 28.5 positions (13 two-year limited-term positions) and $3 million General Fund in 2015-16 to hire and begin training staff in preparation for an increase in the frequency of inspections for all facility types beginning in 2016-17. In 2016-17, in order to further comply with the increased frequency of inspections including annual random inspections, and various other legislative requirements related to caregiver background checks, licensing and registration activities, and appeals and Residential Care Facility for the Elderly (RCFE) ownership disclosure, the budget included funding of $3.7 million General Fund for 36.5 positions.

In 2017-18, an additional $3.3 million from the Technical Assistance Fund (TAF) was approved to help complete timely complaint allegations, address the growing backlog of RCFE and Adult Residential Facilities (ARF), continue implementation efforts related to the RCFE Reform Act of 2014, and 5.5 permanent LPAs and one-half Attorney III. In 2019-20, the budget made many of the temporary positions approved in previous years permanent. In total, the 2019 budget approved permanent position authority for 207 positions to increase the frequency of inspections for licensed child care facilities.

Issue 1: Update on New Inspection Tools

Background. All facilities licensed by CCL must meet minimum licensing standards, as specified in California's Health and Safety Code and Title 22 regulations. Approximately 1.4 million Californians rely on CCL enforcement activities to ensure that the care they receive is consistent with standards set in law. DSS conducts pre- and post-licensing inspections for new facilities and unannounced visits to licensed facilities under a statutorily required timeframe. The 2015 budget increased the frequency of inspections from at least once every five years to at least once every three years or more frequently, depending on facility type. These reforms went into effect incrementally through 2018-19. The 2019 Budget Act approved permanent position authority for 207 positions to increase the frequency of inspections for licensed childcare facilities, and trailer bill language stated the intent of the Legislature that inspections in those facilities occur annually.

2020 Mandated Inspection Frequency by Facility Type

Facility Type	Inspection Mandate
Adult and Senior Care	1 year
Children's Residential	2 years
Child Care	3 years/1 year[a]

[a] By November 2020, mandated inspection frequency for child care facilities will increase from once every three years to an annual basis.

Key Indicator Tool. After various changes in 2003, and because of other personnel reductions,[2] CCL fell behind in meeting the visitation frequency requirements. In response, DSS designed and implemented the key indicator tool (KIT), which is a shortened version of CCL's comprehensive licensing inspection instruction, for all of its licensed programs. The CCL began using several KITs as complements to their comprehensive inspection processes. KITs are intended to (1) standardize the inspection protocol between facilities and between inspectors, (2) enhance the efficiency of the inspection process, and (3) appropriately identify whether a more comprehensive inspection is warranted. Some facilities, such as facilities on probation, those pending administrative action, or those under a noncompliance plan, were ineligible for a key indicator inspection and would receive an unannounced comprehensive health and safety compliance inspection.

In 2017, the Legislature approved Supplementary Reporting Language that required the department to meet with legislative staff and stakeholders to discuss the KIT analysis and current status of inspections, and to provide a report on the long-term plan for the use of the KIT. In September 2017, the department released a report detailing its planned approach for a new tool.

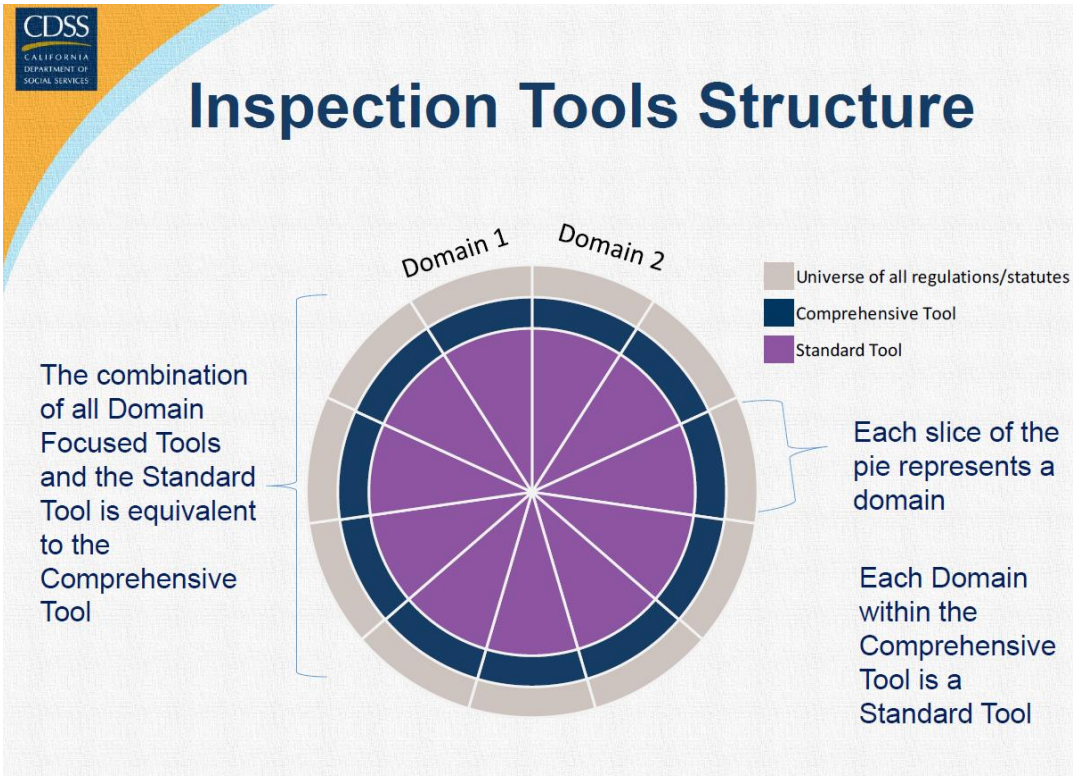
New Inspection Tools. In light of the absence of a standardized inspection tool, CCL is developing a variety of standardized inspection tools to improve the effectiveness and quality of the inspection process. These tools will also be developed differently for the various licensing categories,

[2] CCL estimates that over 15 percent of its staff was lost due to retirements, transfers, and resignations, as well as a prolonged period of severe fiscal constraints.

understanding that different facility types will have different statutory requirements and indicators of compliance to meet. These tools will replace the KITs, designed for each CCL program type.

There are two types of inspection tools; a standard tool, which replaces the KIT, and domain focused tools. The standard tool includes regulations most critical to the health and safety of the individuals in that particular type of care facility. The domain-focused tools are organized into broad categories, or "domains," such as "physical plant and environmental safety" and "personnel records and training." The domain-focused tools facilitate deeper evaluation of the full array of statutes and regulations within the given domain. There are eleven domains included in the inspection tools for RCFEs. They are: operational requirements; physical plant/environmental safety; staffing; personnel records/staff training; resident rights/information; resident records/incident reports; food service; planned activities; incidental medical and dental; residents with special needs; and disaster preparedness.

Most facilities would be inspected using the standard tool. However, if the licensing program analyst (LPA) notes violations involving certain health and safety risks, the more extensive domain-focused tool is triggered for the domain category where violations were found. If an inspection triggers two or more domain-focused tools, comprehensive inspection is triggered. This requires the completion of all 11 domain-focused tools. The comprehensive tool is also used to inspect facilities that are in substantial noncompliance, on probation and other situations that CCL determines would warrant a higher level of inspection.



The Community Care Licensing Division (CCLD) began with the development and deployment of tools for the Adult and Senior Care (ASC) Program and subsequently completed tools for the Children's Residential and Child Care programs. The Senior Care pilot was carried out from July to September 2018 and statewide implementation of the tool for use in Residential Care Facilities for

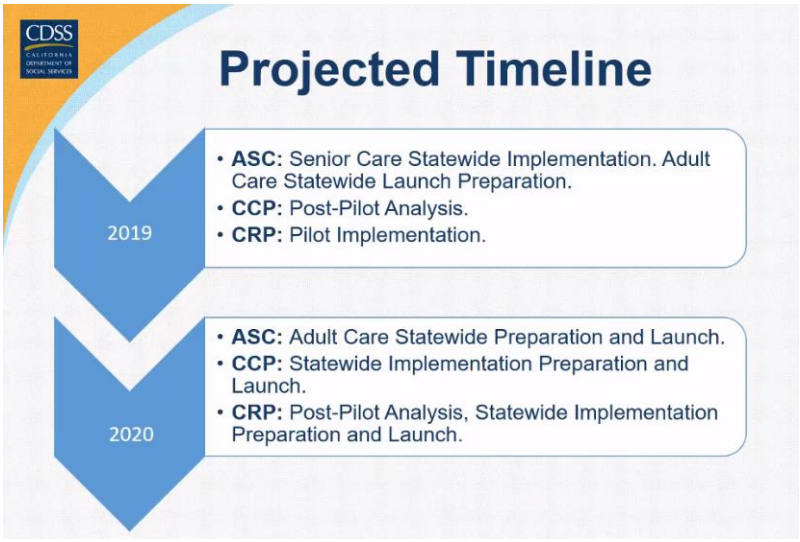
the Elderly (RCFEs) began in September 2019. The inspection tools replaced the KIT for all RCFEs as of November 2019. CCL will continue inspection data analysis and to gather feedback from licensing analysts and licensees to make continuous improvements to the tool. In fall 2019, CCL estimated that a soft launch of the adult care tools would occur in 2020.

The Adult Care program included new tools for the following facilities:

- Adult Day Programs
- Adult Residential facilities
- Adult Residential facilities for persons with special health needs
- Community crisis homes
- Enhanced Behavioral Support Homes
- Residential Care Facilities for the Chronically Ill
- Social Rehabilitation programs

The Child Care program tools, used for family child care homes, preschools, infants and school age children, was piloted during the spring and summer of 2019. At the last update provided by CCL in fall 2019 the next steps for CCL were to conduct post-pilot focus groups and to analyze data from to pilot to revise tools and other materials. The Children's Residential program tools would be used for Foster Family Agencies, group homes, short-term residential therapeutic programs, small family homes, and transitional housing placement programs. At the time of the last update, the pilot for these tools was underway, with a completion date of November 29, 2019.

A projected timeline of the implementation of the inspection tools is below.



*ASC – Adult Senior Care Program, CCP – Child Care Program, CRP – Children's Residential Program

Staff Comment and Recommendation. Informational item. No action necessary.

Questions.

1. Please provide an update on implementation of the new inspection tools developed for CCL.

Issue 2: Informational - Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs)

Background. Over 200,000 Californians live in ARFs or RCFEs. These are adults who cannot live independently due to physical limitations or behavioral health needs and depend on licensed residential care facilities for housing and assistance with activities of daily living (ADLs). These facilities, commonly referred to as board and care or assisted living facilities, are licensed by the DSS Community Care Licensing Division (CCLD) as Adult Residential Facilities (ARFs) or Residential Care Facilities for the Elderly (RCFEs). ARFs serve adults ages 18 to 59 and RCFEs serve those 60 and older. All facilities serve individuals with differing needs. Those individuals include people with disabilities, cognitive impairments, and mental and behavioral health needs.

The facilities are typically privately operated and serve individuals with varying needs. Clients may be older adults who cannot safely live on their own, persons with disabilities, cognitive impairments, or behavioral health needs. Often, these facilities are viewed as an alternative to Skilled Nursing Homes or hospitalization, providing lower cost housing and care while also allowing individuals to remain in the community. ARFs and RCFEs do not provide medical services, but rather provide 24-hour, assistance with ADLs, such as meals, help with toileting or bathing, transportation to appointments in the community, and medication management.

Total Capacity and Number of RCFEs and ARFs in 2018-19

	Number of Facilities	Total Capacity
Residential Care Facilities for the Elderly	7,361	188,717
Adult Residential Facilities	5,206	37,240

Payments to ARFs and RCFEs. How individuals pay for these facilities varies as did how much the facilities charge. Some residents pay out of their own pocket. Other times facilities are reimbursed through public assistance programs such as SSI/SSP. The state provides a supplement to SSI/SSP grants known as the Non-medical Out of Home Care (NMOHC) rate. This rate is intended to support SSI/SS recipients who require additional care. As of January 2020, the SSI rate with the NMOHC supplement is $1,069.37 per month for an individual. This amount is meant to cover a resident's room and board and overall care and supervision. Facilities are not permitted to charge individuals receiving SSI above the state-mandated rate.

The Social Security Administration (SSA) reports the number of SSI/SSP recipients who are receiving the NMOHC rate. According to the SSA, the NMOHC rate is distributed for about 45,500 individuals statewide. However, data limitations make it difficult to accurately estimate how many SSI/SSP recipients receiving this rate reside in these facilities.

Supply of Facilities. CCL reports that from 2014-15 to FY 2018-19 the number of licensed ARFs has increased by 132 facilities, while the capacity of these facilities has decreased by 1,572. The number of licensed RCFEs has decreased by 187, but the capacity has increased by 9,159. This suggests newly opening RCFEs have larger capacity than those that closed, while newly opened ARFs have less capacity than those that closed.

CCL Regulation and Enforcement. CCL has a number of tools it can use to enforce applicable statutes and regulations: they have inspection authority; citation authority; authority to require a corrective action plan; authority to issue financial penalties; and, in extreme cases, they can revoke a license. LPAs working out of regional offices conduct inspections and complaint investigations. In addition to its enforcement and compliance activities, CCL has created a Technical Support Program (TSP), which is designed support to licensees and providers who are struggling to meet and maintain the requirements of operating a licensed facility. TSP is free, voluntary, and offers intense onsite assistance to licensees. In addition to hands on direct support for struggling facilities, TSP develops and publishes Resource Guides, which are intended to serve as tools to help licensees understand the requirements of compliance and provide best practice suggestions.

Staff Comment and Recommendation. Informational item. No action necessary.

With the Governor's Homelessness and Housing package including funding to stabilize ARFs and RCFEs, it is important that the Legislature has an understanding of what services these homes provide, who they serve, and the role of CCL in their regulation. As conversations around these types of facilities have increased, in part due to the Governor's proposed budget, questions remain surrounding the scope of the supply and demand of these facilities. Various stakeholders have expressed concerns surrounding reports that board and care facilities are closing at an increased rate. This is, in part, blamed on the low reimbursement rates for facilities that accept SSI/SSP recipients and facilities' generally high operating costs. However, despite these growing concerns, questions remain regarding the severity of closures, reasons for closures, and what happens to residents when facilities close.

Questions.

1. How would the department go about figuring out how many SSI/SSP recipients reside in these facilities?

2. How many of these facilities have closed in recent years? What effect have those closures had on capacity?

3. Describe the process that occurs when a facility is closing and the role of CCL, if any, in that process.

Issue 3: BCP – Caregiver Background Checks

Governor's Proposal. The Administration requests $898,000 ($730,000 General Fund) and seven positions to address criminal background check workload within the CCL Caregiver Background Check Bureau.

Background. The CCL division processes criminal background check requests for licensed community care facilities, their employees, volunteers and non-client adults residing in facilities, as well as for individuals desiring to be registered on license-exempt registries focused on providing care to the elderly and children. Applicants who have criminal histories are required to go through a process to receive a Criminal Record Exemption prior to working or coming into contact with clients. DSS processes approximately 70,000 criminal histories per year, resulting in approximately 40,000 exemption cases per year. In 2016, the California State Auditor found DSS took too long to process exemptions, which resulted in recommendations for the improvement to processing cases expeditiously. At the time, the DSS was taking more than six months to process requests.

Creation of Pilot Unit. In 2018, the DSS performed an in-depth analysis of their business process workflows and determined that the implementation of a specialized pilot unit focused on processing cases by a specific criterion would significantly streamline the exemption case process. This unit allowed other analysts more time to process cases in a timely manner. Because of the unit, less complex cases were identified faster, a quality assurance process was implemented, and cases were distributed equitably to staff with specialized training. The average number of days to process a simplified exemption decreased from 200 days to 7 days, the average number of days to process a transfer decreased from 30 days to 11 days, and the average number of days to process a standard exemption (more complex case) has decreased from 205 days to 120 days.

Staff Comment and Recommendation. Hold open.

Questions.

1. Provide an overview of the proposal.

Issue 4: BCP – Quality Oversight Staffing Resources

Governor's Proposal. The Administration requests $500,000 ($342,000 General Fund) and three positions to support the out-of-state community care facilities certification unit in the CCL's Children's Residential Program.

Background. The DSS is the primary agency responsible for ensuring that all out-of-state community care facilities accepting foster children from California are certified. The certification indicates that the facility meets the same standards as facilities that operate within the state. The Family Code Section 7911.1 establishes the requirements for certification and oversight of out-of-state community care facilities for placement of children. This includes conducting annual inspections, complaint investigations and reviewing serious incident reports. Furthermore, the DSS is responsible for conducting initial and on-going certification inspections, psychotropic medication oversight inspections, and assisting with a facility's efforts to meet California's requirements for a Short Term Residential Therapeutic Program (STRTP). The DSS oversees 26 out-of-state certified group homes/STRTPs in 11 states. Currently, approximately 285 California foster youth are placed in out-of-state facilities.

Inspection and Investigation Workload. According to the DSS, initial, annual, and case management inspections and complaint investigations require a physical inspection of all facility buildings and exterior grounds, review of client, employee, and facility files, and interviews with youth, staff, and home-state licensing personnel. Annual inspections require a minimum of two full days to complete all on-site inspection requirements; combined with travel and associated post-inspection documentation an annual inspection requires a minimum of five days for an analyst to complete. Family Code Section 7911.1(a) requires out-of-state facilities to submit incident reports for all youth in placement regardless of state of origin. The DSS receives approximately 330 reports per month and has a backlog of 1,500 incident reports awaiting review.

To be consistent with in-state licensing practices, staff will conduct initial and post-placement case management inspections of all certified out-of-state facilities that apply to be certified as a STRTP. Annual recertification visits are mandated to maintain the placement of a California client in an out-of-state facility and have been prioritized over other work to ensure the facilities continue to meet California requirements. With the requested resources, staff will make initial or post-placement visits for the facilities who have changed facility types from a group home to an STRTP. Last fiscal year, there was a gap of 18 of these visits that were not made resulting in certification of six programs as STRTPs that were later found to fail to meet STRTP requirements pertaining to staff to child ratios, staff qualifications, and service delivery.

In the last year, the program investigated 35 complaints. DSS staff initiate complaint investigations within ten days, however, due to inadequate staffing, complaint investigations have been conducted remotely with some investigation and delivery of findings occurring in conjunction with annual facility inspections. Of the 35 complaints investigated in 2018, 20 were conducted exclusively via telephone interviews and gathering documentation from out-of-state licensing and social services agencies.

According to the DSS, the requested resources will allow consistent completion of annual inspections, initiation of complaint investigations on-site within ten days, and the conduction of on-site case management inspections when needed.

Staff Comment and Recommendation.

Questions.

1. Provide an overview of the proposal.

2. How many of these out-of-state facilities have an ongoing certification versus a certification for the duration of placement of one child?

3. What is the current ratio of facilities per inspector?

4. Trailer bill language included in the 2019 Budget Act required all out-of-state facilities be certified as STRTPs by 2020. Will the department be able to meet this goal with the additional requested resources? Did the DSS foresee the need for these additional resources last year when this trailer bill language was being discussed?

Issue 5: BCP – Continued Oversight of Psychotropic Medications in Foster Care

Governor's Proposal. The Administration requests $909,000 ($622,000 General Fund) and eight positions ongoing to support the workload associated with monitoring the safe and appropriate usage of psychotropic mediations in short-term residential therapeutic programs (STRTPs) and group homes.

Specifically, the following positions are requested:

- One Licensing Program Manager (LPM)
- Five Licensing Program Analysts (LPA)
- One Associate Program Governmental Analyst (AGPA)
- One Office Assistant

Background. Senate Bill 484 (Beall), Chapter 540, Statutes of 2015, required DSS to establish a methodology to identify STRTPs and group homes that have levels of psychotropic drug utilization warranting additional review. The legislation also required the DSS to consult with the Department of Health Care Services (DHCS) and stakeholders every three years to revise the methodology.

Need for Additional Positions. A non-psychotropic medication inspection at a group home averages 5.5 hours (pre and post visit, related desk work and travel). By contrast, the workload associated with the psychotropic medication annual inspections takes a minimum of 20 hours to complete. Psychotropic medication inspections require more time, attention to detail, and greater depth of knowledge regarding the requirements for prescribing and assisting with self-administration of psychotropic medications for children in foster care. The extensive review of the children's trauma history, case files, employee files, as well as conducting in-depth interviews of staff and children makes the inspections time-consuming.

The DSS requests a LPA in each of its five regional offices along with the other requested positions to develop regulations, policy, procedures and a statewide summary report and to meet the ongoing workload to conduct more focused, time intensive review of STRTPs and group homes statewide. The DSS requests one permanent LPM I to provide supervisory support and guidance, four permanent LPAs who will provide oversight of psychotropic medications, and one LPA to cover inspections for each licensing region to conduct these focused, time-intensive inspections statewide.

With the additional positions, the DSS also plans to expand the scope of the inspections to explore additional topics, including quality of staff training and the licensee's level of initiative in informing children of their medication rights regarding their treatment.

Staff Comment and Recommendation.

Questions.

1. Provide an overview of the proposal.

5180 DEPARTMENT OF SOCIAL SERVICES – ADULT PROTECTIVE SERVICES (APS)

Issue 1: Overview

Background. Each of California's 58 counties has an Adult Protective Services (APS) agency to aid adults aged 65 years and older and dependent adults who are unable to meet their needs, or are victims of abuse, neglect, or exploitation. The APS program provides 24/7 emergency response to reports of abuse and neglect of elders and dependent adults who live in private homes, apartments, hotels or hospitals, and health clinics when the alleged abuser is not a staff member. APS social workers evaluate abuse cases and arrange for services such as advocacy, counseling, money management, out-of-home placement, or conservatorship. APS social workers conduct in-person investigations on complex cases, often coordinating with local law enforcement, and assist elder adults and their families navigate systems such as conservatorships and local aging programs for in-home services. These efforts often enable elder adults and dependent adults to remain safely in their homes and communities, avoiding costly institutional placements, like nursing homes.

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.[3] DSS retains program oversight and regulatory and policymaking responsibilities for the program, including statewide training of APS workers to ensure consistency. DSS also serves as the agency for the purpose of federal funding and administration. APS expenditures since 2011 are in the table below.

Fiscal Year	Expenditures
2011-12	$119.7 million
2012-13	$120.7 million
2013-14	$126.3 million
2014-15	$137.6 million
2015-16	$147.6 million
2016-17	$159.7 million
2017-18	$169.9 million
2018-19	$191.4 million

APS Reports. APS reports have risen since 2011. Between 2014 and 2019, APS received 916,237 reports. During that same time, 800,709 cases were opened and 700,584 cases were resolved. Over the last year, the number of abuse reports received increased by 7.6 percent. Confirmed cases of financial abuse increased 10.3 percent in the last year.

[3] AB 118, (Committee on Budget), Chapter 40, Statutes of 2011, and AB 16 1X (Committee on Budget), Chapter 13, Statutes of 2011, First Extraordinary Session, realigns funding for Adoption Services, Foster Care, Child Welfare Services, and Adult Protective Services, and programs from the state to local governments and redirects specified tax revenues to fund this effort.

Training. The 2014 Budget Act included $150,000 in funding for one staff position within the department to assist with APS coordination and training. In 2015, trailer bill language was adopted that codified the responsibilities of this staff person. In addition, $176,000 ($88,000 General Fund) was allocated to DSS for APS training. The 2016 Budget Act included one-time funding of $3 million General Fund for APS training for social workers. The 2019 Budget Act included $11.5 million ($5.8 million General Fund) to be used over three years for training of APS social workers and public guardians.

Federal Grants. APS received a federal Administration for Community Living (ACL) grant of $198,665 to study and develop an improved comprehensive data collection system in line with the National Adult Maltreatment Reporting System (NAMRS). As a result of this funded the state is now collecting more comprehensive data including statewide staffing figures, services provided as a result of APS investigations, and interagency coordination and services referred. The grant also allows the collection of demographic information on clients and alleged perpetrators.

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

Staff Comment and Recommendation. Informational item. No action necessary.

Questions.

1. Please provide an overview of the APS program.

Issue 2: Housing and Homelessness Programs - Update on Home Safe Program

Background. The Home Safe Program was established by AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018. The program serves APS clients that are homeless or at risk of homelessness due to elder or dependent adult abuse, neglect, or financial exploitation. Local APS agencies provide homelessness prevention and short-term housing interventions to support safety and housing stability.

The goal of the Home Safe Program is to support the safety and housing stability of individuals involved in APS by providing housing-related assistance. Grantees operating Home Safe programs will implement a range of strategies to support housing stability for APS clients, including short-term financial assistance, legal services, eviction prevention, heavy cleaning, and landlord mediation, among other services.

The Housing and Homelessness Bureau of DSS will be offering ongoing technical assistance to counties participating in Home Safe as well as the greater APS community to ensure lessons learned and best practices are shared throughout the state. This will include regular and ongoing telephone and email correspondence as well as in-person site visits and meetings throughout the pilot. DSS is initiating data collection efforts and is collaborating with Dr. Margot Kushel at the University of California-San Francisco to provide an external evaluation of the program.

Funding. The Budget Act of 2018 provided $15 million General Fund (one-time) to fund the program over a three-year period, ending on June 30, 2021. The program is funded with a dollar-for-dollar match requirement, and a portion of funds are reserved for program evaluation purposes.

In December 2018, CDSS allocated funds on a competitive basis to 24 counties. A list of counties and the funds allocated is below.

County	Allocation	County	Allocation
Alameda	955,400	Riverside	1,969,541
Contra Costa	740,079	Sacramento	263,640
Fresno	588,571	San Bernardino	600,000
Humboldt	335,848	San Diego	500,000
Kern	170,000	San Francisco	773,981
Kings	113,440	Santa Clara	720,822
Los Angeles	2,648,128	Santa Cruz	743,440
Mariposa	170,000	Shasta	216,516
Mendocino	216,417	Sonoma	680,000
Merced	747,080	Tehama	170,000
Nevada	50,620	Ventura	170,000
Placer	468,885	Yuba	287,592

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an update on the Home Safe program.

2. What specific outcomes of the program will be measured to determine its success?

3. Has the program been showing any initial successes? If so, please describe them.

Issue 3: Proposals for Investment

1. Expand and Enhance Adult Protective Services

Budget Issue. The role of APS is growing as communities increasingly rely upon APS to address the complex needs of older adults, including those who are at risk of or experiencing homelessness or those with cognitive impairments. According to the California Welfare Directors Association (CWDA), the program will need additional state investment to support those individuals who require longer-term and more intensive assistance in order to remain safe in their homes and communities.

The CWDA is requesting a total of $100 million General Fund to:

- Provide long-term case management, including for those who are homeless and have cognitive impairments and allow APS to serve highly vulnerable adults aged 60-65 ($65 million General Fund).

- Build upon the APS Home Safe Program ($25 million General Fund). According to the CWDA, APS Home Safe should be expanded to interested counties and modified to assist victims of abuse and neglect who have become homeless or who need longer-term housing support as a bridge to other housing programs.

- Encourage Collaborative, Multi-Disciplinary Best-Practices across the state ($10 million General Fund). FAST and Forensic Centers are considered best practices in APS. They allow for a collaborative and targeted, rapid-response approach to the most complex cases. Currently, only a few counties have either model, but those that do see great success in interceding and stopping financial abuse and stabilizing victims who require a cross-systems response.

Staff Comment and Recommendation. Hold open.

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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Andreas Borgeas
Senator Melissa Hurtado

Thursday, March 5, 2020
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Renita Polk

OUTCOMES

Item	Department	Action

4170 Department of Aging (CDA)
Issue 1: Master Plan on Aging Update .....Informational
Issue 2: BCP – Headquarters Relocation Funding.....Hold open
Issue 3: Proposals for Investment .....Hold open

5180 Department of Social Services – In-Home Supportive Services (IHSS)
Issue 1: Overview .....Informational
Issue 2: Update on IHSS MOE .....Informational
Issue 3: Mandatory IHSS Social Worker Training TBL .....Hold open
Issue 4: Proposals for Investment .....Hold open

0530 Health and Human Services Agency Office of Systems Integration (OSI)
5180 Department of Social Services (DSS)
Issue 1: BCP – Electronic Visit Verification (EVV) for In-Home Supportive Services (Phase I).....Hold open

5180 Department of Social Services – SSI/SSP
Issue 1: Overview .....Informational
Issue 2: Housing and Homelessness Programs - Update on Housing and Disability Advocacy Program (HDAP) .....Informational
Issue 3: Proposals for Investment .....Hold open

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

5180 Department of Social Services – Adult Protective Services (APS)

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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Andreas Borgeas
Senator Melissa Hurtado

Thursday, March 12, 2020
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Electronic Visit Verification Phase II Planning

Budget Issue. The Office of Systems Integration (OSI) within the California Health and Human Services Agency (CHHSA), the Department of Health Care Services (DHCS), the Department of Public Health (DPH), and the Department of Developmental Services (DDS) request expenditure authority of $2.9 million ($290,000 General Fund and $2.6 million federal funds) in 2020-21. If approved, these resources would continue the multi-departmental planning effort for the second phase (Phase II) of implementation of Electronic Visit Verification for personal care services and home health care services. These staffing and other resources would support completion of activities required by the Department of Technology's Project Approval Lifecycle (PAL) Stage Gate requirements and federal Advanced Planning Document (APD) requirements.

Program Funding Request Summary (CHHSA-OSI)		
Fund Source	**2020-21***	**2021-22**
9745 – CHHS Automation Fund	$1,970,000	$-
Total Funding Request:	**$1,970,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

***** Transfers from other Departments: DHCS: $985,000; DDS: $985,000

Program Funding Request Summary (DHCS)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$126,000	$-
0890 – Federal Trust Fund	$2,599,000	$-
Total Funding Request:	**$2,725,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Program Funding Request Summary (DPH)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$16,000	$-
0995 – Reimbursements	$133,000	$-
Total Funding Request:	**$149,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Program Funding Request Summary (DDS)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$149,000	$-
0995 – Reimbursements	$1,335,000	$-
Total Funding Request:	**$1,484,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The federal 21st Century CURES Act[1] requires states to implement an electronic visit verification system for all Medicaid-funded Personal Care Services (PCS) by January 1, 2020, and Home Health Care Services (HHCS) by January 1, 2023. Federal law defines an electronic visit verification (EVV) system as a system under which PCS or HHCS visits are electronically verified, including the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends. Services provided under California's Medicaid State Plan in the Medi-Cal program that would be required to implement an EVV system include waiver services for individuals with developmental disabilities administered by DDS, In-Home Supportive Services (IHSS) administered by DSS, Waiver Personal Care Services and Home Health Care Services administered by DHCS, Multipurpose Senior Services Program administered by DHCS and CDA, and AIDS Medi-Cal Waiver services administered by DHCS and DPH. These services are offered under one of two models:

- Self-Directed Model – Services provided under a self-directed model are those in which the service recipient is responsible for hiring and managing direct care workers.
- Agency Model – Services provided under an agency model use a provider agency or vendor to recruit, hire, and manage direct care workers.

The Administration plans to implement EVV in two phases. Phase I will include implementation for the self-directed model components of the IHSS (DSS) and Waiver Personal Care Services (DHCS) programs, which currently use the Case Management Information and Payrolling Systems (CMIPS II) and Electronic Time Sheet (ETS) System (see separate CHHSA BCP: *Electronic Visit Verification for In-Home Supportive Services Phase I*). Phase II will include non-IHSS and non-Waiver Personal Care Services self-directed model components, as well as the agency model components of the IHSS and Waiver Personal Care Services programs.

Electronic Visit Verification Phase II Programs

Department	Program	Self-Directed	Agency Model	PCS	HHCS
DDS	1915 (c) DD Waiver	X	X	X	X
DDS	1915 (i) State Plan Services	X	X	X	X
DDS	1915 (c) Waiver Self-Determination Program	X	X	X	X
DHCS	1915 (c) Home- and Community-Based Alternatives Waiver	X	X	X	X
DHCS	Home Health Care Services		X	X	X
DHCS	Waiver Personal Care Services Agency Model		X	X	
CDA/DHCS	MSSP 1915 (c) and 1115 Waivers		X	X	
DPH/DHCS	1915 (c) AIDS Medi-Cal Waiver		X	X	X
DSS	IHSS Agency Model		X	X	

Under the 21st Century CURES Act, states that do not adopt EVV for PCS programs by January 1, 2020 are subject to an incremental decrease in the federal match available for these programs of 0.25 percent in

[1] 42 United States Code Subsection (*l*), added by 21st Century CURES Act (HR 34, 114th Congress, 2015-16)

calendar year 2020, 0.5 percent in 2021, 0.75 percent in 2022, and one percent annually thereafter. States that do not adopt EVV for HHCS by January 1, 2023, would be subject to an additional decrease in federal match of 0.25 percent in 2023 and 2024, 0.5 percent in 2025, 0.75 percent in 2026, and 1 percent annually thereafter. The CURES Act allows a state to apply for a one-year exemption from the federal match reduction if the state made a good faith effort to comply and has encountered unavoidable delays. DHCS requested and the federal government approved a one-year exemption under this provision, delaying any reduction in federal matching funds until 2021. A state may only apply for a single, one-year exemption. According to DHCS, failure to implement EVV would result in the following reductions in federal matching funds for Medi-Cal services:

- 2021: $11.7 million (PCS penalty)
- 2022: $19.5 million (PCS penalty)
- 2023: $29.6 million (PCS penalty + HHCS penalty)
- 2024: $34.4 million (PCS penalty + HHCS penalty)

OSI, DHCS, DPH, and DDS request expenditure authority of $2.9 million ($290,000 General Fund and $2.6 million federal funds) in 2020-21. The allocation of funds and position equivalents in this request for each of these departments are as follows:

Department/Office	Federal Funds (90 percent)	General Fund (10 percent)	TOTAL FUNDS	Position Equivalents
OSI*	[$1,773,000]	[$197,000]	[$1,970,000]	3.0
DHCS	$1,130,000	$126,000	$1,255,000	2.0
DDS	$1,335,000	$149,000	$1,484,000	3.0
DPH	$134,000	$15,000	$149,000	1.0
Total	**$2,599,000**	**$290,000**	**$2,888,000**	**9.0**

* OSI Allocation is non-add, as this allocation is the result of a transfer from DHCS and DDS of $985,000 each for a total of $2 million ($197,000 General Fund and $1.8 million federal funds) of the approved funding to OSI to fund contract costs and the equivalent of three positions.

The requested position equivalents are as follows:

OSI (Three position equivalents)

- One Project Director – The project director would be responsible for overall management of the planning team; would serve as the primary point of contact for communications between planning team, executive management, stakeholders, and control agencies; would be responsible for oversight and management of a formal governance structure and ensuring business process and organizational change management are incorporated throughout the planning process. Funding for this position equivalent was approved for one year in the 2019 Budget Act.

- Procurement and Contract Management Analyst – The procurement and contract management analyst would be responsible for the management and tracking of consultant contract deliverables, conducting market research activities during planning, developing documents for the Stage 2 Alternatives Analysis as part of the Department of Technology's PAL Stage Gate process. Funding for this position equivalent was approved for one year in the 2019 Budget Act.

- Fiscal Feasibility Analyst/Budget Analyst – The fiscal/budget analyst develops fiscal and budget related documents, tracks actual expenditures, develops financial documents to comply with state and federal laws and regulations, and conducts fiscal feasibility analysis on solutions assessed by the planning team. Funding for this position equivalent was approved for one year in the 2019 Budget Act.

DHCS (Two position equivalents)

- Health Program Specialist – The health program specialist would be responsible for development and maintenance of EVV-specific policies and procedures related to DHCS and affected contractors, serve as a subject matter expert to provide information and updates to DHCS divisions, act as liaison to outside entities and stakeholders, and provide training and development for DHCS and outside contractor staff. Funding for this position equivalent was approved for two years in the 2018 Budget Act.

- Associate Governmental Program Analyst (AGPA) – The AGPA would support planning and maintenance of the EVV solution, develop and maintain policies and procedures related to EVV requirements, support stakeholder engagement and training, support federal reporting, and track implementation and compliance. Funding for this position equivalent was approved for two years in the 2018 Budget Act.

DDS (Three position equivalents)

- Staff Services Manager I – The staff services manager would coordinate with, and issue guidance to, regional centers, providers, stakeholders, and other departments relevant to EVV implementation, training, monitoring provider compliance, federal reporting, and continued stakeholder engagement. Funding for this position equivalent was approved for two years in the 2018 Budget Act.

- Lead Technical Architect – The lead technical architect would be responsible for designing and documenting systems architecture and interfaces with the EVV system, developing and maintaining system hardware and software documentation and technical system documentation, serving as subject matter expert and providing guidance and technical assistance to program staff, stakeholders, and other state departments. Funding for this position equivalent was approved for one year in the 2019 Budget Act.

- Technical Project Manager – The technical project manager would design and develop standards and high level workflow of software systems, work with program staff and stakeholders to assist with identifying implementation requirements, collaborate with leads to prioritize system fixes and enhancements, advise management on technical issues, assist in project management functions, facilitate meetings and reporting to state control agencies, perform risk analysis and mitigation planning, develop user manuals and support materials, and review programming results. Funding for this position equivalent was approved for two years in the 2018 Budget Act at a lower level classification. However, the Administration is not requesting renewal of two AGPA positions approved for one year in the 2019 Budget Act.

DPH (One position equivalent)

- Health Program Specialist – The health program specialist would be responsible for developing EVV-specific policies and procedures related to DPH programs and contractors, acting as a subject matter expert for DPH management and staff, and acting as a liaison to other state departments and stakeholders. Funding for this position equivalent was approved for one year in the 2019 Budget Act.

In addition to the position equivalents, OSI is requesting $1.2 million for a consultant contract for project management support and independent verification and validation services, as well as Statewide Technology Procurement fees.

OSI is also requesting $169,000 for facilities costs, and $345,000 for other operating expenses and equipment.

Timeline of Planning for EVV Phase II Implementation. According to OSI, documentation for the Stage 2 Alternatives Analysis of the Department of Technology's PAL process was submitted on February 27, 2020. Approval is expected by the end of March 2020, and OSI is preparing for commencement of Stage 3 Solution Development activities. The federal government has approved the Planning Advance Planning Document, which is the first stage for receiving enhanced federal funding for the project, and expects to submit an Implementation Advance Planning Document to support the design, development and implementation activities of EVV Phase II after identification of a preferred solution. OSI expects to submit this documentation in the summer of 2020. A 60-day review period is required, and federal approval of all documentation is necessary prior to proceeding to Stage 4 Project Readiness and Approval and procurement and implementation of the EVV Phase II solution.

Federal Guidance Creates Uncertainty for Approval. On December 20, 2019, DHCS received federal guidance that the state's electronic timesheet system was not sufficient to meet federal EVV requirements that data elements be electronically verified. DHCS is engaging with the federal government to navigate a path forward towards compliance and avoiding federal matching fund penalties. While this guidance directly impacts the more near-term Phase I implementation of EVV for IHSS and Waiver Personal Care Services, the extent to which Phase II implementation might be impacted will depend on the resolution of these federal issues.

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

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

1. Please provide a brief overview of this proposal.

2. What is the current expected timeline for implementation of Phase II for EVV?

3. How will the recent federal guidance on Phase I implementation impact planning and solution development for Phase II? Would any current planning or analysis need to be revised?

Issue 2: Office of the Surgeon General – Trauma-Informed Training and Public Awareness

Budget Issue. CHHSA's Office of the Surgeon General requests General Fund expenditure authority of $10 million in 2020-21. If approved, these resources would allow the Office of the Surgeon general to develop a cross-sector training program and public awareness campaign for Adverse Childhood Experiences. These funds would be available for encumbrance and expenditure until June 30, 2022.

Program Funding Request Summary (CHHSA-OSG)		
Fund Source	**2020-21***	**2021-22**
0001 – General Fund	$10,000,000	$-
Total Funding Request:	**$10,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

***** Resources available for encumbrance and expenditure until June 30, 2022.

Background. The Office of the Surgeon General was established in the 2019 Budget Act and associated trailer bill language, after appointment of California's first Surgeon General, Dr. Nadine Burke Harris, by Governor Newsom in Executive Order N-02-19. The Office of the Surgeon General is responsible for the following:

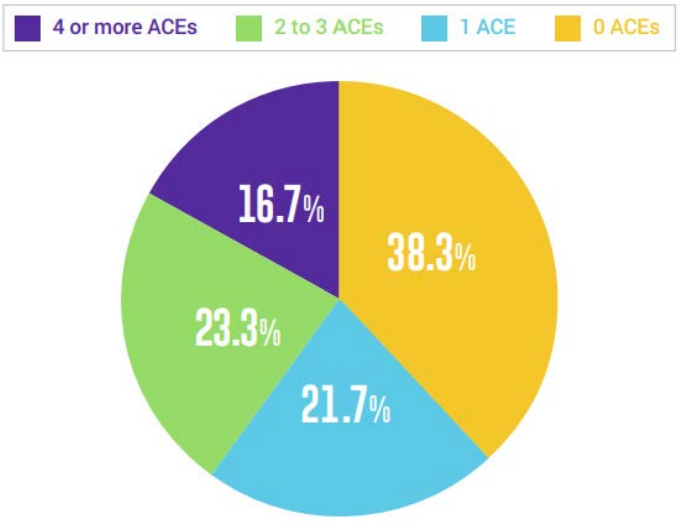
- Raising public awareness on and coordinating policies governing scientific screening and treatment for toxic stress and adverse childhood events.
- Advising the Governor, the Secretary of the California Health and Human Services Agency, and policymakers on a comprehensive approach to address health issues and challenges, including toxic stress and adverse childhood events, as effectively and early as possible.
- Marshalling the insights and energy of medical professionals, scientists, and other academic experts, public health experts, public servants, and everyday Californians to solve our most pressing health challenges, including toxic stress and adverse childhood events.

Adverse Childhood Experiences (ACEs). In 1998, a study conducted at Kaiser Permanente's San Diego Health Appraisal Clinic by researchers Vincent Felitti, Robert Anda, and colleagues[2] uncovered some of the first compelling evidence of the impact of adverse childhood experiences (ACEs) on health risk behavior and disease in adulthood. A questionnaire about experience with seven categories of ACEs was mailed to more than 13,000 adults who had completed a standardized medical evaluation. The seven categories were psychological, physical, or sexual abuse; violence against a mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of ACEs respondents reported was then compared to measures of adult risk behavior, health status, and disease. The researchers found that individuals who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had a four- to twelve-fold increased health risk for alcoholism, drug abuse, depression, and attempting suicide; a two- to four-fold increased risk in smoking, poor self-rated health, a high number of sexual partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. The number of categories of

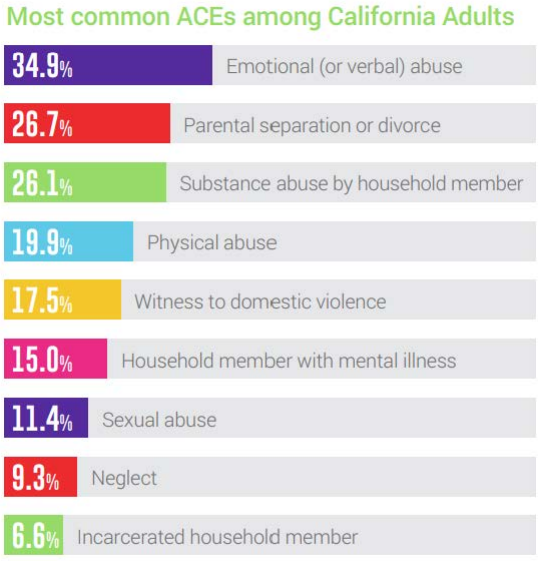
[2] Felitti V., Anda R., Nordenberg D., Williamson D., Spitz A., Edwards V., Koss M., Marks J. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Deaths in Adults". Am J Prev Med 1998;14(4) 245-258.

ACEs individuals experienced also demonstrated a dose-dependent relationship to physical health issues including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Later research has demonstrated that an individual experiencing four or more ACEs has a greater risk of the following leading causes of death in the United States: heart disease (2.1-fold), cancer (2.3-fold), accidents (2.6-fold), chronic lower respiratory disease (3.1-fold), stroke (2.0-fold), Alzheimer's disease (4.2-fold), diabetes (1.4-fold), kidney disease (1.7-fold), and suicide (37.5-fold).

The Center for Youth Wellness, a health organization founded by Dr. Burke Harris in 2012 to address ACEs and toxic stress in children, analyzed four years of data collected by the California Behavioral Risk Factor Surveillance System to determine the prevalence and impact of ACEs in Californians [3]. According to the study, 61.7 percent of California adults have experienced at least one ACE and 16.7 percent have experienced four or more.



Prevalence of number of ACEs among California adults



Most common ACEs among California adults

Trauma Screening for Children and Adults in Medi-Cal. The 2019 Budget Act included $45 million ($22.5 million Healthcare Treatment Fund and $22.5 million federal funds) annually to support trauma screenings for all children and adults in Medi-Cal. Trauma screening will be provided through both the managed care and fee-for-service delivery systems and the supplemental payment to providers for the screening is in addition to the amount paid for the office visit during which the screening occurs. The screenings for children will use a tool recommended by the AB 340 Trauma Screening Advisory Workgroup, known as PEARLS and developed by the Bay Area Research Consortium on Toxic Stress and Health (BARC). According to DHCS, there are two versions of the tool. One version is for ages one through 12 and the other for teens ages 13 through 19. For adults, DHCS reports it will use the Adverse Childhood Experiences (ACEs) assessment or a similar tool. The additional reimbursement to providers for developmental screenings would be $29 per screen.

[3] Center for Youth Wellness. "A Hidden Crisis: Findings on Adverse Childhood Experiences in California". 2014.

In addition to funding for trauma screening, the 2019 Budget Act included $50 million ($25 million Healthcare Treatment Fund and $25 million federal funds) to train providers to deliver trauma screenings to patients enrolled in Medi-Cal. The Office of the Surgeon General and DHCS have launched the ACEsAware initiative, to give Medi-Cal providers training, clinical protocols, and payment for screening children and adults for ACEs.

According to the Office of the Surgeon General, there is currently no standard of care for children or adults that screen positive for ACEs. Although Dr. Burke Harris has recognized the importance of several specific interventions including sleep, mental health treatment, healthy relationships, exercise, nutrition, and mindfulness, there is no clear guidance for providers to help patients cope with the accumulation of toxic stress caused by ACEs. The Office of the Surgeon General reports that the clinical advisory subcommittee of the ACEsAware initiative is working on development of a standard of care or best practices for the treatment and mitigation of the negative health impacts of ACEs.

The Office of the Surgeon General requests General Fund expenditure authority of $10 million in 2020-21, available for encumbrance and expenditure until June 30, 2022. These resources would support two budget needs identified by the Office of the Surgeon General:

1) Public Awareness Campaign – $8 million of this request would support a public education campaign to raise awareness and understanding of ACEs and toxic stress. The campaign would aim to validate an individual's experience and encourage Californians to seek out or accept assistance and begin to heal, as well as equip Californians with a shared language to better navigate the needs they or a loved one may be needing to heal. Design, development, and piloting of the media campaign would take place in 2020-21, with full-scale campaign airing in 2021 through 2022. The campaign would be primarily focused on alignment with Medi-Cal provider screening and encouraging Medi-Cal beneficiaries to learn more about ACEs and seek screening and treatment from their providers.

2) Cross-Sector Trauma-Informed Training - $2 million of this request would support development of standardized and accredited cross-sector training materials to ensure that front-line providers such as educators and law enforcement officers can recognize the symptoms of an overactive stress response due to ACEs and respond with trauma-informed principles and refer to care, rather than escalating the encounter with harsh, punitive measures. Training materials would be developed by leading experts and consultants and would be provided to key sectors including early childhood, education, government, and law enforcement. The trainings would include the latest evidence on trauma-informed and trauma-sensitive responses and would be made available to statewide entities that participate in the training of the early childhood workforce, educators, government employees and law enforcement officers. According to the Office of the Surgeon General, this request was prompted by interest from state departments on how to effectively train staff on recognizing and responding to impacts of trauma.

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

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

1. Please provide a brief overview of this proposal.

2. Please describe how the Office of the Surgeon General would implement the public awareness campaign. Would these activities be performed by a contractor?

3. Would this effort build upon existing media campaign resources, such as at the Department of Public Health?

4. Which department or other entities would receive the cross-sector training materials? How would those trainings be conducted?

Issue 3: Center for Data Insights and Innovation

Trailer Bill Language Proposal. The Administration proposes trailer bill language to establish the Center for Data Insights and Innovation within CHHSA. If approved, the proposed language would merge the current Office of Patient Advocate, Office of Health Information Integrity, and the California Committee for the Protection of Human Subjects into the new Center, which would combine functions from these entities including annual reporting on quality of care and patient experience of public health coverage programs, guidance on health data sharing and compliance with health information privacy laws, and review of research proposals using state data assets. In addition, the Center would develop and administer a Research Data Hub and the Open Data Portal, engage and coordinate with other departments to address social determinants of health, expand health data sharing and health information privacy compliance guidance among state entities, improve data processes and knowledge management within state departments, and develop and manage future data initiatives within the agency.

Background. The California Health and Human Services Agency (CHHSA) oversees departments and other entities that provide a range of health care services, social services, mental health services, alcohol and drug services, income assistance, and public health services to Californians from all walks of life. Within CHHSA there are several offices that support health and human services departments and entities. Two of these offices are the Office of Patient Advocate and the Office of Health Information Integrity.

Office of Patient Advocate. The Office of Patient Advocate (OPA) coordinates, provides assistance to, and collects data from state health care consumer assistance call centers. According to OPA, the goal of these efforts is to better enable health care consumers to access the health care services for which they are eligible. OPA produces the following:

1. **Health Care Quality Report Cards** with clinical performance and patient experience data for the state's largest health plans and over 200 medical groups
2. **Complaint Data Reports and Baseline Review of State Consumer Assistance Call Centers** with data findings based on health care consumer complaint data and call center information submitted to OPA from the Department of Managed Health Care, Department of Insurance, Department of Health Care Services, and Covered California
3. **Model Protocols for State Consumer Assistance Call Centers** with recommendations for responding to and referring calls outside of a call center's jurisdiction.

OPA was originally established as part of the Department of Managed Health Care (DMHC) to represent the interests of enrollees served by health care service plans regulated by the department. AB 922 (Monning), Chapter 522, Statutes of 2011, transferred the office to the Health and Human Services Agency, and established the Office of Patient Advocate Trust Fund to provide ongoing funding for the office's activities. The fund receives, upon appropriation by the Legislature, transfers from the Insurance Fund and Managed Care Fund proportionate to the number of covered lives regulated by the California Department of Insurance (CDI) and DMHC, respectively. AB 922 also required OPA to operate a toll-free telephone line to act as a single point of entry for consumer assistance with their health benefits.

The 2014 Budget Act revised the role of OPA to remove its direct consumer assistance responsibilities and clarify its directive to track, analyze, and produce reports about problems, complaints, and questions received by other state departments from health care consumers. The Administration's rationale for

elimination of OPA as a single point of entry was that existing consumer assistance programs were sufficient for consumers' needs. The OPA was instead tasked with creating a series of reports on complaint data received by four reporting entities: 1) DMHC, 2) CDI, 3) DHCS, and 4) Covered California. The goal of these reports is to collect and analyze data to identify trends and make recommendations to improve the consumer assistance protocols for these four reporting agencies.

Office of Health Information Integrity. The California Office of Health Information Integrity (CalOHII) within CHHSA provides statewide guidance, planning, and technical assistance to state departments and agencies for compliance with the Health Insurance Portability and Accountability Act (HIPAA). HIPAA, implemented in 1996, was intended to allow for portability and continuity of an individual's health care coverage by imposing significant administrative simplification and standardization requirements on health care entities, and strict security standards for protected health information. CalOHII was established in 2001 with the following responsibilities and authority:

- Provide statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA implementation by impacted state departments.
- Establish policy, provide direction to state entities, monitor progress, and report on HIPAA implementation efforts.
- Determine which provisions of state law concerning personal health information are preempted by HIPAA for state agencies.

HIPAA administrative simplification and security rules apply to certain individuals or organizations known as covered entities or business associates. According to the U.S. Department of Health and Human Services (HHS), covered entities include the following:

1. Health care providers including physicians, clinics, psychologists, dentists, chiropractors, nursing homes, and pharmacies that transmit HIPAA-protected information in an electronic format.
2. Health plans including commercial health care service plans, health insurers, group health plans, and public health care programs, such as Medicare, Medicaid, and military or veteran's health care programs.
3. Health care clearinghouses that process nonstandard information they receive from another entity into a standard electronic format or data content, or vice versa.

According to HHS, a business associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. CalOHII is responsible for conducting periodic reviews of state departments, agencies, and other organizations that are considered covered entities or business associates with administrative and security responsibilities under HIPAA. CalOHII also evaluates whether state entities are impacted in other ways by state or federal laws and regulations related to HIPAA or generally to the privacy and security of protected health information. CalOHII completed its most recent statewide HIPAA assessment in 2017 and determined the state's covered entities, business associates, and impacted entities are as follows:

Covered Entities and Business Associates	Impacted State Entities
CA Correctional Health Care Services	Board of Behavioral Sciences
Dept. of Aging	Board of Chiropractic Examiners
Dept. of Corrections and Rehabilitation	Board of Pharmacy
Dept. of Developmental Services	Board of Pilot Commissioners for the Bays
Dept. of Forestry and Fire Protection	Board of Podiatric Medicine
Dept. of General Services	Board of Psychology
Dept. of Health Care Services	Board of Registered Nursing
Dept. of Public Health	Board of Voc. Nursing and Psych. Technician Examiners
Dept. of Social Services	Bureau of Medical Cannabis Regulation
Dept. of State Hospitals	CA Acupuncture Board
Dept. of Technology	CA Board of Accountancy
Dept. of Veterans Affairs	CA Cmte on Employment of People with Disabilities
Emergency Medical Services Authority	CA Highway Patrol (CHP)
Office of Systems Integration	CA State Athletic Commission
Public Employees' Retirement System	CA Student Aid Commission
State Controller's Office	Council on Mentally Ill Offenders
	Covered CA
	Dental Board of CA
	Dental Hygiene Committee of CA
	Department of Consumer Affairs
	Department of Industrial Relations
	Department of Insurance
	Department of Managed Health Care
	Department of Motor Vehicles
	Department of Parks and Recreation
	Department of Pesticide Regulation
	Department of Rehabilitation
	Employment Development Department
	Health and Human Services Agency
	Medical Board of CA
	MH Services Oversight & Accountability Commission
	Naturopathic Medicine Committee
	Office of Health Information Integrity (CalOHII)
	Office of Law Enforcement Support
	Office of Statewide Health Planning and Development
	Office of the Inspector General
	Office of the Patient Advocate
	Office of the State Public Defender
	Osteopathic Medical Board
	Physical Therapy Board of CA
	Respiratory Care Board
	Speech-Lang Path. & Aud. & Hearing Aid Disp. Board
	State Board of Optometry
	State Personnel Board
	State Teachers' Retirement System

	Victim Compensation Board

Committee for the Protection of Human Subjects. The Committee for the Protection of Human Subjects (CPHS) serves as the institutional review board (IRB) for the California Health and Human Services Agency (CHHSA). The role of the CPHS and other IRBs is to assure that research involving human subjects is conducted ethically and with minimum risk to participants. CPHS reviews all research involving human participants conducted or supported by CHHSA and all research using private information held by CHHSA. The CPHS conducts reviews of research in compliance with Title 45, Part 46 of the Code of Federal Regulations (Common Rule) and when applicable, Title 21, Parts 50 and 56 of the Code of Federal Regulations (FDA Regulations). The CPHS also reviews the eligibility of research for a waiver of (or alteration of) patient authorization for release of protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

Center for Data Insights and Innovation. The Administration proposes trailer bill language to establish the Center for Data Insights and Innovation within CHHSA. If approved, the proposed language would merge OPA, CalOHII, and CPHS into the new Center, which would combine functions from these entities including annual reporting on quality of care and patient experience of public health coverage programs, guidance on health data sharing and compliance with health information privacy laws, and review of research proposals using state data assets. In addition to absorbing these existing responsibilities, the Center would develop and administer a Research Data Hub and the Open Data Portal, engage and coordinate with other departments to address social determinants of health, expand health data sharing and health information privacy compliance guidance among state entities, improve data processes and knowledge management within state departments, and develop and manage future data initiatives within the agency.

According to the Administration's proposed language, the new Center for Data Insights and Innovation would no longer conduct the Complaint Data Reports and Baseline Review of State Consumer Assistance Call Centers reporting currently prepared by OPA. CHHSA indicates the planned reporting by the new Center on quality of care and patient experience of public health coverage programs would include some information about consumer complaints. However, it is unclear whether the Legislature, stakeholders, and the general public would receive the same level of information about the performance of Covered California, county eligibility offices, the Department of Managed Health Care, and the Department of Health Care Services with regard to responding to consumer complaints.

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

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

1. Please provide a brief overview of this proposal.

2. Why does this proposal eliminate the OPA Complaint Data Report? How does the Administration intend to track performance of call centers at DMHC, DHCS, and others for responding to consumer complaints?

3. Please describe how the new Center would maintain the mandate of CalOHII to comply with HIPAA and protect patient information.

4. Please describe what barriers to data sharing the Administration has identified that the establishment of this Center would mitigate.

Issue 4: Office of Health Care Affordability

Trailer Bill Language Proposal. The Administration intends to propose trailer bill language to establish the Office of Health Care Affordability. If approved, the proposed Office would be charged with analyzing the health care market for cost trends and drivers of spending, enforcing health care cost targets and creating a state strategy for controlling the cost of health care and ensuring affordability for consumers.

Background. California has made significant gains in reducing the number of uninsured individuals in the state through expansion of the Medi-Cal program and the establishment of Covered California, the state's health benefit exchange, which provides state and federal premium affordability subsidies to improve access to health care coverage. Despite these gains in coverage, Californians remain concerned about the cost of paying for health care. A 2018 statewide survey by the Kaiser Foundation and the California Healthcare Foundation found approximately one in five Californians reported problems paying medical bills, nearly half of Californians experiences some type of cost-related health care access problem, and more than two in five reported delaying or forgoing care in the past year due to cost. Californians with lower incomes, those who lack health insurance, and black and Latino residents were more likely than their white or Asian American counterparts to forgo care due to cost.

According to the Centers for Medicare and Medicaid Services, Californians spent $292 billion on personal health care in 2014. Per-capita health spending in the state has grown steadily over time, with those covered by private health insurance experiencing the highest growth rates of approximately four percent per year. Prescription drug costs have grown at a particularly high rate, averaging seven percent per year.

Other State Efforts to Control Health Care Costs. Four other states have established regulatory bodies or independent entities aimed at controlling the growth of health expenditures. Each of these states (Maryland, Massachusetts, Oregon, and Rhode Island) approach the problem of controlling health expenditures differently.

1) Massachusetts Health Policy Commission – In 2012, Massachusetts established the Health Policy Commission (HPC) to set statewide targets for reducing health care spending growth. The growth targets are comprehensive and cover both public and private payers, as well as all medical expenses, non-claims-related payments, patient out-of-pocket expenses, and the net cost of private insurance. The HPC imposes mandatory reporting requirements on health care organizations to improve transparency and encourage containment of spending growth. If a provider organization exceeds certain growth targets, the HPC may require a performance improvement plan. Health care organizations must also testify at an annual two day hearing regarding efforts to contain costs. During the commission's first five years, Massachusetts' annual cost growth averaged 3.44 percent, which was lower than the target rate of 3.6 percent.

2) Maryland Health Services Cost Review Commission – In 1972, Maryland established the Health Services Cost Review Commission (HSCRC), focused on setting payment rates for hospital services. In 2019, Maryland expanded the model of the HSCRC to include all care for Maryland's Medicare enrollees, adopting a total cost of care model that encourages value-based health care redesign and provides tools and resources for primary care providers to better meet the needs of patients with complex health care needs and achieve better health for all Maryland residents. The HSCRC sets a

hospital per capita cost growth limit of 3.58 percent per year, sets and enforces the quality of care and population health goals, and provides incentive programs to reward population health and encourage value-based care.

3) Rhode Island Office of the Health Insurance Commissioner – In 2004, Rhode Island established the Office of the Health Insurance Commissioner (OHIC) to conduct rate reviews for health insurance plans. In 2009, the state expanded the focus of OHIC to mandate insurers spend one percent more in total spending on primary care for five years, expand a statewide multi-payer medical home program to better manage patients with chronic conditions, expand the use of electronic medical records, and reform payment systems to incentivize quality. Beginning in 2018, the state established a Working Group on Healthcare Innovation to develop recommendations for establishing a global health spending cap, linking payments to quality, developing standardized health information technology systems, and establishing performance frameworks to achieve population health and wellness goals.

4) Oregon Health Policy Board – In 2009, Oregon created the Oregon Health Policy Board (OHPB) which works to establish a baseline for sustainable health expenditures. In 2019, Oregon established the Sustainable Health Care Cost Target program and mandated development of a statewide spending growth target and recommendations for instituting a benchmark to contain the growth of health spending.

According to the Administration, the proposed Office of Health Care Affordability would do the following:

- **Increase public transparency on total health care spending in the state.** The Office would require reporting of total health care expenditure data, broken down by service category (e.g., hospital care, physician services, drugs, etc.). This data would be supplemented with analyses from the emerging Health Care Payments Data System, as well as other provider level reporting as necessary. The Office would publish an annual report in conjunction with a public meeting on health care spending trends and underlying factors, along with policy recommendations to control costs and improve quality performance of the health care system.
- **Set an overall statewide cost target and specific targets for different sectors of the health care industry.** The Office would establish an overall health care cost target for changes in per capita spending in California, and have the ability to set specific targets by health care sector, including payers, providers, insurance market and line of business, as well as by geographic region. The targets would be based on established economic indicators.
- **Enforce compliance with the cost target.** The Office would progressively enforce compliance with cost targets, beginning with technical assistance and increasing in escalation to other actions including but not limited to testimony at public meetings, corrective action plans, and assessment of escalating financial penalties.
- **Promote and measure quality and equity through adopting standard measures.** Because focusing on cost alone can have unanticipated consequences, performance on quality measures would be reported for health plans, hospitals, and physician organizations or medical groups, with special consideration of access and equity. Given the proliferation of measures in the health care industry, alignment with other payers and programs is paramount to reduce administrative burden and avoid duplication.

- **Set a statewide goal for adoption of alternative payment models and develop standards for use by payers and providers during contracting.** The Office would set a statewide goal for adoption of alternative payment models that shift payments from fee-for-service to payments that reward high quality and cost-efficient care. The Office would measure progress towards the goal and adopt standards for alternative payment models that may be used by providers and payers during contracting. The standards for alternative payment models would consider the current best evidence for strategies such as investments in primary care and behavioral health, risk sharing arrangements, and population-based contracts.
- **Monitor and address health care workforce stability.** Where appropriate, the Office would examine and analyze the role of the health care workforce as an input cost for total health care expenditures. The Office would also assist health care entities with strategies to implement cost-reduction strategies that do not exacerbate existing workforce shortages and promote high quality jobs and the stability of the healthcare workforce.
- **Address health care consolidation and other forms of market power.** Research has linked higher prices paid for health care services to increased market consolidation among health insurance plans, hospitals, medical groups or physician organizations and pharmacy benefit managers. For example, consolidation and other forms of market power in California's hospital market have been associated with private insurance payments ranging from 89 percent to as high as 364 percent of Medicare payments, with the average payment more than double the rates paid by Medicare. The Office would consider how these issues impact health care costs and work with other regulators to address them.

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

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

1. Please provide a brief overview of this proposal.

2. How would the Office arrive at determinations of cost growth targets? How would the specific sectors be determined?

3. Please describe the escalating enforcement actions the Office would implement for entities that exceed growth targets?

4. Would the cost growth targets include growth in the out-of-pocket costs for health care consumers? How would the Office avoid shifting of cost growth onto patients through increased cost sharing?

Issue 5: Proposals for Investment

Stakeholder Proposals for Investment. The subcommittee has received the following proposals for investment:

Multi-Payer Patient-Centered Medical Homes Working Group. The California Academy of Family Physicians requests General Fund expenditure authority of $75,000 in 2020-21, $150,000 in 2021-22, and $75,000 in 2022-23. These resources would allow the California Health and Human Services Agency to act as a "convener" to bring together public payers, private carriers, third-party purchasers, and providers, among others, to identify appropriate payment methods and align incentives to support and potentially expand patient-centered medical homes that accept multiple sources of coverage.

Multiple studies show patient-centered medical homes improve outcomes, increase patients' take up of preventive services, and decrease expenditures in outpatient, lab, and specialist costs. However, there are legal barriers to bringing together multiple payers to align payments and incentives, chiefly anti-trust concerns. This prevents primary care providers from being able to fully implement this practice type. The state can convene payers and providers to develop consistent models for care management, performance and outcomes measures, and aligned incentives. Through the state-action doctrine there can be immunity from this, as long as there is clear articulation that the anticompetitive behavior is endorsed as state policy and there is active state supervision. Over 15 other states have enacted such policy to further the expansion of patient-centered medical homes.

Children's Mental Health Access Network. The California Children's Hospital Association requests General Fund expenditure authority of $138.5 million in 2020-21 available for five years. If approved, these resources would fund creation of a competitive grant program, to be administered by the California Health and Human Services Agency, to establish a statewide network of up to ten telemedicine hubs that train and support primary care providers to serve the mental health needs of their child and adolescent patients ages 0 to 18, and provide direct mental health treatment to these patients when their care cannot be adequately managed in a primary care setting but there is a shortage of available specialty mental health providers in the community. These hubs would:

- Reach out to community-based providers, including pediatricians, family practitioners and nurse practitioners, to educate them about the services that the hub can provide and solicit participation in the hub's network.
- Provide ongoing education to participating providers to build their capacity to identify and manage common pediatric behavioral health conditions, when appropriate, and help them know when to refer to specialty care providers.
- Offer monthly Project ECHO webinar trainings and in-person trainings to participating PCPs.
- Provide tele-consults to participating providers on specific cases to assist them in managing the behavioral health needs of particular patients.
- Provide timely telephonic or tele-video behavioral health services directly to patients located in rural areas within the hub's region, as needed.
- Place a priority on working with community providers that predominantly serve low-income populations or those serving in rural/underserved areas of California.

Eligible entities would include children's hospitals and other community-based behavioral health providers with clinical expertise in pediatric behavioral health that have the capacity to serve as a hub in a particular region.

Pediatric Trauma-Informed Medical Home Model Pilot. Loma Linda University Children's Hospital requests General Fund expenditure authority of $2.3 million in 2020-21, $1.9 million in 2021-22 and $1.9 million in 2022-23. If approved, these resources would support a trauma-informed primary care medical home model pilot for child abuse victims. This proposal could be implemented by the Office of the Surgeon General or California Health and Human Services Agency.

The Trauma-Informed Medical Home Model seeks to apply our expertise gained from decades of treating children with disproportionately high ACE scores and apply this to a system of ongoing coordinated medical and mental health care for child victims. The goal is to adapt this experience to a larger population and build upon known resiliency factors to develop an effective evidence-based treatment and service approach for child abuse victims in the largest geographic county in the nation, San Bernardino County.

The clinic model will incorporate additional multi-disciplinary providers into the current medical evaluation to deliver a more holistic approach to care including developmental assessment, nutritional assessments, dental evaluations, hearing and vision screening, vaccinations and routine care, as well as evaluations for needed allied healthcare such as speech and physical therapy. Evaluations will culminate into a multi-disciplinary evaluation summary to use for follow-up and referrals. Records will be stored in electronic health records (EHR) for ease of information retrieval and sharing. Orders and referrals will be conducted in EHR to provide tracking and ensure completion.

This new expanded program will seek to provide a seamless continuum of multi-disciplinary, resiliency-informed medical care targeting the nearly 2,500 children placed into foster care each year. In addition, services will be offered to the larger current population of over 6,000 foster youth in the county, as well as additional victims of child abuse and neglect not placed into the system.

Experts working within this system of care will conduct county-wide training to regional care providers, multi-disciplinary partners and caregivers to create a network of trauma-informed care within the county. Under this model, training medical students, residents and fellows in Child Abuse Pediatrics will continue but with a broader trauma-informed primary care approach.

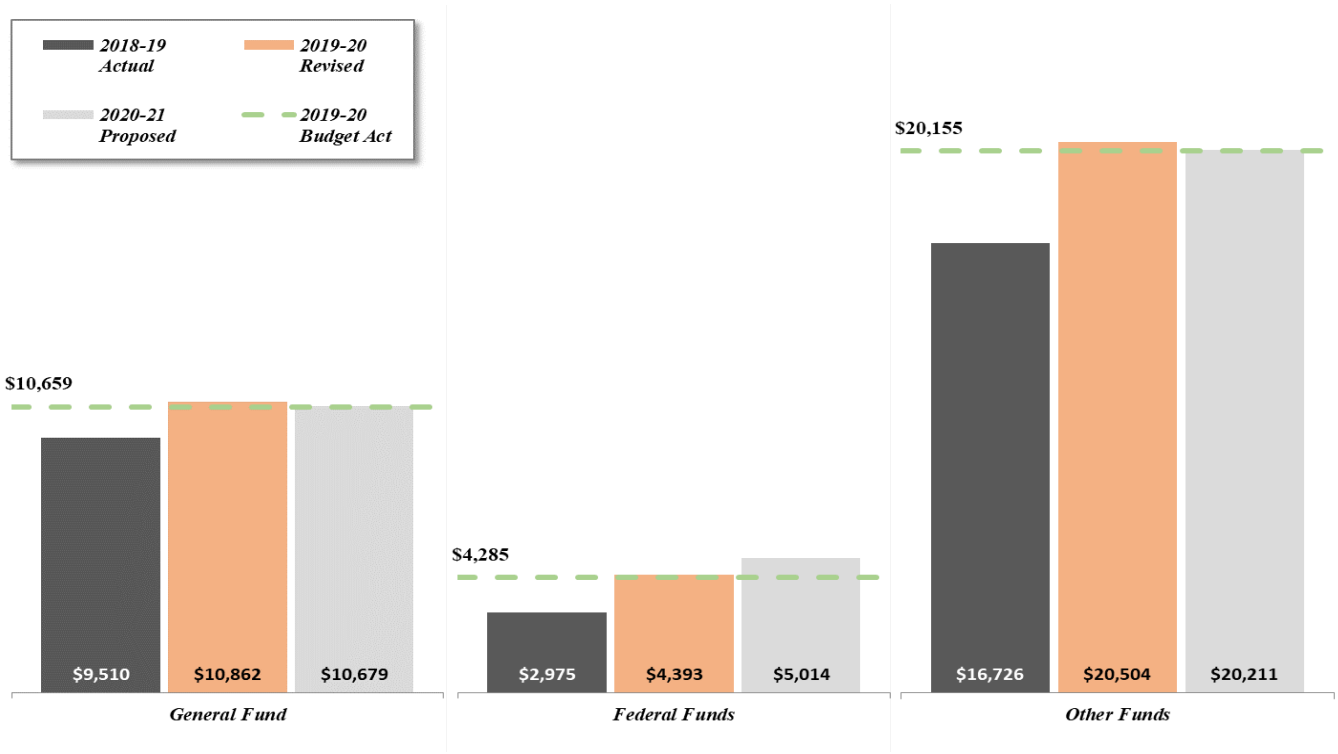
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested stakeholders to present these proposals for investment.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Overview

Emergency Medical Services Authority – *Three-Year Funding Summary*



(dollars in thousands)

Emergency Medical Services Authority - *Department Funding Summary*			
Fund Source	***2019-20 Budget Act***	***2019-20 Revised***	***2020-21 Proposed***
General Fund (0001)	$10,659,000	$10,862,000	$10,679,000
Federal Funds (0890)	$4,285,000	$4,393,000	$5,014,000
Other Funds (*detail below*)	$20,155,000	$20,504,000	$20,211,000
Total Department Funding:	**$35,099,000**	**$35,759,000**	**$35,904,000**
Total Authorized Positions:	**78**	**69.8**	**70.8**
Other Funds Detail:			
EMS Training Prog. Approval Fund (0194)	*$218,000*	*$226,000*	*$226,000*
EMS Personnel Fund (0312)	*$2,682,000*	*$2,813,000*	*$2,618,000*
Reimbursements (0995)	*$15,560,000*	*$15,708,000*	*$15,710,000*
EMT Certification Fund (3137)	*$1,695,000*	*$1,757,000*	*$1,657,000*

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

Disaster Medical Services Division. The Disaster Medical Services Division coordinates California's medical response to major disasters by carrying out EMSA's mandate to provide medical resources to local governments in support of their disaster response efforts. The division coordinates with the Governor's Office of Emergency Services, the Office of Homeland Security, the California National Guard, the Department of Public Health, and other local, state, and federal agencies, private sector hospitals, ambulance companies, and medical supply vendors, to promote and improve disaster preparedness and emergency medical response in California.

EMS Personnel Division. The EMS Personnel Division is responsible for the certification, licensing, and discipline of all active paramedics throughout the state. The division develops and implements regulations that set training standards and the scope of practice for various levels of personnel; sets standards for and approves training programs in pediatric first aid, cardiopulmonary resuscitation (CPR), and preventive health practices for child day care providers and school bus drivers; and develops standards for emergency medical dispatcher training, pre-arrival emergency care instructions, and epinephrine auto-injector training.

EMS Systems Division. The EMS Systems Division is in charge of developing and implementing EMS systems throughout California, including supporting local Health Information Exchange projects that will allow the state to collect more meaningful data so emergency medical services providers can deliver better patient care. The division oversees system development and implementation by the local EMS agencies, the statewide trauma system, and emergency medical dispatcher and communication standards. It establishes regulations and guidelines for local agencies, reviews and approves local plans to ensure they meet minimum state standards, coordinates injury and illness prevention activities with the Department of Public Health and the Office of Traffic Safety, manages the state's EMS data and quality improvement processes, conducts Ambulance Exclusive Operating Area evaluations, and oversees the operation of California's Poison Control System and EMS for Children programs.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of EMSA's mission and programs.

2. How is EMSA participating in the state's coordinated response to the COVID-19 outbreak?

Issue 2: Regional Disaster Medical Health Response (RDMHS) Local Assistance

Budget Issue. EMSA requests General Fund expenditure authority of $365,000 annually. If approved, these resources would allow EMSA to improve regional medical and health mitigation, preparedness, response and recovery by funding three additional Regional Disaster Medical Health Specialists (RDMHS).

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$365,000	$365,000
Total Funding Request:	**$365,000**	**$365,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2021-22.

Background. The California Emergency Services Act authorized the creation of six mutual aid regions for the effective application, administration, and coordination of mutual aid and other emergency-related activities. The Emergency Medical Services System and Prehospital Emergency Care Act authorizes EMSA and the State Public Health Officer to establish a regional disaster medical health coordination program in each mutual aid region of the state and designate a regional disaster medical health coordinator (RDMHC). The RDMHC is a voluntary position and may be either a county health officer, a county coordinator of emergency services, or an administrator or medical director of a local EMS agency, or a medical director of a local EMS agency. In the event of a major disaster, the RDMHC may coordinate the acquisition of medical, public, environmental, and behavioral health mutual aid resources.

Because the RDMHC position is voluntary and filled by individuals with other full-time local government positions, EMSA provides local assistance funding for regional disaster medical health specialists (RDMHS) that support the RDMHC by addressing routine and emergent needs within the mutual aid region and outside the region, if necessary. EMSA currently funds one RDMHS in each of the six mutual aid regions. When an RDMHS is not engaged in immediate disaster response activities, this individual is engaged in planning, training, and preparing for disasters.

According to EMSA, while the six RDMHS staff statewide have been able to perform many of the expected functions for RDMHC programs, certain types of workload have been neglected. In particular, certain planning, training, and engagement activities have not been performed including development of new disaster preparedness and response plans, conducting California Patient Movement Plan courses, supporting Mobile Medical sheltering training and exercises, participating in various medical and health workgroups and meetings, and participating in the Statewide Medical Health Exercise workgroup.

EMSA requests General Fund expenditure authority of $365,000 annually to fund three additional RDMHS in three of the six mutual aid regions. The three regions chosen were the administrative regions designated by the California Office of Emergency Services. If approved, these additional positions would be able to perform some of the unmet workload of the existing RDMHS in the six mutual aid regions.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Emergency Medical Dispatch (SB 438)

Budget Issue. EMSA requests one position and General Fund expenditure authority of $356,000 in 2020-21, $342,000 in 2021-22, and $171,000 annually thereafter. If approved, this position and resources would allow EMSA to implement provisions of SB 438 (Hertzberg), Chapter 389, Statutes of 2019, which prohibits a public agency from delegating, assigning, or entering into a contract for "911" call processing services regarding the dispatch of emergency response resources with a non-public agency.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0001 – General Fund	$356,000	$342,000
Total Funding Request:	**$356,000**	**$342,000**
Total Requested Positions:	**1.0**	**1.0**

* Additional fiscal year resources requested – 2022-23 and ongoing: $171,000

Background. The Warren 911 Emergency Assistance Act requires every public agency to establish and operate, or be part of, an emergency telephone service which automatically connects a person dialing the digits "911" to an established public safety answering point (PSAP). A PSAP receives 911 requests from the area where the person is calling and, if the caller requests emergency medical assistance, the primary PSAP may retain the caller if it directly provides emergency medical services (EMS) dispatch, or may transfer the caller to a secondary PSAP for EMS response.

SB 438 (Hertzberg), Chapter 389, Statutes of 2019, prohibits a public agency from delegating, assigning, or entering into a contract for 911 call processing services regarding the dispatch of EMS resources with a non-public agency. This legislation was prompted, in part, by county EMS contracts awarded to private entities, such as a private ambulance company, that did not always alert city fire departments about medical emergency calls, even when the fire department could arrive at the scene faster than the private ambulance.

Local EMS agencies would be the primary entities responsible for compliance with the requirements of SB 438. According to EMSA, as the state regulator of local EMS agencies, EMSA would review local EMS plans for compliance and provide technical assistance to local EMS agencies as they transition private dispatch center contracts to public dispatch agencies. EMSA estimates that local EMS agencies would be required to close 20 to 26 centers that are contracted private companies that deploy EMS resources in their jurisdictions.

In addition, EMSA indicates that new regulations would be needed to amend requirements for local EMS plans, which are submitted annually. The new regulations would: 1) develop 911 call processing regulations for dispatch centers, 2) develop an implementation tool kit to assist local EMS agencies in altering EMS systems, and 3) amend paramedic regulations for the provision of advanced life support provider approvals, denials, and appeals.

EMSA requests **one Associate Governmental Program Analyst** (AGPA) position and General Fund expenditure authority of $356,000 in 2020-21, $342,000 in 2021-22, and $171,000 annually thereafter. The AGPA would serve as the Emergency Medical Dispatch Communications Coordinator within EMSA to provide oversight and make operational the requirements of SB 438. The AGPA would also manage

the drafting and promulgation of regulations, as well as ensure local EMS agency submit compliant annual EMS communications plans.

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

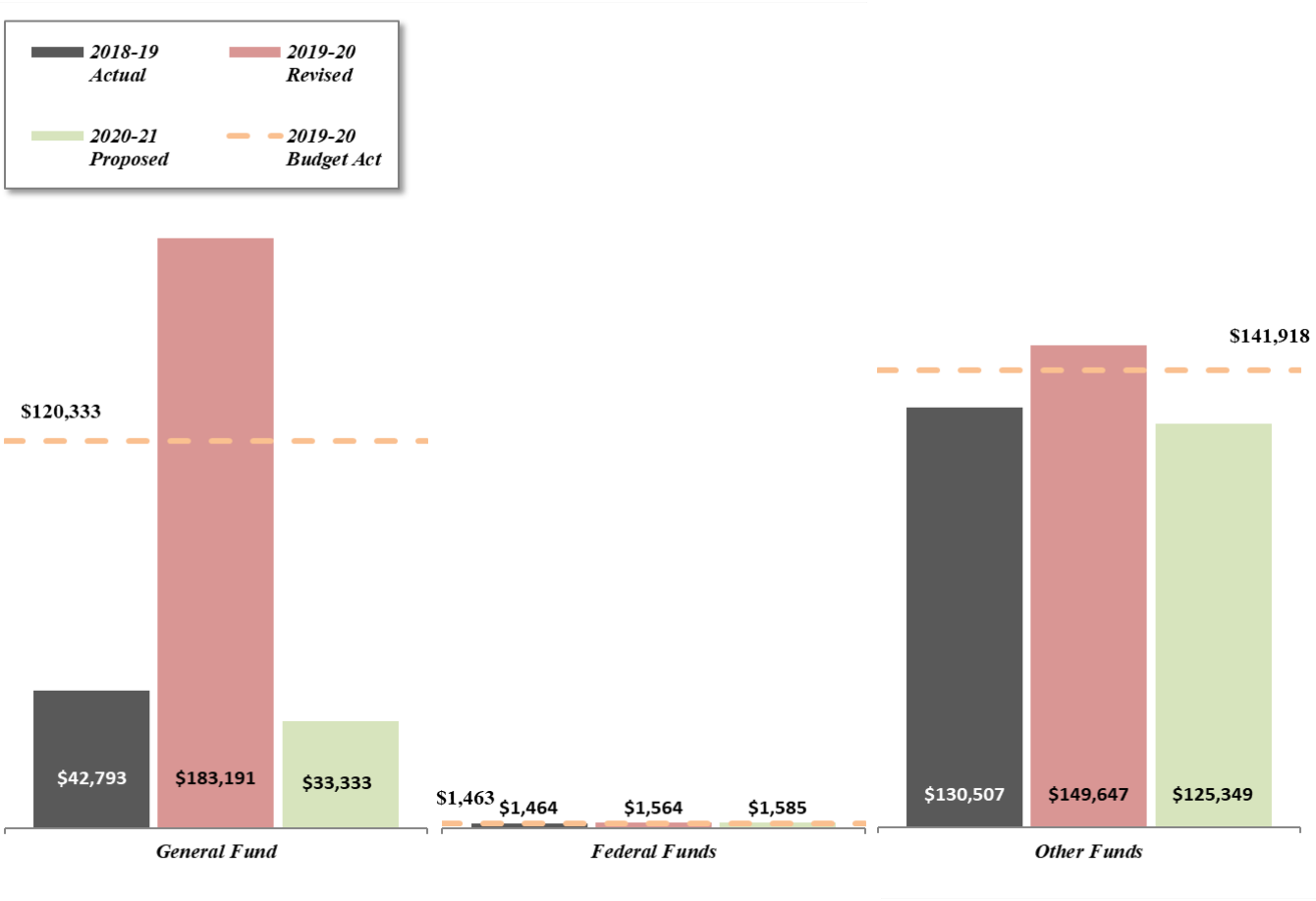
Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Overview

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



Emergency Medical Services Authority - *Department Funding Summary*			
Fund Source	***2019-20 Budget Act***	***2019-20 Revised***	***2020-21 Proposed***
General Fund (0001)	$120,333,000	$183,191,000	$33,333,000
Federal Funds (0890)	$1,463,000	$1,564,000	$1,585,000
Other Funds (*detail below*)	$141,918,000	$149,647,000	$125,349,000
Total Department Funding:	**$263,714,000**	**$334,402,000**	**$160,267,000**
Total Authorized Positions:	**434.5**	**423.9**	**428.9**
Other Funds Detail:			
Hospital Building Fund (0121)	*$65,762,000*	*$68,269,000*	*$68,319,000*
CA Health Data and Planning Fund (0143)	*$33,407,000*	*$34,396,000*	*$35,365,000*

Registered Nurse Education Fund (0181)	*$2,192,000*	*$2,200,000*	*$2,203,000*
Health Facility Const. Loan Ins. Fund (0518)	*$5,079,000*	*$5,212,000*	*$5,215,000*
Health Professions Education Fund (0829)	*$1,111,000*	*$3,233,000*	*$3,123,000*
Medically Underserved Account/Phys (8034)	*$4,402,000*	*$4,403,000*	*$4,403,000*
Reimbursements (0995)	*$868,000*	*$3,116,000*	*$3,116,000*
Mental Health Practitioner Ed. Fund (3064)	*$821,000*	*$827,000*	*$827,000*
Vocational Nurse Education Fund (3068)	*$225,000*	*$226,000*	*$226,000*
Mental Health Services Fund (3085)	*$28,051,000*	*$27,765,000*	*$2,552,000*

Background. The Office of Statewide Health Planning and Development (OSHPD) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

Health Care Workforce Development Division. OSHPD administers programs designed to increase access to healthcare to underserved populations and provide a culturally competent healthcare workforce. Specifically, OSHPD encourages demographically underrepresented groups to pursue healthcare careers, incentivizes primary care and mental health professionals to work in underserved communities, evaluates new and expanded roles for health professionals and new health delivery alternatives, designates health professional shortage areas, and serves as the state's central repository of health education and workforce data.

OSHPD awards scholarships and loan repayments to aspiring health professionals and graduate students who agree to provide direct patient care in medically underserved areas for one to four years. OSHPD serves as California's Primary Care Office supporting the state's healthcare workforce through pipeline development, training and placement, financial incentives, systems redesign, and research and policy with a focus on underserved and diverse communities.

Song-Brown Program. The Song-Brown Health Care Workforce Training Act (Song-Brown Program) was established in 1973 to increase the number of family physicians to provide needed medical services to the people of California. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas and provides financial support to family medicine, internal medicine, OB/GYN, and pediatric residency programs, as well as family nurse practitioner, physician assistant, and registered nurse education programs throughout California. The Song-Brown program is aided by the California Healthcare Workforce Policy Commission (CHWPC), a 15-member citizen advisory board that provides expert guidance and statewide perspectives on health professional education issues, reviews applications, and recommends contract awards.

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

grant from the California Endowment for family medicine and family nurse practitioner/physician assistant training.

The 2017 Budget Act authorized $100 million over three years for augmentation of health care workforce initiatives at OSHPD. The 2019 Budget Act included ongoing funding for this program beginning in 2020-21. The $33.3 million annual allocation provides up to $18.7 million for existing primary care residency slots, up to $3.3 million for new primary care residency slots at existing residency programs, up to $5.7 million for primary care residency slots at teaching health centers, up to $3.3 million for newly accredited primary care residency programs, up to $333,000 for the State Loan Repayment Program, and up to $2 million for OSHPD state operations costs. Unspent funds in each of these categories from prior years are available for expenditure for the subsequent five fiscal years. For example unspent funds from 2017-18 are available until June 30, 2023, and unspent funds from previous years are available until June 30, 2024. According to OSHPD, the Song-Brown program awarded the following in 2019-20:

Song-Brown: Existing Primary Care Residency Slots Awards – September 2019

Residency Program Name	Award	Residency Program Name	Award
Adventist Health Glendale	$125,000	Riverside Community Hospital/UCR (IM)	$125,000
Adventist Health Hanford	$375,000	Riverside Community Hospital/UCR (FM)	$375,000
Adventist Health Ukiah Valley	$125,000	Riverside University Health System/UCR	$625,000
Alameda Health System – Highland Hospital	$250,000	San Joaquin General Hospital (FM)	$625,000
Borrego Community Health	$375,000	San Joaquin General Hospital (IM)	$125,000
Centro de Salud de la Comunidad de San Ysidro	$375,000	Santa Rosa	$375,000
Charles R. Drew University	$375,000	Scripps Memorial, Chula Vista	$625,000
Children's Hospital Los Angeles	$125,000	Shasta Community Health Center	$125,000
Clinica Sierra Vista – Rio Bravo	$625,000	St. Joseph Hospital Eureka	$125,000
Contra Costa Family Medicine Residency Program	$375,000	St. Joseph Medical Center – Stockton	$250,000
Dignity Health California Hospital Medical Center	$625,000	Stanford Health Care – O'Connor Hospital	$250,000
Eisenhower Health	$125,000	UCSD FM and Psych. Residency Program	$125,000
Emanate Health	$250,000	UCSF Benioff Children's Hosp. Oakland	$125,000
Family Health Centers of San Diego	$375,000	UCSF Fresno (FM)	$625,000
Harbor-UCLA (FM)	$625,000	UCSF Fresno (IM)	$250,000
Harbor-UCLA (Peds)	$125,000	UCSF Fresno (OB/GYN)	$125,000
John Muir	$125,000	UCSF Fresno (Peds)	$250,000
Kaiser Permanente Fontana	$125,000	UCSF-SF Gen. Family/Comm. Medicine	$625,000
Kaiser Permanente Los Angeles (FM)	$125,000	UC Davis (FM)	$125,000
Kaiser Permanente Los Angeles (IM)	$125,000	UC Davis (Peds)	$125,000
Kaiser Permanente Santa Rose	$125,000	UC Davis (IM)	$250,000
Kaiser Permanente Woodland Hills	$250,000	UC Irvine	$625,000
Kaweah Delta Health Care District	$250,000	UCLA (FM)	$375,000
Kern Medical	$125,000	UCLA (Peds)	$125,000
LifeLong Medical Care	$375,000	UC Riverside (IM)	$125,000

Loma Linda–Inland Empire Consortium (FM)	$250,000	UC Riverside (FM)	$625,000
Loma Linda–Inland Empire Consortium (OB/GYN)	$125,000	UC San Francisco (IM)	$250,000
Loma Linda University – Primary Care Track	$500,000	UC San Francisco (OB/GYN)	$250,000
Long Beach Memorial	$125,000	Valley Fam. Medicine Residency Modesto	$125,000
Marina Regional Medical Center	$125,000	Valley Health Team	$375,000
Mercy Medical Center Merced	$375,000	Ventura County Medical Center	$250,000
Natividad Medical Center	$625,000	White Memorial Med. Center (FM)	$625,000
Northridge Hospital	$125,000	White Memorial Med. Center (IM)	$250,000
Olive View Medical Center	$375,000	White Memorial Med. Center (OB/GYN)	$125,000
PIH Health Hospital-Whittier	$125,000	**TOTAL - $20,375,000**	
Pomona Valley Hospital	$375,000		

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

Song-Brown: New Primary Care Residency Slots Awards – September 2019

Residency Program Name	Award	Residency Program Name	Award
AltaMed	$800,000	UHS SoCal Med Educ Consort (IM)	$800,000
Saint Agnes Medical Center	$800,000	UHS SoCal Med Educ Consort (OB/GYN)	$800,000
St. Joseph's Medical Center, Stockton	$800,000	**TOTAL - $4,800,000**	
UHS SoCal Med Educ Consort (FM)	$800,000		

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

Song-Brown: Teaching Health Center Awards – September 2019

Residency Program Name	Award	Residency Program Name	Award
Clinica Sierra Vista – Rio Bravo	$1,360,000	Shasta Community Health Center	$510,000
Family Health Centers of San Diego	$1,020,000	Valley FM Residency-Modesto	$1,190,000
LifeLong Medical Care	$1,020,000	Valley Health Team	$680,000
Loma Linda-Inland Empire Consortium (FM)	$1,190,000	**TOTAL - $8,160,000**	
Loma Linda-Inland Empire Consortium (Peds)	$1,190,000		

* FM = Family Medicine, Peds = Pediatrics

Song-Brown: Primary Care Residency Expansion Awards – September 2019

Residency Program Name	Award	Residency Program Name	Award
Children's Hospital Los Angeles	$900,000	Scripps Memorial, Chula Vista	$300,000
Clinica Sierra Vista – Rio Bravo	$600,000	UCSF Fresno (FM)	$900,000
Eisenhower Health	$900,000	UCSF Fresno (IM)	$900,000
Kaweah Delta Health Care District	$300,000	White Memorial Med. Center (FM)	$300,000
Kern Medical Center	$600,000	White Memorial Med. Center (IM)	$300,000
Loma Linda-Inland Empire Consortium	$300,000	White Memorial Med. Center (OB/GYN)	$300,000
Loma Linda University	$900,000	**TOTAL - $2,100,000**	

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

Workforce Education and Training (WET) Program. In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directs the majority of revenues to county mental health programs for community services and supports, prevention and early intervention, innovative programs, WET, and capital facilities and technological needs. For WET programs, Proposition 63 allocated $210 million to counties and $234.5 million to the state over a ten-year period beginning in 2008. The state's WET programs were originally administered by the Department of Mental Health (DMH), which developed the first five-year plan for the program. After dissolution of DMH in 2012, program responsibility was transferred to OSHPD, which developed the second five-year plan for 2014-2019 in coordination with the California Mental Health Planning Council.

WET Program Five-Year Plan 2020-2025. In February 2019, OSHPD released the third five year WET plan covering the period from 2020-2025. After engaging with stakeholders, the report is meant to guide efforts to improve and expand the public mental health system (PMHS) workforce throughout California. The 2019 Budget Act included expenditure authority of $60 million ($35 million General Fund and $25 million Mental Health Services Fund) to implement the 2020-25 Five-Year WET Plan. This funding is available for encumbrance and expenditure until June 30, 2026. The funding also included budget bill language requiring regional partnerships to provide a 33 percent match of local funds to be eligible for funding through the plan. The plan sets out the following goals and objectives:

Goals

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

Objectives

1. Expand awareness and outreach efforts to effectively recruit racially, ethnically, and culturally diverse individuals into the PMHS workforce.
2. Identify and enhance curricula to train students at all levels in competencies that align with the full spectrum of California's diverse and dynamic PMHS needs.
3. Develop career pathways for individuals entering and advancing across new and existing PMHS professions.
4. Expand the capacity of postsecondary education to meet the identified PMHS workforce needs.

5. Expand financial incentive programs for the PMHS workforce to equitably meet identified PMHS needs in underrepresented, underserved, unserved, and inappropriately served communities.
6. Expand education and training programs for the current PMHS workforce in competencies that align with the full spectrum of PMHS needs.
7. Increase the retention of PMHS workforce identified as high priority.
8. Evaluate methods to expand and enhance the quality of existing PMHS delivery systems to meet California's PMHS needs.
9. Develop and sustain new and existing collaborations and partnerships to strengthen recruitment, training, education, and retention of the PMHS workforce.
10. Explore stakeholder-identified policies that aim to further California's efforts to meet its PMHS needs.
11. Provide flexibility to allow local jurisdictions to meet their unique needs.
12. Standardize PMHS workforce education and training programs across the state.
13. Promote care that reduces demand for high-intensity PMHS services and workforce.

State Loan Repayment Program. The State Loan Repayment Program (SLRP) is a federally funded, state-run program that provides student loan repayment funding to healthcare professionals who commit to practicing in Health Professional Shortage Areas (HPSAs) in California. Professionals eligible for awards under SLRP include physicians (M.D. and D.O.), psychiatric nurse specialists, dentists, mental health counselors, registered dental hygienists, health service psychologists, nurse practitioners (primary care), licensed clinical social workers, physician assistants (primary care), licensed professional counselors, certified nurse midwives, marriage and family therapists, and pharmacists. Recipients must also, among other requirements, commit to a two-year (four-year, if half-time) initial service obligation at a SLRP Certified Eligible Site (CES) in one of the areas designated as an HPSA.

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

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

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

These programs are funded by a combination of foundation grant funding and licensing fees collected by professional licensing boards for the professions benefitting from HPEF training programs. Foundations providing funding include the California Endowment, the California Medical Services Program, the California Wellness Foundation, and Kaiser Permanente California Community Benefit Foundation.

Facilities Development Division – Hospital Seismic Safety. In 1971, the Sylmar earthquake struck the northeast San Fernando Valley, killing 64 people and causing significant damage to structures. In particular, the San Fernando Veterans Administration Hospital in Sylmar, constructed in 1926 with unreinforced concrete, collapsed, resulting in the deaths of 44 individuals trapped inside the building. In addition, a more recently constructed psychiatric ward at Sylmar's Olive View Community Hospital collapsed during the quake, resulting in three deaths and the evacuation of more than 1,000 patients. In response to these tragic events, the Legislature approved the Alfred E. Alquist Hospital Facilities Seismic Safety Act (Alquist Act), which required hospitals to meet stringent construction standards to ensure they are reasonably capable of providing services to the public after a disaster. In 1983, the act was amended to transfer all hospital construction plan review responsibility from local governments to OSHPD, creating the state's largest building department, the Facilities Development Division.

In 1994, the Northridge earthquake struck the San Fernando Valley again, resulting in major structural damage to many hospitals constructed prior to the Alquist Act, many of which were evacuated. In contrast, hospitals constructed in compliance with Alquist Act standards resisted the Northridge earthquake, suffering very little structural damage. In response, the Legislature approved SB 1953 (Alquist), Chapter 740, Statutes of 1994, which amended the Alquist Act to require hospitals to evaluate and rate all general acute care hospital buildings for seismic resistance according to standards developed by OSHPD to measure a building's ability to withstand a major earthquake. SB 1953 and subsequent OSHPD regulations also require hospitals to submit plans to either retrofit or relocate acute care operations according to specific timeframes. According to OSHPD, there are 476 general acute care and acute psychiatric hospitals comprised of 3,066 hospital buildings and 88,126 licensed beds covered by the seismic safety provisions of SB 1953. In addition to oversight of seismic safety compliance for acute care

hospitals, OSHPD is responsible for ensuring seismic and building safety compliance for skilled nursing facilities and intermediate care facilities. According to OSHPD, SB 1953 covers 1,162 skilled nursing facilities with 1,200 buildings and 114,333 licensed beds. The Facilities Development Division receives funding from fees paid by hospitals and skilled nursing facilities for plan review and building permits of construction projects, as follows:

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

Cal-Mortgage Loan Insurance Division. OSHPD's Cal-Mortgage Loan Insurance Division administers the California Health Facility Construction Loan Insurance Program. Cal-Mortgage provides credit enhancement for eligible health care facilities when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of California, which permits borrowers to obtain lower interest rates. Eligible health facilities must be owned and operated by private, nonprofit public benefit corporations or political subdivisions such as cities, counties, healthcare districts or joint powers authorities. Health facilities eligible for Cal-Mortgage include hospitals, skilled nursing facilities, intermediate care facilities, public health centers, clinics, outpatient facilities, multi-level facilities, laboratories, community mental health centers, facilities for the treatment of chemical dependency, child day care facilities (in conjunction with a health facility), adult day health centers, group homes, facilities for individuals with developmental disabilities, and office or central service facilities (in conjunction with a health facility). As of January 31, 2020, Cal-Mortgage insures 77 loans with a total value of approximately $1.7 billion.

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

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

Data Collection and Management. The division collects and publicly discloses facility level data from more than 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics, home health agencies, and hospices. These data include financial, utilization, patient characteristics, and services information. In addition, approximately 450 hospitals report demographic and utilization data on approximately 16 million inpatient, emergency department, ambulatory surgery patients, and by physician, about heart surgery patients.

Healthcare Data Analytics. The division produces more than 100 data products, including maps and graphs, summarizing rates, trends, and the geographic distribution of services. Risk-adjusted hospital and physician quality and outcome ratings for heart surgery and other procedures are also published. The division conducts a wide range of special studies on such topics as preventable hospital admissions and readmission, trends in care, and racial or ethnic disparities. The division also provides information to the public on non-profit hospital and community benefits, and hospital prices and discount policies.

Engagement and Technical Assistance. The division provides assistance to the members of the public seeking to use OSHPD data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments and stakeholders.

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

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

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

Issue 2: County Medical Services Program Loan Repayment Administration

Budget Issue. OSHPD requests reimbursement authority of $2.2 million in 2020-21, $180,000 in 2021-22, and $60,000 in 2022-23. If approved, these resources would allow OSHPD to continue to administer the County Medical Services Program Loan Repayment Program.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0995 - Reimbursements	$2,240,000	$180,000
Total Funding Request:	**$2,240,000**	**$180,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2022-23: $60,000

Background. The County Medical Services Program (CMSP) provides health coverage for uninsured, low-income, indigent adults that are not otherwise eligible for other publicly funded health care programs, including Medi-Cal, in thirty-five mostly rural counties in California. Coverage is funded through 1991 Realignment revenue and the CMSP Governing Board, established in 1995, has program and fiscal responsibility for the program including setting eligibility standards, defining the scope of covered healthcare benefits, and determining payment rates for providers. CMSP counties include: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

Figure 1. County Medical Services Program Counties

OSHPD administers the CMSP Loan Repayment Program, which supports healthcare professionals working in one of the 35 CMSP counties including physicians, psychiatrists, physician assistants, nurse practitioners, and dentists. The program provides loan repayment awards up to $50,000 per year in exchange for a two-year service obligation providing direct patient care at a contracted provider site in a CMSP county. In 2018-19, 55 applications were received, and 40 loan repayments were awarded. Each of the awards was for the maximum of $50,000 per year for two years.

CMSP provides funding to OSHPD for the CMSP Loan Repayment Program through a service agreement that fund the costs of the loan repayment awards and administration of the program. The program began in 2016 with total funding of $3.4 million over three

years, expiring in 2019-20. In May 2019, OSHPD and CMSP agreed to extend the termination date until 2022-23 and increase total reimbursement funding to $4.72 million. In August 2019, the Department of Finance approved a request from OSHPD for increased reimbursement authority of $2.24 million under Section 28.00 of the 2019 Budget Act for this purpose. OSHPD requests reimbursement authority of $2.2 million in 2020-21, $180,000 in 2021-22, and $60,000 in 2022-23 to fund the remaining years of the extended agreement with CMSP. Loan repayment awards would be funded from $2 million of the 2020-21 allocation, while administration of the program would be funded from $240,000 in 2020-21, $180,000 in 2021-22, and $60,000 in 2022-23. According to OSHPD, this funding combined with the funding approved by the Department of Finance would support 40 awards at the maximum award amount of $50,000 per year for two years.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Healthcare Data Disclosure (SB 343)

Budget Issue. OSHPD requests one position and expenditure authority from the California Health Data and Planning Fund of $119,000 in 2020-21 and $107,000 annually thereafter. If approved, this position and resources would allow OSHPD to implement new data reporting requirements for certain health facilities pursuant to the requirements of SB 343 (Pan), Chapter 247, Statutes of 2019.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0143 – CA Health Data and Planning Fund	$119,000	$107,000
Total Funding Request:	**$119,000**	**$107,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and Resources ongoing after 2021-22.

Background. Since 1971, OSHPD and its predecessor agencies have been responsible for setting standards for hospital uniform accounting and reporting to enable the public, third-party payers, and other interested parties to study and analyze the financial aspects of hospitals in California. OSHPD is currently the primary repository for healthcare data in California, collecting facility-level financial, utilization, and services inventory data reported by over 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics, home health agencies and hospices. OSHPD also collects approximately 16 million individual confidential patient records annually regarding hospital patient discharges, emergency department encounters, ambulatory surgery encounters, and coronary artery bypass graft surgeries.

SB 343 (Pan), Chapter 247, Statutes of 2019, removes alternative reporting requirements authorized for health facilities that receive a preponderance of their revenue from associated comprehensive group practice prepayment health care service plans. Kaiser Permanente is the only plan with health facilities that qualify for the alternative reporting requirements. All hospitals must report financial data, including patient revenue by type of service provided, statement of assets, liabilities, and net worth, operating expenses and operating margin, and salaries and wages for each individual institution. Kaiser, under its alternative reporting requirements, was permitted to report costs and revenues as a group of institutions, Northern California Kaiser or Southern California Kaiser, rather than as individual institutions. SB 343 removes these alternative reporting requirements and instead requires Kaiser hospitals to report data to OSHPD similarly to other hospitals. According to OSHPD, these changes would require Kaiser to provide individual reports for each of its 33 facilities, rather than two reports for Northern California and Southern California. The first quarterly reporting is scheduled to be submitted by May 2020, for the first quarter of this year, with the first annual report scheduled to be submitted by April 2021 for calendar year 2020.

OSHPD requests one position and expenditure authority from the California Health Data and Planning Fund of $119,000 in 2020-21 and $107,000 annually thereafter. These resources would support **one Health Program Auditor II position** that would perform desk audits of the additional annual and quarterly financial and utilization reports for each facility that Kaiser would be required to provide. Desk audits are generally undertaken for other hospital financial reporting and include analysis of reporting, identification of errors, resolution of compliance issues, and documentation of issues and resolution. This position would also provide technical support for public users of reported data.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Hospital Community Benefits Plan Reporting (AB 204)

Budget Issue. OSHPD requests two positions and expenditure authority from the California Health Data and Planning Fund of $519,000 in 2020-21, and $245,000 annually thereafter. If approved, these positions and resources would allow OSHPD to implement hospital community benefits plan data reporting requirements pursuant to AB 204 (Wood), Chapter 535, Statutes of 2019.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0143 – CA Health Data and Planning Fund	$519,000	$245,000
Total Funding Request:	**$519,000**	**$245,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2021-22.

Background. Beginning in 1995, California non-profit hospitals, except children's hospitals or small and rural hospitals, are required to complete a community needs assessment and adopt a community benefits plan. A community needs assessment identifies unmet community needs and is updated every three years, while a community benefits plan is a written document prepared for annual submission to OSHPD that includes a description of the activities the hospital has undertaken to address identified community needs within its mission and financial capacity and the process the hospital utilized to develop the plan in consultation with the local community. In addition, OSHPD reports that 12 of the 28 rural hospitals that are not subject to these reporting requirements voluntarily submit community benefit plans.

Prior to the passage of AB 204 (Wood), Chapter 535, Statutes of 2019, California law defined community benefit as a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status and included charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, the California Children's Services Program, or county indigent programs. However, there was no definition of charity care and no standardized reporting requirements for the value of community benefits provided under a hospital's community benefits plan.

AB 204 defines charity care as free health services provided without expectation of payment to persons who meet the organization's criteria for financial assistance and are unable to pay for all or a portion of the services. The definition excludes uncollectible debt the hospital recorded as revenue but was written off due to failure to pay. Hospitals will also be required to follow a specific methodology to value the benefits provided to the community and that the amount be consistent with charity care cost as reported to OSHPD. OSHPD is required to publish an annual report identifying the hospitals that failed to comply with community benefit reporting requirements and may fine hospitals up to $5,000 for failure to adopt, update, or submit a community benefit plan consistent with the new requirements.

OSHPD requests two positions and expenditure authority from the California Health Data and Planning Fund of $519,000 in 2020-21, and $245,000 annually thereafter. These resources would support the following staff and consulting:

- **One Associate Governmental Program Analyst** would promulgate regulations, standardize community benefit plan reporting, develop and maintain tracking systems for reporting, monitor timely compliance, assess fines, and coordinate with the legal office on assessing and collecting fines.
- **One Health Program Auditor III** would develop and review procedures to ensure compliance with reporting requirements, review community benefit plans for compliance and provide technical assistance for 250 reportable hospitals and prepare the annual report on statewide community benefits spending and compliance.
- **Consulting services** of $250,000 in 2020-21 would leverage existing OSHPD systems to add capability to collect community benefit data and track deadlines and penalties. The consultant services would include project management, business analysis, system software development and engineering.

According to OSHPD, Stage 1 documentation has been submitted under the Department of Technology's Project Approval Lifecycle Stage Gate process. OSHPD reports that the first year of submissions would be subject to manual review, while standardization of the process would occur after promulgation of regulations.

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Hospital Procurement Contracts Reporting (AB 962)

Budget Issue. OSHPD requests two positions and expenditure authority from the California Health Data and Planning Fund of $790,000 in 2020-21, and $290,000 annually thereafter. If approved, these positions and resources would allow OSHPD to implement hospital procurement contract reporting requirements pursuant to AB 962 (Burke), Chapter 815, Statutes of 2019.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0143 – CA Health Data and Planning Fund	$790,000	$290,000
Total Funding Request:	**$790,000**	**$290,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2021-22.

Background. AB 962 (Burke), Chapter 815, Statutes of 2019, requires each licensed hospital with operating expenses of at least $25 million to submit an annual supplier diversity report to OSHPD, beginning July 1, 2020, detailing its minority, women, LGBT, and veteran-owned business enterprise procurement. The supplier diversity report must include the following elements: 1) the hospital's supplier diversity policy statement; 2) the hospital's outreach and communications to minority, women, LGBT, and veteran-owned business enterprises, including how the hospital encourages and seeks out these enterprises to become potential suppliers, how the hospital conducts outreach and communication to these enterprises, how the hospital supports organizations that promote or certify these enterprises, and information regarding appropriate contacts at the hospital for interested enterprises; and 3) information about which procurements are made from minority, women, LGBT, and veteran-owned business enterprises. By July 31, 2020, OSHPD is required to establish and maintain a link on its website that provides, for informational purposes only, public access to the contents of each licensed hospital's supplier diversity report. OSHPD is also authorized to administer penalties of $100 per day on hospitals that fail to file the required supplier diversity report.

AB 962 also requires OSHPD to convene a hospital diversity commission comprised of public and health care, diversity, and procurement stakeholders appointed by the director of OSHPD. The commission will advise and provide recommendations to the OSHPD director and the hospital industry on the best methods to increase procurement with diverse suppliers and promote and provide outreach to hospitals that are actively engaged in supplier diversity issues.

OSHPD requests two positions and expenditure authority from the California Health Data and Planning Fund of $790,000 in 2020-21, and $290,000 annually thereafter. These resources would support the following staff and consulting services:

- **One Staff Services Manager I position** would manage stakeholder relations, administer the quarterly supplier diversity commission meetings, staff commission members, and oversee the collection, review, and compliance functions, including penalties, for the report submissions from hospitals.
- **One Office Technician** would coordinate meeting materials and setup, manage travel arrangements and reimbursements for commission members, and provide administrative support to the Staff Services Manager I position.

- **Commission member reimbursement** of $50,000 for actual and necessary expenses in connection with attending a meeting of the commission.
- **Consulting services** of $500,000 in 2020-21 would modify current data collection systems to track and collect hospital supplier diversity reports. Contracted services would include project management, business analysis, system design, and software development and engineering. OSHPD reports it is working with the Department of Technology and the Department of Finance to request project delegation authority, which it expects would be approved in the next several months.

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

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

1. Please provide a brief overview of this proposal.

Issue 6: Proposals for Investment

Stakeholder Proposals for Investment. The subcommittee has received the following proposals for investment:

Psychiatry Graduate Medical Education. The California Hospital Association requests General Fund expenditure authority of $22.2 million to provide additional funding to hospitals and teaching health centers to train psychiatry residents, leading to expansion of existing programs and establishment of new programs. These resources, which would be available for encumbrance and expenditure until June 30, 2023, would build on the state's commitment of funding to the 2020-2025 Mental Health Services Act Workforce Education and Training (WET) Program 5-Year Plan included in the 2019 Budget Act.

Advanced Practice Clinician Education and Training to Improve Access in Underserved Communities. California Health+ Advocates requests General Fund expenditure authority of $49.7 million one-time to support expansion and establish new CSU and UC nurse practitioner education programs in underserved communities administered by the Song-Brown Program. In addition, these resources would expand the current authority and provide new funding to stabilize, expand, and establish physician assistant and nurse practitioner postgraduate fellowships.

Debt Relief for Primary Care and Behavioral Health Providers. California Health+ Advocates and Planned Parenthood Affiliates of California request General Fund expenditure authority of $77 million one-time to support the following investments:

- $40.6 million to fund the initial cohort of California Future Health Workforce Commission developed Emerging California Health Leaders Scholarship Program, which aims to cover tuition for 10 percent of all students enrolled in eligible California health professions to enable more Californians to pursue degrees in high-end professions and practice in underserved communities.
- $27.4 million to fund existing loan repayment programs that are currently underfunded and incentivize health professionals to provide direct patient services in medically underserved areas of California.
- $4 million to increase the State Loan Repayment Program to expand the number of primary care physicians, dentists, dental hygienists, physician assistants, nurse practitioners, certified nurse midwives, pharmacists, and mental/behavioral health providers practicing in Health Professional Shortage Areas.
- $5 million to expand the number of physician assistants and nurse practitioners who primarily provide comprehensive reproductive health care by practicing with a 501(c)(3) Community Health Center that primarily serves low-income patients, yet is not within a federally designated Health Professional Shortage Area.

Primary Care and Behavioral Health Residency Investment. California Health+ Advocates and the California Hospital Association request General Fund expenditure authority of $42.6 million one-time to expand primary care and psychiatry residency programs. Specifically, $20.4 million would support new primary care residency slots under the existing Song-Brown Program and $22.2 million would support psychiatry residency slots through the Psychiatry Residency Grant Program.

Substance Use Disorder Workforce Expansion. The California Council of Community Behavioral Health Agencies, the California Consortium of Addiction Programs and Professionals, and the California Association of Alcohol and Drug Program Executives request General Fund expenditure authority of $4.7

million one-time to provide: 1) tuition assistance for vocational, community college, and university education, and improvement to the pipeline by providing tuition reimbursement and fee waivers for tests and certification for potential new applicants; 2) recruitment of a diverse workforce and creation of English learner education and examination materials; and 3) development of a statewide substance use disorder needs assessment.

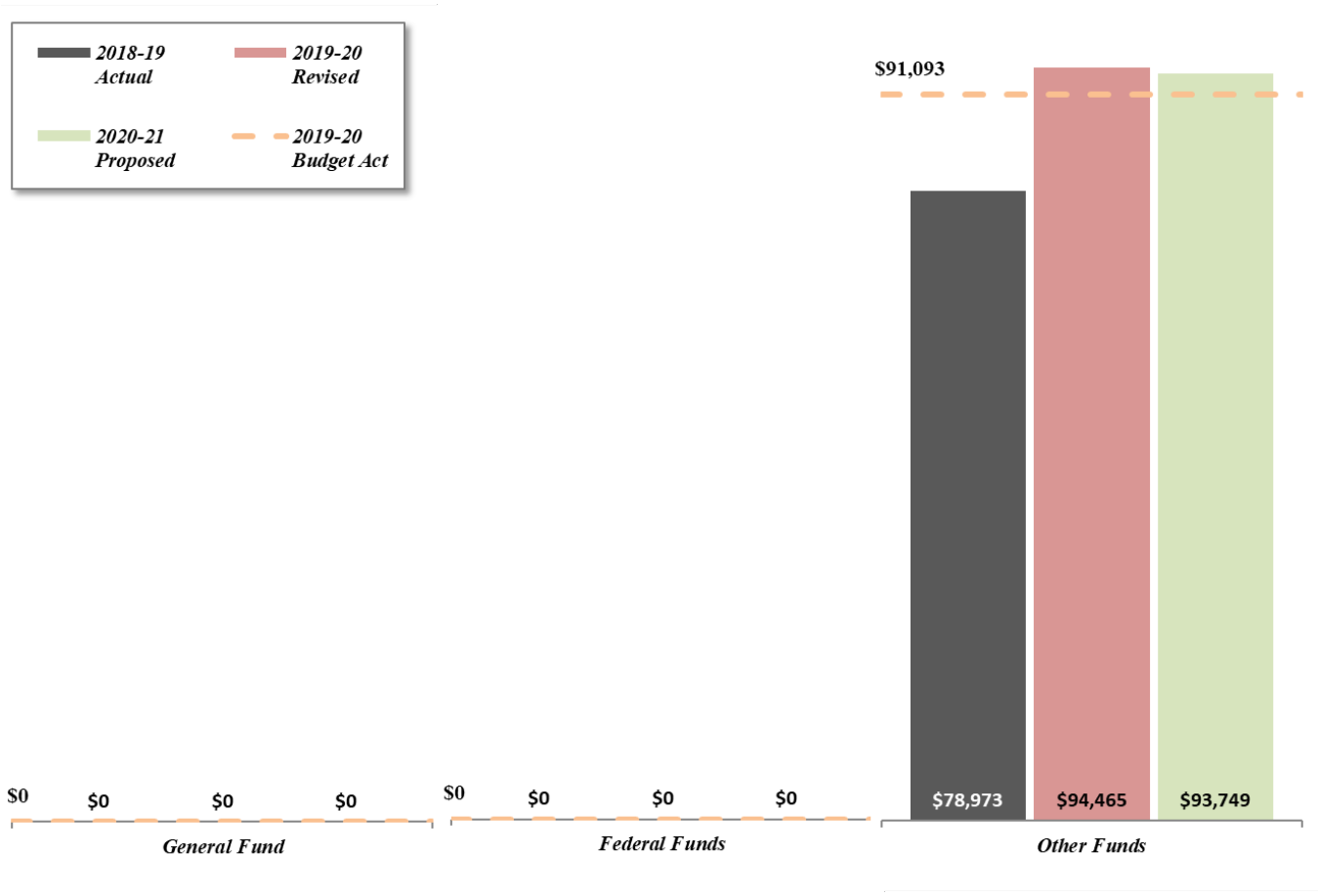
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested stakeholders to present these proposals for investment.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview

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



Department of Managed Health Care - *Department Funding Summary*			
Fund Source	***2019-20 Budget Act***	***2019-20 Revised***	***2020-21 Proposed***
General Fund (0001)	$0	$0	$0
Federal Funds (0890)	$0	$0	$0
Other Funds (*detail below*)	$91,093,000	$94,465,000	$93,749,000
Total Department Funding:	**$91,093,000**	**$94,465,000**	**$93,749,000**
Total Authorized Positions:	**448.6**	**417.3**	**425.8**
Other Funds Detail:			
Managed Care Fund (0933)	*$90,922,000*	*$94,294,000*	*$93,749,000*
Reimbursements (0995)	*$171,000*	*$171,000*	*$0*

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 126 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 26 million Californians. Established in 2000, DMHC enforces the Knox-Keene Health Care Service Plan Act of 1975, which implemented California's robust oversight regime of the managed care system. In fulfilling its regulatory responsibilities under the Act, DMHC conducts medical surveys and financial examinations to ensure health plan compliance and financial stability, provides a 24-hour call center to help consumers resolve health plan complaints, and administers Independent Medical Reviews of services denied by health plans.

Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene Health Care Service Plan Act of 1975, and subsequent amendments, is one of the most robust regulatory regimes for managed care organizations in any state in the nation. In addition to regulatory requirements related to consumer protections and plans' financial stability, the Knox-Keene Act imposes various network adequacy requirements on health care service plans designed to provide timely access to necessary medical care for those plans' beneficiaries. These requirements generally include the following standards for appointment availability: 1) Urgent care without prior authorization: within 48 hours; 2) Urgent care with prior authorization: within 96 hours; 3) Non-urgent primary care appointments: within 10 business days; 4) Non-urgent specialist appointments: within 15 business days; 5) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: within 15 business days. The Knox-Keene Act also requires plans to ensure primary care physicians are located within 15 miles or 30 minutes of a beneficiary and there is at least one primary care provider for every 2,000 beneficiaries in a plan's network.

Implementation of Timely Access Standards (SB 964). SB 964 (Hernandez), Chapter 573, Statutes of 2014, required DMHC to implement stricter oversight of health plans' compliance with standards meant to ensure timely access to care. SB 964 was introduced in response to significant expansions of managed care enrollment in both Medi-Cal and Covered California, as well as reports that certain plan products offered "narrow" provider networks that were inadequate to provide timely access to medical care for beneficiaries. SB 964 requires annual review of plans' compliance with Knox-Keene standards for providing timely access to care. DMHC previously reviewed plans' compliance every three years. SB 964 also requires plans to report the following information regarding provider networks:

1. Provider office location
2. Area of specialty
3. Hospitals where providers have admitting privileges, if any
4. Providers with open practices
5. Number of patients assigned to a primary care provider or a provider's capacity to be accessible and available to enrollees
6. Network adequacy and timely access grievances received by the plan

Plans are also required to provide these data separately for Medi-Cal and small group lines of business. DMHC is required to create a standardized methodology for plan reporting on timely access to care by January 2020.

In February 2017, DMHC published its timely access report for calendar year 2015. According to DMHC, 90 percent of the timely access compliance reports submitted by plans contained one or more significant

inaccuracies including: 1) submission of data for providers not in the plan's network, 2) errors in calculating compliance rates, and 3) omission of compliance data for one or more required provider types. The use of an external vendor by 24 health plans to gather data and prepare compliance reports contributed to the submission of erroneous reports. The widespread inaccuracy of the data submissions made it impossible for DMHC to analyze whether plans were in compliance with timely access standards for 2015. In response, DMHC required the use of a department-approved vendor to monitor data accuracy for the 2016 calendar year submissions.

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

According to DMHC, although data reported for calendar years 2017 and 2018 suffered from some of the same individual categories of inaccuracies, the overall quality of the data improved significantly. The key findings for calendar year 2018, published in January 2020, were as follows:

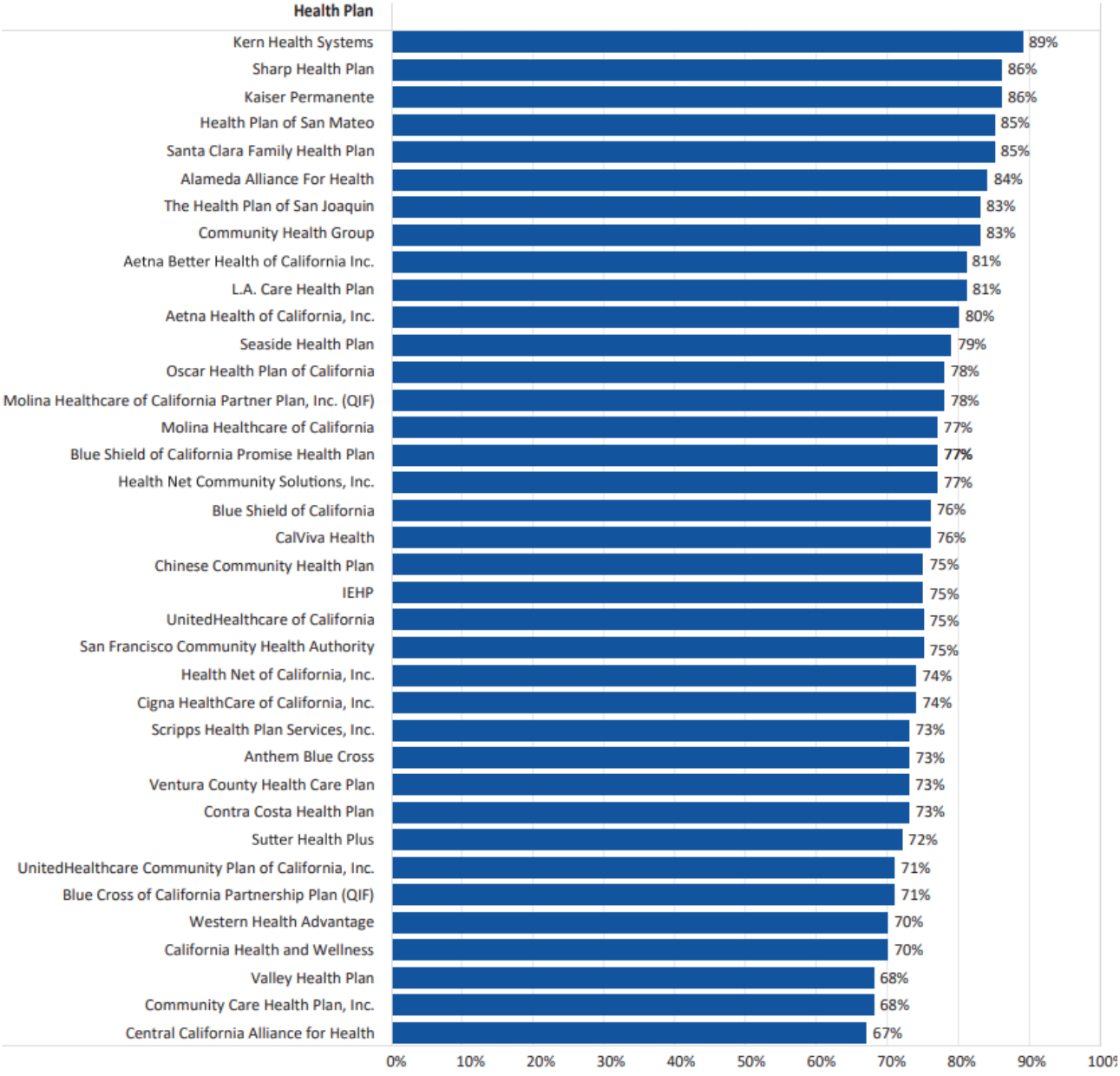
Full-Service Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 89 percent to a low of 67 percent.
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 94 percent to a low of 71 percent.
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 83 percent to a low of 57 percent

Behavioral Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 80 percent to a low of 73 percent.
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 90 percent to a low of 82 percent.
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 70 percent to a low of 64 percent.

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



Managed Care Prescription Drug Expenditures Reporting (SB 17). SB 17 (Hernandez), Chapter 603, Statutes of 2017, was intended to provide drug cost transparency in response to the significant growth in expenditures for prescription drugs by public health care programs, commercial health plans, and the general public. These increased expenditures have been attributable to both specialty drugs newly brought to market, such as new treatments for hepatitis C, and existing drugs, often no longer under patent protection, for which a single manufacturer controls the drug's supply and substantially increases its price. SB 17 requires health care service plans to publicly report to DMHC certain information regarding expenditures on prescription drugs on behalf of beneficiaries.

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

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

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

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

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

SB 17 also requires DMHC by January 1 of each year to compile and publish this information by plan in a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. DMHC's SB 17 Prescription Drug Cost Transparency Report for calendar year 2018 included the following key findings:

- Health plans paid nearly $9.1 billion for prescription drugs in 2018, an increase of over $400 million from 2017.
- Prescription drugs accounted for 12.7 percent of total health plan premiums in 2018, a slight decrease from 12.9 percent in 2017.
- Health plans' prescription drug costs increased by 4.7 percent in 2018, whereas medical expenses increased by 2.7 percent. Health plan premiums increased 6.2 percent from 2017 to 2018.
- Health plans received manufacturer drug rebates of approximately $1.1 billion, up from $922 million in 2017. This represents about 11.7 percent of the $9.1 billion spent on prescription drugs in 2018.
- While specialty drugs accounted for only 1.6 percent of all prescription drugs, they accounted for 52.6 percent of total annual spending on prescription drugs.
- Generic drugs accounted for 87 percent of all prescribed drugs but only 22.4 percent of the total annual spending on prescription drugs.
- Brand name drugs accounted for 11.4 percent of prescriptions and constituted 25 percent of the total annual spending on prescription drugs. The 25 most frequently prescribed drugs represented

48.2 percent of all drugs prescribed and approximately 43.2 percent of the total annual spending on prescription drugs.

- For the 25 most frequently prescribed drugs enrollees paid 3.1 percent of the cost of specialty drugs and 55.7 percent of the cost of generics.
- Of the 12.7 percent of total health plan premium that was spend on prescription drugs, the 25 most costly drugs accounted for 6.9 percent.
- Overall, plans paid 91.9 percent of the cost of the 25 most costly drugs across all three categories (generic, brand name and specialty).

Subcommittee Staff Comment. This is an informational item.

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

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

2. Please provide a brief overview of the key findings from the department's Managed Care Timely Access Report for 2018.

3. Please provide a brief overview of the key findings from the department's Prescription Drug Cost Transparency Report for 2018.

Issue 2: Information Security Resources

Budget Issue. DMHC requests two positions and expenditure authority from the Managed Care Fund of $384,000 in 2020-21, $368,000 in 2021-22 and 2022-23, and $328,000 annually thereafter. If approved, these resources would allow DMHC to address information security and cybersecurity vulnerabilities.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0933 – Managed Care Fund	$384,000	$368,000
Total Funding Request:	**$384,000**	**$368,000**
Total Requested Positions:	**2.0**	**2.0**

* Additional fiscal year resources requested – 2022-23: $368,000; 2023-24 and ongoing: $328,000

Background. AB 670 (Irwin), Chapter 518, Statutes of 2015, authorizes the California Department of Technology (CDT) to conduct independent security assessments of state departments and agencies, requiring no fewer than 35 assessments be conducted annually. AB 670 requires CDT to prioritize for assessment state departments or agencies that are at higher risk due to handling of personally identifiable information or health information protected by law, handling of confidential financial data, or levels of compliance with certain information security and management practices. Independent security assessments are conducted by the Cyber Network Defense (CND) Team at the California Military Department. In June 2019, the CND Team conducted a vulnerability assessment of DMHC's services and assets, resulting in identification of widespread vulnerabilities in software, technical configuration, and maintenance of the department's technical systems.

State Administrative Manual Section 5300 requires each state entity to be responsible for establishing an information security program to effectively manage risk, provide protection of information assets and prevent illegal activity, fraud, waste, and abuse. The 2017 Budget Act included two positions and consultant resources to implement a forward-looking IT roadmap, reduce use and continued investments in its legacy applications, and accelerate migration of its systems to the CDT's Office of Technology Services Cloud, consistent with the CDT Technology Letter 14-04, which details the state's "Cloud First" policy. The consulting resources in the 2017 Budget Act request allowed DMHC to contract with Business Advantage Consulting to review the department's business processes and perform a security assessment of its infrastructure, cybersecurity technologies, tools in place, and the current maturity. The assessment concluded DMHC had no cybersecurity technologies in place for 41 percent of the categories assessed and that 12 percent of the existing technologies required additional configuration.

In addition to these assessments, DMHC participated in the National Cybersecurity Review offered by the Center for Information Security in fall 2018. The review is a self-assessment designed to measure gaps and capabilities of state, local, tribal, and territorial governments' cybersecurity programs. DMHC scored below the recommended minimum maturity level and below the average in comparison to other state and federal departments. DMHC also reports its security-related IT tickets have doubled in the past year, with only two security positions available to resolve issues. DMHC indicates it is unclear whether the increase in tickets would persist once security vulnerabilities are addressed.

DMHC requests two positions and expenditure authority from the Managed Care Fund of $384,000 in 2020-21, $368,000 in 2021-22 and 2022-23, and $328,000 annually thereafter. These resources would support implementation of new applications and systems to address vulnerabilities and other issues identified by the three cybersecurity assessments and address the increase in security-related IT tickets. Specifically, these resources would support the following staff and consulting services:

- **One Information Technology Specialist II position** would maintain a host-hardening process for image hardening, reduce risk of unauthorized connections, conduct credentialed vulnerability scans against internal facing web applications, conduct ongoing systems audits for default credentials and account authorizations, and conduct monthly internal scans for unencrypted transmission configurations. These activities address assessment findings related to continuous security monitoring, vulnerability scanning, privileged access management, and security platform monitoring.
- **One Information Technology Specialist I position** would configure, operate, and monitor existing tools and critical business processes related to multi-factor authentication, file access monitoring, data classification, endpoint detection and response, data loss prevention and network traffic monitoring, and triage security-related IT tickets. These activities address assessment findings related to malicious code protection and continuous security monitoring.
- **Consulting services** of $40,000 in 2020-21, 2021-22, and 2022-23 to assist the department with updating, configuring, and maintaining the log management infrastructure to improve detection of misconfigurations and diagnose system issues with greater speed, providing greater insight into the threat landscape affecting DMHC.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Large Group Rate Review (AB 731)

Budget Issue. DMHC requests five positions and expenditure authority from the Managed Care Fund of $1.7 million in 2020-21, and $2.6 million annually thereafter. If approved, these positions and resources would allow DMHC to create a new process for review of rates in the large group market and modify existing reporting requirements in the individual and small group markets, pursuant to AB 731 (Kalra), Chapter 807, Statutes of 2019.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0933 – Managed Care Fund	$1,747,000	$2,617,000
Total Funding Request:	**$1,747,000**	**$2,617,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and resources ongoing after 2021-22.

Background. Under state and federal law, health plans must submit detailed data and actuarial justification for small group and individual market rate increases to DMHC at least 120 days in advance of an increase. Plans must submit rates to both DMHC and their customers 120 days in advance and must submit an analysis performed by an independent actuary. A health plan's rate filing consists of a single filing that covers all of the plan's benefit designs for that market, and DMHC's finding whether a rate is unreasonable or not justified applies to all of the benefit designs covered by the plans' filing.

For the large group market, state law requires health plans to file aggregate rate information on an annual basis and requires DMHC to conduct an annual public meeting to discuss changes in rates, benefits, and cost sharing in the market. According to DMHC, it currently regulates 26 health plans with large group products to nearly 14,000 large employer groups.

Prior to the passage of AB 731 (Kalra), Chapter 807, Statutes of 2019, plans were not required to submit large group rate filings to determine whether rate increases are reasonable. AB 731 requires a health care service plan offering a contract or policy in the large group market to file rate information with DMCH annually and at least 120 days prior to a rate change, similar to small group and individual market filings. However, AB 731 does not require review of every contract holder rate in the large group market, but authorizes DMHC to determine whether the methodology, factors, and assumptions used to develop rates are reasonable. Beginning July 2021, AB 731 allows certain individual contract holders to request DMHC review of rate increases.

AB 731 also changes plan reporting requirements for small group and individual products, as well as large group products, by requiring disclosure by geographic region of: 1) integrated care management or similar fees, 2) reclassification of services from one benefit category to another, and 3) aggregated additional data that demonstrates or reasonably estimates year-to-year cost increases in specific benefit categories. All plans are also required to disclose certain information about certain variation and trend factor information for benefit categories.

DMHC requests five positions and expenditure authority from the Managed Care Fund of $1.7 million in 2020-21, and $2.6 million annually thereafter. These resources would support the following staff and consulting services in the following DMHC divisions:

Office of Financial Review

- **Three Senior Life Actuaries** would review approximately 20 percent of experience rated or community rated large group filings, all other large group filings, and additional geographic region disclosures for individual, small, and large group coverage. Actuarial consultants would review the remaining 80 percent of experience rated or community rated large group filings (*see below*)
- **Consulting services** of $50,000 in 2020-21 to assist with development of reporting templates necessary to obtain large group rate information and geographic cost and benefit variation and trend factor data.
- **Actuarial consulting services** of $567,000 in 2020-21 and $960,000 annually thereafter to review 80 percent of community rated and experience rated large group filings and provide ongoing technical assistance with the large group rate review process including determinations of reasonableness of rate changes. According to DMHC, the use of consultant services for this purpose is consistent with its practice under its individual and small group rate review responsibilities. DMHC reports it has only disagreed with its consultant's recommendations regarding reasonableness for individual and small group rate increases in five instances.

Office of Legal Services

- **One Attorney** would conduct legal research, promulgate a regulation package to interpret and implement the requirements of AB 731, prepare recurrent legal memoranda, and address ongoing legal workload resulting from the new rate review and reporting requirements. According to DMHC, plans do not have appeal rights for rate review determinations but may seek relief through the judicial system. As there is no federal guidance regarding large group rate review, DMHC expects ongoing legal workload as it implements AB 731.

Office of Technology and Innovation

- **One Information Technology Specialist II** would design, implement, and maintain user interfaces to accommodate large group rate filings and geographic region information submissions and processing requirements. This position would also design, implement, and maintain a user interface to allow large group contract holders to request a review of a health plan's proposed rate increase for a specific group.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Health Care Coverage – Telehealth (AB 744)

Budget Issue. DMHC requests 1.5 positions and expenditure authority from the Managed Care Fund of $331,000 in 2020-21, and $379,000 annually thereafter. If approved, these positions and resources would allow DMHC to review health care service plan contracts, documents, and claims coverage of telehealth services, pursuant to AB 744 (Aguiar-Curry), Chapter 867, Statutes of 2019.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0933 – Managed Care Fund	$331,000	$379,000
Total Funding Request:	**$331,000**	**$379,000**
Total Requested Positions:	**1.5**	**1.5**

* Positions and resources ongoing after 2021-22.

Background. AB 744 (Aguiar-Curry), Chapter 867, Statutes of 2019, requires health care service plan contracts after January 1, 2021, to specify that the plan is required to cover and reimburse diagnosis, consultation, or treatment delivered through telehealth on the same basis and to the same extent the plan is responsible for coverage and reimbursement for the same service provided through in-person diagnosis, consultation, or treatment. According to DMHC, AB 744 requires review of: 1) health care service plan documents for compliance with reimbursement requirements for telehealth services, 2) plan records regarding payments for telehealth services, and 3) telehealth claim samples when conducting financial examinations.

DMHC reports it regulates 56 plans with provider contracts that would need to meet the AB 744 requirements, including 22 full service commercial plans, 20 dental plans, and 14 behavioral health plans. Each of the 56 plans may file two different provider contracts (general services providers and specialized services providers) with the DMHC for review, resulting in a total of 112 provider contracts for review. The 22 full service commercial plans are comprised of three separate lines of business, including 15 plans in the individual market, 16 plans in the small group market and 11 plans in the large group market, with separate evidence of coverage (EOC), subscriber contracts, disclosure and plan documents for each line of business. As a result, DMHC will be required to review 42 separate EOCs, subscriber contracts, disclosure and plan documents for the full service commercial plans, an additional 20 EOCs, subscriber contracts, disclosure and plan documents for the 20 dental plans, and an additional 14 EOCs, subscriber contracts, disclosure and plan documents for the 14 behavioral health plans for a total review of 76 EOCs, subscriber contracts, disclosure and plan documents each year.

DMHC requests 1.5 positions and expenditure authority from the Managed Care Fund of $331,000 in 2020-21, and $379,000 annually thereafter. These resources would support the following staff and consulting services in the following DMHC divisions:

Office of Financial Review

- **One Corporation Examiner** would develop new examination procedures for compliance with the new telehealth-related requirements and review telehealth claim samples during routine financial examinations.

- **Actuarial consulting services** of $60,000 in 2020-21 and $120,000 annually thereafter would assist the Office's Division of Premium Rate Review with the review of the cost-sharing portion of telehealth contracts for plans offering mental health services.

Office of Plan Licensing

- **0.5 Attorney III position** would be responsible for the ongoing review of provider contracts and plan documents for compliance with the new telehealth-related requirements.

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Health Plans and Health Insurance – Third-Party Payments (AB 290)

Budget Issue. DMHC requests expenditure authority from the Managed Care Fund of $1.2 million in 2020-21, and $775,000 in 2021-22. If approved, these resources would allow DMHC to establish an Independent Dispute Resolution Process, promulgate regulations, receive health plan data regarding cost savings, and review Evidence of Coverage documents to verify health plan compliance with AB 290 (Wood), Chapter 862, Statutes of 2019.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22**
0933 – Managed Care Fund	$1,163,000	$775,000
Total Funding Request:	**$1,163,000**	**$775,000**
Total Requested Positions:	**0.0**	**0.0**

Background. AB 290 (Wood), Chapter 290, Statutes of 2019, prohibits a financially interested entity from providing premium assistance for health care coverage unless it: 1) provides assistance for the full plan year; 2) notifies enrollees prior to open enrollment if financial assistance will be discontinued; 3) agrees not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device; 4) informs an applicant of financial assistance annually of all available health care coverage options including Medicare, Medicaid, individual market plans, and employer plans; 5) agree not to steer, direct, or advise a patient into or away from a specific coverage program option or health care service plan contract; 6) agree that financial assistance shall not be conditioned on the use of a specific facility, health care provider, or coverage type; and 7) agree that financial assistance shall be based on financial need with uniformly applied and publicly available criteria. AB 290 also governs provider reimbursement for financially interested entities for covered services through a third-party premium payment arrangement and requires DMHC to establish an independent dispute resolution process (IDRP) for determining if the reimbursement amount was appropriately determined and paid. In addition, if a health care service plan subsequently discovers that a financially interested entity failed to provide the proper disclosure, the plan may recover 120 percent of the difference between the payment made and the payment to which the provider was entitled and must notify and remit a portion of the overpayment to DMHC.

DMHC requests expenditure authority from the Managed Care Fund of $1.2 million in 2020-21, and $775,000 in 2021-22. These resources would fund the following temporary help resources in the following DMHC divisions:

Office of Financial Review

- Resources equivalent to **one Corporation Examiner IV position** would serve as lead on implementation of AB 290, review submissions from health plans regarding premium payments made by financially interested entities, perform initial review of cost saving filings, work with the actuarial consultant during their review, verify the accuracy of overpayments submitted to DMHC, and updating financial examination processes and reviewing affected claims.
- **Actuarial consulting services** of $31,000 in 2021-22 to assist the department with reviewing the cost saving schedule submitted with rate filings.

Office of Legal Services

- Resources equivalent to **one Attorney III position** would conduct complex policy research and legal analysis, issue legal memoranda and promulgate regulations to clarify the annual report format and process for collecting overpayments pursuant to AB 290 requirements.
- Resources equivalent to **0.5 Attorney position** would assist in promulgating regulations and conducting less complex policy research and legal analysis.

Help Center

- Resources equivalent to **one Attorney** would review complex IDRP requests, prepare legal correspondence, conduct special investigations, and review contracts between providers and health plans for administering the IDRP and compliance with AB 290 requirements.
- Resources equivalent to **one Associate Governmental Program Analyst** would respond to provider inquiries, determine appropriate resolution of sensitive complaints, and assist in processing less complex IDRP requests and contracts between providers and health plans for compliance with AB 290 requirements.

Office of Technology and Innovation

- **Consulting services** of $470,000 in 2020-21 would build the AB 290 IDRP process on top of the existing modernization process for the department's Provider Complaint System (PCS). The 2019 Budget Act included resources to modernize the PCS following implementation of AB 2674 (Aguiar-Curry), Chapter 303, Statutes of 2018.
- Resources equivalent to **one Information Technology Specialist I position** would monitor and maintain system requirements in the PCS to receive IDRP requests from providers and health plans efficiently, enhance the department's Consolidated Account Receivable System to accept and process invoices for the IDRP, and provide other maintenance and support.
- Resources equivalent to **0.5 Information Technology Supervisor II position** would manage the development of the PCS platform to receive IDRP requests from providers and health plans.

Office of Plan Licensing

- Resources equivalent to **one Attorney III position** would assess EOC amendments at the benefit plan level and provider contracts at the health care service plan level for compliance with AB 290 requirements.

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

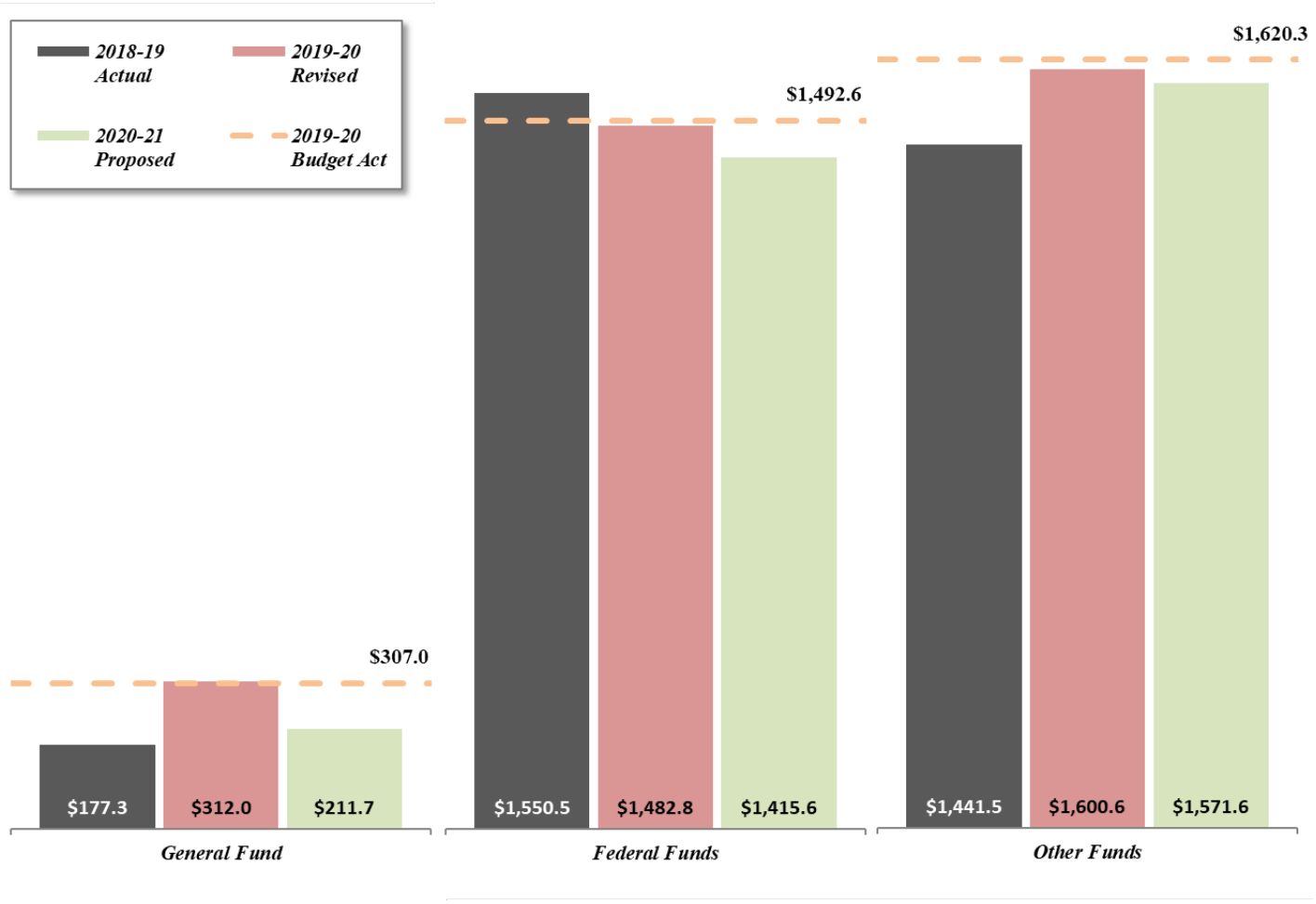
Questions. The subcommittee has requested DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Overview

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



Department of Public Health - *Department Funding Summary*			
Fund Source	***2019-20 Budget Act***	***2019-20 Revised***	***2020-21 Proposed***
General Fund	$306,970,000	$312,035,000	$211,734,000
Federal Funds	$1,492,632,000	$1,482,787,000	$1,415,563,000
Other Funds	$1,620,292,000	$1,600,601,000	$1,571,574,000
Total Department Funding:	**$3,419,894,000**	**$3,395,423,000**	**$3,198,871,000**
Total Authorized Positions:	**3807.0**	**3611.9**	**3755.4**
Other Funds Detail:			

Breast Cancer Research Account (0007)	*$1,179,000*	*$1,265,000*	*$818,000*
Nuclear Planning Assessment Acct (0029)	*$984,000*	*$1,003,000*	*$1,004,000*
Motor Vehicle Acct, Trans. Fund (0044)	*$1,550,000*	*$1,595,000*	*$1,598,000*
Sale of Tobacco to Minors Ctrl Acct (0066)	*$1,098,000*	*$1,180,000*	*$190,000*
Occup. Lead Poisoning Prev Acct (0070)	*$3,585,000*	*$3,786,000*	*$2,320,000*
Medical Waste Management Fund (0074)	*$2,786,000*	*$2,884,000*	*$2,887,000*
Radiation Control Fund (0075)	*$27,319,000*	*$28,623,000*	*$30,157,000*
Tissue Bank License Fund (0076)	*$638,000*	*$665,000*	*$1,182,000*
Childhood Lead Poisoning Prev Fund (0080)	*$41,402,000*	*$42,045,000*	*$35,153,000*
Export Document Program Fund (0082)	*$801,000*	*$859,000*	*$861,000*
Clinical Lab. Improvement Fund (0098)	*$12,818,000*	*$13,458,000*	*$15,586,000*
Health Statistics Special Fund (0099)	*$29,115,000*	*$30,246,000*	*$31,608,000*
Dept. of Pesticide Regulation Fund (0106)	*$328,000*	*$330,000*	*$330,000*
Air Pollution Control Fund (0115)	*$303,000*	*$305,000*	*$305,000*
CA Health Data and Planning Fund (0143)	*$240,000*	*$240,000*	*$240,000*
Food Safety Fund (0177)	*$11,371,000*	*$12,237,000*	*$10,276,000*
Genetic Disease Testing Fund (0203)	*$142,975,000*	*$144,122,000*	*$143,760,000*
Health Education Account, Prop 99 (0231)	*$52,510,000*	*$52,576,000*	*$45,219,000*
Research Account, Prop 99 (0234)	*$7,459,000*	*$7,507,000*	*$6,491,000*
Unallocated Account, Prop 99 (0236)	*$4,444,000*	*$4,506,000*	*$3,938,000*
Infant Botulism Treatment/Prev Fund (0272)	*$14,202,000*	*$14,300,000*	*$10,387,000*
Child Health and Safety Fund (0279)	*$551,000*	*$551,000*	*$551,000*
Registered Enviro. Health Spec Fund (0335)	*$446,000*	*$467,000*	*$428,000*
Indian Gaming Spec Dist Fund (0367)	*$8,270,000*	*$8,369,000*	*$8,374,000*
Vectorborne Disease Account (0478)	*$204,000*	*$216,000*	*$167,000*
Toxic Substances Control Acct (0557)	*$468,000*	*$543,000*	*$548,000*
Domestic Violence Training/Ed Fund (0642)	*$617,000*	*$636,000*	*$637,000*
CA Alzheimers Research Fund (0823)	*$657,000*	*$657,000*	*$657,000*
Special Deposit Fund (0942)	*$7,625,000*	*$10,079,000*	*$9,617,000*
Reimbursements (0995)	*$252,763,000*	*$255,602,000*	*$254,195,000*
Drug and Device Safety Fund (3018)	*$7,212,000*	*$6,552,000*	*$5,009,000*
WIC Manufacturer Rebate Fund (3023)	*$213,678,000*	*$208,188,000*	*$193,110,000*
Medical Marijuana Program Fund (3074)	*$174,000*	*$163,000*	*$10,000*
AIDS Drug Assistance Program Fund (3080)	*$323,427,000*	*$324,239,000*	*$365,243,000*
Cannery Inspection Fund (3081)	*$2,931,000*	*$3,145,000*	*$3,153,000*
Mental Health Services Fund (3085)	*$33,307,000*	*$33,414,000*	*$2,443,000*
Licensing and Certification Fund (3098)	*$189,638,000*	*$193,927,000*	*$227,127,000*
Gambling Addiction Program Fund (3110)	*$150,000*	*$150,000*	*$150,000*
Birth Defects Monitoring Prog Fund (3114)	*$2,353,000*	*$2,410,000*	*$2,410,000*

Lead-Related Construction Fund (3155)	*$775,000*	*$861,000*	*$865,000*
Cost/Impl Acct, Air Poll. Ctrl Fund (3237)	*$358,000*	*$379,000*	*$381,000*
Cannabis Control Fund (3288)	*$29,011,000*	*$29,781,000*	*$8,737,000*
State Dental Program Acct., Prop 56 (3307)	*$30,188,000*	*$26,749,000*	*$26,449,000*
DPH Tobacco Law Enforc, Prop 56 (3318)	*$9,686,000*	*$9,183,000*	*$5,003,000*
DPH, Tobacco Prev/Ctrl, Prop 56 (3322)	*$148,696,000*	*$120,608,000*	*$112,000,000*

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

According to DPH, their goals include the following:

- Achieve health equities and eliminate health disparities.
- Eliminate preventable disease, disability, injury, and premature death.
- Promote social and physical environments that support good health for all.
- Prepare for, respond to, and recover from emerging public health threats and emergencies.
- Improve the quality of the workforce and workplace.

The department is composed of seven major program areas:

(1) Center for Healthy Communities – This center works to prevent and control chronic diseases, such as cancer, cardiovascular diseases, asthma, adverse pregnancy outcomes, and diabetes; to reduce the prevalence of obesity; to provide training programs for the public health workforce; to prevent and control injuries, violence, deaths, and diseases related to behavioral, environmental, and occupational factors; to promote and support safe and healthy environments in all communities and workplaces; and to prevent and treat problem gambling.

(2) Center for Environmental Health – This center works to protect and improve the health of all California residents by ensuring the safety of drinking water, food, drugs, and medical devices; conducting environmental management programs; and overseeing the use of radiation through investigation, inspection, laboratory testing, and regulatory activities.

(3) Center for Family Health – This center works to improve health outcomes and reduce disparities in access to health care for low-income families, including women of reproductive age, pregnant and breastfeeding women, and infants, children, and adolescents and their families.

(4) Center for Health Care Quality – This center regulates the quality of care in approximately 8,000 public and private health facilities, clinics, and agencies throughout the state; licenses nursing home administrators, and certifies nurse assistants, home health aides, hemodialysis technicians, and other direct care staff.

(5) Center for Infectious Disease – This center works to prevent and control infectious diseases, such as HIV/AIDS, viral hepatitis, influenza and other vaccine preventable illnesses, tuberculosis, emerging infections, and foodborne illnesses.

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

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

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

Item 4265-001-0001—Department of Public Health

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

DPH has expressed a willingness to continue to provide an annual State of the State's Public Health report to the Assembly and Senate budget subcommittees during the budget process.

Subcommittee Staff Comment and Recommendation. This is an informational item.

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

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

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

Issue 2: Novel Coronavirus (COVID-19) Update – Prevention and Response Activities

Informational Issue. The state of California, like much of the rest of the United States and the world, is responding to an outbreak of novel coronavirus (COVID-19), which causes mild-to-moderate respiratory illness with symptoms similar to the flu, including fever, cough, and shortness of breath. COVID-19 can also cause more severe respiratory illness. The California Office of Emergency Services (CalOES), DPH, and local health departments are leading the public response to the outbreak with containment and mitigation strategies to slow the spread of COVID-19 and avoid overwhelming the health care system.

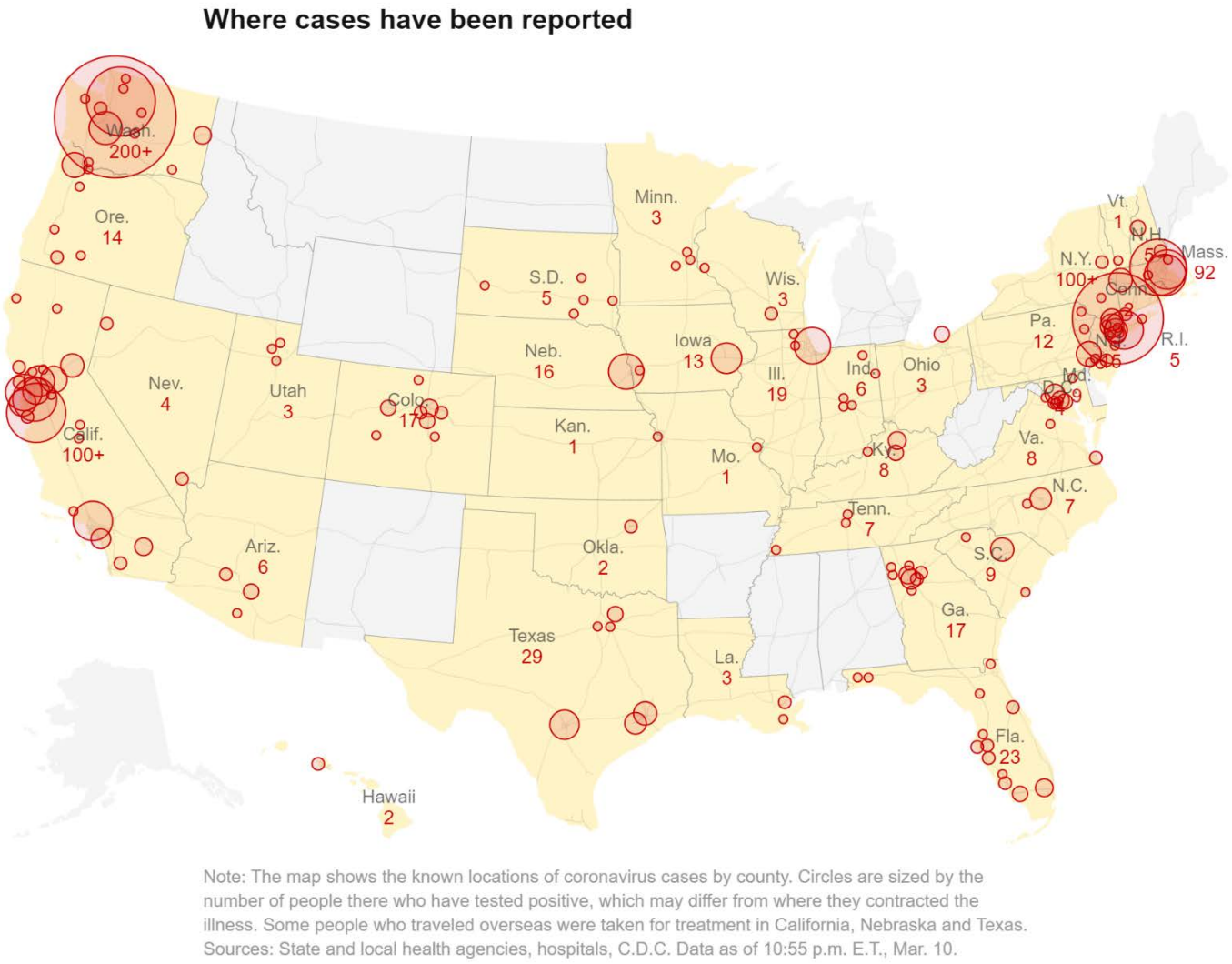
Outbreak Origin and Transmission. COVID-19 was first identified in Wuhan, Hubei Province, China. However, cases of COVID-19 have been reported in several countries internationally, including the United States. According to DPH, California is actively working with the White House, Centers for Disease Control and Prevention (CDC), local governments, health facilities, and health care providers across the state to prepare and protect Californians from COVID-19.

According to the CDC, coronaviruses are a large family of viruses that are common in people and many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with MERS-CoV and SARS-CoV.

COVID-19 is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir.

Early on, many of the patients at the epicenter of the outbreak in Wuhan had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside Hubei and in countries outside China, including in the United States. Some international destinations now have apparent community spread with the virus that causes COVID-19, as do some parts of the United States. Community spread means some people have been infected and it is not known how or where they became exposed.

Epidemiological studies of the initial stages of the outbreak in Wuhan suggest that COVID-19 may have an extremely high transmission rate for infected individuals. The initial studies estimated infected individuals transmitted COVID-19 to an average of 2.5 additional people. For reference, the equivalent transmission rate of influenza A is 1.1 to 1.5. DPH reports that, according to available international data, of those who have tested positive for COVID-19, approximately 80 percent do not exhibit symptoms that would require hospitalization.



Note: The map shows the known locations of coronavirus cases by county. Circles are sized by the number of people there who have tested positive, which may differ from where they contracted the illness. Some people who traveled overseas were taken for treatment in California, Nebraska and Texas. Sources: State and local health agencies, hospitals, C.D.C. Data as of 10:55 p.m. E.T., Mar. 10.

Current Status of Individuals Affected in California. DPH reports that, as of the morning of March 10, 2020, there are a total of 157 confirmed, positive cases in California. 24 cases are from repatriation flights, and the other 133 confirmed cases include:

- 50 travel related cases
- 30 person-to-person transmission
- 29 community transmission
- 24 cases currently under investigation
- 2 death

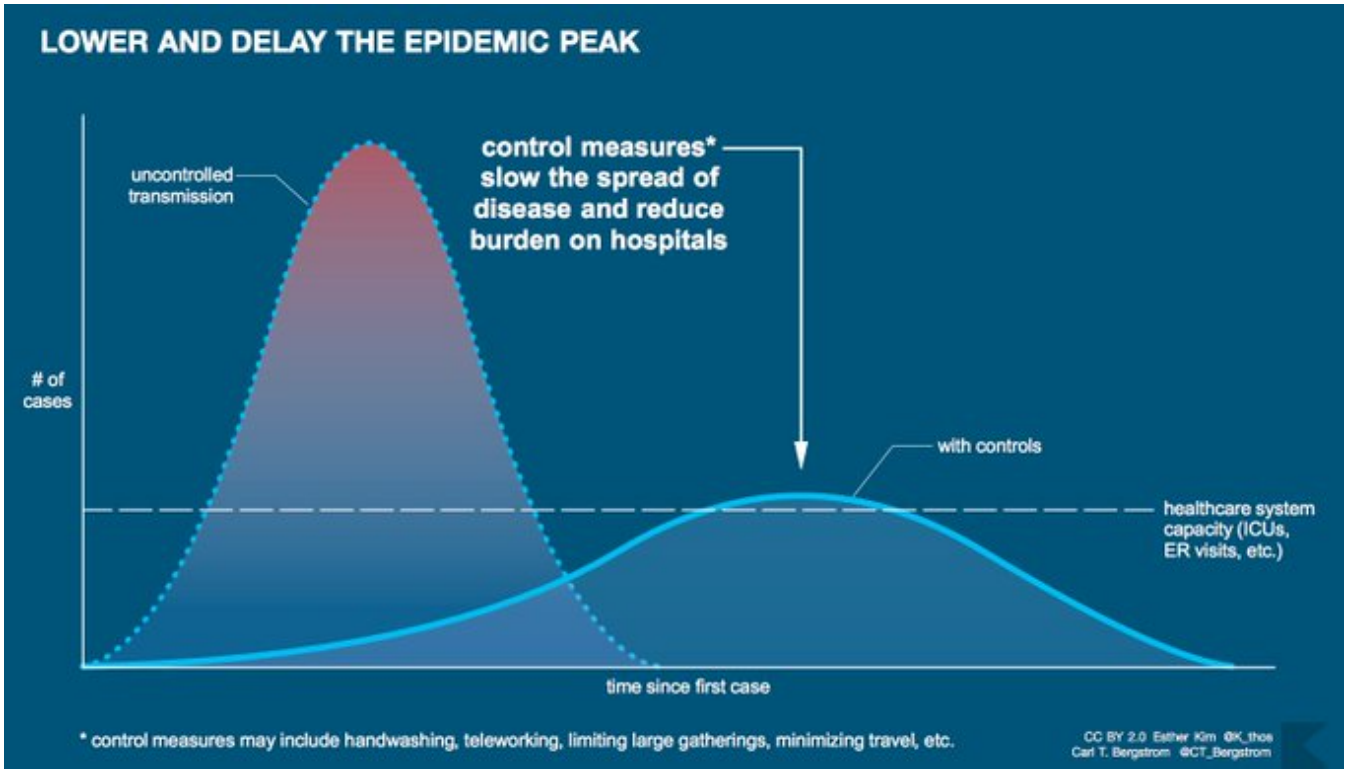
Nationwide, there have been 25 deaths reported from COVID-19, with positive cases reported in 36 states, including the District of Columbia.

More than 10,320 individuals who traveled on commercial flights through San Francisco International Airport or Los Angeles International Airport are self-monitoring across 49 local health jurisdictions. This self-monitoring is precautionary, and these individuals are not currently displaying symptoms.

22 individuals have tested positive that were aboard the Grand Princess cruise ship returning from Hawaii to San Francisco.

Status of Testing Capabilities. According to DPH, 18 public health laboratories in California are testing for COVID-19. These labs include the DPH State Laboratory in Richmond, and county public health laboratories in Alameda, Contra Costa, Humboldt, Los Angeles, Monterey, Napa-Solano-Yolo-Marin (located in Solano), Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, Santa Clara, Shasta, Sonoma, Tulare and Ventura. The Richmond Laboratory will provide diagnostic testing within a 48-hour turnaround time. More public health labs will soon be able to test for COVID-19, which will improve testing response time. Quest Laboratories is also now online and capable of processing 1,200 tests daily. DPH reports two additional commercial labs will begin testing March 24.

Containment and Mitigation Strategies. The potentially significant rate of transmission poses risks of overwhelming the health care system's capacity if a significant number of people are infected with COVID-19 simultaneously. During the initial stages of the worldwide outbreak, DPH and local health departments were conducting disease surveillance, implementing local testing, managing suspect and confirmed cases, and conducting contact tracing to track and contain the potential spread of the outbreak. With the significant incidence of community transmission of COVID-19 among individuals with no history of travel to affected regions or known contact with positive individuals, much of the state and local response has turned to mitigation, including expanded testing, encouraging hygiene, and social distancing.



DPH and the CDC currently estimates the health risk of COVID-19 to the general public remains low. DPH guidance to the general public includes the following recommendations:

1) Wash hands with soap and water
2) Avoid touching eyes, nose or mouth with unwashed hands
3) Avoid close contact with people who are sick
4) Follow guidance from public health officials
5) Individuals experiencing symptoms of COVID-19 (fever, cough, and shortness of breath) should contact their health care provider first before seeking medical care so appropriate precautions may be taken
6) Individuals experiencing symptoms of COVID-19 should stay away from work, school, or other people.

While DPH is not currently recommending the cancellation of public events, or other restrictions on public gatherings, several instances of social distancing actions have been occurring throughout the state and across the nation. For example, several California universities, including many University of California campuses, Stanford University, the University of Southern California, among others, have modified academic schedules and implemented flexibility for classes to be conducted online or remotely for the remainder of the academic term. The Elk Grove Unified School District closed its schools and accelerated its spring break to begin March 9. The state of Washington, which has also experienced a significant number of positive COVID-19 cases, announced restrictions on gatherings of more than 250 people. Certain high-profile public events, such as a management conference for the biotechnology company Biogen, have resulted in an alarming rate of transmission of COVID-19 among participants.

DPH has issued guidance on responses to the outbreak for health care facilities (hospitals and long-term care facilities), community care facilities (assisted living and child care facilities), schools and institutes of higher education, event organizers, first responders, employers, health care plans, and laboratories. DPH also has issued guidance on home, school, and child care facility cleaning for those testing positive for COVID-19.

Local Health Officers and Health Facilities COVID-19 Response Panel. The subcommittee has requested the following panelists to discuss the local health department and health facility response to the COVID-19 outbreak:

- Kat DeBurgh, Executive Director, Health Officers Association of California
- Amanda Willard, Sr Program Coord – Dental/Emergency Preparedness, CA Primary Care Association
- Carmela Coyle, President and CEO, California Hospital Association
- Jackie Bender, Vice President of Policy, CA Association of Public Hospitals and Health Systems
- Amy Blumberg, Director of Legislative Affairs, and Jason Belden, Director of Disaster Preparedness, California Association of Health Facilities

Subcommittee Staff Comment and Recommendation—This is an informational item.

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

1. Please provide a brief overview of the current incidence, morbidity, and mortality statistics for COVID-19 infection in California and the United States.

2. Please provide a brief overview of the state's coordinated prevention and response activities for COVID-19.

3. What should the public expect in the coming weeks and months regarding the spread of COVID-19? How should the public prepare?

4. Is the department sufficiently resourced to respond to the spread of COVID-19? What additional resources might be needed to support prevention and response efforts?

5. Are local health jurisdictions sufficiently resourced to respond to COVID-19?

6. Has the current COVID-19 response highlighted any gaps in readiness that might help the state and DPH to prepare for the next infectious disease crisis? What would constitute an adequately resourced preparedness effort?

7. How does DPH or the state more broadly plan for the need for public health surge capacity during outbreaks such as COVID-19? What percentage of the current public health workforce is currently engaged in response to COVID-19?

The subcommittee has also requested local health officers and health facility panelists to respond to the following:

1. Local Health Officers – How are local health officials coordinating with DPH and other state entities to manage the COVID-19 outbreak? Do local health departments have any current resource needs to address the outbreak? Has the response identified any gaps in readiness or resources that should be addressed once the current outbreak is under control?

2. Hospitals/Public Hospitals/Clinics - How have your facilities/clinics been impacted by the COVID-19 outbreak? How would your facilities and clinics manage a potential surge in intensive care needs if the outbreak continues to spread rapidly? What is the capacity of the health system to respond to the outbreak? How many high-intensity cases could the health system absorb?

3. Skilled Nursing Facilities – COVID-19 appears to have a significantly higher mortality rate among seniors and unchecked transmission within skilled nursing facilities or other facilities for seniors has had catastrophic results in other states. How are skilled nursing facilities responding to the COVID-19 outbreak? What protective measures have been implemented? Is there any general guidance skilled nursing facilities are following regarding family visitors or employees of facilities?

Issue 3: Master Data Management Sustainability

Budget Issue. DPH requests ten positions and expenditure authority from the Health Statistics Special Fund of $1.5 million annually. If approved, these positions and resources would allow DPH to increase department-wide analytics for public health decision-making, to continue implementing master data management strategies, and implementation of data-driven community interventions.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0099 – Health Statistics Special Fund	$1,500,000	$1,500,000
Total Funding Request:	**$1,500,000**	**$1,500,000**
Total Requested Positions:	**10.0**	**10.0**

* Positions and Resources ongoing after 2021-22.

Background. In 2018-19, grant funding provided by an Emergency Response: Public Health Crisis Response Cooperative Agreement with the federal Centers for Disease Control and Prevention allowed DPH to establish the Analytic Services Unit (ASU) within the Center for Health Statistics and Informatics (CHSI). The ASU assists with implementation of an enterprise-level data governance structure, implementation of standard processes and procedures for master data management within DPH programs, and to provide advanced descriptive and predictive analytics services to DPH programs. The ASU consists of six positions and worked with a health information management lead within CHSI to procure advanced analytics software and actively developed a menu of analytics services DPH programs may request. According to DPH, the ASU and health information management lead have been receiving informal requests for analytics since March 2019. The federal grant that funded the ASU positions expired on November 30, 2019, and the federal Public Health and Health Services Block Grant that funds the health information management lead will expire on June 30, 2020.

The analytic services provided by the ASU and health information management lead have included various data operations. For example, the ASU provided consultation to the DPH Center for Health Communities to: 1) conduct data dictionary assessments of possible opioid-related data sources for cross-analysis; 2) collect requirements for a technical infrastructure capable of automated ingestion, integration, and cross-analysis of multiple opioid-related data sources; and 3) develop a system design blueprint for software development of a surveillance system capable of performing these automated processes. These analyses allow DPH to produce data visualizations and reports to show a more complete picture of opioid overdoses in California to support data-driven, science-based decision-making and interventions for opioid overdose prevention.

DPH also reports the addition of the ASU positions and others to its Informatics Branch within CHSI have led to increasing needs for administrative workload that are currently supported by part-time redirection of two CHSI staff members. These staff members provide training and travel coordination, timekeeping, meeting coordination, notetaking, policy analysis, and legislative analysis.

DPH requests ten positions and expenditure authority from the Health Statistics Special Fund of $1.5 million annually to allow DPH to expand provision of department-wide analytics for public health

decision-making, continue implementing master data management strategies, and implementation of data-driven community interventions. These resources would fund the following positions:

- **One Research Data Supervisor II position, two Research Data Specialist II positions,** and **one Research Data Analyst II position** would provide the analytics services to support DPH programmatic needs.
- **Three Information Technology Specialist II positions** would act as liaisons for communicating with DPH programs that include assistance with mature data collection or storage systems, data management services and implementation of data management practices. One of these positions would serve as the health information management lead.
- **One Associate Governmental Program Analyst, one Staff Services Analyst,** and **one Office Technician** would provide administrative support to the ASU and the Informatics Branch within CHSI.

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

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

1. Please provide a brief overview of this proposal.

2. Please describe some of the analytics that have been performed by the ASU for DPH programs.

3. What other programs does DPH expect to benefit from these analytics capabilities and how?

Issue 4: AIDS Drug Assistance Program (ADAP)

Background. The Office of AIDS within DPH administers the AIDS Drug Assistance Program (ADAP), which provides access to life-saving medications for Californians living with HIV and assistance with costs related to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for Californians at risk for acquiring HIV. Clients are eligible for ADAP services if they meet the following criteria:

1. are HIV infected;
2. are a resident of California;
3. are 18 years of age or older;
4. have a Modified Adjusted Gross Income that does not exceed 500 percent of the Federal Poverty Level; and
5. are not fully covered by or eligible for Medi-Cal or any other third-party payer.

ADAP Programs. ADAP provides services to its clients through support for medications, health insurance premiums and out-of-pocket costs. Participating clients generally fall into one of five categories:

1. *Medication-only clients* are people living with HIV who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals, who only receive services associated with medication costs.
2. *Medi-Cal Share of Cost clients* are persons living with HIV enrolled in Medi-Cal who have a share of cost for Medi-Cal services. ADAP covers the share of cost for medications for these clients, who only receive services associated with medication costs.
3. *Private insurance clients* are persons living with HIV who have some form of health insurance, including through Covered California, privately purchased health insurance, or employer-based health insurance and who receive services associated with medication costs, health insurance premiums and medical out-of-pocket costs.
4. *Medicare Part D clients* are persons living with HIV enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group of clients receives services associated with medication co-pays, medical out-of-pocket costs, Medicare Part D health insurance premiums, and has the option for premium assistance with Medigap supplemental insurance policies, which cover medical out-of-pocket costs.
5. *Pre-exposure prophylaxis (PrEP) clients* are individuals who are at risk for, but not infected with, HIV and have chosen to take PrEP as a way to prevent infection. For insured clients, the PrEP Assistance Program (PrEP-AP) pays for PrEP-related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's co-payment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP-related medical costs, as medication is provided free by the manufacturer's medication assistance program.

ADAP is funded by federal funds and the ADAP Rebate Fund (Fund 3080). The federal government began funding state programs to assist people living with HIV to purchase antiretroviral medications in 1987. Since 1990 with the passage of the Ryan White Comprehensive AIDS Resources Emergency Act,

now known as the Ryan White Program, the federal Health Resources and Services Administration (HRSA) provides funding to states for ADAP programs. In addition to federal funds, ADAP receives significant funding from mandatory and voluntary manufacturer rebates for ADAP drug expenditures.

ADAP Local Assistance Estimate. The November 2019 ADAP Local Assistance Estimate reflects revised 2019-20 expenditures of $431.3 million, which is a decrease of $18.2 million or four percent compared to the 2019 Budget Act. According to DPH, this decrease is primarily due to reduction in medication expenditures partially offset by an increase in private insurance medical out-of-pocket expenditures. DPH indicates these offsetting changes are partially due to the success of the Access, Adherence, and Navigation (AAN) Program transitioning medication-only clients to private insurance or Medi-Cal and partially due to projections of higher insurance premium costs that will be updated at May Revision. For 2020-21, DPH estimates ADAP expenditures of $467.5 million, an increase of $18 million or four percent compared to revised expenditures for 2019-20. According to DPH, this increase is similarly attributable to the transition of medication-only clients to private insurance or Medi-Cal and higher insurance premium cost projections.

ADAP Local Assistance Funding Summary		
Fund Source	**2019-20**	**2020-21**
0890 – Federal Trust Fund	$116,571,000	$113,259,000
3080 – AIDS Drug Assistance Program Rebate Fund	$314,709,000	$354,205,000
Total ADAP Local Assistance Funding	**$431,280,000**	**$467,464,000**

ADAP tracks caseload and expenditures by client group. DPH estimates ADAP caseload and expenditures for 2019-20 and 2020-21 will be as follows:

Caseload by Client Group	**2019-20**	**2020-21**
Medication-Only	12,307	12,580
Medi-Cal Share of Cost	107	136
Private Insurance	10,170	10,687
Medicare Part D	7,627	7,683
PrEP Assistance Program	2,412	3,542

Expenditures by Client Group	**2019-20**	**2020-21**
Medication-Only	$304,049,841	$310,204,641
Medi-Cal Share of Cost	$1,049,441	$1,180,878
Private Insurance	$87,428,538	$112,917,214
Medicare Part D	$23,457,664	$26,910,401
PrEP Assistance Program	$6,069,446	$7,868,071

In addition, enrollment costs are estimated to be $7.9 million in 2019-20 and $8.4 million in 2020-21. Beginning in 2017-18, ADAP introduced a new reimbursement methodology for enrollment sites which

includes a payment floor and variable payments dependent on new client medication enrollment, client bi-annual self-verification, client annual re-enrollment, client insurance assistance enrollment and re-enrollment, and PrEP client enrollment and re-enrollment.

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

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

1. Please provide a brief overview of the major changes to the ADAP Estimate.

Issue 5: ADAP Modified Adjusted Gross Income (MAGI) Information

Trailer Bill Language Proposal. DPH proposes trailer bill language to allow for electronic retrieval of AIDS Drug Assistance Program clients' modified adjusted gross income data from the California Franchise Tax Board.

Background. The AIDS Drug Assistance Program (ADAP) provides access to life-saving medications for Californians living with HIV and assistance with costs related to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for Californians at risk for acquiring HIV. Clients are eligible for ADAP services if they meet the following criteria:

1. are HIV infected;
2. are a resident of California;
3. are 18 years of age or older;
4. have a Modified Adjusted Gross Income that does not exceed 500 percent of the Federal Poverty Level; and
5. are not fully covered by or eligible for Medi-Cal or any other third-party payer.

Currently, ADAP receives adjusted gross income information from the Franchise Tax Board FTB under a three-year agreement. According to DPH, state law only allows FTB to provide the adjusted gross income, which does not include household data necessary to calculate modified adjusted gross income (MAGI), which forms the basis of determinations of ADAP client eligibility. DPH reports enrollment workers receive tax returns from potential clients and calculate MAGI separately, following up with FTB staff if additional calculations or information is necessary.

DPH proposes trailer bill language to amend state law to use federal definitions of "household" and "family size" and changes references from "taxpayer" to "taxpayer household". These changes would allow FTB to provide sufficient information to ADAP to determine client eligibility, streamlining data collection, reducing administrative burdens and eliminating conflicts in current law.

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

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

1. Please provide a brief overview of this trailer bill language proposal.

Issue 6: PrEP Assistance Program – 30 Day Initial Supply of PrEP and PEP Medication

Trailer Bill Language Proposal. DPH proposes trailer bill language to allow the Pre-Exposure Prophylaxis Assistance Program to pay for an initial 30-day supply of pre-exposure prophylaxis and post-exposure prophylaxis medication.

Background. AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018, authorized the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) to provide assistance with medical out-of-pocket costs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), as well as access to medications on the PrEP-AP formulary for the prevention of HIV. However, AB 1810 limited the quantiy of prescriptions as follows:

- PrEP-AP may furnish up to 14 days of PrEP and PEP medication to clients.
- PrEP-AP may furnish up to 28 days of PEP medication to clients who are victims of sexual assault.

Currently, the combination medication tenofovir disoproxil fumarate and emtricitabine, marketed under the brand name Truvada by Gilead Sciences, is the only FDA-approved medication for PrEP and is a component of the recommended PEP regimen. According to DPH, Gilead Sciences only packages Truvada in bottles containing 30 tablets, enough for a 30-day supply. The package insert specifically instructs providers to dispense only in the original container and Gilead Sciences has been explicitly instructing providers that bottles of Truvada may not be split. Due to these restrictions, DPH has experienced barriers to compliance with the 14-day and 28-day limits imposed by AB 1810 for the provision of PrEP and PEP medication to PrEP-AP clients.

DPH proposes trailer bill language to allow ADAP to furnish an initial 30-day supply of PrEP and PEP medication to PrEP-AP clients, consistent with the current packaging practices of the manufacturer. According to DPH, this change would impact approximately 400 PrEP-AP clients and would result in increased ADAP Rebate Fund costs of between $830,000 and $1.7 million annually, depending on whether the client is insured or uninsured or if they are eligible for the manufacturer's medication assistance program.

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

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

1. Please provide a brief overview of this trailer bill language proposal.

2. Is there any clinical relevance to the manufacturer guidance that bottles containing 30 tablets of Truvada not be split?

Issue 7: ADAP Enrollment System Maintenance and Operations Support

Budget Issue. DPH requests nine positions and expenditure authority from the ADAP Rebate Fund of $4.8 million annually. If approved, these positions and resources would allow DPH to support ongoing maintenance and operations of the ADAP Enrollment System, which manages eligibility determinations, enrollment, and medication access for clients of the ADAP program.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
3080 – AIDS Drug Assistance Program Rebate Fund	$4,750,000	$4,750,000
Total Funding Request:	**$4,750,000**	**$4,750,000**
Total Requested Positions:	**9.0**	**9.0**

* Positions and resources ongoing after 2021-22.

Background. Prior to July 2016, ADAP's pharmacy benefits manager (PBM) contract included both pharmaceutical and enrollment services. After the expiration of the PBM contract, the 2016 Budget Act approved contract resources to separate these functions into two contracts: a PBM contract with Magellan and a new enrollment benefits manager (EBM) contract with A.J. Boggs & Company. A.J. Boggs, under the terms of the contract, was required to provide a web-based eligibility portal that would allow local enrollment sites and other Ryan White programs to simplify enrollment and access to services. In November 2016, the enrollment portal was unexpectedly unavailable for enrollment worker and client use. DPH identified security vulnerabilities in the new system and identified two breaches of confidential client information. After the portal became unavailable, DPH took several actions to address the problems with enrollments and eligibility determinations:

- Enrollment workers were instructed to fax client applications directly to A.J. Boggs
- Eligibility was extended until the next reenrollment or recertification period after June 2017
- Paper applications were shortened to streamline the faxed application process
- DPH staff actively worked with enrollment sites, clients, and advocates to monitor problems and ensure continued access to medications and health insurance
- DPH provided semi-weekly updates on the issue with enrollment workers and stakeholders
- ADAP ceased secondary, state-level review of new applications to expedite access to medications.

DPH staff also engaged consultants at Deloitte to provide an independent assessment of the security issues and future viability of the enrollment portal.

DPH terminated its EBM vendor relationship with A.J. Boggs in March 2017, citing material breach of contract. A.J. Boggs ceased processing applications and DPH began processing applications received by fax. At the same time, DPH began implementation of a new enrollment system developed in consultation with Deloitte since the failure of the A.J. Boggs enrollment portal. DPH staff provided training and access to the new system for enrollment workers and redirected 21 staff positions from other divisions to support these efforts.

The 2018 Budget Act included 15 positions and expenditure authority from the ADAP Rebate Fund of $2.7 million annually to manage the workload of transitioning eligibility and enrollment services to the interim ADAP Enrollment System (AES) within the Office of AIDS.

The interim AES was built as a custom web-based solution with approximately 600 users, which include DPH staff and enrollment workers at approximately 193 certified enrollment sites throughout California. Working with the California Department of Technology through the Project Approval Lifecycle (PAL) Stage Gate process, DPH completed eight enhancements to the interim AES to transition the system to serve as a long-term solution for ADAP enrollment benefit management and system integration.

DPH requests nine positions and expenditure authority from the ADAP Rebate Fund of $4.8 million annually to support ongoing maintenance and operations of the permanent AES solution. Specifically, these resources would support the following positions in the following DPH divisions:

Office of AIDS

- **Two Research Scientist II positions** would manage advanced analytical and statistical work needed to integrate eligibility enrollment, clinical, demographic, and drug and service utilization, drug spend, premium payment, and out-pocket claim records; oversee development of data created from routine data exchange workflows; lead analyses of medication adherence and client health outcomes using transactional data and laboratory results; develop, implement, and monitor quality improvement metrics and projects.
- **One Health Program Specialist I position** would support non-technical programmatic functions, coordinate completion of vendor risk questionnaire and coordinate data submissions in response to federal reporting requirements.
- **Two Associate Governmental Program Analysts** would perform the following functions related to the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP): 1) review and track clinical provider applications for providers and entities wanting to join the PrEP-AP networks; 2) manage contracts associated with PrEP-AP clinical provider and PrEP-AP enrollment site networks; 3) perform secondary review of PrEP-AP applications; 4) provide technical assistance to clinical providers, enrollment workers, and clients; and 5) assist in implementation and administration of recently authorized PrEP-AP service enhancements.

Information Technology Services Division

- **One Information Technology Specialist II position** would build, configure, and provide technical support for all AES servers and database environments; participate in database maintenance, change management, and documentation standards; provide oversight and technical support in the maintenance of operational data stores, data warehouse, and data marts; provide high-level technical expertise in the maintenance of business architecture, information architecture, application architecture, networking architecture, and technology architecture; and ensure enterprise and architectural requirements, strategies, standards, plans, and policies are met.
- **One Information Technology Specialist I position** would assist and facilitate maintenance to standards for applications and systems; serve as a subject matter expert and lead on application maintenance, system administration, and security; provide technical consultation to customers, staff, and management as necessary; provide recommendations regarding application or system issues in

support of strategic planning, goals, and operations; develop and revise various documents including different phases of the Software Development Life Cycle (SDLC), migration plans, task checklists, installation and configuration procedures, disaster recovery manuals, software evaluation reports, data history logs, and upgrade proposal presentations.

Office of Compliance

- **One Associate Management Auditor** and **one Staff Services Management Auditor** would ensure compliance with contract requirements, state and federal laws, federal Health Resources and Services Administration programmatic, fiscal, and monitoring requirements, and assist in maintaining fiscal integrity.

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

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

1. Please provide a brief overview of this proposal.

Issue 8: Immunization Medical Exemption Program

Budget Issue. DPH requests 15 positions and General Fund expenditure authority of $3.4 million in 2020-21, and $3.1 million annually thereafter. If approved, these positions and resources would allow DPH to standardize processes for immunization medical exemption requests and build new capacity into the California Immunization Registry.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0001 – General Fund	$3,400,000	$3,100,000
Total Funding Request:	**$3,400,000**	**$3,100,000**
Total Requested Positions:	**15.0**	**15.0**

* Positions and resources ongoing after 2020-21.

Background. Health and Safety Code Section 120372 requires DPH to develop, by January 1, 2021, a standardized medical exemption form to be used statewide by physicians and surgeons for a child for whom a physician does not recommend immunization. The form, which must be transmitted electronically to the California Immunization Registry (CAIR), must include physician contact information, child and parents' names, a statement certifying physical examination of the child, and a description of the medical reason for which the exemption is required. DPH is required to establish a system to monitor immunization rates at schools and institutions, review these rates annually, and review medical exemptions for any schools or institutions with immunization rates of less than 95 percent, schools or institutions that do not report, or of physicians who have submitted five or more medical exemptions in a calendar year. If medical exemptions do not meet applicable Centers for Disease Control, Advisory Committee on Immunization Practices, or American Academy of Pediatrics criteria, or are found to be otherwise invalid, the State Public Health Officer or designee must review and may revoke the exemptions. Parents may appeal an exemption revocation to the Secretary of the California Health and Human Services Agency. DPH is also required to report physicians that meet certain criteria to the medical licensing boards of California.

DPH requests 15 positions and General Fund expenditure authority of $3.4 million in 2020-21, and $3.1 million annually thereafter to implement standardized medical exemption electronic reporting to the CAIR, monitoring of immunization rates and review of provider medical exemption requests, manage the medical exemption appeals process, and reporting of providers to medical licensing boards. Specifically, these resources would support the following staff and consulting services:

- **Database Development** – **Two Information Technology Technicians** would build functionality into CAIR to support the online submission of medical exemption requests, develop and test these functionality enhancements, manage ongoing maintenance and operations, and train new and existing users on the new functionality.
- **Medical Exemption Review – One Public Health Medical Officer III-Supervisor, two Public Health Medical Officer III,** and **two Nurse Consultant III Specialists** would provide first-level review of medical exemption requests that meet the review criteria, as well as additional review of more complex requests and second-level review of denied exemption requests. According to DPH, first-level review would be required for 9,468 exemptions, 947 exemptions would exhibit sufficient

complexity to require additional review, approximately 4,000 denied exemption requests would require second-level review, with approximately 1,000 requiring final review by the expert review panel.

- **Medical Exemption Review Support - Two Associate Governmental Program Analysts** would support clinical staff within DPH in reviewing medical exemptions submitted to CAIR for any schools or childcare institutions with immunization rates less than 95 percent or who do not report, or of physicians who have submitted five or more medical exemptions in a calendar year.
- **Program Activities - Three Office Technicians, one Research Scientist III, and one Staff Services Analyst** would serve as liaisons with other state agencies and stakeholders; provide consultation on development of and updates to the exemption form; provide technical assistance to physicians, local health departments, schools, and childcare facilities; develop a communications plan, educational materials, and a training module on how to complete the exemption process; respond to inquiries about the exemption requirements; track the status of exemptions under review; send communications about revocations to parents, schools, childcare facilities, medical licensing boards, issuing physicians, and local health officers; analyze exemption data; and prepare ad hoc reports regarding the program and exemption rates and trends.
- **Legal Support – One Attorney III position** would provide support for legal challenges to the new review requirements, consult with legal staff on issues related to protection of health information for children with exemptions, public-facing program materials, and program procedures and guidelines.
- **Medical Consultants** – UC Davis would provide consulting services of $10,000 annually to provide medical expertise regarding immunization contraindications and precautions.
- **Expert Review Panel Consultants** – Three medical consultants at a cost of $507,200 annually would support the expert review panel, which would meet at designated times each year to review revoked exemptions under appeal. Costs would support the consultants, travel, and other support costs.

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

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

1. Please provide a brief overview of this proposal.

Issue 9: Proposals for Investment

Stakeholder Proposals for Investment. The subcommittee has received the following proposals for investment:

End the Epidemics Coalition Proposals. The End the Epidemics Coalition has proposed the following seven investments in ending the epidemics of human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexually transmitted diseases (STDs):

- Master Plan on HIV, HCV, and STDs – The End the Epidemics coalition requests General Fund expenditure authority of $2 million one-time for the Secretary of Health and Human Services and the Chief of the Office of AIDS to develop a Master Plan on HIV, HCV, and STDs. This proposal would provide HHS and OA with resources to convene a stakeholder advisory committee and work with relevant state agencies to set targets for ending the HIV, HCV, and STD epidemics and identify recommended programs, policies, strategies, and funding for achieving these targets. This proposal is consistent with SB 859 (Wiener).
- Increase ADAP Eligibility Levels – The End the Epidemics coalition requests expenditure authority from the ADAP Rebate Fund to increase ADAP and PrEP-AP eligibility from 500 percent to 600 percent of the federal poverty level to align with the new state subsidies for individuals enrolled in Covered California. ADAP rebates can be used to fund this increased eligibility limit. This proposal would be implemented by the Office of AIDS.
- Expand Family PACT Eligibility to Address Rising STD Rates – The End the Epidemics coalition is requesting an ongoing General Fund expenditure authority of $12 million to support policy changes outlined in SB 885 (Pan) to expand access to sexually transmitted disease (STD) services covered by the Family Planning, Access, Care, and Treatment program (Family PACT) to help address California's STD public health crisis. Family PACT already covers STD services for low-income and uninsured Californians, but only within the context of a family planning visit. Individuals not at risk for experiencing or causing an unintended pregnancy – including many LGBT patients – are currently forced to pay out of pocket for STD services, or forgo care – fueling rising STD rates.
- Hepatitis C Prevention, Linkage to and Retention in Care Services – The End the Epidemics Coalition is requesting ongoing General Fund expenditure authority of $15 million for HCV prevention, linkage to and retention in care services, with a focus on those at greatest risk, people who are using drugs. California has invested in the relatively inexpensive, simple, tolerable and extremely effective HCV cure, ensuring that most who need it will get the medication if they know their status and can navigate their health care systems or services. However, the state has provided very little to fund the prevention and linkage services that are necessary to address the barriers faced by most people living with and at risk of HCV, including stigma, homelessness, drug use, mental health challenges and other social determinants. As a result, the HCV epidemic is growing at alarming rates in California, particularly among young people.
- HIV Prevention Funding – The End the Epidemics coalition requests ongoing General Fund expenditure authority of $15 million to address HIV health inequities, particularly among communities of color. While new HIV cases declined roughly 9 percent from 2014 to 2018, progress has been uneven and Black and Latinx communities remain disproportionally impacted by the epidemic. The proposed funding would support biomedical and structural interventions to improve HIV health outcomes among the state's most underserved residents, particularly Black and Latinx people living

with and vulnerable to HIV. Funding would be distributed by the Office of AIDS through a competitive grant process to local health jurisdictions and community-based organizations.

- Addressing the STD Public Health Crisis – The End the Epidemics coalition is requesting an additional ongoing General Fund investment of $3 million – for a total of $10 million for the Department of Public Health's STD Control Branch to dispense throughout the state to support a comprehensive, evidence-informed approach to STD prevention and improve the capacity of local health jurisdictions to address rising STD rates in their region. Funding would be prioritized to serve communities disproportionately impacted by STDs, and would be distributed through a competitive grant process to local health jurisdictions (LHJs). Once the funds are received, LJHs would be required to sub-grant out at least 50 percent of the funding to community-based organizations.
- Increase Investment in the California Supply Clearinghouse – In order to reduce the rate of overdose deaths, as well as rates of HIV and viral hepatitis among people who inject drugs, the End the Epidemics Coalition respectfully urges the Legislature to increase the annual budget for the State Office of AIDS Syringe Exchange Supply Clearinghouse from the current $3 million to $8 million per year. This change is urgently needed to meet the rapid expansion of programs, and the increased number of people seeking assistance to prevent fatal overdose and the transmission of potentially deadly infections. These funds would provide hundreds of thousands of Californians with the tools they need to protect themselves and their families.

Sexually Transmitted Disease (STD) Navigators. The County Health Executives Association of California requests General Fund expenditure authority of $20 million annually to be allocated to all 61 local health departments to provide services to 1) individuals who are experiencing reinfections of syphilis, chlamydia, and gonorrhea; 2) individuals who are diagnosed with more than two STDs at the same time; and 3) individuals diagnosed with HIV and STDs. The services would include the following:

1) Assess the health and social needs of the client.
2) Identify and resolve client risk factors and obstacles to care.
3) Establish routine contact with clients, including those who may be difficult to locate.
4) Coordinating referrals and connections to address health and social needs, including behavioral health services, housing, homelessness assistance, and harm reduction counseling and services.
5) Ensure clients receive care and follow-up in a timely manner including follow-up with primary care providers.
6) Provide outreach and navigation services to the client's sexual partners.
7) Routine follow-up education and access to prevention and screening services.

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

Questions. The subcommittee has requested stakeholders to present these proposals for investment.

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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Melissa Hurtado
Senator Melissa Melendez

Sunday, May 24, 2020
9:00 am
State Capitol - Room 4203

PART A - HEALTH

Consultant: Scott Ogus

PUBLIC COMMENT

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

VOTE CALENDAR

Summary of Issues and Recommendations – Table Display

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY						
(dollars in thousands) (AAB=approve as budgeted; DWOP=defer without prejudice)						
GOVERNOR'S BUDGET ISSUES UNCHANGED AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
1	Center for Data Insights and Innovation Trailer Bill Proposal	$-	$-	0.0	The Administration proposes trailer bill language to establish the Center for Data Insights and Innovation, which would merge functions of the current Office of Patient Advocate, Office of Health Information Integrity, and the California Committee for the Protection of Human Subjects, as well as other data analysis and management of privacy protection. Staff recommends deferring this proposal without prejudice to allow the Administration to address concerns with the elimination of consumer complaint reporting and changes to privacy protection. (This issue was heard on March 12th, 2020).	DWOP
GOVERNOR'S BUDGET ISSUES MODIFIED OR WITHDRAWN AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
2	Electronic Visit Verification Phase 2 Planning - GB 0530-003-BCP-2020-GB 4260-069-BCP-2020-GB 4265-075-BCP-2020-GB 4265-100-BBA-2020-GB 4300-007-BCP-2020-GB	$290	$2,599	9.0	These resources support the multi-departmental planning effort for the second phase of implementation of Electronic Visit Verification (EVV) for personal care services and home health care services. These staffing and other resources would support completion of activities required by the Department of Technology's Project Approval Lifecycle (PAL) Stage Gate requirements and federal Advanced Planning Document (APD) requirements. (This issue was heard on March 12th, 2020)	AAB

3	Electronic Visit Verification Phase 2 Planning - MR 0530-035-BCP-2020-MR 4260-198-BCP-2020-MR 4300-062-BCP-2020-MR	$705	$3,046	12.0	These resources are in addition to the January budget request for resources to support the EVV project. The Administration asserts additional project resources are needed to implement the project and avoid reductions in federal financial participation. While these resources may be necessary, the Administration has not adequately justified in its budget documents why the January budget request is not sufficient to perform the required implementation activities. Given the risk to federal funding, staff recommends deferring this request without prejudice to allow the Administration to justify the additional resources.	DWOP
4	Office of Surgeon General – Trauma-Informed Training Development and Public Awareness Campaign 0530-033-BCP-2020-GB 0530-046-BCP-2020-MR	$-	$-	0.0	WITHDRAWN - The Administration is withdrawing its January budget request for $10 million General Fund expenditure authority to develop a cross-sector training program and public awareness campaign for Adverse Childhood Experiences. (This issue was heard on March 12th, 2020).	AAB/ Withdrawn
5	Office of Healthcare Affordability Trailer Bill Proposal	$-	$-	0.0	WITHDRAWN – The Administration is withdrawing its January budget request to establish the Office of Healthcare Affordability to analyze the health care market for cost trends and drivers of spending, enforce health care cost targets and create a state strategy for controlling the cost of health care and ensuring affordability for consumers. (This issue was heard on March 12th, 2020).	AAB/ Withdrawn

NEW MAY REVISION PROPOSALS						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
6	Administrative Resources for Prescription Drug Proposals 0530-039-BCP-2020-MR	$197	$-	0.0	CHHSA requests General Fund expenditure authority of $197,000 in 2020-21, and $184,000 in 2021-22 and 2022-23. If approved, these resources would support research and analytical tasks associated with the Governor's prescription drug proposals, primarily the implementation of a state generic drug label. The Administration does not intend to propose trailer bill language to implement the state generic drug label. Given pending legislation on this topic, staff recommends deferring these proposed resources.	DWOP

4120 EMERGENCY MEDICAL SERVICES AUTHORITY						
(dollars in thousands) (AAB=approve as budgeted; DWOP=defer without prejudice)						
GOVERNOR'S BUDGET ISSUES UNCHANGED AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
7	Emergency Medical Dispatch (SB 438) 4120-011-BCP-2020-GB	$356	$-	1.0	EMSA requests one position and General Fund expenditure authority of $356,000 in 2020-21, $342,000 in 2021-22, and $171,000 annually thereafter to implement provisions of SB 438 (Hertzberg), Chapter 389, Statutes of 2019, which prohibits a public agency from delegating, assigning, or entering into a contract for "911" call processing services regarding the dispatch of emergency response resources with a non-public agency.	AAB

GOVERNOR'S BUDGET ISSUES MODIFIED OR WITHDRAWN AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
8	Regional Disaster Medical Health Response (RDMHS) Local Assistance 4120-003-BCP-2020-GB 4120-025-BCP-2020-MR Budget Bill Language	$365	$-	0.0	EMSA requests General Fund expenditure authority of $365,000 annually to improve regional medical and health mitigation, preparedness, response and recovery by funding three additional Regional Disaster Medical Health Specialists (RDMHS). At May Revision, EMSA requests provisional language to augment these General Fund resources by up to an additional $365,000 to fund additional RDMHS positions. Given the ongoing pandemic emergency, staff recommends approval. (This issue was heard on March 12th, 2020).	AAB/ Adopt Placeholder BBL
9	Adjustment to Reflect Available Resources in the EMS Personnel Services Fund 4120-021-BBA-2020-GB 4120-028-BBA-2020-GB	$-	$-	12.0	WITHDRAWN - The Administration requests to withdraw a technical adjustment of $200,000 in the EMS Personnel Services Fund to reflect available resources.	AAB/ Withdrawn

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT						
(dollars in thousands) (AAB=approve as budgeted; DWOP=defer without prejudice)						
GOVERNOR'S BUDGET ISSUES UNCHANGED AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
10	CMSP Loan Repayment Administration 4140-005-BCP-2020-GB	$-	$2,240	0.0	OSHPD requests reimbursement authority of $2.2 million in 2020-21, $180,000 in 2021-22, and $60,000 in 2022-23 to continue to administer the County Medical Services Program Loan Repayment Program. (This issue was heard on March 12th, 2020).	AAB
11	Healthcare Data Disclosure (SB 343) 4140-020-BCP-2020-GB	$-	$119	1.0	OSHPD requests one position and expenditure authority from the California Health Data and Planning Fund of $119,000 in 2020-21 and $107,000 annually thereafter to implement new data reporting requirements for certain health facilities pursuant to the requirements of SB 343 (Pan), Chapter 247, Statutes of 2019. (This issue was heard on March 12th, 2020).	AAB
12	Hospital Community Benefits Plan Reporting (AB 204) 4140-021-BCP-2020-GB	$-	$519	2.0	OSHPD requests two positions and expenditure authority from the California Health Data and Planning Fund of $519,000 in 2020-21, and $245,000 annually thereafter to implement hospital community benefits plan data reporting requirements pursuant to AB 204 (Wood), Chapter 535, Statutes of 2019. (This issue was heard on March 12th, 2020).	AAB

13	Hospital Procurement Contracts Reporting (AB 962) 4140-028-BCP-2020-GB	$-	$790	2.0	OSHPD requests two positions and expenditure authority from the California Health Data and Planning Fund of $790,000 in 2020-21, and $290,000 annually thereafter to implement hospital procurement contract reporting requirements pursuant to AB 962 (Burke), Chapter 815, Statutes of 2019. (This issue was heard on March 12th, 2020).	AAB
GOVERNOR'S BUDGET ISSUES MODIFIED OR WITHDRAWN AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
14	Healthcare Payments Database Program Implementation Trailer Bill Proposal	$-	$-	0.0	OSHPD proposes trailer bill language to establish the Health Care Payments Data System, originally authorized by AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018. The language would establish the system, establish a health care data advisory committee, authorize the types of data collected (e.g. utilization, claims, payments, etc.), require health care payers to submit health care data, authorize OSHPD to require health care providers and suppliers to submit data, authorize OSHPD to supplement information with public and private data sources, require publicly available reporting and data releases, require the protection of personal information, and allow OSHPD to assess a fee for access to non-public information in the system. The fee would be deposited in the Health Care Data Payments Fund, created by the language, and serve as the non-General Fund financing mechanism for the data system required by AB 1810. This language was the result of stakeholder engagement as part of the AB 1810 authority for the system. However, there is not yet consensus and a policy bill is pending.	Hold Open

NEW MAY REVISION PROPOSALS						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
15	Elimination of Song-Brown Healthcare Workforce Training Program 4140-097-BCP-2020-MR	($33,333)	$-	0.0	OSHPD requests elimination of ongoing General Fund expenditure authority of $33.3 million approved in the 2019 Budget Act. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
16	Loan from Hospital Building Fund (0121) to General Fund Budget Bill Language	$-	$-	0.0	Provides for a loan in the amount of $40 million from the Hospital Building Fund to the General Fund.	AAB/ Adopt Placeholder BBL
17	Mental Health Services Fund Reappropriation 4140-091-BBA-2020-MR 4140-092-BBA-2020-MR Budget Bill Language	$-	$-	0.0	Reappropriates Mental Health Services Fund expenditures to support the 2014-2019 Workforce Education and Training (WET) Program from prior budget years, as follows: 1) extend the period to liquidate encumbrances for funding approved in the 2017 Budget Act, and 2) reappropriate $7.2 million approved in the 2018 Budget Act.	AAB/ Adopt Placeholder BBL
18	Reversion of 2017 Administrative Savings for Song-Brown Program 4140-101-BCP-2020-MR	$-	$-	0.0	Reverts $2 million General Fund approved in the 2017 Budget Act for state operations related to the Song-Brown program, but was not spent.	AAB
19	Shift General Fund Support for WET 2020-2025 to Mental Health Services Fund 4140-102-BCP-2020-MR	($20,000)	$20,000	0.0	Reverts $20 million General Fund approved in the 2019 Budget Act for the 2020-2025 WET Program. Replaces the reverted General Fund with $20 million Mental Health Services Fund from the State Administration account.	AAB

4150 DEPARTMENT OF MANAGED HEALTH CARE						
(dollars in thousands) (AAB=approve as budgeted; DWOP=defer without prejudice)						
GOVERNOR'S BUDGET ISSUES UNCHANGED AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
20	Health Care Coverage – Telehealth (AB 744) 4150-021-BCP-2020_GB	$-	$331	1.5	DMHC requests 1.5 positions and expenditure authority from the Managed Care Fund of $331,000 in 2020-21, and $379,000 annually thereafter to review health care service plan contracts, documents, and claims coverage of telehealth services, pursuant to AB 744 (Aguiar-Curry), Chapter 867, Statutes of 2019. (This issue was heard on March 12th, 2020).	AAB
21	Health Plans and Health Insurance – Third-Party Payments (AB 290) 4150-022-BCP-2020-GB	$-	$1,163	0.0	DMHC requests expenditure authority from the Managed Care Fund of $1.2 million in 2020-21, and $775,000 in 2021-22 to establish an Independent Dispute Resolution Process, promulgate regulations, receive health plan data regarding cost savings, and review Evidence of Coverage documents to verify health plan compliance with AB 290 (Wood), Chapter 862, Statutes of 2019. (This issue was heard on March 12th, 2020).	AAB
22	Information Security Resources 4150-005-BCP-2020-GB	$-	$384	2.0	DMHC requests two positions and expenditure authority from the Managed Care Fund of $384,000 in 2020-21, $368,000 in 2021-22 and 2022-23, and $328,000 annually thereafter to address information security and cybersecurity vulnerabilities. (This issue was heard on March 12th, 2020).	AAB

23	Large Group Rate Review (AB 731) 4150-020-BCP-2020-GB	$-	$1,747	5.0	DMHC requests five positions and expenditure authority from the Managed Care Fund of $1.7 million in 2020-21, and $2.6 million annually thereafter to create a new process for review of rates in the large group market and modify existing reporting requirements in the individual and small group markets, pursuant to AB 731 (Kalra), Chapter 807, Statutes of 2019. (This issue was heard on March 12th, 2020).	AAB
NEW MAY REVISION PROPOSALS						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
24	Behavioral Health Focused Investigations 4150-028-BCP-2020-GB	$-	$2,757	14.5	DMHC requests 14.5 positions and expenditure authority from the Managed Care Fund of $2.8 million in 2020-21, 18.5 positions and $4.7 million in 2021-22, and 18.5 positions and $4.7 million annually thereafter to conduct focused investigations and enforcement of health plan compliance with behavioral health parity requirements.	AAB
25	Loan from Managed Care Fund (0933) to General Fund Budget Bill Language	$-	$-	0.0	Provides for a loan in the amount of $2 million from the Managed Care Fund to the General Fund.	AAB/ Adopt Placeholder BBL
26	Technical Adjustment to Reflect Lower Consulting Costs for AB 2674 4150-030-BBA-2020-GB	$-	($472)	0.0	Technical adjustment to reflect funding not approved in the Project Approval Lifecycle process for information technology costs related to implementation of AB 2674 (Aguiar-Curry), Chapter 303, Statutes of 2018. The adjustment results in a reduction of $472,000 Managed Care Fund.	AAB

4260 DEPARTMENT OF HEALTH CARE SERVICES						
(dollars in thousands) (AAB=approve as budgeted; DWOP=defer without prejudice)						
GOVERNOR'S BUDGET ISSUES UNCHANGED AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
27	Adult Use of Marijuana Act: Prop 64 Youth Education, Prevention, and Treatment Workload 4260-170-BBA-2020-GB	$-	$199,666	0.0	The Administration proposes to allocate $199.7 million of Proposition 64 revenue in 2020-21 to support education, prevention, and treatment of youth substance use disorders and school retention. These allocations are unchanged from the level approved in 2019-20.	AAB
28	Aligning Rate Review with Access Monitoring Plan Trailer Bill Proposal	$-	$-	0.0	DHCS proposes trailer bill language to eliminate obsolete requirements for rate reviews for physician and dentist services to align with federal access-to-care requirements. The language would allow review every three years, clarify the review refers to fee-for-service, specify consistency in rate review with DHCS' federally approved access monitoring plan, and remove obsolete references to data sources for the review.	AAB/ Adopt Placeholder TBL
29	Behavioral Health Network Adequacy 4260-061-BCP-2020-GB	$605	$605	4.0	DHCS requests four positions and expenditure authority of $1.2 million ($605,000 General Fund and $605,000 federal funds) in 2020-21, $1.1 million ($569,000 General Fund and $569,000 federal funds) in 2021-22, and $585,000 ($293,000 General Fund and $292,000 federal funds) annually thereafter to assist county mental health plans and Drug Medi-Cal Organized Delivery System programs comply with federal network adequacy requirements for the delivery of behavioral health services.	AAB

30	California 1115 Waiver – Medi-Cal 2020 4260-064-BCP-2020-GB	$142	$141	0.0	DHCS requests expenditure authority of $283,000 ($142,000 General Fund and $142,000 federal funds) in 2020-21 and 2021-22 to support reporting, monitoring, and evaluation of the Whole Person Care, Seniors and Persons with Disabilities, and California Children's Services Programs. This request is a two-year extension of previously approved resources.	AAB
31	County Eligibility Oversight and Monitoring 4260-062-BCP-2020-GB	$140	$139	0.0	DHCS requests expenditure authority of $279,000 ($140,000 General Fund and $139,000 federal funds) in 2020-21 to continue oversight, monitoring, and analysis of county eligibility funding, pursuant to SB 28 (Hernandez), Chapter 442, Statutes of 2013.	AAB
32	Dental Services Program Procurements Administrative Services Organization 4260-065-BCP-2020-GB	$331	$330	0.0	DHCS requests expenditure authority of $661,000 ($331,000 General Fund and $330,000 federal funds) in 2020-21 and $625,000 ($313,000 General Fund and $312,000 federal funds) in 2021-22 and 2022-23 to oversee the procurement, contract transition, and related activities for annual procurement of the Administrative Services Organization contract for the Denti-Cal program.	AAB

33	Drug Medi-Cal Reimbursement for Medication Assisted Treatment for Opioid Use Disorders Trailer Bill Proposal	$-	$-	0.0	DHCS proposes trailer bill language to provide statewide reimbursement to all State Plan Drug Medi-Cal certified providers for the provision of Medication Assisted Treatment services to treat opioid use disorders. Currently, reimbursement is only allowed for methadone and naltrexone. This language would allow reimbursement for all FDA-approved medication for the treatment of opioid use disorders, as well as counseling services and behavioral therapy in pursuant to the requirements of the federal SUPPORT for Patients and Communities Act.	AAB/ Adopt Placeholder TBL
34	Electronic Record Incentive Program Name Change and Extension Trailer Bill Proposal	$-	$-	0.0	DHCS proposes trailer bill language to change the name of the Electronic Health Record Incentive Program to the Medi-Cal Promoting Interoperability Program, to reflect a renewed focus on program and data interoperability, and to extend the sunset date for the program from July 1, 2021, to January 1, 2024.	AAB/ Adopt Placeholder TBL
35	Family PACT Program Administration and Integrity 4260-067-BCP-2020-GB	$186	$1,668	0.0	DHCS requests expenditure authority of $1.9 million ($186,000 General Fund and $1.7 million federal funds) annually to increase monitoring, oversight, and program integrity activities of the Family PACT program. Given the General Fund condition, staff recommends deferring this proposal to allow time to further evaluate the availability of funding.	DWOP

36	Managed Care Alternative Access Standards (AB 1642)	$500	$949	0.0	DHCS requests expenditure authority of $1.4 million ($500,000 General Fund and $949,000 federal funds) in 2020-21, and $1.4 million ($482,000 General Fund and $931,000 federal funds) annually thereafter to support the External Quality Review Organization for monitoring of managed care provider network adequacy standards, pursuant to AB 1642 (Wood), Chapter 465, Statutes of 2019.	AAB
37	Managed Care Organization Provider Tax (AB 115)	$140	$140	0.0	DHCS requests expenditure authority of $280,000 ($140,000 General Fund and $140,000 federal funds) to support implementation and oversight of the managed care enrollment tax implemented by AB 115 (Committee on Budget), Chapter 348, Statutes of 2019.	AAB
38	Medi-Cal Home- and Community-Based Services (SB 289) 4260-084-BCP-2020-GB	$70	$70	0.0	DHCS requests expenditure authority of $140,000 ($70,000 General Fund and $70,000 federal funds) in 2020-21 and $131,000 ($66,000 General Fund and $65,000 federal funds) annually thereafter to implement secondary waiting lists for home- and community-based services programs specific to military families on active duty, pursuant to SB 289 (Archuleta), Chapter 846, Statutes of 2019.	AAB

39	Pharmacy Proposals Trailer Bill Proposal	$-	$-	0.0	DHCS proposes trailer bill language to implement several initiatives and other changes to reduce the cost of prescription drugs in the state, including: 1) allowing Medi-Cal to negotiate for rebates based on the international "best price", 2) allow DHCS to seek federal approval to establish a prescription drug rebate program for non-Medi-Cal populations, and 3) eliminate copays and the six prescription limit in Medi-Cal fee-for-service.	AAB/ Adopt Placeholder TBL
40	Program of All-Inclusive Care for the Elderly (AB 1128) 4260-086-BCP-2020-GB	$549	$460	0.0	DHCS requests expenditure authority of $1 million ($460,000 PACE Oversight Fund and $549,000 federal funds) in 2020-21, and $1.7 million ($771,000 PACE Oversight Fund and $917,000 federal funds) annually thereafter to support transfer of oversight and regulatory responsibilities for PACE licensure exemption process from the Department of Public Health to DHCS, pursuant to AB 1128 (Petrie-Norris), Chapter 821, Statutes of 2019. The non-federal share of these resources is funded from the PACE Oversight Fund, established by AB 1128 to collect revenue from PACE organizations that they would have otherwise spent on licensure.	AAB

41	Restoration of Dental Fee-for-Service in Sacramento and Los Angeles Trailer Bill Proposal	($8,305)	($12,182)	0.0	DHCS proposes trailer bill language to eliminate dental managed care in Sacramento and Los Angeles Counties and transition beneficiaries into fee-for-service. DHCS estimates 773,524 beneficiaries will receive dental benefits from a dental managed care plan in these two counties. According to DHCS, this transition would allow implementation of more effective and uniform provider and beneficiary outreach plans and increase utilization. Given the significant turmoil in dental practices as a result of the pandemic, staff recommends deferring this proposal to allow for further assessment of the feasibility of disrupting the usual source of dental care for such a significant number of Medi-Cal beneficiaries at this time.	DWOP
42	STRTP Mental Health Program Approval, Oversight, and Monitoring 4260-057-BCP-2020-GB	$690	$690	0.0	DHCS requests expenditure authority of $1.4 million ($690,000 General Fund and $690,000 federal funds) in 2020-21 and 2021-22 to continue monitoring, oversight, and approvals of mental health services in Short-Term Residential Therapeutic Programs (STRTPs). These resources were previously approved in the 2018 Budget Act in the Department of Social Services through an interagency agreement with DHCS. This request would extend those resources for an additional two years and fund them in the DHCS budget.	AAB

GOVERNOR'S BUDGET ISSUES MODIFIED OR WITHDRAWN AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
43	340B Supplemental Payment Pool 4260-185-ECP-2020-MR 4260-276-ECP-2020-MR	$-	$-	0.0	WITHDRAWN – DHCS requests to withdraw its January budget proposal of $52.5 million ($26.3 million General Fund and $26.3 million federal funds) to provide supplemental payments to non-hospital providers in the federal 340B program. These payments were intended to replace lost revenue from implementation of Medi-Cal Rx. While DHCS is withdrawing the supplemental payment proposal, it intends to proceed with Medi-Cal Rx.	Hold Open
44	Aged, Blind, and Disabled FPL Program (AB 1088) 4260-083-BCP-2020-GB 4260-264-BCP-2020-MR	$-	$-	0.0	WITHDRAWN – DHCS requests to withdraw its January budget request for resources to direct, plan, implement and monitor the implementation of AB 1088 (Wood), Chapter 450, Statutes of 2019, which allows individuals in the Aged and Disabled program to remain eligible for the program regardless of the state's payment of Medicare Part B premiums, which would otherwise be counted as income. DHCS is also proposing to not implement AB 1088.	Hold Open
45	Behavioral Health Quality Improvement Program 4260-182-BCP-2020-GB 4260-239-BCP-2020-MR	$-	$-	0.0	WITHDRAWN – DHCS requests to withdraw its January budget proposal to implement a Behavioral Health Quality Improvement Program to incentivize system changes and process improvements in county behavioral health programs. This funding was part of the Behavioral Health Payment Reform component of the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, which DHCS is proposing to delay.	AAB/ Withdrawn

46	Conform Inmate Eligibility to Federal Law 4260-131-BCP-2020-GB 4260-209-BCP-2020-MR Trailer Bill Proposal	$1,244	$2,504	0.0	DHCS is requesting to modify its January proposal to implement the provisions of the federal SUPPORT for Patients and Communities Act, which prohibits states from terminating Medi-Cal eligibility for a juvenile under age 21 or foster care youth under age 26 while incarcerated. The modified request is for $3.7 million ($1.2 million General Fund and $2.5 million federal funds) in 2020-21, and $139,000 ($70,000 General Fund and $69,000 federal funds) annually thereafter. DHCS also proposes trailer bill language to align state law with the SUPPORT Act.	AAB/ Adopt Placeholder TBL
47	Data Transparency Workload 4260-059-BCP-2020-GB 4260-236-BCP-2020-MR	$-	$-	0.0	WITHDRAWN – DHCS requests to withdraw its January budget proposal to address departmental data transparency efforts, including HIPAA-compliant data management and reporting, as well as data submissions to the Open Data Portal.	AAB/ Withdrawn
48	Drug Medi-Cal Organized Delivery System Resources 4260-060-BCP-2020-GB 4260-235-BCP-2020-MR	$575	$575	0.0	DHCS requests to modify its January budget proposal for oversight of Drug Medi-Cal Organized Delivery System (DMC-ODS) programs. The modified request is for $1.2 million ($575,000 General Fund and $575,000 federal funds) in 2020-21 to support the External Quality Review Organization contract, which conducts independent review of DMC_ODS counties for quality of care, timeliness of services, and access to services. This review is required by the terms of the state's 1115 Waiver.	AAB

49	Drug Rebate Fund Reserve 4260-183-ECP-2020-GB 4260-290-ECP-2020-MR	$-	$-	0.0	WITHDRAWN – DHCS requests to withdraw its January budget allocation of $181 million of prescription drug rebate funds to the Drug Rebate Fund. This fund was created to smooth volatility in prescription drug rebate revenue to the state. Instead, these rebate reserve funds will support the delivery of health care services in the Medi-Cal program.	AAB/ Withdrawn
50	CalAIM Resources 4260-128-ECP-2020-GB 4260-301-ECP-2020-MR	$-	$-	0.0	WITHDRAWN – DHCS requests to withdraw its January budget proposal to provide $347.5 million for enhanced care management benefits and incentives for the provision of in-lieu-of services as part of the CalAIM initiative. Due to the pandemic, DHCS is delaying CalAIM and these funds are no longer necessary.	AAB/ Withdrawn
51	Hearing Aids Grant Program 4260-142-ECP-2020-GB 4260-267-ECP-2020-MR	$-	$0	0.0	WITHDRAWN – DHCS requests to withdraw its January budget proposal for $5 million General Fund to provide hearing aids and associated services to uninsured non-Medi-Cal children up to 600 percent of the federal poverty level.	Hold Open

52	Medi-Cal Local Assistance Estimate 4260-092-ECP-2020-GB 4260-230-ECP-2020-MR 4260-241-ECP-2020-MR	$2,260,861	$4,777,261	0.0	The May 2020 Medi-Cal Estimate includes $99.5 billion ($23 billion General Fund, $65.3 billion federal funds, and $12.8 billion special funds and reimbursements) for expenditures in 2019-20, and $112.1 billion ($23.2 billion General Fund, $72.9 billion federal funds, and $16.1 billion special funds and reimbursements) for expenditures in 2020-21. These figures represent a decrease in estimated General Fund expenditures in the Medi-Cal program of $332.3 million in 2019-20 and $2.8 billion in 2020-21 compared to the Governor's January budget. In 2019-20, the May Estimate assumes average monthly Medi-Cal caseload of 13 million, an increase of 1.6 percent compared to the January budget. In 2020-21, the May Estimate assumes average monthly Medi-Cal caseload of 14.2 million, an increase of 10.6 percent compared to the January budget and an increase of 9.2 percent compared to the revised caseload estimate for 2019-20. This significant increase in caseload is driven by the decline in economic conditions due to the pandemic, which were not reflected in the January budget.	Approve the balance of Estimate, with any changes necessary to conform to other actions that have been, or will be, taken.

53	Family Health Estimate 4260-093-ECP-2020-GB 4260-229-ECP-2020-MR	$18,304	($26,633,000)	0.0	The May 2020 Family Health Estimate includes $199.9 million ($148.1 million General Fund, -$38.5 million federal funds, and $90.3 million special funds and reimbursements) for expenditures in 2019-20, and $267.7 million ($226.8 million General Fund, $5.1 million federal funds, and $35.7 million special funds and reimbursements) for expenditures in 2020-21. These figures represent a decrease in estimated General Fund expenditures of $46.6 million in 2019-20 and an increase of $32.3 million in 2020-21 compared to the January budget. The 2019-20 changes are primarily attributed to increased rebates in the California Children's Services program and the 2020-21 changes are attributed to increased costs in the Genetically Handicapped Persons Program for base expenditures.	Approve the balance of Estimate, with any changes necessary to conform to other actions that have been, or will be, taken.
54	Medi-Cal Dental Program Integrity 4260-053-BCP-2020-GB 4260-234-BCP-2020-MR	$234	$233	0.0	DHCS requests to modify its January budget request for resources to support oversight and auditing of the dental program. The modified request is for $467,000 ($234,000 General Fund and $233,000 federal funds) annually. Due to the significant turmoil in dental practices as a result of the pandemic, staff recommends deferring this proposal to allow for further assessment of how to support dental providers and maintain the availability of dental services in the Medi-Cal program.	DWOP

55	Medi-Cal Dental Program Workload 4260-066-BCP-2020-GB 4260-238-BCP-2020-MR	$-	$-	0.0	WITHDRAWN – DHCS requests to withdraw its January budget proposal to perform monitoring and oversight of contracted vendors, establish quality improvements in contracts, and address other workload increases.	AAB/ Withdrawn
56	MEDS Modernization Reduction 0530-040-BCP-2020-MR 4260-210-BBA-2020-MR	($402)	($4,160)	0.0	The Administration requests to modify the resources allocated for the Medi-Cal Eligibility Data System (MEDS) Modernization project, currently overseen by the Office of Systems Integration at CHHSA. The modified proposal is for a reduction in the DHCS budget of $4.6 million ($402,000 General Fund and $4.2 million federal funds) to reflect a shift in focus to an enterprise-wide modernization approach, known as Medi-Cal Enterprise System (MES).	AAB
57	Medi-Cal Enterprise System Modernization – Federal Draw and Reporting Project 4260-193-BCP-2020-MR Budget Bill Language	$1,135	$10,037	0.0	DHCS requests expenditure authority of $11.2 million ($1.1 million General Fund and $10 million federal funds) in 2020-21 to continue the Federal Draw and Reporting (FDR) project, which was part of the California Medicaid Management Information System (CA-MMIS) project. CA-MMIS, MEDS, and the California Behavioral Health Data System Modernization projects are being combined into the new Medi-Cal Enterprise System (MES) enterprise-wide modernization effort. DHCS also requests budget bill language to allow an augmentation of up to $1.1 million of General Fund, contingent upon satisfactory progress of milestones for the project.	AAB/ Adopt Placeholder BBL

58	Medi-Cal Rx (Pharmacy Carve-Out) – State Operations and Local Assistance 4260-068-BCP-2020-GB 4260-184-ECP-2020-GB 4260-345-ECP-2020-MR	($67,312)	($104,957)	0.0	DHCS requests expenditure authority of $1.9 million ($765,000 General Fund and $1.1 million federal funds) in 2020-21 to support Medi-Cal Rx, the carve-out and ongoing management of the Medi-Cal pharmacy benefit in the fee-for-service delivery system. DHCS assumes General Fund savings of $54.6 million for the Medi-Cal Rx transition. This transition results in significant impacts to health care providers that participate in the federal 340B drug rebate program. The January budget included resources to support supplemental payments to offset the lost revenue to these providers. DHCS has requested to withdraw the supplemental payment request. Staff recommends holding this item open to evaluate the overall impact of this and other proposals on Medi-Cal providers.	Hold Open
59	Program and Policy Lead Support for Eligibility and Enrollment Projects 4260-063-BCP-2020-GB 4260-237-BCP-2020-MR	$-	$-	0.0	WITHDRAWN – DHCS requests to withdraw its January budget proposal for resources to oversee and manage automation projects related to eligibility and enrollment.	AAB/ Withdrawn
60	Undocumented Seniors Medi-Cal Eligibility Expansion 4260-187-ECP-2020-GB 4260-278-ECP-2020-MR 4260-341-ECP-2020-MR	$-	$-		WITHDRAWN – DHCS requests to withdraw its January budget proposal to expand full-scope Medi-Cal coverage to income-eligible seniors regardless of immigration status.	Hold Open

NEW MAY REVISION PROPOSALS						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
61	Adjust Managed Care Capitation Payments July 2019-December 2020 4260-294-ECP-2020-MR Trailer Bill Proposal	($181,978)	($403,938)	0.0	DHCS requests a reduction of $586 million ($182 million General Fund and $404 million federal funds) to adjust Medi-Cal managed care capitation payments for the period of July 2019 to December 2020. The adjustment lowers the gross medical expense portion of the capitation payments for this period due to anticipated lower costs and utilization related to the pandemic. DHCS also requests trailer bill language to implement this proposal.	Hold Open
62	CA-MMIS Reappropriation 4260-196-BCP-2020-MR Budget Bill Language	$5,138	$13,062	0.0	DHCS requests to reappropriate expenditure authority of $18.2 million ($5.1 million General Fund and $13.1 million federal funds) for turnover and takeover efforts for the CA-MMIS project. According to DHCS, this reappropriation is necessary due to the timing of final contract payments.	AAB/ Adopt Placeholder BBL
63	COVID-19 Estimate Impacts 4260-346-ECP-2020-MR Trailer Bill Proposal	$203,274,000	$8,681,165	0.0	DHCS requests $8.9 billion ($203.3 million General Fund and $8.7 billion federal funds) to reflect several impacts on the Medi-Cal program related to the COVID-19 pandemic. These impacts include increased caseload, suspension of annual redeterminations, increased federal flexibilities, and the increase in federal matching percentage. Staff and LAO analysis of caseload estimates have raised concerns about the assumed distribution of caseload increases across various Medi-Cal eligibility categories. Staff recommends holding this item open to allow further time to evaluate whether these assumptions are reasonable.	Hold Open

64	Restore "Senior Penalty" in Aged and Disabled Program 4260-274-ECP-2020-MR	($67,734)	($67,734)	0.0	DHCS requests to restore the "senior penalty" in Medi-Cal by declining to implement the increase in income eligibility for the Aged and Disabled Program to 138 percent of the federal poverty level approved in the 2019 Budget Act. DHCS estimates this proposal would result in General Fund savings of $67.7 million in 2020-21.	Hold Open
65	Eliminate Aged and Disabled Medicare Part B Disregard (AB 1088) 4260-277-ECP-2020-MR	($478)	($478)	0.0	DHCS requests to eliminate the Medicare Part B disregard to determine eligibility for the Aged and Disabled program, pursuant to AB 1088 (Wood), Chapter 450, Statutes of 2019. DHCS estimates this proposal would result in General Fund savings of $478,000.	Hold Open
66	Eliminate Medi-Cal Extension for Post-Partum Mental Health 4260-310-ECP-2020-MR	($34,291)	$-	0.0	DHCS requests to eliminate the extension of pregnancy-only Medi-Cal coverage for up to 12 months after delivery for patients diagnosed with a maternal mental health condition, adopted in the 2019 Budget Act. DHCS estimates this proposal would result in General Fund savings of $34.3 million. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
67	Eliminate Non-Medical Transportation Broker 4260-269-ECP-2020-MR	($8,750)	($8,750)	0.0	DHCS requests to eliminate funding for a broker to coordinate the delivery of the Medi-cal non-medical transportation benefit. DHCS estimates this proposal would result in General Fund savings of $8.8 million.	AAB

68	Eliminate Screening, Brief Intervention, Referral to Treatment (SBIRT) for Opioids and Other Drugs 4260-309-ECP-2020-MR	($466)	($827)	0.0	DHCS requests to eliminate funding for screening, brief intervention, and referral to treatment (SBIRT) for opioids and other drugs, adopted in the 2019 Budget Act. DHCS estimates this proposal would result in General Fund savings of $466,000. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
69	Electronic Cigarette Products Tax 4260-303-ECP-2020-MR	($9,600)	$9,600	0.0	The Administration is proposing an additional tax on electronic cigarettes to address the rapid increase in youth use of these products. The tax will begin on January 1, 2021, and will be used to increase enforcement and offset costs in the Medi-Cal program. DHCS estimates the tax will result in General Fund offsets for expenditures in the Medi-Cal program of $9.6 million.	AAB
70	Eliminate Caregiver Resource Centers Augmentation 4260-283-ECP-2020-MR	($10,000)	$-	0.0	DHCS requests to eliminate funding approved in the 2019 Budget Act for caregiver resource centers, which provide support to family caregivers of adults needing assistance to allow them to remain in the community. DHCS estimates this proposal will result in General Fund savings of $10 million. Given the concerns about COVID-19 outbreaks in skilled nursing facilities, and the need to support seniors remaining in the community, staff recommends rejecting this proposal.	Reject

71	Eliminate Community-Based Adult Services 4260-273-ECP-2020-MR	($95,200)	($96,100)	0.0	DHCS proposes to eliminate Community-Based Adult Services (CBAS) as a Medi-Cal benefit. CBAS provides services to eligible older adults or persons with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. DHCS estimates this proposal will result in General Fund savings of $95.2 million. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
72	Eliminate EPSDT Case Management Allocation to Counties 4260-271-ECP-2020-MR Trailer Bill Proposal	($6,576)	($12,100)	0.0	DHCS proposes to eliminate funding for case management for counties administering the Early and Periodic Screening Diagnosis and Treatment (EPSDT) benefit to Medi-Cal eligible children. DHCS estimates this proposal will result in General Fund savings of $6.6 million. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
73	Eliminate Family Mosaic Project 4260-320-ECP-2020-MR	($1,100)	$-	0.0	DHCS proposes to eliminate funding for the Family Mosaic Project, which manages children diagnosed with emotional disturbance who are at risk for out-of-home placement. The program is state-funded and based in San Francisco. DHCS estimates this proposal will result in General Fund savings of $1.1 million.	Hold Open

74	Elimination of Optional Medi-Cal Benefits 4260-284-ECP-2020-MR 4260-285-ECP-2020-MR 4260-286-ECP-2020-MR 4260-287-ECP-2020-MR 4260-289-ECP-2020-MR 4260-307-ECP-2020-MR 4260-308-ECP-2020-MR 4260-314-ECP-2020-MR 4260-315-ECP-2020-MR 4260-316-ECP-2020-MR 4260-317-ECP-2020-MR 4260-318-ECP-2020-MR 4260-321-ECP-2020-MR Trailer Bill Proposal	($54,265)	($123,747)	0.0	DHCS proposes to eliminate optional benefits in the Medi-Cal program. Optional benefits refers to benefits that are not required by the federal government to be offered to Medicaid recipients. The benefits proposed for elimination include: • Adult dental (partial reduction) • Optometry • Optician/optical lab • Audiology • Incontinence creams/washes • Pharmacist-delivered Services • Speech therapy • Podiatry • Acupuncture • Nurse anesthetists • Occupational therapy • Physical therapy • Diabetes prevention program Many of these benefits were recently restored in the current fiscal year for the first time since 2009. DHCS estimates these proposals will result in General Fund savings of $54.3 million. DHCS also proposes trailer bill language to implement these benefit reductions. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open

75	Eliminate Multipurpose Senior Services Program 4260-302-ECP-2020-MR Trailer Bill Proposal	$-	($13,700)	0.0	DHCS proposes to eliminate the multipurpose senior services program, administered under a federal waiver by the California Department of Aging. DHCS also proposes trailer bill language to implement the elimination of this benefit. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
76	Eliminate Rate Carve-Outs for Community Clinics 4260-339-ECP-2020-MR Trailer Bill Proposal	($50,000)	($50,000)	0.0	DHCS proposes to eliminate services carved out of a community clinic's Prospective Payment System (PPS) rate. Currently, a clinic may carve out pharmacy or dental services, as well as specialty mental health and Drug Medi-Cal services, from its PPS rate. This proposal would still allow specialty mental health and Drug Medi-Cal services to be carved out. DHCS estimate this proposal will result in General Fund savings of $50 million. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open

77	Eliminate Proposition 56 Supplemental Payments, Value-Based Payments, Loan Repayment and Staffing 4260-186-ECP-2020-GB 4260-279-ECP-2020-MR 4260-280-ECP-2020-MR 4260-281-ECP-2020-MR 4260-282-ECP-2020-MR 4260-331-ECP-2020-MR 4260-332-BCP-2020-MR 4260-334-ECP-2020-MR 4260-335-ECP-2020-MR Budget Bill Language Trailer Bill Proposal	($1,176,585)	$668,764	0.0	DHCS proposes to eliminate nearly all supplemental payments to Medi-Cal providers supported by Proposition 56 tobacco tax revenue, and instead use that revenue to support growth in the Medi-Cal program. The 2020-21 reductions of Proposition 56 expenditures are as follows: • Physician services - $389 million • Dental services - $183.8 million • Women's health services - $18.7 million • Family planning - $35.9 million • Developmental screenings - $20.8 million • CBAS - $6.7 million • Non-emergency medical transportation - $2.7 million • Intermediate care facilities – developmental disabilities - $12.4 million • Hospital-based pediatric physicians - $2 million • Adverse childhood experiences (ACEs) screening - $7.6 million • ACEs provider training - $21 million DHCS also proposes to revert $177.8 million approved in the 2018 Budget Act and $120 million approved in the 2019 Budget Act for physician and dentist loan repayment, as well as $147 million allocated to the Value-Based Payment program. DHCS also proposes trailer bill language to implement these reductions. Subject to budget control section "trigger" language, these reductions would be restored if the state received sufficient federal funds.	Hold Open

78	Eliminate the California Health Information Exchange Onboarding Program (Cal-HOP) 4260-295-ECP-2020-MR	($2,131)	($19,179)	0.0	DHCS proposes to eliminate funding for the California Health Information Exchange Onboarding Program (Cal-HOP), which provides funding to assist Medi-Cal providers to access and use health information exchange technology. DHCS estimates this proposal will result in General Fund savings of $2.1 million.	AAB
79	Eliminate the Health Insurance Premium Program 4260-291-ECP-2020-MR	($336)	($336)	0.0	DHCS proposes to eliminate the Health Insurance Premium Program, which covers premiums and cost-sharing for Medi-Cal beneficiaries with a high-cost medical condition that voluntarily enroll in other health coverage. There are approximately 140 individuals enrolled in this program. DHCS estimates this proposal will result in General Fund savings of $336,000. Staff recommends rejecting this proposal to avoid loss of insurance coverage for these individuals during the pandemic.	Reject
80	Eliminate Martin Luther King Jr. Community Hospital Supplemental Payments 4260-293-ECP-2020-MR	($8,158)	($16,600)	0.0	DHCS proposes to eliminate funding for supplemental payments that support the Martin Luther King Jr. Community Hospital in Los Angeles. DHCS estimates this proposal will result in General Fund savings of $8.2 million. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
81	Fund 0009 Expenditure Adjustments 4260-219-BBA-2020-MR	$-	$1,600	0.0	DHCS requests a technical adjustment to expenditure authority in the Breast Cancer Fund to align expenditures with revenues in support for early breast cancer detection for uninsured and underinsured women in the Every Woman Counts program.	AAB

82	Freeze on Medi-Cal County Administration Cost of Doing Business Increases 4260-323-ECP-2020-MR Trailer Bill Proposal	($11,000)	($20,400)	0.0	DHCS proposes to freeze cost-of-doing-business increases for county eligibility determination workload. Previously, county eligibility offices received a cost-of-doing business adjustment equivalent to the California Consumer Price Index. DHCS estimates this proposal will result in General Fund savings of $11 million. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
83	Managed Care Efficiencies 4260-327-ECP-2020-MR Trailer Bill Proposal	($87,806)	($184,079)	0.0	DHCS proposes to reduce costs for managed care capitation payments by implementing several managed care efficiency adjustments, including: 1) an inpatient maximum fee schedule for private and district/municipal public hospitals, 2) an adjustment based on the potential to avoid emergency room visits by low-acuity patients, 3) reduction in contracting levels through coding changes, and 4) a reduced managed care underwriting gain from 2 percent to 1.5 percent. DHCS estimates this proposal would result in General Fund savings of $87.8 million.	Hold Open
84	Managed Care Organization Tax – General Fund Savings 4260-343-ECP-2020-MR	($1,686,645)	$-	0.0	DHCS estimates net revenue from the Managed Care Organization tax of $1.7 billion, which offsets the non-federal share of expenditures in the Medi-Cal program. The tax was recently approved by the federal government effective January 1, 2020.	AAB

85	Miscellaneous Baseline Adjustments 4260-220-BBA-2020-MR 4260-240-BBA-2020-MR	$-	$143,165	0.0	DHCS requests increased federal fund expenditure authority of $18.5 million in Item 4260-115-0890 and $124.7 million in 4260-116-0890 to reflect the receipt of federal grant funds for mental health and substance use disorder treatment.	AAB
86	Nursing Facility Financing Reform 4260-337-ECP-2020-MR Trailer Bill Proposal	$92,802	$92,802	0.0	DHCS requests trailer bill language to reauthorize a quality assurance fee on free-standing skilled nursing facilities that supports the non-federal share of reimbursement increases to these facilities. This fee was originally enacted by AB 1629 (Frommer), Chapter 875, Statutes of 2004, and the current authority for the fee expires on July 31, 2020. DHCS estimates the General Fund cost of implementation of its new fee proposal, along with the associated increased reimbursement rates, will be $92.8 million in 2020-21. DHCS has been working with stakeholders to reach consensus on its trailer bill language proposal. However, the language was released publicly by the Administration on May 21, 2020. As a result, staff recommends approving the budget adjustments assumed for reauthorization of the fee, but deferring the trailer bill language proposal to allow sufficient time to evaluate its contents.	AAB/ Defer TBL

87	Estate Recovery from Deceased Medi-Cal Beneficiaries 4260-272-ECP-2020-MR Trailer Bill Proposal	($16,900)	($16,900)	0.0	DHCS proposes to renew its estate recovery program that was eliminated in the 2016 Budget Act. Federal law currently requires the state to recover from the estates of deceased Medi-Cal beneficiaries 55 or older for the costs of providing nursing facility services, home- and community-based services, and related hospital and prescription drug services. Federal law gives states the option to recover for other health care services. Until the 2016 Budget Act, California recovered for all health care services from deceased Medi-Cal beneficiaries' estates. This proposal seeks to renew that practice. DHCS estimates this proposal will result in General Fund savings of $16.9 million. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
88	Reversions of Previously Funded Programs 4260-268-ECP-2020-MR 4260-275-ECP-2020-MR 4260-328-ECP-2020-MR 4260-349-BBA-2020-MR	($39,291)	$-	0.0	DHCS proposes to revert funding for programs previously funded by the Legislature, including: • Medi-Cal Enrollment Navigators - $15 million • Medi-Cal Interpreters Pilot - $5 million • Behavioral Health Counselors in Emergency Departments - $20 million	Hold Open
89	Richmond Laboratory Lease Payment 4260-249-BBA-2020-MR Budget Bill Language	$620	$620	0.0	DHCS requests $1.2 million ($620,000 General Fund and $620,000 federal funds) to reimburse the Department of Public Health for lease-revenue bond based rental payments at its Richmond Laboratory.	AAB/ Adopt Placeholder BBL

90	State-Only Claiming Adjustment (Behavioral Health) 4260-342-ECP-2020-MR	$148,514	($148,514)	0.0	DHCS requests General Fund expenditure authority of $148.5 million to repay the federal government for inappropriately claimed federal financial participation for non-emergency services provided to eligible, non-exempt, qualified immigrants. This request is for behavioral health services provided by county behavioral health programs. DHCS reports the General Fund will be used to repay the federal government and it expects counties to repay the state the portion for which they are responsible. Given the significant General Fund impacts of this proposed repayment, and relatively little detail provided by the department regarding how this error occurred, staff recommend deferring this proposal without prejudice to allow DHCS to provide additional information.	DWOP
91	State-Only Claiming Adjustment (Non-Behavioral Health) 4260-344-ECP-2020-MR	$1,292,692	($1,590,425)	0.0	DHCS requests General Fund expenditure authority of $1.3 billion to repay the federal government for inappropriately claimed federal financial participation for non-emergency services provided to eligible, non-exempt, qualified immigrants. This request is for the non-behavioral health components of the services subject to federal repayment. Given the significant General Fund impacts of this proposed repayment, and relatively little detail provided by the department regarding how this error occurred, staff recommend deferring this proposal without prejudice to allow DHCS to provide additional information.	DWOP

92	Utilize Fund Balances to Support Medi-Cal 4260-304-ECP-2020-MR 4260-305-ECP-2020-MR	($136,552)	$136,552	0.0	DHCS proposes to utilize balances from the following special funds to support the Medi-Cal program: 1) Fund 3156 - Children's Health and Human Services Special Fund ($100 million); and 2) Fund 3311 – Health Care Plan Fines and Penalties Fund ($36.6 million).	AAB
SENATE PROPOSALS						
93	Medically Tailored Meals Pilot Extension Legislative Proposal	$-	$-	0.0	The 2017 Budget Act included General Fund expenditure authority of $2 million annually for three years and trailer bill language to implement a pilot project to deliver a medically tailored meal intervention to Medi-Cal beneficiaries with complex and high-cost health conditions. The program was initially scheduled to be completed in three years, but due to delayed implementation, the program will not be able to complete its full, three-year project before the sunset date in statute. Advocates are requesting an extension of program authority for an additional year. This proposal has no budgetary impact, as funding has already been allocated and encumbered.	Adopt Placeholder TBL

4265 DEPARTMENT OF PUBLIC HEALTH						
(dollars in thousands) (AAB=approve as budgeted; DWOP=defer without prejudice)						
GOVERNOR'S BUDGET ISSUES UNCHANGED AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
94	ADAP MAGI Information Trailer Bill Proposal	$-	$-	0.0	DPH proposes trailer bill language to allow for electronic retrieval of AIDS Drug Assistance Program clients' modified adjusted gross income data from the California Franchise Tax Board (FTB). According to DPH, state law only allows FTB to provide the adjusted gross income, which does not include household data necessary to calculate modified adjusted gross income (MAGI), which forms the basis of determinations of ADAP client eligibility. (This issue was heard on March 12th, 2020).	AAB/ Adopt Placeholder TBL
95	Immunization Medical Exemption Program 4265-059-BCP-2020-GB	$3,400	$-	15.0	DPH requests 15 positions and General Fund expenditure authority of $3.4 million in 2020-21, and $3.1 million annually thereafter to standardize processes for immunization medical exemption requests and build new capacity into the California Immunization Registry. (This issue was heard on March 12th, 2020).	AAB
96	Lead-Related Construction Fee APA Exemption Trailer Bill Proposal	$-	$-	0.0	DPH proposes trailer bill language to exempt from the Administrative Procedures Act the fee report mechanism implemented in the 2018 Budget Act to address funding issues in the Lead Related Construction Program. The 2018 Budget Act set a new fee of $87 to provide a one-time increase to the program, under the assumption the fee report mechanism would address funding issues.	AAB/ Adopt Placeholder TBL

97	Master Data Management Sustainability 4265-051-BCP-2020-GB	$-	$1,500	10.0	DPH requests ten positions and expenditure authority from the Health Statistics Special Fund of $1.5 million annually to increase department-wide analytics for public health decision-making, to continue implementing master data management strategies, and implementation of data-driven community interventions. (This issue was heard on March 12th, 2020).	AAB
98	Pregnancy-Related Deaths and Severe Maternal Morbidity Data (SB 464) 4265-073-BCP-2020-GB	$348	$-	2.0	DPH requests two positions and General Fund expenditure authority of $348,000 annually to track and publish data on pregnancy-related deaths and severe maternal morbidity, pursuant to the requirements of SB 464 (Mitchell), Chapter 533, Statutes of 2019.	AAB
99	PrEP-AP – Initial 30-Day Supply of PrEP and PEP Trailer Bill Proposal	$-	$-	0.0	DPH proposes trailer bill language to allow the Pre-Exposure Prophylaxis Assistance Program to pay for an initial 30-day supply of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) medication. The 2018 Budget Act authorized the ADAP program to furnish up to 14 days of PrEP or PEP to clients and up to 28 days of pep to clients who are victims of sexual assault. Currently these medications are only available from the manufacturer in packages comprising a 30 day supply. This proposal would allow ADAP to furnish an initial 30 day supply of medications to clients, consistent with current packaging practices of the manufacturer.	AAB/ Adopt Placeholder TBL

100	Protecting Health Through Weatherization and Energy Efficiency Programs (AB 1232)	$140	$-	1.0	DPH requests one position and General Fund expenditure authority of $140,000 annually to support the implementation of the Energy Efficiency Low-Income Weatherization Program, including development of a recommended action plan, providing health and financial benefits, and an assessment of the program. These activities are mandated pursuant to AB 1232 (Gloria), Chapter 754, Statutes of 2019.	AAB
GOVERNOR'S BUDGET ISSUES MODIFIED OR WITHDRAWN AT MAY REVISION						
Budget Change Proposals, Trailer Bill Language, or Technical Adjustments						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
101	ADAP Enrollment System Maintenance and Operations Support 4265-057-BCP-2020-GB 4265-161-BBA-2020-MR	$-	$4,750	9.0	DPH requests nine positions and expenditure authority from the ADAP Rebate Fund of $4.8 million annually to support ongoing maintenance and operations of the ADAP Enrollment System (AES), which manages eligibility determinations, enrollment, and medication access for clients of the ADAP program. At May Revision, DPH requests a net-zero shift between programs to accurately display expenditures. The AES is the system implemented by ADAP after its enrollment contractor failed to implement a secure enrollment system. (The January budget proposal was heard on March 12th, 2020).	AAB
102	California Cognitive Care Coordination Initiative 4265-122-BCP-2020-GB 4265-205-BCP-2020-MR	$-	$-	0.0	DPH requests to withdraw its January budget proposal for General Fund expenditure authority of $3.6 million in 2020-21 for UC Davis to create a comprehensive coordinated statewide dementia care program.	AAB/ Withdrawn

103	Center for Health Care Quality Operations Expansion 4265-124-BCP-2020-GB 4265-202-BCP-2020-MR	$-	$-	53.0	DPH requests to modify its January budget proposal to improve provider application processing times, and centralize provider support and regulatory assistance services in the Center for Health Care Quality. The modified request is for 53 positions and no additional funding to support existing licensing efforts.	AAB
104	Cybersecurity Program Augmentation 4265-053-BCP-2020-GB 4265-171-BBA-2020-MR	$-	$1,900	9.0	DPH requests to modify its January budget proposal to address cybersecurity and privacy risks identified by security assessments conducted by the California Military Department, the California Department of Technology, and other assessments. The modified request is for nine positions and annual expenditure authority of $1.9 million from federal funds, various special funds, and reimbursements.	AAB
105	Public Health Electronic Tissue and Biologics (ETAB) Project 4265-056-BCP-2020-GB 4265-203-BCP-2020-MR	$-	$-	0.0	WITHDRAWN – DPH requests to withdraw its January budget proposal to implement the final stage of an electronic online licensing process for tissue bank and biologics and for annual maintenance and operations to support the system.	AAB/ Withdrawn
Local Assistance Estimates						

106	AIDS Drug Assistance Program (ADAP) – May Revision Estimate 4265-080-ECP-2020-GB 4265-235-ECP-2020-MR	$-	($11,130)	0.0	The May 2020 ADAP Local Assistance Estimate reflects revised 2019-20 expenditures $414.1 million, which is a decrease of $17.2 million or four percent compared to the January budget. According to DPH, this decrease is primarily due to reduction in medication expenditures, private insurance premiums and out-of-pocket expenditures. For 2020-21, DPH estimates ADAP expenditures of $438.3 million, a decrease of $29.1 million or 6.2 percent compared to the January budget. According to DPH, this increase is similarly attributable to a reduction in medication costs, and lower insurance premium and out-of-pocket cost projections. Caseload is projected to be 33,884 in 2019-20, an increase of 1,261 or 3.9 percent compared to the January budget, and 36,523 in 2020-21, an increase of 2.604 or 7.7 percent compared to the January budget.	AAB

107	Women, Infants, and Children (WIC) Program – May Revision Estimate 4265-078-ECP-2020-GB 4265-234-ECP-2020-MR	$-	($67,747)	0.0	The May 2020 WIC Estimate includes total expenditure authority of $1.1 billion ($854.9 million federal funds and $210.1 million WIC manufacturer rebate funds) in 2019-20, a decrease of $23.2 million ($25.1 million federal funds offset by an increase of $1.9 million WIC manufacturer rebate funds) compared to the January budget. The Estimate includes $1.1 billion ($834.6 million federal funds and $189 million WIC manufacturer rebate funds) in 2020-21, a decrease of $5.3 million ($1.2 million federal funds and $4.1 million WIC manufacturer rebate funds) compared to the January budget. The federal fund amounts include state operations costs of $62.3 million in 2019-20 and $59.2 million in 2020-21. According to DPH, these declines in expenditures are due to decreased participation in the program. WIC caseload is estimated to be 869,627 in 2019-20 and 818,547 in 2020-21.	AAB

108	Genetic Disease Screening Program (GDSP) – May Revision Estimate 4265-079-ECP-2020-GB 4265-233-ECP-2020-MR	$-	$32	0.0	The May 2020 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $142.1 million ($31.4 million state operations and $110.7 million local assistance) in 2019-20, a decrease of $893,000 or 0.6 percent compared to the January budget. The estimate also includes $141.3 million ($31.7 million state operations and $109.7 million local assistance) in 2020-21, a decrease of $1.2 million or 0.9 percent compared to the January budget, and a decrease of $747,000 or 0.5 percent compared to the revised 2019-20 estimate. According to DPH, the decreased costs in both fiscal years are primarily attributable to reduced estimates of live births in California.	AAB
109	Center for Healthcare Quality (CHCQ) – May Revision Estimate		$8,100	59.0	The May 2020 Estimate for the Center for Health Care Quality includes $322.7 million ($4.3 million General Fund, $101 million federal funds, and $217.4 million special funds and reimbursements) in 2019-20, an increase of $980,000 special fund compared to the Governor's January budget, and $350.3 million ($4.3 million General Fund, $99.6 million federal funds, and $246.5 million special funds and reimbursements) in 2020-21, an increase of $2.7 million special funds compared to the Governor's January budget. The center will employ 1,350.3 staff in 2019-20, unchanged from the January budget, and 1,425.3 in 2020-21, a decrease of 16.5 or 1.2 percent compared to the January budget. As of February 2020, DPH reports a vacancy rate of 3.7 percent in its Health Facilities Evaluator Nurse classification due to recruitment consultants and other recruiting efforts.	AAB

NEW MAY REVISION PROPOSALS						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
110	Adjustment to Extend Suspended Programs 4265-257-BBA-2020-MR Budget Bill Language	$-	$-	0.0	DPH requests to remove provisional language in Items 4265-001-0001 and 4265-111-0001 that suspend funding for sexually transmitted disease, human immunodeficiency virus, and hepatitis C prevention programs adopted in the 2019 Budget Act. This action would maintain ongoing funding for these programs.	AAB/ Adopt Placeholder BBL
111	Various Technical Adjustments 4265-232-BBA-2020-MR 4265-157-BBA-2020-MR	$-	($27)	0.0	DPH requests technical adjustments, as follows: 1) a decrease of $27,000 in the Breast Cancer Research Fund to reflect changes in cigarette tax revenue, and 2) a net-zero funding shift between programs to accurately display expenditures.	AAB
112	Black Infant Health Program Adjustment 4265-208-BBA-2020-MR	($4,500)	$-	0.0	DPH requests reduction of General Fund resources for the Black Infant Health Program of $4.5 million annually. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
113	Center for Laboratory Sciences – Protecting California from Infectious Diseases	$5,893	$-	3.0	DPH requests three positions and General Fund expenditure authority of $5.9 million in 2020-21 and $4.8 million annually thereafter to support emergency response, public health laboratory capacity, disease surveillance, and emergency response. These resources extend funding for previously approved positions in the Infectious Disease Laboratory, establish three new positions to assist with coronavirus and other testing workload for local jurisdictions, and increase whole genome sequencing methods for foodborne disease identification.	AAB

114	Enhanced Health Care Quality Services 4265-206-BCP-2020-MR	$-	$424	2.0	DPH requests two positions and expenditure authority from the Licensing and Certification Fund of $424,000 annually to support detection and containment of antimicrobial resistant and high concern pathogens in health care settings.	AAB
115	Facilitating Projects to Benefit Nursing Home Residents 4265-254-BCP-2020-MR	$-	$6,000	0.0	DPH requests expenditure authority from the Federal Health Facilities Citation Penalties Account of $6 million in 2020-21, 2021-22, and 2022-23, to support federally approved projects to benefit nursing home residents. The proceeds of federal citations of skilled nursing facilities are required to be used to improve the quality of life of residents. DPH solicits requests for projects and, upon federal approval, oversees implementation.	AAB
116	Special Fund Loans to the General Fund Budget Bill Language	$-	$-	0.0	Provides for the following special fund loans to the General Fund: 1) $100 million from the ADAP Rebate Fund (3080) 2) $3 million from the Genetic Disease Testing Fund (0203) 3) $3 million from the Health Statistics Special Fund (0099) 4) $3 million from the Infant Botulism Treatment and Prevention Fund (0272) Staff recommends adopting modified budget bill language to better ensure the ADAP Rebate Fund loan does not impact ADAP clients' access to medication and other support in the program.	AAB/ Adopt Modified Placeholder BBL

117	Manufactured Cannabis Safety 4265-177-BCP-2020-MR	$-	$21,856	0.0	DPH requests expenditure authority of $15.2 million ($14.7 million Cannabis Control Fund and $527,000 reimbursements) in 2020-21, and $15 million ($14.5 million Cannabis Control Fund and $527,000 reimbursements) annually thereafter to continue support for the Medicinal and Adult-Use Cannabis Regulations and Safety Act and to continue the Medical Marijuana Identification Card Program. DPH also requests expenditure authority from the Cannabis Control Fund of $5.6 million in 2020-21, 2021-22, and 2022-23 to support administrative hearings, IT system maintenance and operations and the California Cannabis Track and Trace System contract and tags.	AAB
118	Proposition 99 Expenditure Adjustments 4265-249-BBA-2020-MR	$-	($3,419)	0.0	DPH requests a technical adjustment to Proposition 99 tobacco tax revenue amounts, as follows: 1) a reduction of $3 million in the Health Education Account, 2) a reduction of $289,000 in the Research Account, and 3) a reduction of $139,000 in the Unallocated Account. These adjustments reflect changes in estimates of Proposition 99 revenue.	AAB
119	Protecting Children from the Damaging Effects of Lead Exposure 4265-136-BCP-2020-MR	$-	$10,300	0.0	DPH requests expenditure authority from the Childhood Lead Poisoning Prevention Fund of $10.3 million annually to increase interventions and other activities designed to reduce exposure of children to lead. This resource request is in response to a state audit that recommended responding to increased caseload, requiring additional environmental enforcement by local jurisdictions, and setting evaluation requirements for outreach.	AAB

120	Reducing Lead Exposure in Housing and Public Buildings 4265-148-BCP-2020-MR	$-	$415	0.0	DPH requests expenditure authority from the Lead Related Construction Special Fund of $415,000 annually to support the Lead Related Construction Program's new online certification and payment system, conduct required activities, and address the program's financial sustainability.	AAB
121	Reversion of Prior Year Savings Budget Bill Language	$-	$-	0.0	DPH requests reversion of unexpended General Fund balances approved in the 2019 Budget Act. These unspent funds were originally appropriated for sickle cell disease centers ($60,000 unspent of $15 million), a farmworker health study ($150,000 unspent of $1.5 million), and mental health disparities reduction grants ($8 million unspent of $8 million).	Reject
122	Safe Cosmetics Program Reduction 4265-239-BBA-2020-MR	($500)	$-	0.0	DPH requests to reduce General Fund expenditure authority of $500,000 annually for the Safe Cosmetics Program approved in the 2019 Budget Act. These resources were intended to support enforcement positions for the program, which requires cosmetics manufacturers to submit information regarding toxic ingredients in their products. Prior to this augmentation, there were no enforcement staff for this program.	Reject

4440 DEPARTMENT OF STATE HOSPITALS						
(dollars in thousands) (AAB=approve as budgeted; DWOP=defer without prejudice)						
GOVERNOR'S BUDGET ISSUES UNCHANGED AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
123	Mission-Based Review – Protective Services 4440-044-BCP-2020-GB	$7,900	$-	46.3	DSH requests 46.3 positions and General Fund expenditure authority of $7.9 million in 2020-21, 47.8 positions and $13.4 million in 2021-22, and $12 million annually thereafter to implement the first phase of a staffing standard to support protective services functions at DSH. The staffing standard was developed in collaboration with the Department of Finance and identified particular challenges with use of overtime at DSH-Napa. However, given the significant ongoing General Fund costs related to this proposal, staff recommends deferring to evaluate available budget resources.	DWOP
124	Post-Incident Debriefing and Support 4440-008-BCP-2020-GB	$831	$-	5.0	DSH requests five positions and General Fund expenditure authority of $831,000 annually to establish a statewide Employee Post-Incident Debriefing and Support Services program. This program would provide resources and medical, physical, and emotional support to DSH employees involved in a violent incident or assault.	AAB
125	Patton Over-Bedding Sunset Extension Trailer Bill Proposal	$-	$-	0.0	DSH proposes trailer bill language to extend the sunset date from September 2020 to September 2030 to continue to operate 1,530 beds at Patton State Hospital. According to DSH, allowing this authority to sunset would Patton's patient-occupied bed capacity by 194.	AAB/ Adopt Placeholder TBL

126	Medical Director Exempt Positions Trailer Bill Proposal	$-	$-	0.0	DSH proposes trailer bill language to transfer appointment authority of state hospital medical directors from the DSH Director to the Governor, upon recommendation from the Director. The language would also allow the Director to designate additional employees as officers beyond the hospital administrator, hospital director, and chief of police services.	AAB/ Adopt Placeholder TBL
127	Atascadero: Potable Water Booster Pump System – Working Drawings Phase 4440-046-COBCP-2020-GB	$229	$-	0.0	DSH requests General Fund expenditure authority of $229,000 in 2020-21 for the working drawings phase of the project to install a potable water booster pump system at Atascadero State Hospital. According to DSH, the hospital has experienced significant issues with water pressure below the level necessary for normal facility operations.	AAB
GOVERNOR'S BUDGET ISSUES MODIFIED OR WITHDRAWN AT MAY REVISION						
Budget Change Proposals, Trailer Bill Language, or Technical Adjustments						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
128	Cooperative Electronic Document Management System 4440-010-BCP-2020-GB 4440-101-BCP-2020-GB	$-	$-	0.0	WITHDRAWN – The Administration requests to withdraw its January budget request for four positions and General Fund expenditure authority of $6.4 million in 2020-21, $4.1 million in 2021-22, and $700,000 annually thereafter to support a Cooperative Electronic Document Management System for the three entities, including DSH, scheduled to relocate to the Allenby building.	AAB/ Withdrawn

129	Electronic Health Records within Clinical Assessments, Reports, and Evaluation System – Phase 2 4440-002-BCP-2020-GB 4440-097-BCP-2020-MR	$2,425	$-	4.0	DSH requests to modify its January budget proposal to continue planning and procurement of the electronic health record (EHR) component of the "Continuum" patient care system. The request would support the completion of Stages 3 and 4 of the Project Lifecycle Approval process. The modified request is for four positions and General Fund expenditure authority of $2.4 million in 2020-21 and eight positions and $3.2 million annually thereafter. The January budget requested 18 positions and $9.6 million in 2020-21 and $3.4 million annually thereafter. DSH estimates the full project cost over a period of six years is $200 million. As a result, staff recommends deferring this proposal for further evaluation of available budget resources.	DWOP
130	Increased Resources for Regulation Promulgation 4440-011-BCP-2020-GB 4440-103-BCP-2020-GB	$-	$-	0.0	WITHDRAWN – DSH requests to withdraw its January budget proposal for General Fund expenditure authority of $483,000 in 2020-21 and 2021-22 to manage workload related to the promulgation of regulations.	AAB/ Withdrawn
131	Metropolitan – Fire Alarm Upgrade Reappropriation 4440-073-COBCP-2020-MR	$-	$-	0.0	DSH requests reappropriation language to extend the liquidation period for the construction phase of funding for the Metropolitan Fire Alarm System Upgrade project. An extension of the liquidation period is needed due to delays in the regulatory review process.	AAB

132	Patton- Fire Alarm System Upgrade Reappropriation 4440-071-COBCP-2020-MR	$-	$-	0.0	DSH requests reappropriation language for the construction phase of funding for the Patton Fire Alarm System Upgrade project. According to DSH, reappropriation of previously approved funding is needed due to delays in the regulatory review process and would allow DSH to complete the working drawings phase of the project and proceed to construction in 2020-21.	AAB
133	Mission-Based Review – Treatment Team 4440-049-BCP-2020-GB 4440-109-BCP-2020-MR	$9,400	$-	36.3	DSH requests to modify its January budget proposal to modify clinical treatment staffing to support additional workload for providing psychiatric and medical care to DSH patients, as determined by a Clinical Staffing Study developed by DSH and the Department of Finance. The modified request is for 36.3 positions and General Fund expenditure authority of $9.4 million in 2020-21, 149.9 positions and $37.7 million in 2021-22, 198.6 positions and $49.7 million in 2022-23, 228.6 positions and $57.5 million in 2023-24, and 250.2 positions and $64.2 million in 2024-25. The total General Fund cost across the five year budget horizon would be $218.5 million. As a result, staff recommends deferring this proposal for further evaluation of available budget resources.	DWOP

134	Pharmacy Modernization – Phase 2 4440-003-BCP-2020-GB 4440-096-BCP-2020-GB	$928	$-	0.0	DSH requests to modify its January budget proposal to support the modernization of pharmacy management systems at its state hospitals. The modified request is for General Fund expenditure authority of $928,000 in 2020-21, $5.6 million in 2021-22, and $823,000 annually thereafter. The 2019 Budget Act included $2.2 million to fund complete Project Lifecycle Approval stages 2 through 4 by May 2020. The modification delays the timeline for Phase 2 of this project, with all five hospitals completed by 2022-23. While General Fund costs for this project in the next two years are significant, the project is near completion and ongoing costs are reasonable. As a result, staff recommends approval of the modified request.	AAB

135	Relocation to the Clifford L. Allenby Building-Phase 2 4440-009-BCP-2020-GB 4440-100-BCP-2020-MR Budget Bill Language	$3,250	$-	0.0	The Administration requests to modify its January budget request to support relocation of CHHSA, DSH and the Department of Developmental Services (DDS) to the Clifford L. Allenby Building. The modified request is for General Fund expenditure authority of $3.3 million in 2020-21. The modified request eliminates funding for 2021-22 and beyond that was part of the January budget proposal, as the Administration is reevaluating space needs, the use of telework, and restacking opportunities in state-owned buildings. The Administration also proposes budget bill language to allow expenditure of these funds until June 30, 2023, and that they shall not be available until the State's evaluation of telework and restacking is complete. Given the shift in working conditions due to the pandemic, this approach is reasonable and staff recommends approval of the modified request.	AAB

136	Statewide Integrated Health Care Provider Network 4440-006-BCP-2020-GB 4440-106-BCP-2020-MR	$3,156	$-	0.0	DSH requests to modify its January budget proposal to contract for a Statewide Integrated Health Care Provider Network, including prior authorization and third-party administration services. The modified request is for General Fund expenditure authority of $3.2 million in 2020-21, $2.2 million in 2021-22 and 2022-23, and $1.4 million annually thereafter. DSH reports its five hospitals each independently contract with outside medical providers for patients requiring specialty care, with each experiencing unique challenges of provider availability, rate negotiation, geographic location, and an aging population. While the use of a vendor to manage a standardized provider network, prior authorization, and third party administration may alleviate some of these challenges, this request must be evaluated in the context of a significant General Fund shortfall. As a result, staff recommends deferring this proposal for further evaluation of available budget resources.	DWOP

137	Statewide Ligature Risk Special Repair Funding 4440-005-BCP-2020-GB 4440-102-BCP-2020-MR	$5,257	$-	0.0	DSH requests to modify its January budget proposal to mitigate ligature risk within four of its Joint Commission accredited hospitals. The modified request is for General Fund expenditure authority of $5.3 million in 2020-21 and 2021-22, $8.4 million in 2022-23 and 2023-24, and $15.4 million in 2024-25, 2025-26, and 2026-27. The federal Centers for Medicare and Medicaid Services, as well as the Joint Commission have indicated an increased focus on ligature risks, which are defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. The modified request prioritizes the highest risk repairs for mitigation. Although the General Fund costs for this proposal remain significant, these expenditures protect patient safety and are subject to federal and accreditation requirements. Staff recommends approval.	AAB

138	Statewide Roof Repairs and Replacement 4440-004-BCP-2020-GB 4440-099-BCP-2020-GB	$26,700	$-	1.0	DSH requests to modify its January budget proposal to replace roofs at its state hospitals. The modified request is for one position and $26.7 million in 2020-21 and $129,000 annually thereafter. Instead of replacing seven roofs, the modified request would replace three of the most extensively deteriorated roofs at Napa, Metropolitan, and Patton. According to DSH, each of these roofs is subject to water intrusion into the building, which may lead to mold, licensure violations, and negative impacts to bed capacity. Given the significant General Fund costs of this proposal, and the expectation that the timeline for these projects will extend over multiple fiscal years, staff recommends deferring this proposal to evaluate the timing and availability of budget resources for these projects.	DWOP
Local Assistance Estimate – Program Updates						
139	Admission, Evaluation, and Stabilization (AES) Center 4440-032-ECP-2020-GB 4440-091-ECP-2020-MR	$5,283	$-	0.0	The May Estimate reflects General Fund costs of $432,000 in 2019-20 and $5.3 million in 2020-21, a reduction of $3.1 million in 2019-20 and no change in 2020-21 compared to the Governor's January budget for activation of beds at the Kern AES Center. These changes are the result of unforeseen delays in Kern County's process for procuring service contracts to renovate treatment space. DSH expects to complete this 30-bed expansion in the fall of 2020.	AAB

140	Community Care Collaborative Pilot Program 4440-059-ECP-2020-GB 4440-088-ECP-2020-GB Trailer Bill Proposal	$-	$-	0.0	WITHDRAWN – DSH requests to withdraw its January budget proposal for a six-year pilot program in three counties to provide incentives to treat and serve individuals deemed incompetent to stand trial on felony charges in the community. The total cost of the six-year program would have been $364.2 million.	AAB/ Withdrawn
141	Conditional Release Program (CONREP) Continuum of Care 4440-078-ECP-2020-MR	$-	$-	0.0	The May Estimate reflects a one-time reduction of $3.4 million General Fund compared to the January budget for the establishment of a 78 bed step-down program for patients ready for the CONREP program in 18-24 months, as adopted in the 2019 Budget Act. According to DSH, this reduction is due to delays in regulatory approvals for building retrofits and DSH expects program activation to begin in July 2020.	AAB
142	CONREP – Non-Sexually Violent Predators (Non-SVP) Provider Contract Funding 4440-028-ECP-2020-GB	$2,200	$-	0.0	The November Estimate reflects General Fund costs of $2.2 million in 2020-21 and $2.4 million in 2021-22 to increase support of placement evaluations for CONREP-Non-SVP patients through the use of contracted staff. According to DSH, these resources are needed to address increased caseload in this population. These costs are unchanged at May Revision.	AAB
143	Enhanced Treatment Program (ETP) 4440-022-ECP-2020-GB 4440-030-ECP-2020-GB 4440-081-ECP-2020-MR	($994)	$-	(9.9)	The May Estimate reflects reduced General Fund costs of $8.4 million in 2019-20 and $994,000 in 2020-21, as well as a reduction of 53.4 positions in 2019-20 and 9.9 positions in 2020-21, due to delayed activation of ETP units at Atascadero and Patton. ETP units accept patients who are at the highest risk of violence and cannot be safely treated in a standard treatment environment.	AAB

144	Incompetent to Stand Trial (IST) "Off-Ramp" Services 4440-025-ECP-2020-GB 4440-090-ECP-2020-MR	$1,000	$-	0.0	The May Revision reflects General Fund costs of $1 million in 2020-21 and $2 million annually thereafter for the IST Off-Ramp team in Los Angeles County, which assesses potential IST patients for restoration of competency prior to admission to a DSH program. These costs represent a $1 million reduction in 2020-21 compared to the January budget, due to a delay in activation. This program was approved in the 2019 Budget Act.	AAB
145	Jail-Based Competency Treatment (JBCT) Program – Existing and Patient Rights 4440-031-ECP-2020-GB 4440-033-ECP-2020-GB 4440-082-ECP-2020-MR	($6,906)	$-	0.0	The May Estimate reflects a reduction of General Fund costs of $3.7 million in 2019-20 and $6.9 million in 2020-21 due to delayed activation of existing JBCT programs, which are administered by counties to provide restoration of competency services to IST patients while in county jail facilities.	AAB
146	Jail-Based Competency Treatment (JBCT) Program - Existing 4440-029-ECP-2020-GB 4440-084-ECP-2020-MR	$6,130	$-	0.0	The May Estimate reflects increased General Fund costs of $76,000 in 2019-20 and $6.1 million in 2020-21 for expansions of new JBCT programs in new counties. Bed capacity is expected to increase in three northern California counties, one central California county and one southern California county.	AAB
147	Lanterman-Petris-Short Adjustment 4440-019-ECP-2020-GB 4440-083-ECP-2020-MR	$-	$5,757	0.0	The May Estimate reflects increased reimbursements from counties of $5.8 million in 2020-21 and $5.8 million in 2021-22 to reflect increased referrals of involuntary civil commitments under the Lanterman-Petris-Short Act.	AAB

148	Metropolitan State Hospital Increased Secure Bed Capacity 4440-021-ECP-2020-GB 4440-027-ECP-2020-GB 4440-087-ECP-2020-MR	($6,464)	$-	(41.7)	The May Estimate reflects decreased General Fund costs of $34.4 million in 2019-20 and $6.5 million in 2020-21, and increased General Fund costs of $294,000 in 2021-22, related to delays in the activation of secure bed capacity at Metropolitan State Hospital due to construction and fire marshal delays. The Estimate also reflects reduction of 222.4 positions in 2019-20 and 41.7 positions in 2020-21.	AAB
149	Mission-Based Review – Court Evaluations and Reports 4440-060-ECP-2020-GB 4440-085-ECP-2020-MR	($3,270)	$-	(17.7)	The May Estimate reflects decreased General Fund costs of $895,000 in 2019-20, $3.3 million in 2020-21, and $2 million in 2021-22 due to delays in recruiting and hiring for court evaluation and legal staff approved in the 2019 Budget Act. The Estimate also reflects reduction of 2.7 positions in 2019-20, 17.7 positions in 2020-21, and 7.7 positions in 2021-22.	AAB
150	Mission-Based Review – Direct Care Nursing 4440-061-ECP-2020-GB 4440-086-ECP-2020-MR 4440-113-ECP-2020-MR	($20,969)	$-	(162.1)	The May Estimate reflects decreased General Fund costs of $11.1 million in 2019-20, $21 million in 2020-21, and $15.1 million in 2021-22 to reflect revised implementation timeline of direct care nursing staff approved in the 2019 Budget Act due to the COVID-19 pandemic. The May Estimate also reflects reduction of 83.5 positions in 2019-20, 162.1 positions in 2020-21, and 135.5 positions in 2021-22.	AAB

NEW MAY REVISION PROPOSALS						
Budget Change Proposals, Trailer Bill Language, or Technical Adjustments						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
151	Disaster Preparedness, Response, and Recovery 4440-105-BCP-2020-MR	($535)	$-	(5.0)	DSH requests to decrease five positions and General Fund expenditure authority of $535,000 approved in the 2019 Budget Act for disaster preparedness, response, and recovery. This reduction reflects the Administration's reevaluation of expenditures in the context of a workload budget. Subject to budget control section "trigger" language, this reduction would be restored if the state received sufficient federal funds.	Hold Open
152	Napa Earthquake Special Repair Loan Reappropriation 4440-111-BBA-2020-GB	$-	$-	0.0	DSH requests reappropriation of loan funding approved in the 2017 Budget Act for earthquake repairs at Napa State Hospital to allow additional time for receipt of Federal Emergency Management Agency (FEMA) funding.	AAB
153	Vocational Services and Patient Wages Technical Adjustment 4440-089-ECP-2020-MR	$-	$-	0.0	DSH requests a technical adjustment to reflect a net-zero funding shift between programs to accurately display expenditures and simplify administrative processes for the augmentation in the 2019 Budget Act related to vocational services and patient wages in state hospitals.	AAB

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION						
(dollars in thousands) (AAB=approve as budgeted; DWOP=defer without prejudice)						
GOVERNOR'S BUDGET ISSUES UNCHANGED AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
154	Contract and Information Technology Workload 4560-006-BCP-2020-GB	$-	$144	1.0	MHSOAC requests one position and expenditure authority from the Mental Health Services Fund of $144,000 annually to support one Information Technology Associate to mitigate the risks due to key-person dependence, mitigate IT security risks, address increased IT help desk assistance workload, and address recently implemented web-based technologies workload.	AAB
155	Prevention and Early Intervention Statewide Prioritization and Oversight 4560-007-BCP-2020-GB	$-	$272	2.0	MHSOAC requests two positions and expenditure authority from the Mental Health Services Fund of $272,000 annually to support administrative responsibilities under Chapter 843, Statutes of 2018 (SB 1004), including analyzing Prevention and Early Intervention program reports, providing logistical support, developing meeting materials, and providing technical assistance to counties.	AAB

SENATE PROPOSALS						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
156	Authority and Flexibility for Contract Renegotiation to Reflect COVID-19 Budget Bill Language	$-	$-	0.0	Oversight of funding for school mental health, youth drop-in centers, and early psychosis prevention funding, has revealed the Administration may be improperly applying a freeze in state contracts to MHSOAC for implementation of these programs, which are not proposed for reduction or modification in the May Revision. In addition, many of these contracts, as well as county innovation plans were developed prior to the pandemic and may need to be redesigned to reflect current realities. The Senate proposes placeholder budget bill language to: 1) pause reversion of Mental Health Services Act funds for 12 months to allow counties to renegotiate plans with MHSOAC that reflect the pandemic, and 2) require the Administration to allow MHSOAC to enter into contracts for previously authorized expenditures including, but not limited to, for school mental health, youth drop-in centers, and early psychosis prevention.	Adopt Placeholder BBL

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)						
(dollars in thousands) (AAB=approve as budgeted; DWOP=defer without prejudice)						
GOVERNOR'S BUDGET ISSUES UNCHANGED AT MAY REVISION						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
157	Clinical Volunteering for Covered California Board and Staff Trailer Bill Proposal	$-	$-	0.0	Covered California proposes trailer bill language to create an exception to conflict of interest requirements for board members and staff to authorize volunteer services or affiliations with a governmental entity, or a health facility, health clinic, or health care provider group that is associated with an educational institution, if the member or staff does not receive compensation or possess an ownership interest in the entity, facility, clinic, or provider group. Consumer advocates have raised concerns about relaxation of conflict of interest provisions for positions that negotiate health care plan offerings and premium costs for Californians in the individual marketplace. Staff recommends deferring this proposal without prejudice to address these issues.	DWOP
NEW MAY REVISION PROPOSALS						
Issue	**Subject (BR Title)**	**GF**	**OF**	**Pos.**	**Staff Comments**	**Staff Reco**
158	State Premium Subsidy Program 4800-012-ECP-2020-MR	($90,261)	$-	0.0	Covered California requests reduction in General Fund expenditure authority of $164.2 million in 2019-20 and $90.3 million in 2020-21 to reflect lower than projected state subsidy program enrollment in the Covered California Health Benefit Exchange. According to the Administration, these resources are intended to be sufficient to maintain the 2020 state subsidy program design for the 2021 plan year.	AAB

159	Actuarial Value of Non-Grandfathered Health Plans and Insurance Policies Trailer Bill Proposal	$-	$-	0.0	Covered California proposes trailer bill language to allow exchange plans in the Bronze metal tier to vary from the 60 percent actuarial value requirement by plus five percent or minus two percent. The 2019 Budget Act included similar language to allow variance of plus four percent or minus two percent for Bronze tier high deductible health plans. Federal rules that govern benefit design in these plans has resulted in actuarial values that exceed the plus four percent variance limit in state law. This language would align with the federal upper limit variance of plus five percent. Without this language, Bronze plans approved for the 2021 plan year would not be allowed. No concerns have been raised with this proposal.	AAB/ Adopt Placeholder TBL

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: May Revision Updates

May Revision Presentation. The subcommittee requests the California Health and Human Services Agency (CHHSA) to present the significant proposals included in its 2020-21 budget, as reflected in the Governor's May Revision. In particular, the presentation should highlight the following items:

- Electronic Visit Verification Phase 2 Planning – May Revision Update
- Center for Data Insights and Innovation
- Administrative Resources for Prescription Drug Proposals

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

1) Please describe the changes in the Electronic Visit Verification Phase 2 Planning request.
2) Please describe how the proposed Center for Data Insights and Innovation maintains the activities of the Offices and other entities it would absorb, particularly health information integrity, privacy protection, and complaint data reporting.
3) Please briefly describe the current status of the Administration's plan to create a state generic drug label. How do the requested resources further that plan? What is the Administration's expected timeline for implementation of the generic drug label?

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: May Revision Updates

May Revision Presentation. The subcommittee requests the Emergency Medical Services Authority (EMSA) to present the significant proposals included in its 2020-21 budget, as reflected in the Governor's May Revision. In particular, the presentation should highlight the following items:

- Regional Disaster Medical Health Response (RDMHS) Local Assistance
- Enhanced disaster planning related to COVID-19 pandemic

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

1) Please describe the rationale and distribution of RDMHS staff within the modified local assistance request.
2) What activities has EMSA undertaken that in response to the pandemic that would be reimbursed by the Federal Emergency Management Agency?

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: May Revision Updates

May Revision Presentation. The subcommittee requests the Office of Statewide Planning and Development to present the significant proposals included in its 2020-21 budget, as reflected in the Governor's May Revision. In particular, the presentation should highlight the following items:

- Elimination of Song-Brown Healthcare Workforce Training Program
- WET Program Funding Shifts
- Healthcare Payments Database Program Implementation
- Loan from Hospital Building Fund (0121) to General Fund

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

1) Please describe the criteria used to determine the funds proposed to be shifted out of workforce programs? In particular, why were the reductions disproportionately for primary care workforce programs compared to mental health workforce programs? Will any existing programs be negatively affected?
2) Please describe the Office's progress in reaching consensus with stakeholders on the Healthcare Payments Database Program Implementation.
3) What are the terms for how the Administration intends to repay the loan from the Hospital Building Fund? How will the Administration respond if the program is in need of the funds?

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: May Revision Updates

May Revision Presentation. The subcommittee requests the Department of Managed Health Care (DMHC) to present the significant proposals included in its 2020-21 budget, as reflected in the Governor's May Revision. In particular, the presentation should highlight the following items:

- Behavioral Health Focused Investigations
- Loan from Managed Care Fund (0933) to General Fund

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

1) Please provide additional detail on the proposed methodologies to identify enrollee experiences with regard to access to behavioral health services and barriers to care.
2) What are the terms for how the Administration intends to repay the loan from the Managed Care Fund? How will the Administration respond if the program is in need of the funds?
3) How is the department monitoring the adequacy of health plan provider networks during the pandemic? What are the plans' responsibilities to ensure their provider networks do not deteriorate during this extended period of reduced utilization? How is the department ensuring plans fulfill their responsibilities to provide access to care and an adequate provider network? Will health plans be sanctioned or be subject to any other enforcement action if they allow their provider networks to deteriorate?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: May Revision Updates

May Revision Presentation. The subcommittee requests the Department of Health Care Services (DHCS) to present the significant proposals included in its 2020-21 budget, as reflected in the Governor's May Revision. In particular, the presentation should highlight the following items:

- May 2020 Medi-Cal Local Assistance Estimate – Significant Adjustments
- May 2020 Family Health Estimate – Significant Adjustments
- COVID-19 Estimate Impacts
- Program Reductions and Other Solutions:
  - Elimination of Optional Medi-Cal Benefits
  - Elimination of Proposition 56 Supplemental Payments
  - Elimination of Proposition 56 Loan Repayment Program
  - Restoration of the "Senior Penalty" for Aged and Disabled Program
  - Restoration of Estate Recovery provisions
  - Elimination of Senior Programs (MSSP, CBAS, Caregiver Resource Centers)
  - Elimination of FQHC PPS Carve-Outs
  - Reversion of Previously Approved Programs (Enrollment Navigators, Medical Interpreters, Behavioral Health Counselors in Emergency Depts.)
- CalAIM Delay and 1115 Waiver Extension
- Managed Care Efficiencies and Capitation Payment Adjustments
- Medi-Cal Rx (Pharmacy Carve-Out) and 340B Supplemental Payment Pool
- Restoration of Dental Fee-for-Service in Sacramento and Los Angeles Counties
- Nursing Facility Financing Reform (AB 1629 Reauthorization)
- Medi-Cal Enterprise System (MES) Reorientation and Consolidation of Projects
- State Only Claiming Adjustment

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

1) Please briefly describe the caseload and overall expenditure changes in the Medi-Cal Estimate.
2) Please briefly describe the caseload and overall expenditure changes in the Family Health Estimate.
3) Please provide an overview of the COVID-19 impacts on the Medi-Cal Estimate reflected at May Revision. In particular, please discuss the department's assumptions for increases in Medi-Cal caseload, the level of new federal fund support, and the current status of approved federal flexibilities. Please respond to the caseload revision suggested by the Legislative Analyst's Office.
4) Has DHCS considered continuing the flexibilities for eligibility and telehealth that were adopted during the pandemic?
5) Please provide information on what efforts DHCS and Medi-Cal managed care plans are undertaking or will undertake to preserve networks and adequate access to providers? What are plans' responsibilities to ensure their provider networks do not deteriorate during the pandemic? What is DHCS doing to ensure plans are fulfilling their responsibilities to maintain adequate provider networks?

6) With all the proposed reimbursement reductions to community clinics and hospitals, as well as the reduced level of utilization and revenue to providers, does DHCS have any concerns about the fiscal stability of these providers and impacts to access to care for Medi-Cal beneficiaries?
7) Please explain the rationale for eliminating home- and community-based programs and other programs that support seniors and persons with disabilities to remain safely in the community, particularly MSSP, CBAS and Caregiver Resource Centers. Given the challenges in preventing COVID-19 outbreaks in congregate care settings, does the department have a strategy for avoiding unnecessary admissions to skilled nursing facilities?
8) Please describe the current status of CalAIM and the department's request for an extension of the existing 1115 Waiver, including whether the department is seeking the same annual level of federal funding for the extension as it received in the five year Waiver period.
9) Please provide additional details regarding the proposed risk corridor associated with the changes to managed care capitation rate development.
10) Please describe the rationale for proceeding with the Medi-Cal Rx pharmacy carve out from managed care while withdrawing the supplemental funding for non-hospital 340B entities that will suffer a revenue loss as a result of the carve out.
11) What is the status of stakeholder consensus on the proposed Nursing Home Financing Reform (Quality Assurance Fee extension) proposal?
12) Please describe the rationale for proceeding with the elimination of dental managed care during a period of significant challenges in the delivery of dental care due to the pandemic. How can the department ensure no disruption in access to dental care during a transition implemented during the pandemic?
13) Please provide information on the reorientation and consolidation of IT projects under the Medi-Cal Enterprise System. What is the rationale for this change in focus and how would it improve the program? Are any projects being delayed, eliminated, or modified?
14) Please describe the details of the technical adjustment related to federal claiming. Given the apparent frequency of significant accounting or other forecasting errors related to Medi-Cal in recent years, what is the department's strategy for correcting the systemic failures that led to these significant adjustments?

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: May Revision Updates

May Revision Presentation. The subcommittee requests the Department of Public Health (DPH) to present the significant proposals included in its 2020-21 budget, as reflected in the Governor's May Revision. In particular, the presentation should highlight the following items:

- May 2020 ADAP Estimate
- May 2020 WIC Estimate
- May 2020 GDSP Estimate
- May 2020 CHCQ Estimate
- Black Infant Health Program Adjustment
- Reversion of Prior Year Savings
- Protecting Children from the Damaging Effects of Lead Exposure
- Center for Laboratory Sciences – Protecting California from Infectious Diseases

- Special Fund Loans to the General Fund
  - ADAP Rebate Fund - $100 million
  - Health Statistics Special fund - $3 million
  - Genetic Disease Screening Fund - $3 million
  - Infant Botulism Treatment and Prevention - $3 million

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

1) Please briefly describe the caseload and overall expenditure changes in the ADAP Estimate.
2) Please briefly describe the caseload and overall expenditure changes in the WIC Estimate.
3) Please briefly describe the caseload and overall expenditure changes in the GDSP Estimate.
4) Please briefly describe the caseload and overall expenditure changes in the CHCQ Estimate.
5) What are the fiscal and programmatic impacts of the reversion of prior year savings from previously approved programs, including the sickle cell disease program, the farmworker health study, and the mental health disparities funding?
6) Please describe the rationale and the newly funded activities for the renewed effort to protect children from lead exposure.
7) How will the augmentation for the Center for Laboratory Sciences improve the state's testing capacity?
8) What are the terms for how the Administration intends to repay the loan from the ADAP Rebate Fund? How will the Administration respond if the program is in need of the funds? Will client access to medication or other supports be impacted?
9) How is the department monitoring quality and compliance in skilled nursing facilities during the pandemic? Have there been any concerns about quality or any changes to the receipt of complaints? How is the department monitoring facility efforts regarding communicable disease control? What are facilities' responsibilities during the pandemic and how is the department ensuring facilities are fulfilling those responsibilities and protecting residents from infection or other deteriorations in the quality of care?

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: May Revision Updates

May Revision Presentation. The subcommittee requests the Department of State Hospitals to present the significant proposals included in its 2020-21 budget, as reflected in the Governor's May Revision. In particular, the presentation should highlight the following items:

- May 2020 DSH Estimate – Program Updates
- Statewide Ligature Risk Special Repair Funding
- Statewide Roof Repairs and Replacement
- Statewide Integrated Health Care Provider Network
- Mission Based Review – Treatment Teams
- Mission Based Review – Direct Care Nursing

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

1) Please briefly describe the caseload and overall expenditure changes in the DSH Estimate, including significant program updates.
2) Please describe the timeline for the roof repair projects, in particular the cost and timing for planning and other preparations, as well as the cost of construction and expected start and completion dates. What is the department's plan for addressing the other four roofs that were removed from this proposal at May Revision?
3) Please describe the changes to the Treatment Teams and Direct Care Nursing proposals at May Revision.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: May Revision Updates

May Revision Presentation. The subcommittee requests the Mental Health Services Oversight and Accountability Commission (MHSOAC) to present the significant proposals included in its 2020-21 budget, as reflected in the Governor's May Revision. In particular, the presentation should highlight the following items:

- Contract and Information Technology Workload
- Prevention and Early Intervention Statewide Prioritization and Oversight
- Authority and Flexibility for Contract Renegotiation to Reflect COVID-19

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

1) In light of the COVID-19 pandemic, what challenges does the Commission expect counties to face in using their Mental Health Services Act (Proposition 63) funds? How does the Commission expect the delivery of mental health services to change under current conditions?
2) How has the pandemic affected the Commission's ability to fund grant programs?

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE – COVERED CALIFORNIA

Issue 1: May Revision Updates

May Revision Presentation. The subcommittee requests Covered California to present the significant proposals included in its 2020-21 budget, as reflected in the Governor's May Revision. In particular, the presentation should highlight the following items:

- State Premium Subsidy Program – General Fund Reductions
- Clinical Volunteering for Board and Staff Trailer Bill Proposal
- Bronze Plan Actuarial Value Trailer Bill Proposal

Questions. The subcommittee has requested Covered California respond to the following:

1) Please provide an update and characterization of enrollment in the Exchange during the original open enrollment period and the special enrollment period.
2) Please provide an overview of the impact of the current year subsidies and the proposed distribution of state subsidies for the next year.
3) Please explain how the estimated take-up and distribution of state subsidies differed from actuals.
4) Is the level of funding remaining in the state premium subsidy program sufficient to maintain the current program design?
5) How does Covered California expect premiums to change as a consequence of the pandemic in the next open enrollment period?
6) Please describe the need for the trailer bill changes to the Bronze Plan actuarial value requirements requested at May Revision.

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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Melissa Hurtado
Senator Melissa Melendez

Sunday, May 24, 2020

2:00 PM

State Capitol - Room 4203

Part B – Human Services

Consultant: Renita Polk

OUTCOMES

Proposal	Outcome
$2 million reduction in the Long-Term Care Ombudsman program	Hold open.
$23.9 million ($22.2 million General Fund) reduction for the elimination of the Multipurpose Senior Services Program (MSSP)	Hold open.
$3 million ($1.6 million General Fund) reduction for the elimination of the Community Based Adult Services (CBAS) Program	Hold open.
One-time reduction of $8.5 million GF for the department's nutrition programs	Staff Recommendation: Reject May Revision and approve $8.5 million GF for senior nutrition programs. Approve staff recommendation, 3-0.
One-time reduction of $3 million for Aging and Disability Resource Centers	Staff Recommendation: Reject May Revision and approve $3 million GF for Aging and Disability Resource Centers Approve staff recommendation, 3-0.

Vote Only: Sustained and Withdrawn January Governor's Budget Proposals

Issue	BU	Department	BR Title	General Fund BY	Other Funds BY	Positions BY	Staff Comments	Outcome
1	0530	HHS	Electronic Visit Verification for In-Home Supportive Services (Phase I)	--	20,684,000	--	The May Revision sustains the Administration's January proposal for $20.7 million.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
2	4170	CDA	Electronic Visit Verification Penalty Backfill	31,000	--	--	The May Revision withdraws the Administration's January proposal for $31,000.	Hold open
3	4300	DDS	Southern California Headquarters Office	1,600,000	400,000	--	The May Revision sustains the Administration's January proposal for $2 million ($1.6 million General Fund).	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.

4	4300	DDS	Community State Staff Program - Reimbursement	--	9,700,000	--	The May Revision sustains the Administration's January proposal for $9.7 million.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.
5	4300	DDS	Developmental Centers - Regional Resources Developmental Program for Southern California	1,078,000	--	8.0	The May Revision sustains the Administration's January proposal for $1 million.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
6	4300	DDS	Developmental Centers - Fairview Warm Shutdown	11,954,000	--	54.0	The May Revision sustains the Administration's January proposal for $11.9 million General Fund.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.
7	4300	DDS	Regional Centers - Electronic Visit Verification Phase II Penalties	5,089,000	--	--	The May Revision sustains the Administration's January proposal for $5 million General Fund to pay EVV Phase II penalties	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.

8	4300	DDS	Developmental Centers - Community State Staff Program Lump Sum	1,495,000	--	--	The May Revision sustains the Administration January proposal for $1.5 million General.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.
9	4300	DDS	Developmental Center Retention Stipend Carryover	15,689,000	--	--	This issue is not a request for new funding. It reflects already appropriated funds from the 2016 Budget Act to retain development center employees at closing developmental centers. These stipend funds are still being paid out. The 2016 Budget Act had provisional language stating the funds are available until June 30, 2021 and available for liquidation until December 31, 2021.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.
10	4300	DDS	Information Security Office	234,000	59,000	2	The May Revision sustains the Administration's January proposal for $293,000 ($234,000 General Fund).	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.

11	4300	DDS	Uniform Fiscal System (UFS) Modernization Withdrawal	-1,344,000	-67,000	-2.0	The May Revision withdraws the Administration's January proposal for $1.4 million ($1.3 million General Fund) to plan for the replacement of the UFS.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 3-0.
12	4300	DDS	Cooperative Electronic Document Management System Withdrawal	-531,000	-183,000	-4.6	The May Revision withdraws the Administration's January proposal for $714,000 ($531,000 General Fund) for a cooperative electronic document management system.	Staff Recommendation: Adopt the May Revision proposal. Approve staff recommendation, 3-0.
13	4300	DDS	Information Technology and Data Planning Withdrawal	-1,927,000	-272,000	-7.0	The May Revision withdraws the Administration's January proposal for $2.2 million ($1.9 million General Fund) for IT data planning.	Staff Recommendation: Adopt the May Revision proposal. Approve staff recommendation, 3-0.
14	4300	DDS	Withdraw Additional Supplemental Provider Rate Adjustments	-10,778,000	-7,185,000	--	The May Revision withdraws the January proposal for $18 million ($10.8 million General Fund)	Hold open.

15	4300	DDS	Enhanced Caseload Ratios for Young Children Withdrawn	-11,808,000	-5,557,000	--	The May Revision withdraws the Administration's January proposal for $17.4 million ($11.8 million General Fund) for enhanced caseload ratios for children aged three to five.	Staff Recommendation: Adopt the May Revision proposal. Approve staff recommendation, 3-0.
16	4300	DDS	Enhanced Performance Incentive Program Withdrawn	-60,000,000	-18,000,000	--	The May Revision withdraws the Administration's January proposal for $78 million ($60 million General Fund) for a regional center performance incentive program.	Staff Recommendation: Adopt the May Revision proposal. Approve staff recommendation, 3-0.
17	4300	DDS	Systemic, Therapeutic, Assessment, Resources, and Treatment Training Withdrawn	-2,555,000	-1,985,000	--	The May Revision withdraws the Administration's January proposal for $4.5 million ($2.6 million General Fund) for START training. The committee may want to consider delaying implementation of the program for two years instead of withdrawing the proposal	Hold open.
18	4700	CSD	Reimbursements for California Earned Income Tax Credit Program and VITA	--	10,000,000	--	The May Revision withdraws the Administration's January proposal for $10 million in reimbursement authority.	Staff Recommendation: Adopt the May Revision proposal. Approve staff recommendation, 3-0.

19	5160	DOR	Extension of Reimbursement Authority for the Deaf and Disabled Telecommunications Program	--	2,000,000	2.7	The May Revision sustains the Administration's January proposal for $2 million and 2.7 positions.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
20	5160	DOR	Systems and Privacy Protections	670,000	0	4.0	The May Revision sustains the Administration's January proposal for $670,000 for systems and privacy protections.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
21	5165	DYCR	Transition of the Division of Juvenile Justice	-25,352,000	--	-112.0	The May Revision withdraws the Administration's January proposal to transition the DJJ to a standalone department within the California Health and Human Services Agency.	Staff Recommendation: Adopt the May Revision proposal. Approve staff recommendation, 3-0.
22	5165	DYCR	Transition of the Division of Juvenile Justice	-250,775,000	-5,408,000	-1,250.9		
23	5165	DYCR	Transition of the Division of Juvenile Justice	-8,115,000	--	-53.0		
24	5170	State ILC	Reversal of 2018 Removal of CFS Funding	--	116,000	--	The May Revision sustains the Administration's January proposal for $116,000.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.

25	5175	DCSS	Automation Changes for Child Support Disregards	-300,000	-500,000	--	The Governor's January budget proposed to increase the amount of monthly child support a CalWORKs family could retain from $50 to $100 for a family with one child and to $200 for a family with two or more children effective January 1, 2021. As a result of withdrawing this proposal, CalWORKs families will continue to retain only $50 of monthly child support payments. The May Revision withdraws the Administration's January proposal for $800,00 ($300,000 General Fund) for automation changes relating to child support payments.	Hold open.
26	5175	DCSS	Local Assistance Estimate	1,052,000	705,000	--	The May Revision sustains the Administration's January proposal for $1.7 million ($1 million General Fund) for local assistance.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
27	5180	DSS	Immigration Services Operation Support	551,000	--	3.0	The May Revision sustains the Administration's January proposal for $551,000 General Fund and three positions for immigration services and support.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.

28	5180	DSS	Protecting Data and Systems	1,043,000	--	6.0	The May Revision sustains the Administration's January proposal for $1 million to protect data and systems.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
29	5180	DSS	Caregiver Background Check Bureau: Criminal Record Exemption Case Processing	733,000	165,000	7.0	The May Revision sustains the Administration's January proposal for $898,000 ($733,000 General Fund)	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.
30	5180	DSS	Community Care Licensing: Quality Oversight Staffing Resources	342,000	158,000	3.0	The May Revision sustains the Administration's January proposal for $500,000 ($342,000 General Fund).	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.
31	5180	DSS	Housing and Homelessness Operations Support	1,280,000	--	8.0	The May Revision sustains the Administration's January proposal for $1.3 million General Fund.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.

32	5180	DSS	Information Technology Systems Improvements and Federal Compliance	673,000	--	4.0	The May Revision sustains the Administration's January proposal for $673,000 General Fund.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
33	5180	DSS	Increased State Hearings Workload	630,000	1,070,000	8.0	The May Revision sustains the Administration's January proposal for $1.7 million ($630,000 General Fund).	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
34	5180	DSS	Expansion of Housing Providers (AB 960)	196,000	337,000	--	The May Revision sustains the January proposal for $533,000 ($196,000 General Fund) to implement AB 960.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.
35	5180	DSS	CalWORKs Income Exemptions (AB 807)	--	500,000	--	The May Revision sustains the January proposal for $500,000 to implement AB 807.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.

36	5180	DSS	Civil Rights Unit Support	196,000	234,000	3.0	The May Revision sustains the January proposal for $430,000 ($196,000 General Fund) and three positions.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.
37	5180	DSS	California Newcomer Education and Well-Being Project	15,000,000	--	--	The May Revision sustains the Administration's proposal for trailer bill language and $15 million for the CalNEW project.	Staff Recommendation: Approve and adopt placeholder trailer bill language. Approve staff recommendation, 2-1.
38	5180	DSS	In-Home Supportive Services: Mandatory Training for County Social Workers and Managers	1,858,000	1,829,000	--	The May Revision sustains the Administration's proposal for $3.7 million ($1.6 million General Fund) for IHSS mandatory training.	Staff Recommendation: Approve as budgeted and adopt placeholder trailer bill language. Approve staff recommendation, 3-0.

39	5180	DSS	CalFresh Application Assistance	5,000,000	--	--	The May Revision sustains the January proposal for $5 million for CalFresh application assistance.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.
40	5180	DSS	Commercially Sexually Exploited Children 2018 Budget Act Reappropriation (Pending 2020 Budget Act)	8,424,000	--	--	The May Revision sustains the January proposal for $8.4 million General Fund.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
41	5180	DSS	AB 85 FY 2017-18 County Repayment	-325,662,000	--	--		Staff Recommendation: Approve as budgeted. Approve staff recommendation, 3-0.
42	5180	DSS	Subsidized Childcare Provider Collective Bargaining Activities (AB 378)	290,000	20,000	2.0	The May Revision sustains the January proposal for $310,000 ($290,000 General Fund) to implement AB 378.	Staff Recommendation: Approve as budgeted. Approve staff recommendation, 2-1.

43	5180	DSS	Restaurant Meal Program (AB 942 and AB 612)	-413,000	-413,000	-6.0	The May Revision withdraws the January proposal for $826,000 ($413,000 General Fund) to implement the Restaurant Meal Program.	Staff Recommendation: Reject the May Revision and approve the funding. Approve staff recommendation, 2-1.
44	5180	DSS	Establish the CA Access to Housing and Services Fund	-750,000,000	5,577,000	--	The May Revision withdraws the January proposal to establish the Access to Housing and Services Fund.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 3-0.
45	5180	DSS	Establish the CA Access to Housing and Services Fund	--	-5,577,000	-10.0		
46	5180	DSS	In-Home Supportive Services: Medi-Cal Expansion for Undocumented Immigrants Age 65 and Older	-6,812,000	--	--	The May Revision withdraws the January proposal to expand Medi-Cal for undocumented immigrants age 65 and older.	Hold open.
47	5180	DSS	EBT Fraud and Theft Prevention	-201,000	-364,000	-4.0	The May Revision withdraws the Administration's January proposal for $565,000 ($201,000 General Fund) for resources to detect EBT fraud.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 2-1.

48	5180	DSS	Continued Oversight of Psychotropic Medication in Foster Care	-622,000	-287,000	--	The May Revision withdraws the Administration's January proposal for $909,000 ($622,000 General Fund) for continued oversight of psychotropic medication in foster care.	Staff Recommendation: Reject the May Revision and approve $909,000 for continued oversight of psychotropic medication in foster care. Approve staff recommendation, 3-0.
49	5180	DSS	Foster Care Audits and Rates Branch: Eligibility Program Development and Monitoring	-319,000	-369,000	--	The May Revision withdraws the Administration’s January proposal for $688,000 ($369,000 General Fund) for eligibility program development and monitoring.	Staff Recommendation: Adopt the May Revision proposal. Approve staff recommendation, 3-0.
50	5180	DSS	Office of Tribal Affairs: Increased Workload and Training Contract Resources	-136,000	-85,000	--	The May Revision withdraws the Administration’s January proposal for $221,000 ($136,000 General Fund) for increased resources within the Office of Tribal Affairs.	Staff Recommendation: Adopt the May Revision proposal. Approve staff recommendation, 3-0.

51	5180	DSS	Federal Title IV-E Well-Being Project Evaluation Contract	-600,000	--	--	The May Revision withdraws the proposal for $600,000 General Fund for the evaluation of the federal Title IV-E Well-Being contract.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 3-0.
52	5180	DSS	Child Welfare Workforce Development	-5,903,000	-4,145,000	--	The May Revision withdraws the Administration's proposal for $10 million ($5.9 million General Fund) for child welfare workforce development.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 3-0.
53	5180	DSS	Child Support Disregard	-600,000	--	--	The Governor's January budget proposed to increase the amount of monthly child support a CalWORKs family could retain from $50 to $100 for a family with one child and to $200 for a family with two or more children effective January 1, 2021. As a result of withdrawing this proposal, CalWORKs families will continue to retain only $50 of monthly child support payments. The May Revision withdraws the Administration's proposal for $600,000 associated with child support payments.	Hold open.

54	5180	DSS	Foster Youth Bill of Rights (AB 175)	-100,000	-46,000	--	The May Revision withdraws the Administration's proposal for $146,000 ($100,000 General Fund) to implement AB 175.	Staff Recommendation: Reject May Revision and approve $146,000 ($100,000 General Fund) toimplement AB 175. Approve staff recommendation, 2-1.
55	5180	DSS	Documents for Dependent Children (AB 718)	-80,000	-34,000	--	The May Revision withdraws the Administration's proposal for $114,000 ($80,000 General Fund) to implement AB 718.	Staff Recommendation: Reject May Revision and approve $114,000 ($80,000 General Fund) to implement AB 718. Approve staff recommendation, 2-1.

56	5180	DSS	Resource Family Caregiver Training: Commercially Sexually Exploited Children (AB 865)	-39,000	-31,000	--	The May Revision withdraws the Administration's January proposal for $70,000 ($39,000 General Fund) to implement AB 865.	Staff Recommendation: Reject May Revision and approve $70,000 ($39,000 General Fund) to implement AB 865. Approve staff recommendation, 3-0.

Vote Only: Modifications to January Governor's Budget Proposals

Item	BU	Department	BR Title	General Fund BY	Other Funds BY	Positions BY	Staff Comments	Outcome
57	4170	CDA	Headquarters Relocation Funding	743,000	--	--	The January Governor's Budget included a proposal for $2.3 million for headquarters relocation for CDA. The May Revision increases the original proposal by $743,000. The increased costs are attributable to revised one-time tenant improvement costs.	Hold open.

58	4300	DDS	Relocation to Allenby Building Update	-860,000	--	--	The January Governor's Budget included a joint proposal with HHS, DDS, and the Department of State Hospitals for $8.2 million General Fund. The May Revision reduces the original proposal by $860,000. The department's relocation will be evaluated to make government more efficient through workforce telework opportunities.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 3-0.
59	5180	DSS	Increased State Hearings Workload	950,000	1,600,000	10.0	The January Governor's Budget included a proposal for $1.7 million ($630,000 GF) for increased state hearings workload. The May Revision increases the original proposal by $2.55 million to support 10 positions in fiscal year 2020-21 and 20 positions ongoing necessary to address increased workload and reduce federal penalties associated with the state hearings backlog.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 3-0.
60	5180	DSS	Food Banks	30,000,000	--	--	The January Governor's Budget included a proposal for $20 million GF for increased support of food banks. The May Revision requests that Item 5180-151-0001 be increased by $30 million to support food banks response to COVID-19. It is	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.

							also requested that Provision 15 of Item 5180-151-0001 be amended.	
61	5180	DSS	Increasing Support for CalWORKs and CalFresh Program Improvement	-1,302,000	-1,690,000	-20.0	The January Governor's Budget included a proposal for $3 million ($1.3 million GF) for increased support for CalWORKs and CalFresh. The May Revision reduces the original proposal by a total of $3 million and 20 positions consistent with a workload budget.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.

Vote Only: New May Revision Proposals

Issue	BU	Department	BR Title	General Fund BY	Other Funds BY	Positions BY	Staff Comments	Outcome
62	4170	CDA	MIPPA - Technical Adjustment for Expenditure Authority	--	2,214,000	--	The May Revision includes an ongoing augmentation of $2,214,000 in Federal Trust Fund authority ($180,000 in State Operations and $2,034,000 in Local Assistance) as a result of the MIPPA federal grant funding becoming ongoing.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 3-0.

63	4170	CDA	Transfer of Funds from the Department of Public Health to CDA)Adjustment per Item 4265-002-0942, Provision 3, Budget Act of 2019)	--		--	The May Revision includes a request that Item 4170-102-0942 be increased by $1 million to reflect the transfer of funds from the Department of Public Health, pursuant the Budget Act of 2019, which allows fund balance in excess of $6 million to go toward the local long-term care ombudsman program under the CDA.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 3-0.

64	4170	CDA	Loan from HICAP Fund to General Fund	5,000,000	-5,000,000	--	The May Revision requests that Item 4170-011-0289 be added to include loan authority of $5 million to support the General Fund in response to the coronavirus pandemic. It is also requested that the following language be added to Item 4170-101-0289: The Department of Finance may transfer up to $5,000,000 as a loan to the General Fund. The Department of Finance shall order the repayment of all or a portion of the loan if it determines that either of the following circumstances exists: (a) the fund or account from which the loan was made has a need for the moneys, or (b) there is no longer a need for the moneys in the fund or account that received the loan. This loan shall be repaid with interest calculated at the rate earned by the Pooled Money Investment Account at the time of transfer.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.

65	4300	DDS	Self-Determination Program Implementation Funding Alignment	3,130,000	1,315,000	--	The May Revision requests that Item 4300-001-0001 be increased by $279,000, and reimbursements be increased by $93,000. It is also requested that Item 4300-101-0001 be increased by $2,851,000, and reimbursements be increased by $1,222,000. This additional funding is necessary to address administrative costs and workload related to expanding the Self-Determination Program. It is further requested that Provision 3 of Item 4300-001-0001 and Provision 6 of Item 4300-101-0001 be eliminated, as the flexibility is no longer required given the requested augmentation.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
66	4300	DDS	Regional Center May Revision	415,137,000	-11,814,000	--	The May Revision requests that Item 4300-101-0001 be increased by $415,137,000 and reimbursements be decreased by $12,541,000, and Item 4300-101-0890 be increased by $727,000 for adjustments made in regional center caseload, utilization, and operations. The General Fund increase is primarily attributed to an adjustment to the claiming of federal funds for state-only populations.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.

67	4300	DDS	Federal Medical Assistance Percentage Increase	-370,789,000	370,789,000	--	The May Revision requests that Item 4300-101-0001 be decreased by $370.8 million and reimbursements be increased by $370.8 million due to the enhanced Federal Medical Assistance Percentage, which is assumed to be effective until June 30, 2021.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
68	4300	DDS	COVID-19 Impacts	237,507,000	99,222,000	--	The May Revision requests that Item 4300-101-0001 be increased by $254.1 million ($170.8 million GF) be increased by $83.3 million and item 4300-001-0001 be increased by 82.6 million ($66.7 million GF) to reflect impacts of COVID-19 on the developmental services system. These changes reflect increased costs associated with increased utilization in purchase of services specific to residential settings, respite, and personal attendants. These costs also reflect surge development at the developmental centers and in the community.	Staff Recommendation: Adopt the May Revision. Approve staff recommendation, 3-0.

69	4300	DDS	Reversion of Prior Year Funds	--	0	--	The May Revision requests that Item 4300-495 be added to revert funding from Item 4300-101-0001, Budget Act of 2017 and Items 4300-001-001 and 4300-101-0001, Budget Act of 2018 related to purchase of services and state operated facilities.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
70	4700	CSD	Reappropriation and Extension of Liquidation of Greenhouse Gas Reduction Funds for the Low Income Weatherization Program	--	0	--	The May Revision requests that Item 4700-490 be added to reappropriate the unencumbered amount from Item 4700-101-3228, Budget Act of 2017 to Item 4700-101-3228. Of the reappropriated balance, it is requested that $750,000 be transferred to Item 4700-001-3228 to allow the Department of Community Services and Development to meet its contractual and programmatic obligations. It is also requested that Item 4700-491 be added to extend the liquidation period to June 30, 2022 for Item 4700-101-3228, Budget Act of 2016 due to projects delayed as a result of COVID-19	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.

71	5160	Department of Rehabilitation	Increase of Reimbursement Authority for CalFresh	--	1,200,000	--	The May Revision requests that is requested that Item 5160-001-0001 be amended by increasing reimbursements by $1.2 million to continue the CalFresh outreach and application assistance to Supplemental Security Income (SSI) recipients who are newly-eligible for CalFresh benefits as part of the reversal of the SSI cash-out policy.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
72	5160	Department of Rehabilitation	Reductions in Independent Living Centers	-2,120,000	--	--	The May Revision requests that Item 5160-101-0001 be decreased by $2,120,000 to reduce the Independent Living Centers funding as part of the statewide budget reduction efforts in response to the coronavirus pandemic.	Hold open
73	5175	Department of Child Support Services	May Revision Local Assistance Estimate	-1,000,000	-1,410,000	--	The May Revision requests that Item 5175-101-0001 be decreased by $1 million, Item 5175-101-0890 be increased by $10,169,000, and Item 5175-101-8004 be decreased by $11,579,000 to reflect revised forecasts of child support collections.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.

74	5180	DSS	Legal Services Supporting Immigration and Refugee Programs	245,000	--	--	The May Revision requests Item 5180-001-0001 be increased by $245,000 to convert a limited-term position to permanent to provide legal support to the Immigration and Refugee programs.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 2-1.
75	5180	DSS	State Emergency Food Operations Support	639,000	--	4.0	The May Revision requests Item 5180-001-0001 be increased by $639,000 and 4 permanent positions to address workload related to administering state-funded emergency food programs.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 2-1.
76	5180	DSS	IHSS Maintenance-of-Effort and Wage Negotiation Workload	240,000	239,000	3.0	The May Revision requests Item 5180-001-0001 be increased by $240,000 and 3 positions, and reimbursements be increased by $239,000 to convert 3 limited-term positions to permanent to address workload associated with IHSS county maintenance-of-efforts and provider wage negotiations.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.

77	5180	DSS	Community Care Licensing: New Facility Management System for Certification Approval and Licensing	6,821,000	--	--	The May Revision requests that Item 5180-001-0001 be increased by $6,821,000 to procure, configure, and deploy a Platform as a Service solution to support Community Care Licensing programs.	Staff Recommendation: Adopt May Revision Approve staff recommendation, 2-1.
78	5180	DSS	Medi-Cal Eligibility Data System Modernization Reduction	-60,000	-541,000	--	The May Revision requests Item 5180-001-0001 be decreased by $60,000 and reimbursements be decreased by $541,000 to reflect a shift in focus from the Medi-Cal Eligibility Data System modernization project to an enterprise-wide modernization approach.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
79	5180	DSS	CalFresh Able Bodied Adult without Dependents Management Evaluations	0	0	--	The May Revision requests provisional language be added to Item 5180-001-0001 and Item 5180-001-0890 to allow the Department of Social Services to expend up to $1 million to comply with the federal Able Bodied Adult without Dependents rule, contingent on the Department of Finance's approval	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 2-1.

80	5180	DSS	Supplemental Security Income/State Supplemental Payment Estimate	43,735,000	--	--	*See Table 1 The May Revision provides $2.7 billion from the General Fund for SSI/SSP in 2020-21, which is slightly lower than the revised estimates of 2019-20 expenditures—by about 2 percent. However, relative to the Governor's January budget, the May Revision proposes slightly higher SSI/SSP General Fund costs in 2020-21 and 2019-20—by about 1 percent. This is primarily due to May Revision including slightly higher SSI/SSP caseload estimates than the Governor's January budget.	Hold open.
81	5180	DSS	Other Social Services Programs Local Assistance Adjustments	14,375,000	396,015,000	--	*See Table 1	Hold open.
82	5180	DSS	Able-Bodied Without Dependents Final Rule	0	--	--	The May Revision requests provisional language be added to Item 5180-141-0001 to allow the Department of Social Services to expend up to $8 million to comply with the federal Able Bodied Adult without Dependents rule, contingent on the Department of Finance's approval. (	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 2-1.

83	5180	DSS	In-Home Support Services Estimate	131,391,000	106,189,000	--	*See Table 1	Hold open.
84	5180	DSS	CalWORKs Estimate	3,514,401,000	19,308,000		*See Table 1	Hold open.
85	5180	DSS	In-Home Supportive Services: Eliminate Proration of Protective Supervision Hours for Recipients in the Same Residence	15,833,000	20,070,000	--	The May Revision requests that Item 5180-111-0001 be increased by $15,833,000 and reimbursements be increased by $20,070,000 to eliminate prorating protective supervision hours for IHSS recipients who are in the same household.	Hold open.
86	5180	DSS	Sick Leave Expansion for IHSS Providers per H.R. 6201	26,932,000	36,203,000	--	The May Revision requests Item 5180-111-0001 be increased by $26,932,000 and reimbursements be increased by $36,203,000 to expand paid sick leave to IHSS providers per H.R. 6201, establish a provider back-up system for IHSS recipients whose provider is sick, and provide pay differential to back-up providers. The expanded paid sick leave benefit, provider back-up system, and pay differential are effective until January 1, 2021.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 2-0.

87	5180	DSS	Statewide Verification Hub	295,000	479,000	5.0	The May Revision requests Item 5180-001-0001 be increased by $295,000 and 2 positions, and reimbursements be increased by $35,000, and Item 5180-001-0890 be increased by $444,000 and 3 positions to reflect positions and resources, and the redirection of one limited-term position and associated resources from the Office of Systems Integration to the Department of Social Services for the planning and development of the Statewide Verification Hub	Staff Recommendation: Adopt May Revision Approve staff recommendation, 2-1.
88	5180	DSS	In-Home Supportive Services: Conform Residual Program to timing of Medi-Cal Coverage	-72,558,000	72,558,000	--	The May Revision requests Item 5180-111-0001 be decreased by $72,558,000 and reimbursements be increased by $72,558,000 to conform the IHSS Residual Program to timing of Medi-Cal coverage. When Medi-Cal is terminated, clients are moved to the Residual Program, which is 100 percent General Fund. If their Medi-Cal status is restored retroactively to the termination date, the Residual Program is not adjusted to account for this change. This conformity saves General Fund because federal funding will be applied.	Hold open.

89	5180	DSS	Transfer of Federal Temporary Assistance for Needy Families Fund from California Student Aid Commission to CalWORKs	-600,000,000	600,000,000	--	The May Revision requests Item 5180-101-0001 be decreased by $600 million and Item 5180-101-0890 be increased by $600 million to reflect a decrease in the amount of federal TANF block grant funds available to offset General Fund costs in the Cal Grant program.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
90	5180	DSS	CalWORKs County Administration Funding	1,906,000	80,408,000	--	The May Revision requests Item 5180-101-0001 be increased by $1.9 million and Item 5180-101-0890 be increased by $80.4 million to reflect revised CalWORKs county administration funding.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
91	5180	DSS	CalFresh County Administration Funding	74,242,000	104,418,000	--	The May Revision requests Item 5180-141-0001 be increased by $74,242,000 and Item 5180-141-0890 be increased by $104,418,000 to reflect revised CalFresh county administration funding,	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
92	5180	DSS	In-Home Supportive Services: Savings due to Enhanced Federal Medical Assistance Percentage	-825,788,000	825,788,000	--	The May Revision requests that Item 5180-111-0001 be decreased by $825,788,000 and reimbursements be increased by $825,788,000 due to the enhanced Federal Medical Assistance Percentage, which is assumed to be effective until June 30, 2021.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.

93	5180	DSS	County Medical Services Program Board Reserve Redirection	-50,000,000	--	--	The May Revision requests that Item 5180-101-0001 be decreased by $50 million to reflect the County Medical Services Program Board reserve redirection to offset General Fund costs in the CalWORKs program.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
94	5180	DSS	Increased AB 85 Savings	-38,051,000	--	--	The May Revision requests that Item 5180-101-0001 be decreased by $38,051,000 to reflect increased AB 85 savings.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
95	5180	DSS	Transition Child Care Programs from Department of Education to DSS	2,000,000	--	--	The May Revision that Item 5180-001-0001 be increased by $2 million to support resources for the transition of Child Care Programs from the Department of Education to the Department of Social Services.	Staff Recommendation: Defer without prejudice. Approve staff recommendation, 3-0.
96	5180	DSS	1991 Realignment Adjustments	232,970,000	--	--	The May Revision requests Item 5180-101-0001 be increased by $232.9 million to reflect updated 1991 realignment projected revenues	Hold open.

97	5180	DSS	Housing and Disability Advocacy Program Reappropriation	0	0	--	The May Revision requests provisional language to allow the reappropriation of unexpended funds for the Housing and Disability Advocacy Program	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.
98	5180	DSS	Reversion of Funding from Various Programs				The May Revision requests Item 5180-495 be added to revert funding from the 2019 Budget Act for the Family Urgent Response System, Immigration Justice Fellowship Program, Youth Civic Engagement Initiative, and Public Health Nursing Early Intervention Program in Los Angeles County.	Hold open.
99	5180	DSS	Suspension Language	0	0	--	The May Revision requests suspension language associated with Family Urgent Response System, Foster Family Agencies Rate and Public Health Nursing Early Intervention Program in Los Angeles County be eliminated	Hold open
100	5180	DSS	Technical Change related to Child Welfare Services-California Automated Response and Engagement System				The May Revision requests that technical changes be made to Provision 11(a) of Item 5180-151-0001.	Staff Recommendation: Adopt May Revision. Approve staff recommendation, 3-0.