

AGENDA**ASSEMBLY BUDGET SUBCOMMITTEE NO. 1****ON HEALTH AND HUMAN SERVICES****ASSEMBLYMEMBER ELOISE GÓMEZ REYES, ACTING CHAIR****TUESDAY, MAY 14, 2019****9:30 AM, STATE CAPITOL, ROOM 126**

ITEMS TO BE HEARD		
ITEM	DESCRIPTION	
4120	EMERGENCY MEDICAL SERVICES AUTHORITY (EMSA)	3
ISSUE 1	DISASTER MEDICAL SERVICES BUDGET CHANGE PROPOSAL	3
4140	OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT (OSHDP)	7
ISSUE 2	WET FUNDING PROPOSAL	7
4260	DEPARTMENT OF HEALTH CARE SERVICES (DHCS)	14
ISSUE 3	MEDI-CAL ESTIMATE UPDATES (MR ISSUES 401, 409)	14
ISSUE 4	FAMILY HEALTH ESTIMATE UPDATES	18
ISSUE 5	PROPOSITION 56 MEDI-CAL EXPENDITURES UPDATES (MR ISSUES 403)	20
ISSUE 6	MEDI-CAL ELIGIBILITY EXPANSION UPDATES (MR ISSUE 407)	25
ISSUE 7	WHOLE PERSON CARE EXPANSION UPDATE (MR ISSUE 450)	27
ISSUE 8	PEER-RUN MENTAL HEALTH WARM LINE PROPOSAL (MR ISSUE 407)	30
ISSUE 9	PROPOSITION 64 YOUTH SUBSTANCE ABUSE PREVENTION PROPOSAL	32
ISSUE 10	CA-MMIS OVERSIGHT TO OWNERSHIP AND MODERNIZATION PROJECTS BUDGET CHANGE PROPOSAL (MR ISSUE 401)	34
ISSUE 11	SUD EMERGING EPIDEMICS, DISASTER RESPONSE AND LICENSING WORKLOAD BUDGET CHANGE PROPOSAL (MR ISSUE 402)	38
ISSUE 12	MEDI-CAL ELIGIBILITY SYSTEMS STAFFING BUDGET CHANGE PROPOSAL (MR ISSUE 400)	45
ISSUE 13	MANAGED CARE SANCTIONS MR TRAILER BILL	48
8860 7730	DEPARTMENT OF FINANCE FRANCHISE TAX BOARD	50
ISSUE 14	COVERED CALIFORNIA SUBSIDIES AND MANDATE PROPOSAL UPDATES	50
ISSUE 15	FRANCHISE TAX BOARD INDIVIDUAL MANDATE BUDGET CHANGE PROPOSAL	55
4260	DEPARTMENT OF PUBLIC HEALTH (DPH)	57
ISSUE 16	INFECTIOUS DISEASE CONTROL PROPOSAL (MR ISSUE 404)	57

ISSUE 17	HIV CARE PROGRAM FINANCIAL ELIGIBILITY TRAILER BILL	60
ISSUE 18	PROPOSITION 64 YOUTH SUBSTANCE ABUSE PREVENTION PROPOSAL	62
ISSUE 19	EMERGENCY PREPAREDNESS RESPONSE AND RECOVERY BUDGET CHANGE PROPOSAL	64
4440	DEPARTMENT OF STATE HOSPITALS (DSH)	66
ISSUE 20	DSH BUDGET UPDATE (MR ISSUES 089, 090, 091, 092, 093, 094, 095, 096, 098, 100, 103)	66
ISSUE 21	DISASTER PREPAREDNESS, RESPONSE AND RECOVERY BUDGET CHANGE PROPOSAL	71
ISSUE 22	PHASE 1 RELOCATION TO THE CLIFFORD L. ALLENBY BUILDING BUDGET CHANGE PROPOSAL (MR ISSUE 077)	76
ISSUE 23	STATEWIDE: ENHANCED TREATMENT PROGRAM CAPITAL OUTLAY PROPOSAL	79

NON-DISCUSSION ITEMS

ITEM	DESCRIPTION	
4260	DEPARTMENT OF HEALTH CARE SERVICES (DHCS)	
ISSUE 24	MISCELLANEOUS DHCS MAY REVISE ADJUSTMENTS (MR ISSUES 402, 405, 313)	81
4265	DEPARTMENT OF PUBLIC HEALTH	
ISSUE 25	MISCELLANEOUS DPH MAY REVISE ADJUSTMENTS (MR ISSUES 401, 402, 403)	83

ITEMS TO BE HEARD

4120 EMERGENCY MEDICAL SERVICES AUTHORITY (EMSA)**ISSUE 1: DISASTER MEDICAL SERVICES BUDGET CHANGE PROPOSAL****PANELISTS**

- **Emergency Medical Services Authority**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

The Emergency Medical Services (EMS) Authority requests 2 positions and \$979,000 General Fund in 2019-20 and \$303,000 General Fund in 2020-21 and annually thereafter for increased disaster medical services, including coordination of mobile medical assets and medical volunteers during emergency response efforts. The resources include one-time funding of \$723,000 General Fund in 2019-20 for the purchase or replacement of additional equipment in preparation for disaster response and \$54,000 General Fund ongoing for equipment maintenance or replacement.

BACKGROUND

The EMS Authority, as the lead agency responsible for coordinating California's medical response to disasters, provides medical resources to local governments in support of their disaster response. This may include the identification, acquisition and deployment of medical supplies and personnel from unaffected regions of the state to meet the needs of disaster victims. Response activities may also include arranging for evacuation of injured victims to hospitals in areas/regions not impacted by a disaster. The medical response to disasters requires the contributions of many agencies. The EMS Authority works closely with the California Governor's Office of Emergency Services (Cal OES), California National Guard (CNG), California Department of Public Health (CDPH) and other local, state, and federal agencies to improve disaster preparedness and response. The EMS Authority also works closely with the private sector: hospitals, ambulance companies, and medical supply vendors.

Responsibilities for disaster medical services preparedness and response include the following:

- Development and maintenance of disaster medical response plans, policies and procedures, such as the Public Health and Medical Emergency Operations Manual (EOM);
- Provision of guidance and technical assistance to local EMS agencies, county health departments, and hospitals for the development of local disaster medical plans, policies and procedures;
- Enhancement of State and local disaster medical response capabilities through the development of civilian disaster medical response teams, known as California Medical Assistance Teams (CAL-MATs). response management teams, disaster medical communications systems, and a statewide medical mutual aid system;
- Testing disaster medical response plans through periodic exercises with local, state, and federal agencies and the private sector; and Management of California's medical response to a disaster.

The EMS Authority's multi-tiered Mobile Medical Assets Program was built for a flexible response. The multi-tiered program is comprised of Ambulance Strike Teams that represent the first tier and respond within two hours, the Cal-MAT Teams that represent the second tier and were developed to respond within 12 hours, deployment of medical shelters which represents the third tier, and coordination of the state's medical response to major disasters.

Ambulance Strike Teams represent the first tier of the EMS Authority's Mobile Medical Assets Program and are organized groups of five ambulances, one support vehicle to support field deployment medical supplies and provisions for Ambulance Strike Team personnel, and one Ambulance Strike Team leader to provide rapid response in meeting emergency medical transport needs in large-scale emergencies or disasters. There are 41 pre-designated teams throughout California with Disaster Medical Support Units provided by the EMS Authority. Ambulance Strike Teams have been used in every major response in recent years to evacuate healthcare facilities; they can respond within 2 hours of request.

Cal-MAT Teams represent the second tier of the EMS Authority's Mobile Medical Assets Program. These teams are activated by the EMS Authority to provide medical care during disasters. There are currently three teams comprised of members from around the state that are rapidly deployable and ready to treat patients within hours at field treatment sites, shelters, existing medical facilities, and alternate care sites. Cal-MAT Teams are sized to

meet the requirements of the medical mission, from 5 members to 50 members. Teams are self-sufficient for 72 hours and include physicians, nurses, pharmacists, and logistical and support staff. The EMS Authority deployed teams to Shasta and Butte counties in the past year with the initial medical teams arriving at the base of operations within 12 hours of notification of activation. The EMS Authority maintains oversight of warehouse operations and cache management including vehicles, equipment and supplies, and coordinates team formation and response. In addition, the EMS Authority staff coordinates, integrates, and may provide resources for other medical volunteers and for other teams such as Medical Reserve Corps, California National Guard, and local jurisdiction volunteers.

Mobile Medical Shelters have been reconfigured from one of the two-hundred bed Mobile Field Hospitals (MFH) into six multi-use thirty to forty bed modules. The modules include the shelters, infrastructure equipment, and durable equipment, but do not include biomedical equipment and medical supplies. The Mobile Medical Shelter Modules allow EMS Authority to rapidly deploy this resource in response to local emergencies and disasters. Potential uses include field sites for local/regional incidents, triage/treatment during flu season surge, medical clinic, medical shelter, emergency operations center, staff quarters, disaster exercise, and any other use that requires a medical field facility. Most of these shelters are currently under control of California National Guard and local jurisdictions who have little experience in deployment of the assets.

Emergency Operations Center Coordination is a role the EMS Authority fulfills in cooperation with Cal OES and in partnership with CDPH and in accordance with the State Emergency Plan. The EMS Authority coordinates the state's medical response to major disasters. This includes development of policies and procedures for the joint CDPH/EMS Authority Medical/Health Coordination Center for Emergency Function #8, the Public Health and Medical Function of the State Emergency Plan. The Disaster Medical Services Division personnel staff the Duty Officer Program for the EMS Authority, conduct medical mission planning, provide Emergency Operations Center coordination, and manage the response

Most recently, the EMS Authority deployed or coordinated the response of these mobile medical assets to assist Butte County Public Health during the Camp Fire. Working with response partners from California Conversation Corps (CCC), CA Air National Guard (GANG), CA Army National Guard and CA Military Reserve the EMS Authority set up 37 mobile medical shelters in eight locations, including Base Camp, to treat patients who were housed in shelters. Six Ambulance Strike Teams were requested from adjoining counties and mutual aid regions and were successful in relocating all in-patients to appropriate health care facilities. The EMS Authority rostered and deployed 135 CAL-MAT members throughout the mission. The medical teams from CAL-MAT, California

National Guard, and disaster healthcare volunteers had more than 2,400 patient encounters.

During this mission, the EMS Authority identified several gaps in response capabilities. The deployment of medical treatment sites and shelters were delayed due to a lack of EMS Authority staff to provide technical oversight and training to support entities including the CCC and California National Guard. The set-up of the shelters at multiple sites took approximately seven days to complete when it could have been done in a couple of days had the EMS Authority had the proper personnel and equipment available. Mobile medical shelter configurations were not updated to meet the response needs for smaller and more mobile configurations. Medical caches were configured for general medical care and fell short in addressing the needs of a large shelter community. Also, information concerning medical needs, medical shelter status and assessments, treatment, patient tracking, and health records was unavailable rapidly.

During the 2018 CARR fire, the EMS Authority deployed 34 CAL-MAT members to provide medical support to nearly 700 citizens displaced in general population shelters. The EMS Authority established a base of operations in Redding and formed CAL-MAT members into task force teams to support medical needs at multiple site locations. The EMS Authority supported the response with medical equipment caches, pharmaceuticals, IT and communications equipment and also assisted with the coordination of multiple Ambulance Strike Teams to evacuate patients from impacted medical facilities.

During the 2017 Napa Fires, the EMS Authority assisted the Sonoma Developmental Center Dixon Fairgrounds sheltering operations by providing 12 Mobile Medical Shelter structures, durable medical equipment, and Communications Platform (C3, VSAT and handheld radios). In addition to medical transportation resources mobilized at the local level, there were 92 ambulances used, which included 14 Ambulance Strike Teams and 22 individual ambulances from four Cal OES Mutual Aid Regions (Regions 2, 3, 4 and 5). In addition, approximately 60 paratransit vehicles, buses, vans, and trucks were acquired through the mutual aid system to move patients and their accompanying equipment.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional consideration of this proposal.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT (OSHPD)**ISSUE 2: WET FUNDING PROPOSAL****PANELISTS**

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- *Public Comment*

PROPOSAL

The Office of Statewide Health Planning and Development (OSHPD) requests multi-year appropriation authority of \$100 million from the Mental Health Services Fund (MHSF) beginning in Fiscal Year (FY) 2019-20 to support the 2020-2025 Workforce Education and Training (WET) Five-Year Plan. OSHPD also requests provisional language to transfer expenditure authority to state operations to administer the 2020-2025 WET Five-Year Plan.

This proposal includes the following proposed provisional language:

4140-101-3085—For local assistance, Office of Statewide Health Planning and Development, payable from the Mental Health Services Fund100,000,000

Schedule:

(1) 3835-Health Care Workforce.....100,000,000

Provisions:

1. Of the funds appropriated in Schedule (1), \$100,000,000 is available to implement the 2020-2025 Workforce Education and Training (WET) Five-Year Plan to address workforce shortages in the state's public mental health system. This amount is available for encumbrance or expenditure until June 30, 2026.
2. The Department of Finance may authorize the transfer of expenditure authority specified in Provision 1 of Item 4140-001-3085 to administer the Workforce Education and Training (WET) Program. Any amounts transferred shall be available for encumbrance or expenditure until June 30, 2026.

BACKGROUND

In November 2004, California voters approved Proposition 63, also known as the Mental Health Services Act (MHSA). The MHSA imposes a one percent tax on personal income greater than \$1 million to support prevention, early intervention, and services in the public mental health system (PMHS). To address the public mental health workforce shortage, MHSA included a component for WET programs and created a ten-year funding allocation to establish the statewide WET programs. California Welfare and Institutions Code Section 5892(a)(1) requires that ten percent of MHSA revenues collected between FY 2004-05 and FY 2007-08 be appropriated for WET purposes. A ten-year budget allocated \$445 million, \$210 million to counties for local WET program implementation and \$234.5 million for state administration of WET programs through FY 2017-18.

The former Department of Mental Health developed the first WET Five-Year Plan, 2008-2013. As of October 2013, \$119,755,910 State and Regional level WET funds had been expended and/or encumbered to support that plan. In July 2012, the legislature transferred the WET program to OSHPD, and mandated OSHPD to develop and implement the second WET Five-Year Plan, 2014-2019. In January 2014, the California Behavioral Health Planning Council (CBHPC) approved \$114,744,090 (the remainder of the \$234.5 million for state administration of WET programs through FY 2017-18) for the second WET Five-Year Plan. The table below shows the budget plan for the 2014-2019 WET Plan.

**Table 1: Mental Health Services Act (MHSA) Workforce Education and Training (WET)
Five-Year Plan Budget**
(approved by the California Behavioral Health Planning Council on January 20, 2016)

Item Number	State Administered WET Program	State WET Funding for 4 Year Budget	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
1	Stipends	\$31,426,699	\$8,207,434	\$6,913,927	\$8,152,669	\$8,152,669
2	Loan Assumption	\$41,500,000	\$10,000,000	\$10,000,000	\$11,500,000	\$10,000,000
3	Education Capacity	\$16,634,556	\$3,750,000	\$3,684,556	\$4,600,000	\$4,600,000
4	Consumer and Family Member	\$12,368,924	\$4,368,924	\$0	\$4,000,000	\$4,000,000
5	Regional Partnership	\$9,000,000	\$3,000,000	\$3,000,000	\$3,000,000	\$0
6	Recruitment (Career Awareness) and Retention	\$4,344,090	\$403,000	\$1,046,428	\$1,447,331	\$1,447,331
7	Evaluation	\$900,000	\$0	\$400,000	\$250,000	\$250,000
Total*		\$116,174,269	\$29,729,358	\$25,044,911	\$32,950,000	\$28,450,000

*The total 2014-2019 WET Five-Year Plan increased from \$114.7 million to \$116.2 million due to unspent funds from the 2008-2013 WET First Five-Year Plan of \$1.4 million.

In coordination with the CBHPC, OSHPD developed the 2020-2025 WET Five-Year Plan. The CBHPC approved this plan in January 2019. The plan provides a framework of strategies that state and local government, community partners, educational institutions, and other stakeholders can pursue to further efforts to remedy the shortage of qualified individuals who provide services in the PMHS. OSHPD is responsible for developing and implementing programs that create, enhance, and grow the PMHS workforce without an established funding source.

A 2018 study by the Healthforce Center at University of California, San Francisco for the California Health Care Foundation showed that the projected demand for behavioral health services outpaces projected supply. If current trends continue, the supply, distribution, and composition of behavioral health professionals will be insufficient to meet demand.

The WET Plan's framework supports a comprehensive system of programs and services, across the state. Additionally, the strategies set forth in the plan support inter-system collaboration to address the mental health needs of multi-system users, and to ultimately achieve positive patient outcomes and reduce costs.

The funding requested would allow OSHPD to implement the 2020-2025 WET Five-Year Plan and address the PMHS workforce shortage. WET programs include pipeline activities to expose youth to the PMHS, as well as scholarships, stipends, and loan repayments to recruit and retain qualified PMHS staff. OSHPD will implement new WET programs to support individuals working within the PMHS in partnership with the MHSR Regional Partnerships, who represent California's 58 counties. Funding allocations will vary year over year based on local needs.

OSHPD will directly administer programs that support systems. These programs include efforts to: increase the psychiatry training of practitioners working outside the PMHS; expand residency programs; support peer personnel within the PMHS; and conduct research and evaluation of the WET programs. The funding requested in this proposal would increase the PMHS workforce in areas with a shortage of qualified mental health personnel to meet the needs of California's diverse population. The 2020-2025 WET Five-Year Plan articulates the following goals:

- Increase the number of competent PMHS professionals and expand capacity of California's current PMHS workforce to address California's diverse and dynamic needs.
- Facilitate a robust statewide, regional, and local infrastructure to develop the PMHS.

- Offer greater access to behavioral health care at a lower level of intensity.
- Support delivery of PMHS services for consumers within an integrated health system that encompasses physical health and substance use services.

WET activities from FY 2014-15 through FY 2016-17 were effective in increasing the number of PMHS professionals, supporting cultural competence, and retaining individuals within the PMHS. In FY 2015-16 and FY 2016-17, the WET program supported about 23,000 participants each fiscal year. Generally, the respective race/ethnicity percentages for underrepresented groups within the WET program surpassed their percentage of California's population. WET program activities supported all regions of the state by operating in 57 of the 58 counties.

Table 2: WET Program Participants

Program Type	WET Program	Participants by Fiscal Year		
		2014-15	2015-16	2016-17
Individuals	MHLAP*	1,085	1,528	1,514
	Stipends	293	325	339
	Peer Personnel	522	933	1,207
	CalSEARCH**	66	30	0
Groups	CFME***	600	4,736	4,510
	Education Capacity	63	106	111
	Mini Grants	0	10,858	7,416
	Retention	0	5,293	7,616
All Programs		2,629	23,809	22,713

*Mental Health Loan Assumption Program

**California's Student and Resident Experiences and Rotations in Community Health

***Consumer and Family Member Employment

Stipend and loan repayment programs were effective in retaining individuals within the PMHS. Of those who graduated and completed their service commitments, 91 percent continued working in the PMHS. Counties and community-based organizations reported that the WET program was effective in increasing the PMHS workforce and increasing PMHS workforce diversity and cultural/linguistic competency.

Legislative Analyst's Office

The LAO provided the following analysis:

January Budget Proposed \$50 Million in One-Time General Fund for Mental Health Workforce. To ameliorate what the Governor considers to be statewide and regional shortages of mental health professionals, the Governor's January budget proposed a \$50 million one-time General Fund augmentation for existing state programs

that provide scholarships and student loan repayment for mental health professionals who agree to work in underserved areas.

May Revision Proposes Additional State Funding for Mental Health Workforce. The May Revision proposes allocating \$100 million in state Mental Health Services Act (MHSA) revenues to fund the 2020-25 mental health Workforce Education and Training (WET) Five-Year Plan. The 2020-25 WET Plan was released by the Office of Statewide Health Planning and Development (OSHPD) in February 2019, but until the May Revision did not come with any attached funding. Under the mental health WET program, the state has historically funded a variety of programs and strategies to improve the supply and distribution of the state's mental health workforce. These programs and strategies include, for example, scholarships, student loan repayment, psychiatric residencies, psychiatric fellowships, and clinical rotations. While the \$50 million in General Fund proposed in January would largely only support the scholarship and student loan repayments, it is our understanding that the Governor's additional \$100 million in MHSA funding would support all of the above strategies and others. As with the \$50 million in General Fund proposed in January, the \$100 million in funding would be available for expenditure through 2025-26.

ASSESSMENT

Mixed Evidence of Statewide Mental Health Workforce Shortages . . . Following a preliminary review of the state's mental health workforce that we conducted earlier this year, we find mixed evidence of a statewide shortage for mental health professionals overall. While certain mental health workforce projections show the state is likely to experience a shortage, other evidence we reviewed does not suggest this to be the case. That said, we find stronger evidence that the state could be experiencing a shortage of psychiatrists.

. . . But Regional Disparities in the Supply of Mental Health Professionals Exist. While the evidence is mixed regarding the presence of a statewide mental health workforce shortage, the evidence is strong that significant regional disparities exist in the supply of mental health professionals. Notably, regions such as the Inland Empire and the San Joaquin Valley have significantly fewer mental health professionals per capita than the state as a whole.

Uncertainty Around Whether Existing State Programs and Strategies Have Been Effective. Overall, existing state mental health workforce programs and strategies may have had some positive impact in increasing the overall number of mental health professionals throughout the state. However, our preliminary review of mental health workforce data showed little relationship between the regions of the state experiencing the greatest workforce challenges and the work locations of former program beneficiaries.

OPTIONS FOR LEGISLATIVE CONSIDERATION

We provide several options for the Legislature to consider as it evaluates the Governor's proposals.

- ***Take Pause to Identify the State's Needs and the Most Cost-Effective Strategies.*** Under the Governor's May Revision, the state would provide \$150 million in 2019-20 for mental health workforce development, prior to necessarily having identified the state's most critical mental health workforce needs and the most cost-effective strategies for ameliorating them. Accordingly, the Legislature could consider taking pause and formulating a more comprehensive long-term strategy on mental health workforce. Exercising this first option would involve delaying funding until many of the outstanding uncertainties related to the state's mental health workforce strategies are better understood.
- ***Scale Back Funding and Require a Local Contribution.*** Historically, what otherwise would have been local MHSA funding for counties was redirected to fund state mental health WET programs. Under the Governor's proposal, however, only funding designated for state purposes (General Fund and the portion of MHSA funding dedicated to state activities and programs) would support state mental health workforce programs. The Legislature could consider reducing the amount of state funding provided for state mental health workforce programs and instead require a financial contribution from counties to ensure similar total funding as under the Governor's proposal. (We would note that counties receive ongoing flexible funding from the state for mental health services, including—at counties' discretion—for workforce programs.)
- ***Establish Parameters for How Funding Is Allocated.*** Another option is to approve the Governor's proposal, but add parameters to ensure the funding is targeted toward the areas of greatest need. For example, funding could be prioritized toward regions of the state—such as the Inland Empire and the San Joaquin Valley—that are likely experiencing the most acute mental health workforce shortages. In addition or alternatively, the Legislature could target the funding toward those mental health professions for which there is the greatest evidence of shortages, such as psychiatrists.

STAFF COMMENTS/QUESTIONS

The Subcommittee discussed the WET program as an oversight issue on March 11, 2019 (Issue #6, page 19). The Subcommittee requests OSHPD present this proposal and respond to concerns and options raised by the LAO.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

4260 DEPARTMENT OF HEALTH CARE SERVICES**ISSUE 3: MEDI-CAL ESTIMATE UPDATES (MR ISSUE 401, 409)****PANELISTS**

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- *Public Comment*

ESTIMATE**Total DHCS Budget***(Includes non-Budget Act appropriations)*

Governor's Budget Fund Source*	2018-19 Budget Act	2019-20 Governor's Budget	2019-20 May Revision	% Change from Budget Act
General Fund	\$23,408,652	\$23,405,017	\$23,574,874	0.71%
Federal Funds	\$68,143,762	\$66,234,871	\$66,983,117	-1.73%
Special Fund & Reimbursements	\$16,098,932	\$14,600,085	\$15,782,342	-1.97%
Total Funds	\$107,651,346	\$104,239,973	\$106,340,333	-1.22%

*Dollars in thousands

State Operations

State Operations by Fund Source *				
Governor's Budget Fund Source*	2018-19 Budget Act	2019-20 Governor's Budget	2019-20 May Revision	% Change from Budget Act
General Fund	\$236,579	\$237,675	\$272,962	13.33%
Federal Funds	\$457,020	\$448,476	\$534,875	14.56%
Special Funds & Reimbursements	\$57,086	\$57,914	\$64,967	12.13%
Total State Operations	\$750,685	\$744,065	\$872,804	13.99%

*Dollars in thousands

Local Assistance

FY 2018-19 Local Assistance by Fund Source *				
Governor's Budget Fund Source*	2018-19 Budget Act	2018-19 Revised Governor's Budget	2018-19 Revised May Revision	% Change from Budget Act
General Fund	\$23,172,073	\$20,968,397	\$19,975,413	-16.00%
Federal Funds	\$67,686,742	\$63,221,717	\$60,328,744	-12.20%
Special Funds & Reimbursements	\$16,041,846	\$17,167,934	\$16,299,048	1.58%
Total Local Assistance	\$106,900,661	\$101,358,048	\$96,603,205	-10.66%

*Dollars in thousands

FY 2019-20 Local Assistance by Fund Source *				
Governor's Budget Fund Source*	2018-19 Budget Act	2019-20 Governor's Budget	2019-20 May Revision	% Change from Budget Act
General Fund	\$23,172,073	\$23,167,342	\$23,301,912	0.56%
Federal Funds	\$67,686,742	\$65,786,395	\$66,448,242	-1.86%
Special Funds & Reimbursements	\$16,041,846	\$14,542,171	\$15,717,375	-2.02%
Total Local Assistance	\$106,900,661	\$103,495,908	\$105,467,529	-1.34%

*Dollars in thousands

The average monthly caseload for fiscal year 2019-20 is projected to be 13,009,800 beneficiaries, which represents a decrease of 210,300 beneficiaries from the Governor's Budget. The decrease in caseload is primarily attributable to a growing economy. Total Medi-Cal expenditures for 2019-20 are projected to be \$102,188,875,000 (\$23,018,406,000 General Fund) which is an increase of \$1,488,997,000 total funds and an increase of \$141,387,000 General Fund from the Governor's Budget.

May 2019 Medi-Cal Estimate (Issue 401)—It is requested that the adjustments below be made to the following items to reflect caseload and other miscellaneous adjustments outlined in the Medi-Cal estimate:

- Item 4260-101-0001 be increased by \$147,985,000, and reimbursements be increased by \$30,571,000
- Item 4260-101--0232 be increased by \$4,678,000
- Item 4260-101--0233 be increased by \$1,336,000
- Item 4260-101--0236 be increased by \$769,000
- Item 4260-101--0890 be increased by \$666,098,000

- Item 4260-101 -3168 be increased by \$378,000
- Item 4260-102--0001 be increased by \$1,614,000
- Item 4260-102--0890 be decreased by \$722,000
- Item 4260-106--0890 be increased by \$4,480,000
- Item 4260-113--0001 be decreased by \$58,307,000
- Item 4260-113--0890 be increased by \$353,036,000
- Item 4260-117--0001 be increased by \$171,000
- Item 4260-117--0890 be increased by \$592,000

Key adjustments:

Current Year—The May Revision assumes decreased expenditures in the Medi-Cal program of approximately \$1 billion General Fund compared to the Governor's Budget. Unlike most programs, Medi-Cal operates on a cash, rather than an accrual, basis of accounting. This means that the timing of transactions can significantly disrupt fiscal year budgetary estimates.

- About 70 percent of the difference is due to shifts in timing for repayments to the federal government. These repayments are now assumed to be made in the budget year, resulting in relatively minor net changes across the two fiscal years.
- Another 12 percent is attributed to increased savings for drug rebates and retroactive managed care payments, offset by increased delinquent fees owed from skilled nursing facilities and other one-time adjustments.
- The remaining variance is primarily due to changes in fee-for-service caseload.

Pharmacy Benefit Transition to Fee-for-Service -- The transition of pharmacy services from Medi-Cal managed care to a fee-for-service benefit is expected to increase California's negotiation for supplemental rebates as well as lower costs in the Medi-Cal program. Savings from the transition are estimated to reach \$393 million General Fund by 2022-23. These savings will not be realized immediately upon the transition in January 2020 due to timing of drug rebates and managed care payments.

Full-Scope Expansion Implementation Shift -- The May Revision includes \$96.1 million (\$72.4 million General Fund) to expand full-scope Medi-Cal coverage to eligible young adults aged 19 through 25 regardless of immigration status, starting no sooner than January 1, 2020. The assumed implementation date is six months later than assumed at the Governor's Budget. This expansion will provide full-scope coverage to approximately 90,000 individuals in the first year. Nearly 75% of these adults are currently in the Medi-Cal program and receiving limited scope benefits.

Proposes \$2.1 billion (\$729 million General Fund) for county eligibility determination activities, an increase of \$15.3 million total funds compared with the Governor's Budget.

Medi-Cal Drug Rebate Fund Reserve (Issue 409)—It is requested that Item 4260-101-0001 be increased by \$172 million to maintain a reserve of the equivalent amount in the Medi-Cal Drug Rebate Fund. The reserve is intended to alleviate the General Fund impact related to drug rebate volatility.

STAFF COMMENTS/QUESTIONS

The Subcommittee discussed the Governor's Budget's proposed DHCS budget and November 2018 Medi-Cal estimate on February 25, 2019 (Issue # 2, page 6). The Subcommittee requests DHCS present the May 2019 estimate and highlight significant differences from the November 2018 estimate.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 4: FAMILY HEALTH ESTIMATE UPDATES (MR ISSUE 402)**PANELISTS**

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- *Public Comment*

ESTIMATE

Family Health May Revision Estimates (Issue 402)—It is requested that Item 4260-111-0001 be decreased by \$2,993,000 and reimbursements be increased by \$1,000. It is also requested that Item 4260-114-0001 be decreased by \$3,824,000. These changes reflect revised expenditures due to caseload and other miscellaneous adjustments outlined in the Family Health Estimate.

Management Summary
Fiscal Year 2019-20
Comparison of Appropriation, November 2018, and May 2019 Estimates

	Approp Est. FY 2018-19	Nov. 18 Est. FY 2019-20	May 19 Est. FY 2019-20	Chg Approp - May 19 Est.	Chg Nov. 18 - May 19 Est.
<u>California Children's Services</u>					
4260-111-0001 (General Fund)	\$ 87,254,000	\$ 80,318,000	\$ 81,148,000	\$ (6,106,000)	\$ 830,000
4260-611-0995 (CDPH Title V Reimb.)	\$ 5,453,000	\$ 5,453,000	\$ 5,453,000	\$ 0	\$ 0
County Funds ¹	\$ 83,629,000	\$ 86,088,000	\$ 86,761,000	\$ 3,132,000	\$ 673,000
TOTAL CCS	\$ 92,707,000	\$ 85,771,000	\$ 86,601,000	\$ (6,106,000)	\$ 830,000
<u>Child Health and Disability Prevention Program</u>					
4260-111-0001 (General Fund)	\$ 3,000	\$ 0	\$ 0	\$ (3,000)	\$ 0
TOTAL CHDP	\$ 3,000	\$ 0	\$ 0	\$ (3,000)	\$ 0
<u>Genetically Handicapped Persons Program</u>					
4260-111-0001 (General Fund)	\$ 138,227,000	\$ 118,146,000	\$ 114,323,000	\$ (23,904,000)	\$ (3,823,000)
4260-611-0995 (Enrollment Fees)	\$ 478,000	\$ 462,000	\$ 463,000	\$ (15,000)	\$ 1,000
4260-601-3079 (Rebates Special Fund)	\$ 16,259,000	\$ 8,300,000	\$ 10,748,000	\$ (5,511,000)	\$ 2,448,000
TOTAL GHPP	\$ 154,964,000	\$ 126,908,000	\$ 125,534,000	\$ (29,430,000)	\$ (1,374,000)
<u>Every Woman Counts Program</u>					
4260-114-0001 (General Fund)	\$ 5,608,000	\$ 16,737,000	\$ 12,913,000	\$ 7,305,000	\$ (3,824,000)
4260-114-0236 (Prop 99)	\$ 14,515,000	\$ 14,515,000	\$ 14,515,000	\$ 0	\$ 0
4260-114-0009 (Breast Cancer Control Acct)	\$ 7,989,000	\$ 7,989,000	\$ 7,989,000	\$ 0	\$ 0
4260-114-0890 (Center for Disease Control)	\$ 5,128,000	\$ 5,128,000	\$ 5,128,000	\$ 0	\$ 0
TOTAL EWC	\$ 33,240,000	\$ 44,369,000	\$ 40,545,000	\$ 7,305,000	\$ (3,824,000)
GRAND TOTAL - ALL FUNDS	\$ 280,914,000	\$ 257,048,000	\$ 252,680,000	\$ (28,234,000)	\$ (4,368,000)
4260-111-0001*	\$ 225,484,000	\$ 198,464,000	\$ 195,471,000	\$ (30,013,000)	\$ (2,993,000)
4260-114-0001	\$ 5,608,000	\$ 16,737,000	\$ 12,913,000	\$ 7,305,000	\$ (3,824,000)
4260-114-0009	\$ 7,989,000	\$ 7,989,000	\$ 7,989,000	\$ 0	\$ 0
4260-114-0236	\$ 14,515,000	\$ 14,515,000	\$ 14,515,000	\$ 0	\$ 0
4260-114-0890	\$ 5,128,000	\$ 5,128,000	\$ 5,128,000	\$ 0	\$ 0
4260-611-0995	\$ 5,931,000	\$ 5,915,000	\$ 5,916,000	\$ (15,000)	\$ 1,000
4260-601-3079	\$ 16,259,000	\$ 8,300,000	\$ 10,748,000	\$ (5,511,000)	\$ 2,448,000
County Funds ¹	\$ 83,629,000	\$ 86,088,000	\$ 86,761,000	\$ 3,132,000	\$ 673,000

¹ County Funds are not included in Total Funds. They are shown for display only.

* As of the November 2018 estimate cycle, projected CHDP expenditures have moved to the Medi-Cal Local Assistance Estimate.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present the Family Health Estimate, highlighting any significant changes from the November 2018 estimate to the May 2019 estimate, and respond to the following:

1. Please explain the significant increase in General Fund in the Every Woman Counts Program.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 5: PROPOSITION 56 MEDI-CAL EXPENDITURES UPDATES (MR ISSUE 403)**PANELISTS**

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- *Public Comment*

PROPOSAL

Proposition 56 Investments (Issue 403)—It is requested that Item 4260-101-3305 be decreased by \$180,216,000. This is the net decrease reflecting shifting expenditures for the Value-Based Payments Program to Item 4260-103-3305, which is offset by increases to fund -3- provider training for trauma screenings, restoration of the optical benefit and optical lab services for adult beneficiaries in the Medi-Cal program, no sooner than January 1, 2020, and revised spending for the Governor's Budget Proposition 56 package. It is also requested that provisional language in Item 4260-101-3305 be amended to reflect these adjustments as follows:

Amend the following provisions of Item 4260-101-3305 as follows:

- "1. The funds appropriated in this item are available for expenditure pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code. The Legislature finds and declares that the expenditures are made in accordance with the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56). The Legislature finds that the expenditures described in this Item ~~Provision 3~~ increase funding for the existing healthcare programs and services described in subdivision (a) of Section 30130.55 of the Revenue and Taxation Code, and that payments and support for the nonfederal share of payments for healthcare, services, and treatment are increased based on the criteria described in this item, which ensures timely access, limiting specific geographic shortages of services or ensuring quality care. Expenditures shall be used only for care provided by health care professionals, clinics, and health facilities that are licensed pursuant to Section 1250 of the Health and Safety Code, and to health plans contracting with the State Department of Health Care Services to provide health benefits pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.
2. To effectively administer the Medi-Cal program, the Department of Finance may decrease or increase this item to conform ~~the~~ appropriation to revised revenue estimates pursuant to subdivision (a) of Section 30130.55 of the Revenue and Taxation Code.
3. The State Department of Health Care Services shall develop the structure and parameters for the payments and rate increases to be made pursuant to this item. Of the amount appropriated in this item, the funding may be available for extending supplemental payments for physician services, and dental services, ~~supplemental payments for Intermediate Care Facilities for the Developmentally Disabled, to facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14132.20 of the Welfare and Institutions Code, Women's Health, and HIV/AIDS waiver providers;~~ and, notwithstanding any other law, rate increases for home health providers of medically necessary in-home services for children and adults in the Medi-Cal fee-for-service system or through home and community-based service waivers, and for pediatric day health care facilities in the Medi-Cal fee-for-service system. ~~The funding may also be available for developmental screenings for children, trauma screenings for children and adults, provider training for trauma screenings, family planning services provided through Medi-Cal fee-for-service and managed care, and, notwithstanding any other law, optical services pursuant to paragraph (1) of subdivision (g) of Section 14131.10 of the Welfare and Institutions Code, and value-based payments for providers in managed care plans.~~ The Department shall post the proposed payment structure of ~~these~~ the physician and dental supplemental provider payments on its Internet Web site by September 30, 2019, upon the approval of the Department of Finance.
4. The payments or rate increases authorized pursuant to this item that are eligible for federal financial participation shall be available after any necessary federal approvals have been obtained, except that the State Department of Health Care Services may make payments available while federal approval is pending, provided that any payment amounts for which federal approval is not obtained shall be recouped from applicable providers. This item shall be implemented only to the extent the State Department of Health Care Services obtains any necessary federal approvals for payments eligible for federal financial participation and

determines that federal financial participation is not otherwise jeopardized. To the extent applicable, each of the payments or rate increases by provider type may be implemented independently as federal approval is received and to the extent federal financial participation is determined and not otherwise jeopardized.

5. The payments or rate increases authorized pursuant to this item will be implemented only to the extent federal Medicaid policy does not reduce federal financial participation as projected in the annual budget act as determined by the Department of Finance.
6. For purposes of provider training related to trauma screenings pursuant to Provision 3 of this item, the State Department of Health Care Services may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this provision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and the State Administrative Manual, and shall be exempt from the review or approval of any division of the State Department of General Services.
7. Notwithstanding Chapter 3.5 (commencing Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement this item by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, without taking regulatory action."

Proposition 56 Medi-Cal Physician and Dentist Loan Repayment Program—It is requested that Item 4260-102-3305 be added in the amount of \$120 million to reflect additional funding for the Proposition 56 Medi-Cal Physician and Dentist Loan Repayment Program. It is also requested that provisional language be added to this item to specify allocations to physicians and dentists and the availability of the funding until June 30, 2029 as follows:

4260-102-3305—For local assistance, State Department of Health Care Services, payable from the Healthcare Treatment Fund..... 120,000,000

Schedule:

(1) 3960022-Benefits (Medical Care and Services).....120,000,000

Provisions:

1. The funds appropriated in this item are allocated for the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act for qualifying, recent graduate physicians and dentists who serve Medi-Cal beneficiaries. Of these funds, \$100,000,000 may be allocated for recent graduate physicians and \$20,000,000 may be allocated for recent graduate dentists. The funds appropriated for this purpose are available for expenditure until June 30, 2029.

Value-Based Payments Program—It is requested that Item 4260-103-3305 be added in the amount of \$250 million for the Value-Based Payments program. It is also requested that provisional language be added to specify \$70 million of this funding be used for behavioral health integration and the availability of the funding until June 30, 2022 as follows:

4260-103-3305—For local assistance, State Department of Health Care Services, payable from the Healthcare Treatment Fund..... 250,000,000

Schedule:

(1) 3960022-Benefits (Medical Care and Services).....250,000,000

Provisions:

1. Of the funds appropriated in this item, \$250,000,000 is allocated for Proposition 56 Value-Based Payment programs to offer financial incentives to health care providers that improve their performance on predetermined measures or meet specified targets that focus on quality and efficiency of care. Of the amount allocated in this item, \$70,000,000 is to be used for behavioral health integration. The funds appropriated for these purposes are available for expenditure until June 30, 2022. These provisions shall be implemented only to the extent the State Department of Health Care Services determines federal financial participation is available and not otherwise jeopardized.

The May Revision continues to include supplemental payments for physicians, dentists, women's health services, intermediate care facilities for the developmentally disabled (ICF/DD) providers, and HIV/AIDS Waiver services. In addition, there are Proposition 56-funded rate increases for home health agencies, private duty nursing, and pediatric day health care programs. The total FY 2019-20 Proposition 56 funding for these providers is \$748.0 million. The Department estimates the total funding (both federal and Proposition 56) in FY 2018-19 for these payments is \$2.315 billion and in FY 2019-20 is \$2.163 billion. The May Revision proposes additional investments that include the following:

- \$120 million additional one-time funding for the CalHealthCares Loan Repayment program for eligible physicians and dentists who agree to specified terms and conditions in exchange for up to \$300,000 in educational debt. Of this one-time amount, \$100 million will be for physicians and \$20 million will be for dentists. This brings the total allocation for CalHealthCares to \$340 million, including the \$220 million from the 2018 Budget Act.
- \$70 million in additional one-time funding for the Value-Based Payments, specifically targeting behavioral health integration. This is in addition to the \$180 million proposed in the Governor's January Budget and brings the total allocation for Value-Based Payments to \$250 million starting in 2019-20.

- A one-time \$60 million allocation for provider training and technical assistance to support the Governor's proposal for pediatric and adult trauma screenings. This allocation will be provided over three fiscal years: \$25 million in 2019-20, \$20 million in 2020-21 and \$15 million in 2021-22.
- \$11.3 million to restore optician and optical lab services for adult beneficiaries in the Medi-Cal program, effective no sooner than January 1, 2020.

The May Revision proposes all Proposition 56 investments will sunset December 31, 2021. Starting January 1, 2022, Proposition 56 revenue will be used to fund growth in the Medi-Cal program compared to the 2016 Budget Act.

STAFF COMMENTS/QUESTIONS

The Subcommittee heard the Governor's Budget proposals on Proposition 56 Medi-Cal expenditures on February 25, 2019 (Issue #5, page 18).

The Subcommittee requests DHCS present the new Proposition 56 proposals contained in the May Revision.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 6: MEDI-CAL ELIGIBILITY EXPANSION UPDATES (MR ISSUE 407 AND TBL)**PANELISTS**

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

It is requested that Item 4260-101-0001 be decreased by \$121,863,000 and Item 4260-101-0890 be decreased by \$39,773,000 to reflect revised costs of expanding full-scope Medi-Cal expansion to undocumented young adults.

The May Revise delays implementation of the proposal in the Governor's Budget to expand Medi-Cal eligibility to young adults, regardless of immigration status, to January 1, 2020, at a revised budget year cost of \$98 million (\$74.3 million General Fund), estimated to extend full-scope coverage to 90,000 individuals.

The May Revise also withdraws the January Budget proposal to change realignment redirection amounts for four "60/40 counties," reflects Yolo County as a County Medical Services Program (CMSP) county, and withholds realignment revenues from the CSMP Board until the Board's projected total reserves fall below two years of expenditures, at which point a 75/25 percent redirection will be implemented. (This reflects updated information from the Governor's Office since the release of the May Revision.)

Trailer Bill:

Amendments to trailer bill language proposed at Governor's Budget are requested to reflect changes to the redirection of realignment revenue pursuant to Chapter 24, Statutes of 2013 (AB 85). Specifically, amendments are requested to reflect Yolo as a County Medical Services Program county, align the change in redirection with -4- the timing of the implementation of the young undocumented adult expansion, and withhold realignment revenues from the County Medical Services Program Board until total projected reserves reach a reasonable level, at which point the Board's health realignment redirection will be reflected as 7 5 percent.

STAFF COMMENTS/QUESTIONS

The Subcommittee heard the Governor's Budget proposal to expand Medi-Cal eligibility to young adults (19-25 years), regardless of immigration status, on April 8, 2019 (Issue #3, page 15). The Subcommittee also heard the Governor's proposed trailer bill related to a modification to AB 85, in order to recoup a portion of county savings associated with this proposed shift in obligation from counties to the state on April 8, 2019 (Issue #4, page 20).

The Subcommittee requests DHCS present the modifications to these proposals that are contained in the May Revise.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 7: WHOLE PERSON CARE EXPANSION UPDATE (MR ISSUE 450)**PANELISTS**

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- *Public Comment*

PROPOSAL

The May Revision includes a one-time \$20 million allocation from the Mental Health Services Fund (4260-115-3085) for counties that do not currently participate in the Whole Person Care pilots, as authorized under California's Section 1115 Medicaid Waiver. With this funding, counties will be able to develop and implement programs focused on coordinating health, behavioral health, and critical social services, such as housing. Like the counties currently participating in Whole Person Care, these funds will be used by counties to target at-risk populations such as those with mental illness or homeless. The Department expects to award funds to interested counties by March 2020.

This proposal includes the following provisional language:

4260-115-3085—For local assistance, State Department of Health Care Services, payable from the Mental Health Services Fund..... 20,000,000

Schedule:

(1) 3960050-Other Care Services.....20,000,000

Provisions:

1. Notwithstanding any other law, the funds appropriated in this item shall be available for encumbrance or expenditure until June 30, 2025 by the State Department of Health Care Services to provide funds to counties for their development and implementation of programs to focus on coordinating health, behavioral health (with a mental health and/or substance use disorder), and critical social services such as housing. The funds may be used to match local county investments towards the specified services, and shall not supplant existing local county investments for these purposes.

BACKGROUND

California's Whole Person Care Pilot program coordinates health, behavioral health and social services in a patient-centered manner with the goal of improved beneficiary health and well-being. The need for Whole Person Care arose due to unmet social, behavioral health, and health needs within vulnerable populations, and from fragmentation of organization and financing of current health and human services systems. Indeed, low-income populations are more likely to experience a multitude of health, behavioral health, and social needs, requiring them to seek care across multiple and fragmented systems. For example, the prevalence of mental illness among Medicaid beneficiaries is twice that of the general population, and nearly half of beneficiaries with disabilities have a psychiatric illness. Research has also shown that individuals with serious mental illness (SMI) are at a greater risk of death, have lower life expectancy by nearly 25 years, and are more likely to have chronic medical conditions compared to the general population. Medicaid beneficiaries with SMI also have significantly higher medical costs than those without SMI.

California has successfully worked with twenty-five (25) Whole Person Care Pilot programs to provide target populations with a range of comprehensive services and supports to address unmet needs and improve the quality and outcome of high-risk populations. The 2019-20 May Revision seeks to encourage additional counties to initiate Whole Person Care-like pilot capacity with a one-time funding allocation of \$20 million and multi-year spending authority through June 30, 2025 from the Mental Health Services Fund.

The Department of Health Care Services (DHCS) will provide start-up funding to counties that are not currently participating in the state's Whole Person Care Pilot program based on a county's demonstration of interest and support from multiple local partners within the county. The amount awarded to each county will be determined at the time of application and informed by the county's proposed budget and readiness activities.

Interested counties may request funds from DHCS to perform the following administrative and programmatic activities that may include:

- Supports necessary to plan, build and run Whole Person Care-like services, including but not limited to intensive care management programs aimed at certain target populations (e.g. high emergency room/inpatient utilizers, homeless, recently incarcerated, individuals with serious mental illness), recuperative care, respite care, etc.
- Core program development and support
- Staffing
- IT infrastructure
- Program governance

- Training
- Ongoing data collection
- Marketing materials

DHCS will make applications available to interested counties by December 2019. Funds are intended to be awarded to successful applicants by March 31, 2020.

STAFF COMMENTS/QUESTIONS

The Subcommittee heard the Governor's Budget proposal to increase funding for the Whole Person Care pilots in order to increase access to housing for homeless mentally ill individuals on March (Issue #1, page 4)

The Subcommittee requests DHCS present the expansion to this proposal included in the May Revise.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 8: PEER-RUN MENTAL HEALTH WARM LINE PROPOSAL (MR ISSUE 407)**PANELISTS**

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

The Department intends to provide \$3.6 million from the Mental Health Services Fund over the next three fiscal years (2019-2022) to support phone and instant messaging to callers across California using peer counselors with lived experience of mental health challenges. The 6 California Peer-Run Warm Line will offer accessible peer support to Californians on a 24/7 basis. These services are expected to decrease unnecessary emergency room visits, avoid public safety involvement and other types of crisis services. The Department of Health Care Services will effectuate a contract with the Mental Health Association of San Francisco to implement the California Peer-Run Warm Line, upon approval of the Legislature and effective July 1, 2019.

BACKGROUND

The Governor's 2019-20 May Revision proposes to support the California Peer-Run Warm Line with \$3.6 million in Mental Health Services Act funds for the next three fiscal years (2019-20 through 2021-22). This funding will allow individuals across California to receive support from peer counselors who have experienced mental health challenges.

The California Peer-Run Warm Line will offer accessible peer support to Californians on a 24/7 basis via phone and instant messaging. Peer counselors with lived experience provide non-judgmental support while also helping to alleviate the burden on other higher-cost or more intensive levels of crisis care. The Peer-Run Warm Line is expected to decrease unnecessary emergency room visits, public safety involvement, and other types of crisis services. In addition to being an easily accessible service for Californians no matter their location or county of residence, the Peer-Run Warm Line offers those struggling with mental illness an opportunity to find meaningful employment. These employment opportunities will allow individuals to be trained as mental health peer counselors – a critical workforce that is needed in our state.

The funds in the Governor's May Revision will support staffing, training, administrative costs, and a program evaluation.

It is expected that the California Peer-Run Warm Line, at full operating capacity, will be able to handle tens of thousands of calls and messages each year, providing an important link for individuals struggling with isolation, anxiety, difficult interpersonal relationships, and other issues that negatively impact their overall health and wellbeing.

The Department of Health Care Services will contract with the Mental Health Association of San Francisco to implement the California Peer-Run Warm Line.

STAFF COMMENTS/QUESTIONS

The Subcommittee heard a nearly-identical stakeholder proposal on May 6, 2019 (Issue #14, page 42).

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 9: PROPOSITION 64 YOUTH SUBSTANCE ABUSE PREVENTION PROPOSAL**PANELISTS**

- Department of Health Care Services
- Department of Finance
- Legislative Analyst's Office
- *Public Comment*

PROPOSAL

Proposition 64 directs the Department of Health Care Services to establish interagency agreements with the Department of Public Health and the Department of Education. The May Revision includes \$119 million in spending from the Youth Education, Prevention, Early Intervention and Treatment Account. The Department will provide \$12 million to the Department of Public Health for surveillance and education activities. The Department will also provide the Department of Education with \$80.5 million to fund up to 9,600 slots for income-eligible families for afterschool and summer care for school-age children up to 13 years old through the General Child Care program. With funding of \$21.5 million, DHCS will support local programs that emphasize prevention, education and early intervention for youth through a competitive grant program and informed through a stakeholder process. Lastly, \$5.3 million will be provided to the California Natural Resources Agency to fund youth community access grants that support natural or cultural resources, with a focus on low-income and disadvantaged communities for positive programming to discourage substance use. Specifically, the May Revision includes:

- ***\$21.5 million to DHCS to implement competitive grants to develop and implement new youth programs in the areas of education, prevention, and early intervention of substance use disorders.***
- \$12 million to the Department of Public Health for cannabis surveillance and education activities.
- \$80.5 million to the Department of Education to subsidize child care for school-age children of income-eligible families.
- \$5.3 million to the California Natural Resources Agency to support youth community access grants to increase access to natural and cultural resources for low-income youth and disadvantaged communities.

STAFF COMMENTS/QUESTIONS

The Subcommittee discussed Proposition 64 on March 25, 2019 (Issue #2, page 17).

The Subcommittee requests DHCS present the DHCS portion of this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

**ISSUE 10: CA-MMIS OVERSIGHT TO OWNERSHIP AND MODERNIZATION PROJECTS BUDGET
CHANGE PROPOSAL (MR ISSUE 401)****PANELISTS**

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

The Department of Health Care Services (DHCS), California Medicaid Management Information Systems (CA-MMIS) Division requests resources necessary to further its strategic Oversight to Ownership (020), Fiscal Intermediary (FI) Turnover and Takeover, and Modernization objectives and fund: 1) the transitional efforts associated with the Turnover and Takeover strategy; 2) the continuation of the 020 strategy; and 3) the continuation of ongoing procurements for design, development and implementation of systems modules.

DHCS requests the following new positions, resources, and Budget Act provisional language in FY 2019-20:

- Total new resources of 11.0 permanent positions and expenditure authority of \$26,771,000 (\$7,885,000 General Fund (GF); \$18,886,000 Federal Fund (FF)):
 - Expenditure authority of \$25,000,000 (\$7,235,000 GF; \$17,765,000 FF) for FI Turnover and Takeover efforts.
 - 9.0 permanent positions and expenditure authority of \$1,418,000 (\$612,000 GF; \$806,000 FF) for continuation of the O2O strategy.
 - 2.0 permanent positions and expenditure authority of \$353,000 (\$38,000 GF; \$315,000 FF) for continuation of Modernization efforts.
- Reappropriation language extending \$7,385,000 GF from FY 2018-19 to FY 2019-20 and corresponding increased Federal Fund of \$15,515,000 in 2019-20 for Turnover and Takeover efforts due to timing of expenses (see Attachment B for proposed budget bill language).

BACKGROUND

California's Medicaid program (Medi-Cal) serves approximately 13.2 million members and its automated system, the California Medicaid Management Information System (CA-MMIS), processes approximately 200 million Fee-for-Service claims to providers, totaling over \$19 billion annually, to providers of health care services. DHCS currently contracts with a FI to operate the system and is solely charged with the oversight, management,

monitoring, and administration of the contract and the services provided by the FI. The services include adjudicating both Medi-Cal and non-Medi-Cal claims, as well as other services to program providers, beneficiaries, and federal and state users of the system. In 2010, DHCS contracted with a vendor to provide Information Technology Maintenance and Operations (IT M&C), Business Operations (Bus Cps) as well as the design, development and implementation (DDI) of a new replacement system (System Replacement Project or SRP). As a result of various challenges experienced by the vendor, a settlement agreement was approved in 2015 by DHCS and the vendor which included, but was not limited to, the FI transferring the DDI requirements of the contract to DHCS while maintaining the IT M&C and Bus. Cps activities through the end of operations for the current vendor (September 2019) and through the run out of the contract and associated stabilization period (through March 31, 2020). DHCS began a procurement process to establish new contracts for: 1) IT M&C; and 2) Bus Cps, prior to the September 2019 end date.

The transfer of the DDI responsibilities to DHCS from the FI presented an opportunity for the State to create a modern, modular solution which will be compliant with all of the requirements of the federal Centers for Medicare and Medicaid Services (CMS). DHCS assumed responsibilities of: 1) performing project management activities; 2) assessing the current CA-MMIS Governance model; 3) managing all of the contracted activities concerning business process reengineering; 4) managing all contracted transition activities; 5) overseeing quality management activities; 6) performing integration, service management, and operations management activities; 7) directing user acceptance testing activities; and 7) other functions.

DHCS developed a "Modernization Approach" to replace the old legacy system and executed organizational transformation activities to transition to C2C. The modernization and transformation activities utilize a modular approach coupled with industry standards-based service and operations management frameworks, alongside agile design and development techniques to incrementally deliver new functionality to CA-MMIS across multiple development fiscal years.

The 2017-18 budget included seven positions for DHCS to begin modernization efforts and adopt a user-centered, iterative, modular approach to the DDI of systems modules, as well as the conversion of 21.0 limited-term positions to permanent positions and funding for personal services to support and oversee the ongoing maintenance and operation of the legacy system. CA-MMIS completed the Cal-ARM statement of work, received CMS approval for a Federal Draw and Reporting (FDR) Digital Services developer team, and completed the MedCompass Project (now in Maintenance and Operation).

In the 2018-19 budget cycle, DHCS received approval of 25.0 additional positions (8.0 of these to begin July 1, 2019), and 2.0 Limited-term positions for the Enterprise Innovation and Technology Services (EITS) Division, the corresponding expenditure authority, and \$14.72 million in Modernization contract authority.

Of the 17.0 permanent positions established in 2018-19, 10.0 positions were for the continued implementation of the mission-critical C2C strategy and related activities and 7.0 positions and project management resources were identified to continue with the implementation and replacement of functionality of the business processes. Specifically, DHCS was able to: 1) for its FDR effort: obtain CMS approval for the Digital Services developer contract, begin tools and platform implementation, release its Request for Offer (RFC) and is expected to award a contract in late 2018-19; 2) begin drafting PAL Stage 3 documents for its California Account Receivable Management (Cal-ARM) effort; and 3) begin drafting PAL Stage 2 and 3 documents for the RAIS project module.

The Oversight to Ownership funding provided the Department with the resources for: 1) transition of Project Management services from the FI to the Department; 2) the transition of service and operations management activities associated with contractor service delivery; 3) the expanded oversight of multiple contractors' performance and work products; 4) policy workload; 5) subject ownership; 6) monitoring; and incident/problem/issue identification; and 7) resolution responsibility. There are also significant additional workloads in the direct State oversight of FI operations for the telephone service center, provider and beneficiary communications and publications, provider training, state training, and program integrity activities, processing claims for reimbursement, and implementing program policy, in accordance with new assumed responsibilities.

To prepare for the multi-year FI Turnover and Takeover transitional activities (July 2018 through March 2020), DHCS received \$22.9 million (\$7,385,000 GF; \$15,515,000 FF) in contract authority in FY 2018-19 which was the estimate DHCS anticipated spending in FY 2018-19 for both the turnover costs of the existing FI vendor and the takeover costs of the two new FI vendors. The FY 2018-19 amount was identified as an estimate in the Spring of 2018 for FY 2018-19 as DHCS anticipated the new FI contracts would not be executed until late Fall 2018, when it would be able to include refined estimates for FY 2019-20.

Subsequently, the FI IT M&O contract was signed in late 2018 but the execution of the FI Bus Ops contract was delayed due to protest. The Department did not receive final approval and contract execution from the Department of General Services on the FI Bus Ops Contract until February 2019. Based on the approved contract, total Turnover and Takeover costs are estimated at \$47.9 million. DHCS requests reappropriation of General Fund resources approved for 2018-19 and an additional \$25 million (\$7,235,000 GF;

\$17,765,000 FF) for FY 2019-20 for the Turnover and Takeover activities. As the FI Bus Ops and IT M&O contracts have now been awarded and assumptions have been validated with the respective vendors, the Department has identified areas of new state responsibility that will require additional state resources prior, and subsequent to, the October 2019 "Assumption Of Operations" (AOO) date in order to implement and support 020 capabilities.

Legislative Analyst's Concerns:

The LAO points out that the cost of the takeover and turnover activities in 2019-20 is expected to be roughly double the estimated cost in 2018-19. The Administration attributes the cost increase to "areas of new state responsibility that will require additional state resources," but does not provide a cost breakdown in the BCP to show what these new state responsibilities are.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal and respond to the following:

1. What does the department expect to spend the \$47.9 million total funds on in 2019-20? Please provide a cost breakdown.
2. What are the "areas of new state responsibility that will require additional state resources" above and beyond what was expected in 2018-19 that warrant an additional \$25 million total funds?

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

**ISSUE 11: SUD EMERGING EPIDEMICS, DISASTER RESPONSE AND LICENSING WORKLOAD
BUDGET CHANGE PROPOSAL (MR ISSUE 402)****PANELISTS**

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

The Department of Health Care Services (DHCS), Substance Use Disorder Compliance Division (SUDCD), requests 7.0 permanent positions and expenditure authority of \$1,060,000 (100% Residential and Outpatient Program Licensing Fund (ROPLF)), in fiscal year (FY) 2019-20, to address the increased workload of responding to: 1) natural disasters and other State Emergencies; 2) the opioid epidemic; 3) the resurgence of methamphetamine abuse; and 4) the rise in number of treatment facilities. In addition, DHCS requests a one-time expense of \$100,000 from General Fund (GF) to migrate DHCS's disaster collection and reporting process into the web-based reporting platform, NC4 through an interagency agreement with the California Department of Public Health (CDPH). This proposal will provide DHCS the staffing and resources to effectively develop and implement policies, and achieve program integrity efforts.

Total funding request:

Fiscal Year	Total Funds
2019-20	\$1,160,000
<i>Disasters, Emergencies and Drug Epidemics</i>	\$615,000 (ROPLF)
<i>Licensing</i>	\$445,000 (ROPLF)
<i>NC4 Database Migration</i>	\$100,000 (GF)
2020-21 and ongoing	\$997,000
<i>Disasters and Drug Epidemics</i>	\$579,000 (ROPLF)
<i>Licensing</i>	\$418,000 (ROPLF)

The following chart identifies the positions requested with the corresponding activity.

Division	Request	Tenure/Effective Date	Activity
Counselors and Medication Assisted Treatment (CMAT) Section	4.0 Permanent Positions <ul style="list-style-type: none"> 1.0 Staff Services Manager II (SSM II) 1.0 Health Program Specialist II (HPS II) 2.0 Associate Governmental Program Analysts (AGPAs) 	Permanent Effective 7/1/19	Disasters, emergencies and opioid and methamphetamine epidemics
Licensing (LCS) Section	3.0 Permanent Positions <ul style="list-style-type: none"> 1.0 Staff Services Manager I (SSM I) 2.0 AGPAs 	Permanent Effective 7/1/19	Substantial increase in substance use disorder licensing facilities

BACKGROUND

The leading cause of death nationally is from drug or alcohol abuse. The average life expectancy of Americans dropped in 2015, stayed stable in 2016 and dropped again in 2017 primarily due to alcohol and drug overdoses. In all, there were 70,237 drug overdose deaths in 2017. Opioids remain to be the leading cause of drug overdose deaths, causing two-thirds of the overdose deaths in 2017. The nation's opioid epidemic continues to reach new proportions, while each year the deaths from synthetic and prescribed opioids outpace the prior year. California is also experiencing this crisis, but in different ways. The US Centers for Disease Control and Prevention (CDC) reported illegally manufactured fentanyl was the driving force behind a 45.2% increase in deaths involving synthetic opioids from 2016 to 2017. As the east coast is crippled with deaths from synthetic opioids, fentanyl and carfentanyl, California has had relatively low numbers of deaths from these drugs. This changed dramatically in 2018. The National Center for Health Statistics indicated that prior to 2017, deaths involving synthetic opioids mainly occurred east of the Mississippi River. The available data now show eight states west of the Mississippi had significant increases in such deaths: Arizona, California, Colorado, Minnesota, Missouri, Oregon, Texas, and Washington.

Also, on the rise is the combination of sedative and stimulant drugs. In particular, mixing an opiate with a stimulant, commonly referred to as a "speedball" is a popular method of obtaining an intense high. In the past, cocaine has been used with heroin or other opiates to create the combination. However, according to research from Pharmacology Biochemistry Behavior, methamphetamine is currently used in the same capacity. This research, along with other studies, shows that combining methamphetamines with morphine or heroin (based on the dosages of each) produces a more potent effect than either drug alone. As a result, fentanyl and heroin, which significantly increases the risk of overdose, are frequently involved in fatal methamphetamine overdoses. While the opiate may slow breathing, the stimulant might accelerate it, making an individual feel like breathing is normal. This can make it harder to feel when the dose of heroin that is tolerated may have been exceeded, which can then lead to overdose and even result in death.

The rates of overdose deaths involving cocaine and psychostimulants, including methamphetamine increased by more than 33% respectively. Opioids were involved in 67.8%, or 47,600 of those deaths. Of those opioid-involved overdose deaths, 59.8% of them, or 28,466, were due to synthetic opioids. The nationwide increase in methamphetamine use and the opioid epidemic highlights the need for treatment services; however, it has also uncovered the current inadequate number of treatment facilities available. In 2017, CDPH's opioid surveillance dashboard reported 2,196 opioid overdose deaths, 500 of those deaths had methamphetamine in their system, and 1,900 deaths from methamphetamines, of which 500 individuals had opioids in their system.

Currently no medications have proven to be effective for people in recovery for methamphetamine polydrug abuse, so treatment focuses heavily on behavioral therapy such as cognitive behavioral therapy, contingency management, and the Matrix Model. In addition to addressing the opioid epidemic, DHCS must address the rise in methamphetamine use. Research projects that deaths from methamphetamine use will continue to rise due to the availability, potency and low cost.

With advances in implementation of Affordable Care Act (ACA), the landscape of healthcare access for individuals has changed dramatically. Linking individuals to healthcare in the community can improve public safety, increase public health, and save money, as lack of access to care in the community is associated with increased recidivism, particularly for individuals with an SUD. ACA parity protections require that coverage for SUD services be no more restrictive than coverage provided for substantially all medical/surgical services. In anticipation of meeting access demands due to healthcare reform, DHCS had identified current gaps in the existing system. DHCS has addressed some of the identified gaps with the approval and implementation of the Drug Medi-Cal Organized Delivery System (DMCODS) Waiver by expanding services. The DMC-ODS Waiver provides the beneficiary with access to the care and system interaction

needed in order to achieve sustainable recovery. In addition, with the passage of Assembly Bill 848, it allows incidental medical services to be provided within the residential treatment programs and increase the care afforded to clients. The expansion of government and non-government funded services, due to state and national efforts, requires an increase in licensing and monitoring activity across all treatment modalities.

California is also the nation's most populous state and is one of the most disaster prone due to wildfires, landslides, flooding, winter storms, severe freeze, tsunami waves, and earthquakes. In December 2017, a series of 29 wildfires ignited across Southern California which caused a series of mudflows in early January 2018. The 2018 wildfire season is the deadliest and most destructive wildfire season on record in California, with a total of 8,527 fires burning an area of 1,893,913 acres, the largest amount of burned acreage recorded in a fire season, according to the California Department of Forestry and Fire Protection (Cal Fire) and the National Interagency Fire Center. The fires have caused more than \$3.5 billion in damages. The Mendocino Complex Fire burned more than 459,000 acres becoming the largest complex fire in the state's history, with the complex's Ranch Fire surpassing the Thomas Fire and the Santiago Canyon Fire of 1889 to become California's single-largest recorded wildfire. With licensed and/or certified substance use disorder treatment facilities located across California, DHCS must assist facilities in the impacted areas.

Counselor and Medication Assisted Treatment Section (CMATS)

CMATS is responsible for the statutory and regulatory compliance of all narcotic treatment programs (NTPs) in California through mandated annual on-site inspections. CMATS responsibilities include the review of initial NTP licensure and annual renewal applications, follow-up on-site inspections for programs that present imminent danger to patients, administrative functions such as grant and contract management, facility complaint investigations, patient death investigations, the monitoring of requests for exceptions to regulations through the Center for Substance Abuse Treatment extranet, providing technical assistance for the submission of various protocol amendments, capacity changes, and oversight of the counselor certifying organizations. In addition to complying with Health and Safety Code (HSC), Sections 11839 through 11839.34, NTPs also must adhere to Title 42 Code of Federal Regulations, Part 8 and Title 9 of California Code of Regulations (CCR), Division 4, Chapter 4, Sections 10000 through 10425.

NTPs are authorized to provide all Food and Drug Administration (FDA) approved medications for the treatment of SUDs, which include narcotic replacement therapy (NRT) medications; a form of medication assisted treatment (MAT) specific to the treatment of an opioid use disorder (OUD). These NRT medications include methadone, a scheduled II controlled substance and buprenorphine, a scheduled III controlled substance and naltrexone a non-scheduled medication. NRT is comprehensive treatment with synthetic opiates approved by the FDA for opiate-addicted patients. MAT is the use of medications,

in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUD. Research shows that when treating SUDs, a combination of medication and behavioral therapies is most successful. Both methadone and buprenorphine are administered daily and unless approved for take-home medications; NTP patients will attend the NTP daily to receive their dose.

The goals of NRT are to prevent relapse, reduce narcotic cravings, and block the euphoric effects of illicit opiate use. MAT access, as prescribed, is critical for a NTP patient's long-term recovery. According to CCR Title 9, Chapter 4, Section 10030(a)(32), NTPs must have procedures in place for use in the event of an emergency or disaster to protect the health and safety of clients and make certain the smooth continuation of treatment services. Requirements include an operational telephone number available 24 hours a day for patients to contact a staff member or be directed to an appropriate referral service. Licensed NTPs may also request temporary exceptions to the regulations adopted under this chapter as outlined in California Code of Regulations (CCR), Title 9, Chapter 4, Section 10425. As shown in the recent disasters, NTPs have utilized their disaster plans to allow patients to have access to services during the events. Without a comprehensive disaster plan to address any potential program relocations or closures due to a disaster, NTP patients would be at a greater risk of experiencing a break in treatment and potential relapse. Additionally, CCR Title 9, Chapter 4 requires NTPs to have protocols in place designed to secure patient medications and prevent diversion. Similar planning and implementation of these protocols, including detection and resolution of multiple registrations, supervised dosing and appropriate medication record keeping are critically necessary for an effective disaster response to make certain ongoing and appropriate access to care as well as the prevention of unsafe distribution of controlled substances.

Contrary to NTPs' disaster plans, the other licensed and/or certified SUD facilities, under the oversight of SUDCD's Driving-Under-the-Influence & Criminal Justice Section (DUI-CJS) and LCS, do not have the same extensive disaster plan requirements. During an emergency, these programs follow their standard emergency protocols, which may not be as comprehensive as NTPs' disaster plans. In the current regulations, a facility is only required to notify DHCS when they have to relocate a facility either in an emergency or non-emergency. There are no existing regulations or statutes that mandate licensed residential facilities to have an emergency plan in place. While some facilities may choose to implement emergency protocols or procedures, there is no consistency statewide on how facilities will address an emergency or disaster. This inconsistency or lack of protocols and procedures only contributes to the confusion while an emergency is occurring. When an emergency or natural disaster occurs, programs may be required to evacuate due to mandatory evacuation orders. Other programs may need to evacuate due to loss of water, electricity, program inaccessibility, or imminent danger caused by the natural disaster. In order to allow no break in treatment, programs must have a

comprehensive disaster plan in place to handle and dispense client's medication appropriately.

During the recent disasters, DHCS has become more cognizant of the importance of disaster response and has taken a more active role in disaster reporting and ensuring that programs are following their individual emergency protocols. Within LCS, residential programs follow their standard emergency plan, which have placed patients in situations that are not always the most conducive to their treatment and recovery. Some programs were forced to relocate their clients to the nearest public lodging, while others in rural areas have relocated to campgrounds. Programs have reported that they have done their best to maintain continuity of treatment, but in these events it has not been easy. Not having an organized and comprehensive disaster plan can be more disruptive to the patient's treatment during these emergencies. For example, patients may not have access to MAT and other treatment services during the time of relocation. The lapse in services such as individual counseling, group counseling, treatment planning, identification of goals, cognitive behavioral interventions, and routine activities increases the likelihood that patients leave treatment and relapse.

According to Substance Abuse and Mental Health Services Administration (SAMHSA), natural disasters can have a lasting impact on those who are forced to flee nature's path causing post-traumatic stress disorders (PTSD). Many patients diagnosed with SUD also have a co-occurring disorder and already suffer PTSD from previous traumas, therefore SUD programs need to be prepared to coordinate with other entities and provide the support system necessary to maintain continuity of care. Inadequate treatment services and access to medications increases the likelihood that patients will leave treatment and relapse.

The recent surge of natural disasters has also shown the significant need of having a more efficient method for disaster reporting. Currently, CDPH notifies DHCS of counties and/or zip codes impact by emergency disaster and requires the completion of an excel spreadsheet named the Facility Status Report (FSR), which is eventually submitted to the Office of Emergency Services (OES). In many cases, DHCS is responsible for trying to determine the potential facilities impacted by the disaster with very limited information. Upon notification of a disaster, SUDCD has redirected existing staff to assess the status of the programs in the affected area(s) and the magnitude of the disaster by manually mapping the disaster location and identifying the facilities that may be impacted. Once the FSR is completed, SUDCD routes it to the main DHCS emergency coordinator who compiles it with the FSRs for other impacted DHCS Divisions, including Mental Health and Primary Rural Indian Health. The consolidated DHCS FSR is submitted to CDPH via email and blended into the excel spreadsheet FSR for other impacted Departments. Through this cumbersome process, DHCS has identified the need for a more efficient reporting structure to make disaster reporting more timely and accurate.

On April 26, 2017, NC4 Public Sector, LLC was awarded a contract (RFC 16-PHE-3742) to provide CDPH with a SaaS Incident Management System. Through this system, CDPH will be able to upload facility status data directly into the NC4 FSR tab, eliminating the need for excel spreadsheets. Multiple staff can complete data entries at the same time and the NC4 database will track events in real time. The data from NC4 is fed into Tableau, a web-based dashboard, which can be utilized to generate detailed reports for the California Health and Human Services (CHHS) Agency and provide a visual "at-a-glance" dashboard summary report.

Licensing and Certification Section (LCS)

LCS has sole authority in state government to license and certify all facilities, regardless of their funding source, that provide residential and outpatient alcohol and other drug (AOD) treatment, detoxification, or recovery services to adults. LCS is responsible for processing initial and renewal applications for residential, outpatient, detoxification, adolescent waivers, incidental medical services, and for conducting site visits for each initial and renewal. LCS is also responsible for monitoring compliance with state, federal and local laws, statutes, and regulations by conducting on-site reviews every two years. Lastly, LCS collects fees and fines, and provides technical assistance to facilities. DHCS currently has a total of 1,895 residential and outpatient facilities. This includes 394 residential licensed, 618 residential licensed and AOD certified, and 883 AOD outpatient.

Senate Bill (SB) 84 (Chapter 177, Statutes of 2007), Health and Safety Code (HSC) Section 11833.02 was signed into law on August 24, 2007 and requires DHCS to charge fees for licensure and certification of all residential AOD recovery or treatment facilities and for certification of outpatient AOD programs. The ROPLF consists of all fines, fees, and penalties assessed to licensed and certified AOD providers. HSC Section 11833.03 establishes the ROPLF in the State Treasury into which all fees, fines, and penalties collected from residential and outpatient programs, which are deposited and made available upon appropriation by the Legislature for supporting the licensing and certification activities of residential and outpatient facilities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

**ISSUE 12: MEDI-CAL ELIGIBILITY SYSTEMS STAFFING BUDGET CHANGE PROPOSAL (MR
ISSUE 400)****PANELISTS**

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

The Department of Health Care Services (DHCS) requests the conversion of 13.0 limited-term (LT) resources to permanent, a two-year extension of 7.0 limited-term positions, and expenditure authority of \$2,968,000 (\$910,000 General Fund (GF)/\$2,058,000 Federal Funds (FF)) in fiscal year (FY) 2019-20. The resources will continue to oversee, govern, support, and implement the new and continuing policy-driven and infrastructure stabilization initiatives of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). These resources are critical in developing and managing these new and continuing initiatives to minimize county workarounds, increase operational efficiencies between various interfaces necessary for a timely Medi-Cal eligibility determination, and compliance with state and federal regulatory changes.

With most of the core statutory requirements of Assembly Bill (AB) XI 1, Chapter 3, Statutes of 2013, the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), collectively known as the Affordable Care Act (ACA), implemented, DHCS resources would oversee the transition of the software/system development lifecycle (SDLC) of CalHEERS to that of an iterative Agile methodology and maintain diligent oversight of an orderly transition and subsequent stabilization activities to a new system integrator contract in FY 2019-20. As CalHEERS transitions to the Agile framework, the DHCS resources will facilitate quality solutions for all functional changes to the Medi-Cal Eligibility Data System (MEDS) and maintain support of MEDS integration with CalHEERS. In parallel, the resources would continue to support policy and system enhancements to facilitate a consistent consumer experience across California using the Agile methodology and align resulting changes comport with Medi-Cal state statute and federal mandates.

The divisions impacted by this request are the Medi-Cal Eligibility Division (MCED) and the Enterprise Innovation and Technology Services Division (EITS).

BACKGROUND

Under the ACA, states were to either create a state-based insurance exchange or use the federal exchange and for such exchanges to be operational by January 1, 2014. Additionally, Medicaid expansions were required to be implemented by January 1, 2014. Covered California (Covered CA), California's state-based insurance exchange, went live on October 1, 2013.

In FY 2012-13, DHCS obtained 12.0 two-year LT positions (3.0 MCED/9.0 EITS) via the FY 2012-13 May Revise Letter MRHBEX12-03 to support the planning, design, development, implementation, and ongoing maintenance of the Medi-Cal eligibility and enrollment system changes and integration with CalHEERS and the county eligibility consortia systems. In FY 2014-15, the 12.0 positions were extended for another two-year term via Budget Change Proposal (BCP) MCED 14-02/030 (3.0 MCED/9.0 EITS). The position extensions were needed due to delays in federal regulations, policy guidance and state policy decisions, which caused significant scope and functionality delays in system delivery timelines. The ongoing workload at this time included continued system integration by EITS and continued development on State legislation. State Plan Amendments (SPAs), policy guidance for counties, incorporation of the Modified Adjusted Gross Income (MAGI) Medicaid and Children's Health Insurance Program (CHIP) eligibility rules into CalHEERS, and coordination of Insurance Affordability Program (IAP) transitions with Covered California by MCED.

In FY 2014-15, in conjunction with the implementation of CalHEERS, DHCS began the implementation of ABX1 1 (Chapter 3, Statutes of 2013). The legislation authorized DHCS to implement Medicaid provisions of the ACA, including the following:

- Implementation of the new "adult group" in California
- Transition of the Low Income Health Program (LIHP) beneficiaries to Medi-Cal
- Use of the MAGI methodology
- Simplifications to the annual renewal and change in circumstances processes for Medi-Cal beneficiaries
- Use of electronic verifications of eligibility criteria at initial application
- Redeterminations of eligibility and performance standards for DHCS, Covered CA, and the Statewide Automated Welfare Systems (SAWS)

DHCS received an additional 8.0 two-year LT positions (4.0 MCED/4.0 EITS) via FY 2014- 15 BCP ABX 1 1/032 to handle the workload mentioned above.

In FY 2016-17, DHCS obtained three-year LT funding for 20.0 staff resources and technical training, as well as 4.0 permanent positions via the Medi-Cal Eligibility Systems BCP (4260- 010-BCP-DP-2016-GB). Seven (7.0) of those positions reside in MCED, and thirteen (13.0) in EITS. Since the majority of the initial requirements had been implemented and CalHEERS project was starting the transition to maintenance and operation (M&O), knowledge transfer to state staff ramped up, with the ultimate goal of M&O assumed by the State.

The 20.0 LT positions are set to expire on June 30, 2019. With significantly reduced contractors, it is requested that DHCS retain these state positions for continued support. The same resources are expected to direct and support the transition-in phase through June 2020, and to effectively manage any business, operations and security risks associated with a potential new system integrator following June 2020 for CalHEERS' continuing maintenance and operations. CalHEERS is a complex and highly utilized system, supporting over 12,000 enrollments with 30,000 transactions per hour. Ongoing policy changes and system enhancements need dedicated resources to keep beneficiaries' data in sync and maintain data integrity between CalHEERS, MEDS and other associated systems. These existing DHCS resources are necessary to maintain the consistency of its delivery to both internal and external stakeholders. The inability to consistently deliver services could result in a delay to implement changes to both CalHEERS and MEDS. DHCS would likely be unable to meet the proposed timelines in the 24-Month Roadmap, which is treated as DHCS' commitment to external stakeholders who rely on timely and accurate eligibility determinations.

The resources requested in this BCP are separate and distinct from any of the resources OSI has supporting CalHEERS workload or other eligibility and enrollment projects. The resources DHCS is requesting are tied to the integration of Medi-Cal policy with MEDS and CalHEERS, as well as any MEDS or interface changes to the integration between MEDS and CalHEERS, CalHEERS reconciliation, and other CalHEERS-related work. Frequently, these policy changes include legislative mandates by the state or federal government that must be met in a specified timeframe.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 13: MANAGED CARE SANCTIONS MR TRAILER BILL**PANELISTS**

- **Department of Health Care Services**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

This proposal would broaden the Department of Health Care Services' (DHCS) authority to sanction any entity that contracts with DHCS to deliver health care services. This proposal would also allow DHCS to enter into contracts, and be exempted from the Department of General Services' (DGS) contract approval process, for the purpose of strengthening oversight and the quality of preventive services for children in Medi-Cal.

BACKGROUND

DHCS contracts with different types of external entities for the provision of health care services. The Medi-Cal managed care delivery system is the largest example of this, with nearly 80 percent of all Medi-Cal beneficiaries enrolled in a Medi-Cal managed care health plan (MCP). DHCS also contracts with other entities for the delivery of health care services, such as specialty plans not governed by Medicaid managed care regulations, County Mental Health Plans, and Drug Medi-Cal Organized Delivery System providers.

In response to recent concerns regarding children in Medi-Cal not receiving the preventive services to which they are entitled, DHCS identified several areas for improvement including access to preventive care and oversight of the delivery of these services.

Existing law authorizes DHCS to impose sanctions, up to and including contract termination, it is limited to MCPs that fail to comply with legal or contractual requirements. However, DHCS needs to be able to hold contractors accountable, in a consistent manner across multiple delivery systems, for the quality of the health care services that they deliver. This proposal would also increase and standardize amounts of monetary penalties; codify specific violations previously included in state regulations; and apply the sanction authority to any contractor providing health care services. Most of the moneys collected as a result of these statutory changes shall be deposited into the General Fund. Additionally, this proposal would allow DHCS to enter into exclusive or non-exclusive contracts, and be exempt from DGS' contract review or approval process, in order to

strengthen oversight and the quality of preventive services for children enrolled in health care programs administered by DHCS.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DHCS present this trailer bill proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

8860 DEPARTMENT OF FINANCE
7730 FRANCHISE TAX BOARD

ISSUE 14: COVERED CALIFORNIA SUBSIDIES AND MANDATE PROPOSAL UPDATES**PANELISTS**

- **Department of Finance**
- **Legislative Analyst's Office**
- **Covered California** *(for questions and technical assistance only)*
- **Public Comment**

PROPOSAL

It is requested that Item 4800-101-0001 be added in the amount of \$295,272,000 to provide resources for advanced premium assistance subsidies to individuals who purchase coverage through the Health Benefit Exchange. Individuals between 200 and 400 percent of the federal poverty level will be eligible for both state and federal premium assistance. Individuals between 400 and 600 percent of the federal poverty level will be solely eligible for state premium assistance.

It is also requested that the following provisional language be added to direct the Exchange to develop a program design within specified parameters for coverage year 2020:

4800-101-0001—For local assistance, California Health Benefit Exchange..... 295,272,000

Schedule:

(1) 4202-State Subsidy Program 295,272,000

Provisions:

1. Pursuant to Title 25 of the Government Code and the program design adopted by the Exchange in accordance with that title, the amount appropriated in this item shall provide advanceable premium assistance subsidies during the 2020 coverage year to individuals with projected and actual household incomes at or below 600 percent of the federal poverty level.
2. Of the amount available in this item, the program design, in accordance to Title 25 of the Government Code, shall allocate approximately 25 percent to provide advanceable premium assistance subsidies to individuals with household incomes above 200 and at or below 400 percent of the federal poverty level and approximately 75 percent to provide advanceable premium assistance subsidies to individuals with household incomes above 400 and at or below 600 percent of the federal poverty level.
3. The Director of Finance may authorize an increase in this appropriation to pay all premium assistance subsidies authorized for the 2020 coverage year pursuant to the program design. Any augmentation under this provision shall be authorized no sooner than 10 days after notification in writing of the necessity thereof to the Joint Legislative Budget Committee, or not sooner than whatever lesser time after notification the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine.
4. Notwithstanding any other provision of law, funds appropriated for the 2020 coverage year pursuant to this item may be encumbered until December 31, 2021.

The May Revise proposes to revise and clarify the January budget proposal for providing new and increased subsidies to populations with health coverage through Covered California by:

- Lowering eligibility for the subsidies from 250 percent of the federal poverty level (FPL) to 200 percent FPL.
- Begins providing subsidies and enforcing an individual mandate penalty on January 1, 2020.
- Includes \$295.3 million General Fund in 2019-20, \$330.4 million in 2020- 21, and \$379.9 million in 2021-22 to cover the costs of the subsidies, and assumes penalty revenue projections of \$317.2 million in 2020-21, \$335.9 million in 2021-11 and \$352.8 million in 2022-23.
- Allocates 75 percent of the subsidy expenditures on subsidies for individuals between 400 and 600 percent FPL, for subsidies that average around \$100 per

month, and 25 percent of expenditures on individuals between 200 and 400 percent FPL, for subsidies averaging around \$10 per month.

- Includes \$8.2 million ongoing General Fund for the Franchise Tax Board to implement the individual mandate and reconcile annual subsidy payments.

Legislative Analyst's Office

The LAO provided the following analysis:

Key Updates to Governor's Proposal Since January

Subsidies to Be Modeled After Federal Advance Premium Tax Credit (APTC). The administration's subsidies would limit a qualifying households' net premium payments to a certain percentage of income. Like the federal APTC, the state subsidy could be advanced to health insurers to immediately reduce the household's monthly premiums. At the end of the year, the state subsidies would be reconciled through the state income tax system.

Eligibility for Subsidies Would Extend Down to 200 Percent of Federal Poverty Level (FPL). In January, the Governor proposed making state subsidies available to households with incomes between 250 percent and 600 percent of FPL. The administration stated that it did not propose making state subsidies available to households under 250 percent of FPL because such households qualify for federal cost-sharing reduction subsidies in addition to the federal APTC. In the May Revision, the administration now proposes making state subsidies available down to 200 percent to FPL, in response to concerns that cost-sharing reduction subsidies are not significant for households with incomes between 200 percent and 250 percent of FPL.

Relatively Larger Subsidies to Be Provided to Currently Unsubsidized Households... In the May Revision, the administration proposes allocating 75 percent of subsidies in 2020 (the first year subsidies would be available) to households with incomes between 400 percent and 600 percent of FPL. These households are currently not eligible for the federal APTC, and therefore pay the full premium cost of coverage. The proposed state subsidies would limit these households' net premiums to a fixed percentage of income. (Detail on what this percentage of income would be is forthcoming from the administration.) The administration estimates that the average subsidy for households in this income range would be about \$100 per month.

...With Relatively Smaller Subsidies for Households Eligible for Federal Assistance. The remaining 25 percent of subsidies in 2020 would be allocated to households with incomes between 200 percent and 400 percent of FPL that are currently eligible for the federal APTC. The administration estimates that the average subsidy for households in this income range would be about \$10 per month.

Subsidies Would Sunset at the End of 2022. The administration proposes to make the subsidies available for three years, with a sunset at the end of 2022. Consistent with the January proposal, subsidies provided over this period would be fully covered by individual mandate penalty revenues. However, because households required to pay the penalty will not do so until early 2021 (when state income taxes are filed for 2020), the state General Fund would cover the cost of subsidies provided in 2019-20, as shown in the table below. Penalty revenues generated after the subsidies sunset would be used to reimburse the General Fund for the costs not covered by penalty revenues in prior years, including in 2019-20. The individual mandate penalty would be ongoing.

Individual Mandate Penalty Revenues and Insurance Subsidy Costs				
<i>Administration Projection (In Millions)</i>				
	2019-20	2020-21	2021-22	2022-23
Penalty revenues	—	\$317.2	\$335.9	\$352.8
Subsidy costs	-295.3	-330.4	-379.9	—
Net General Fund Impact	-\$295.3	-\$13.2	-\$44.0	\$352.8

LAO Comments

Revenue Projections Appear Reasonable. The May Revision provides the administration's estimate of how much penalty revenues would be generated by the state individual mandate, as shown in the above table. The May Revision projections are lower than initial estimates that were based on federal data because fewer people would be subject to the proposed state individual mandate than have been subject to the federal individual mandate. The administration's penalty revenue projections appear reasonable. However, we have not received detailed information at this time on the assumptions that informed the projections. We will advise the Legislature if we have concerns with penalty revenue projections once we have reviewed these assumptions.

No Concerns With Proposal for Administration of Penalty and Subsidy Reconciliation. The May Revision budget includes \$8.2 million in 2019-20 for the Franchise Tax Board to implement the proposed state individual mandate penalty and to reconcile state insurance subsidy payments. Following one-time start-up costs, administration of the individual mandate penalty would be funded on an ongoing basis because it would not have a sunset date.

Proposal to Sunset Subsidies Raises Questions. As we note in our office's [Initial Comments on the Governor's May Revision](#), the Governor sunsets a variety of budget-year proposals, in order to maintain a balanced budget through the forecast period ending in 2022-23. We raise a number of concerns with the Governor's approach, finding that the May Revision understates the true ongoing cost of its policy commitments.

Cost of Subsidies for Currently Unsubsidized Households Could Grow Rapidly. The federal APTC covers the difference between premium costs and a certain percentage of a household's income. While this insulates the household from year-over-year growth in health insurance premiums, nearly all of the cost of increased premiums must be covered by the subsidy. Consequently, the cost of the federal APTC grows more rapidly (on a percentage basis) than health premiums. The proposed state subsidy for households with incomes between 200 percent and 400 percent of FPL would be insulated from increases in health premiums. However, similar to the federal APTC, the proposed state subsidy for households with incomes between 400 percent and 600 percent of FPL could be subject to rapid cost escalation over time. The administration has indicated that subsidies would be adjusted for 2021 and 2022 so that subsidy expenditures would fit within projected penalty revenues. If the subsidies are continued after 2022, the state would need to weigh controlling the cost of the subsidies against controlling households' net health insurance costs on an ongoing basis.

STAFF COMMENTS/QUESTIONS

The Subcommittee heard the Governor's Budget proposal to expand existing, and create new, subsidies for individuals with Covered California health coverage, and to impose a state individual mandate penalty for lack of health care coverage on April 8, 2019 (Issue #1, page 4).

The Subcommittee requests DHCS present the changes to this proposal included in the May Revision, and respond to the following:

1. What factors did the administration consider in developing its projection of individual mandate penalty revenue?
2. What is the rationale for ending subsidies after 2022 but making the individual mandate penalty ongoing? How would the state address pressure to continue subsidies beyond 2022 within the framework of the Governor's May Revision budget structure?
3. Under the proposed subsidy structure, could households with incomes close to 400 percent of FPL be subject to large subsidy repayments if they are ultimately determined to have income less than 400 percent of FPL when filing income taxes?
4. Would proposed subsidies for households in the income range of 200 percent to 400 percent of FPL meaningfully reduce premium costs or ease compliance with the individual mandate for those that currently would be out of compliance?
5. How rapidly might the cost of subsidies for households in the income range of 400 percent to 600 percent of FPL grow in future years if the structure of those subsidies is not adjusted to lower their cost after 2020?

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 15: FRANCHISE TAX BOARD INDIVIDUAL MANDATE BUDGET CHANGE PROPOSAL**PANELISTS**

- **Franchise Tax Board**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

Franchise Tax Board (FTB) requests \$8.2 million and 50 positions in 2019-20; \$11.6 million and 124 positions in 2020-21; \$11.8 million and 122 positions in 2021-22; and \$8.1 million and 100 positions ongoing to administer the provisions in Government Code Title 24 (commencing with Section 100700) Minimum Essential Coverage Individual Mandate and Title 25 (commencing with Section 100801) Affordable Care Access Plus Program.

BACKGROUND

Title 24 (commencing with Section 100700) has been added to the Government Code for the Minimum Essential Coverage Individual Mandate. The individual mandate imposed by this title, and the penalty imposed by Part 32 (commencing with Section 61000) of the Revenue and Taxation Code, are necessary to protect the compelling state interests of:

1. Protecting the health and welfare of the state's residents.
2. Ensuring access to affordable health care coverage in this state.
3. Ensuring a stable and well-functioning health insurance market in this state.

For each month beginning on or after January 1, 2020, an applicable individual shall be enrolled in and maintain at least minimum essential coverage for that month. If an applicable individual fails to meet the requirements of Section 100705 of the Government Code for one or more months, then, except as provided in Section 61020, there is imposed a penalty on the applicable individual with respect to that failure in the amount determined under Section 61015. This penalty is referred to as the Individual Shared Responsibility Penalty. A penalty imposed by this section with respect to any month shall be included with an applicable individual's return.

FTB's civil authority and procedures for purposes of compliance with notice and other due process requirements imposed by law to collect income taxes shall be applicable to the collection of the Individual Shared Responsibility Penalty. Monies collected from the Individual Shared Responsibility Penalty shall be deposited into the General Fund.

Title 25 (commencing with Section 100801) has been added to the Government Code for the Affordable Care Access Plus Program. This program is being established to help low-income and middle-income Californians access affordable health care coverage through the California Health Benefit Exchange (Exchange). The program will provide financial assistance to California residents with household incomes at certain income levels compared to the Federal Poverty Level and may provide other appropriate subsidies designed to make health care coverage more accessible and affordable for individuals and households.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Franchise Tax Board present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

4265 DEPARTMENT OF PUBLIC HEALTH (DPH)

ISSUE 16: INFECTIOUS DISEASE CONTROL PROPOSAL (MR ISSUE 404)**PANELISTS**

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

In the Governor's May Revision, the Department of Public Health (DPH) requests one-time funding of \$40 million from the General Fund, available for expenditure over four years to address prevention and control of infectious diseases. Of the total, \$8 million would fund state operations including four positions and interagency agreements for consulting services and \$32 million would fund grants for local health jurisdictions and tribal communities.

Infectious Diseases Prevention and Control (Issue 404)-It is requested that Item 4265-001-0001 be increased by \$8 million and 4 positions and Item 4265-111-0001 be increased by \$32 million to reflect one-time resources, available over four years, for infectious diseases prevention and control activities. The resources will enable the Department to provide annual grants to local health jurisdictions and tribal communities for infectious disease prevention, testing, and treatment activities. These funds will also be available to support state grant management activities and technical assistance to grant recipients.

It is also requested that provisional language be added to Item 4265-001-0001 and Item 4265-111-0001 to authorize the encumbrance or expenditure of funds until June 30, 2023, as follows:

Add the following provision to Item 4265-001-0001:

4. Of the funds appropriated in Schedule (2), \$8,000,000 shall be available for encumbrance or expenditure until June 30, 2023, to support infectious diseases prevention and control activities by the State Department of Public Health.

Add the following provision to Item 4265-111-0001:

3. Of the funds appropriated in Schedule (2), \$32,000,000 shall be available for encumbrance or expenditure until June 30, 2023, and are available for the State Department of Public Health to issue grants to local health jurisdictions and tribal communities for infectious diseases prevention and control activities. The funds identified in this provision shall not supplant existing services at the local level.

BACKGROUND

California is experiencing a well-documented public health crisis when it comes to rates of sexually transmitted diseases (STDs), which in many cases are at their highest levels in decades. In addition, DPH and local health jurisdictions must respond to other infectious disease outbreaks, such as the norovirus outbreak that occurred in the temporary shelters for individuals displaced by the Camp Fire in 2018. In addition to a request made in January for \$2 million ongoing from the General Fund for STD prevention and treatment, this proposal would significantly increase the funding available to prevent and control infectious disease transmission and outbreaks.

STAFF COMMENTS/QUESTIONS

The Subcommittee heard various Member and stakeholder proposals related to infectious disease control on May 6, 2019 (Issue #5, pages 7-8, and Issue #12, pages 27-30).

The Subcommittee requests DPH present this proposal and respond to the following:

1. What is the extent of current knowledge about what is causing the rapid rise in STDs? (Such increases are occurring in California and nationally.) Without a better understanding of the causes, how will DPH know that it is targeting the right activities through its grant program for local health jurisdictions and tribal communities?
2. Why is 20 percent of the funding going toward state operations? In three of DPH's other proposals this year that would similarly provide grants to local governments, the share requested for state operations ranges from 0 percent to 9 percent (in one case the share was subsequently modified for 2019-20 to reflect new one-time responsibilities associated with the Governor's Task Force on Alzheimer's Prevention and Preparedness). Although some of the state operations funding in the proposal related to infectious diseases would be for consulting services through interagency agreements, it is unclear what services would be provided and which agencies would provide them. We suggest the Legislature ask for additional clarification.

3. How would DPH reach out to tribal communities—which nationally have higher rates of STDs than do whites—to ensure they receive appropriate levels of funding or services either through agreements with local health jurisdictions or through grants directly from DPH?
4. What was the rationale for one-time funding over four years? How will DPH determine at the end of the four-year period whether funding should continue to be provided? What benchmarks and trends will be included in the final report that will allow DPH and the Legislature to assess future funding requirements?

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 17: HIV CARE PROGRAM FINANCIAL ELIGIBILITY TRAILER BILL**PANELISTS**

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

This proposed trailer bill will allow HCP to adopt the financial eligibility requirement used by the AIDS Drug Assistance Program (ADAP). ADAP is a statewide program, is also funded by RWHAP (Part B), and shares many of the same clients as HCP.

California Health and Safety Code Section 120960 defines ADAP's financial eligibility requirement as clients with a Modified Adjusted Gross Income (MAGI) that does not exceed 500 percent of the federal poverty level (FPL) per year based on family size and household income. Should ADAP's requirement change in the future, HCP's will automatically change.

A small number of existing clients will no longer be financially eligible for HCP services. In calendar year 2018, HCP served about 91 clients whose income exceed 500 percent of FPL, less than one percent of all clients served. There is no 2019-20 fiscal impact as any RWHAP (Part B) savings from clients no longer eligible for HCP will be redirected for other eligible services.

In addition to defining the financial eligibility for HCP, the proposed statutory changes will rename the CARE Services Program to the HIV Care Program, as it is currently known. The proposed sections shall become operative on April 1, 2020 to (1) coincide with the start of the RWHAP (Part B) fiscal year; (2) coincide with the conclusion of the next open enrollment period for Covered California; and (3) provide sufficient time for all current HCP clients to complete their biannual recertification

BACKGROUND

The HIV Care Program (HCP) is funded through the Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) (Part B). Local assistance is about \$27 million in base award (X07) and \$6 million in supplemental funds (X08). HCP served about 12,790 clients in calendar year 2018.

The California Department of Public Health (CDPH) contracts with 43 local health departments and community-based organizations to provide HCP services in all 58 counties. Contractors may fund any combination of 21 allowable service categories – ranging from medical case management to outpatient/ambulatory health services, from food bank/home-delivered meals to medical transportation services. The mix of services varies from county to county depending on local resources and needs.

The federal RWHAP defines eligibility for the program as an individual (1) with a medical diagnosis of HIV/AIDS and (2) who is low-income as defined by the State (42 USC Section 300ff-26[b]).

In March 2016, HRSA issued a finding that HCP had no established financial eligibility requirement. Financial eligibility varied from county to county, with some HCP contractors adopting requirements from RWHAP Part A, creating their own requirements, or having none. HRSA findings stated that CDPH did not “consistently define ‘low-income’ in Part B eligibility criteria throughout the state.”

This proposed trailer bill will allow HCP to adopt the financial eligibility requirement used by the AIDS Drug Assistance Program (ADAP). ADAP is a statewide program, is also funded by RWHAP (Part B), and shares many of the same clients as HCP.

California Health and Safety Code Section 120960 defines ADAP’s financial eligibility requirement as clients with a Modified Adjusted Gross Income (MAGI) that does not exceed 500 percent of the federal poverty level (FPL) per year based on family size and household income. Should ADAP’s requirement change in the future, HCP’s will automatically change.

A small number of existing clients will no longer be financially eligible for HCP services. In calendar year 2018, HCP served about 91 clients whose income exceed 500 percent of FPL, less than one percent of all clients served. There is no 2019-20 fiscal impact as any RWHAP (Part B) savings from clients no longer eligible for HCP will be redirected for other eligible services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 18: PROPOSITION 64 YOUTH SUBSTANCE ABUSE PREVENTION PROPOSAL**PANELISTS**

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

Proposition 64 directs the Department of Health Care Services to establish interagency agreements with the Department of Public Health and the Department of Education. The May Revision includes \$119 million in spending from the Youth Education, Prevention, Early Intervention and Treatment Account. The Department will provide \$12 million to the Department of Public Health for surveillance and education activities. The Department will also provide the Department of Education with \$80.5 million to fund up to 9,600 slots for income-eligible families for afterschool and summer care for school-age children up to 13 years old through the General Child Care program. With funding of \$21.5 million, DHCS will support local programs that emphasize prevention, education and early intervention for youth through a competitive grant program and informed through a stakeholder process. Lastly, \$5.3 million will be provided to the California Natural Resources Agency to fund youth community access grants that support natural or cultural resources, with a focus on low-income and disadvantaged communities for positive programming to discourage substance use. Specifically, the May Revision includes the following:

- \$21.5 million to DHCS to implement competitive grants to develop and implement new youth programs in the areas of education, prevention, and early intervention of substance use disorders.
- ***\$12 million to the Department of Public Health for cannabis surveillance and education activities.***
- \$80.5 million to the Department of Education to subsidize child care for school-age children of income-eligible families.
- \$5.3 million to the California Natural Resources Agency to support youth community access grants to increase access to natural and cultural resources for low-income youth and disadvantaged communities.

STAFF COMMENTS/QUESTIONS

The Subcommittee discussed Proposition 64 on March 25, 2019 (Issue #2, page 17).

The Subcommittee requests DPH present the DPH portion of this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

**ISSUE 19: EMERGENCY PREPAREDNESS RESPONSE AND RECOVERY BUDGET CHANGE
PROPOSAL****PANELISTS**

- **Department of Public Health**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

The California Department of Public Health (Public Health), Center for Health Care Quality (CHCQ), and Emergency Preparedness Office (EPQ) request 6 permanent positions and \$959,000 (\$569,000 General Fund and \$390,000 State Department of Public Health Licensing and Certification Program Fund) in 2019-20 and annually thereafter to support health care facilities and mass care shelters during emergency and disaster preparedness, response, and recovery efforts. The request includes resources to train and deploy infection control teams and allow for 24/7 updates to an existing IT mapping application that displays public health and medical facilities.

BACKGROUND

Public Health responds to numerous public health events on a daily basis. Public Health has responded to significant disasters such as the California wildfires of 2003, 2007, 2008, 2009, 2012, 2015, 2016, 2017, and 2018, in which the 2018 wildfire season was the most destructive on record in California history; Hurricane Katrina in 2005; floods in 2006, 2009, 2010, 2017, and 2018; extreme heat events in 2006, 2007, 2008, 2013, and 2016; the Baja California Earthquake in 2010; the tsunami and radiation threat from the Fukushima earthquake in 2011; the Napa Earthquake in 2014; the 2010 Barstow Drinking Water Incident; the 2011 Southern California power outage; Ebola Virus Disease of 2014; Drought of 2014; H1N1 Outbreak of 2009; Influenza Outbreak in 2014, 2017, and 2018; the 2016 Zika Virus Outbreak; 2017 Oroville Dam Incident; 2017 Hepatitis A Virus Outbreak; 2016 Meningococcal Outbreak; and the 2018 Opioids Crisis.

Public Health played an active role in responding to the most recent wildfires. Public Health, along with the Emergency Medical Services Authority (EMSA), activated its Medical and Health Coordination Center (MHCC) to coordinate the public health and medical response across departments in collaboration with local partners; staffed the State Operations Center; provided situational awareness on the impact to health care facilities that Public Health licenses or credentials; assisted health care facilities with resource needs to continue operations or evacuate their patients; provided technical

assistance to repopulate facilities; provided support and guidance to all local health jurisdictions including issues such as air quality, the use of N95 respirators, debris removal, and health officer emergency powers; delivered supplies and equipment to shelters; and deployed infection control teams to reduce the spread of norovirus in the many shelters in Butte County.

In recent years, the number of events occurring in California that has required CHCQ coordination with EPQ has increased substantially. Over the past year, Public Health has activated its MHCC for emerging infectious diseases such as Zika, Hepatitis A, and influenza; major wildfires that have burned through highly populated areas causing mass evacuations and a number of deaths; floods and even mudslides. As a result, the MHCC has been activated nearly every day of the year for the past two years. The Oroville Dam crisis, recent wildfires of Napa/Sonoma, the Thomas Fire in Ventura County, Mendocino Complex Fire, and the deadly Camp Fire in Butte County and subsequent mudslides required swift and immediate action from CHCQ as well as the continued around the clock and 7 days a week response efforts. During the recent fires, CHCQ performed its emergency response and repopulation support duties despite significant personal impact to staff who live in the affected areas. CHCQ fulfills roles beyond the conclusion of emergency events in recovery efforts by determining the readiness of facilities for repopulation. In addition, the decision by utilities to reduce the impact of fires by shutting down power under the Public Safety Power Shutoff program across the state has led to additional workload for staff in mapping the facilities within the impacted utility areas, notifying facilities, and tracking the individual facility impacts.

Public Health's response structure depends on adequate staffing within the local health department, the local emergency medical services agency, the region, and the state. Given the recent experience with multiple fires burning across the state and the impact on both large and small counties, Public Health has assessed the need for additional trained staff to backfill the local health department, the Regional Disaster Medical and Health Coordinators/Specialists (currently up to one of each per mutual aid region), and various state response roles.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

4440 DEPARTMENT OF STATE HOSPITALS (DSH)**ISSUE 20: DSH BUDGET UPDATE (MR ISSUES 089, 090, 091, 092, 093, 094, 095, 096, 098, 100, 103)****PANELISTS**

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- *Public Comment*

PROPOSAL

The May Revision's Budget reflects a net increase of \$7.8 million in General Funds (GF) and 1.2 positions. The following provides specific detail of budget adjustments from the 2019-20 Governor's Budget.

DSH Estimate (\$1.3 million GF)

DSH continues to seek solutions to address the significant growth in its patient population. As of April 29, 2019, DSH has a total of 1,095 patients pending placement, of which 808 are Incompetent to Stand Trial (IST). DSH continues to explore alternatives both in the state hospitals and through contracted facilities to address the waitlist. Additionally, DSH continues to evaluate the services it provides to its patients, its staffing resources, and its infrastructure. Significant adjustments for state hospitals include:

- ***Patient Driven Operating Expenses and Equipment (\$547,000 GF in FY 2019-20 and ongoing) (MR Issue 092).*** In the 2019-20 Governor's Budget, DSH requested \$10.5 million in FY 2019-20 and ongoing to support the operating cost per patient. The request was to fund the 547 state hospital beds activated since FY 2012-13, as well as the beds activated in FY 2018-19. Based on updated projected census figures by June 30, 2020, DSH is requesting an additional \$547,000 in FY 2019-20 and ongoing to support the operating cost per patient.
- ***Lanterman-Petris-Short Population Services Adjustment (\$2.74 million in FY 2019-20 and ongoing) (MR Issue 090).*** DSH admits Lanterman-Petris-Short (LPS) patients through civil commitment processes. LPS beds are funded through reimbursements from counties that use the DSH system. Due to the increasing LPS population, DSH's reimbursement authority is not sufficient for the services provided to counties. In the 2019-20 Governor's Budget, DSH requested an increase of \$606,000 in reimbursement authority in FY 2019-20 based on LPS bed

usage. Based on updated collection figures, DSH is requesting an additional \$2.74 million in reimbursement authority for the 2019-20 May Revision.

- **2014 South Napa Earthquake Repairs (-\$1.14 million in FY 2018-19 and - \$608,000 in FY 2019-20) (MR Issue 091).** Funding via prior Budget Acts have been approved for the repairs associated with the damage at DSHNapa resulting from the South Napa earthquake in August 2014. DSH prioritized the repairs to DSHNapa's buildings into three projects. While funding for Projects 1 and 2 remain status-quo, in the 2019- 20 May Revision, DSH is reporting a one-time savings of \$1,138,958 in FY 2018-19 and \$608,479 in FY 2019-20 because DSH will not be proceeding with completion of the remaining Project 3 repairs which are comprised of minor cosmetic repairs, including plaster repairs and painting. Due to ongoing challenges and delays in the availability and hiring of casual labor, DSH has not been able to make significant efforts towards completing Project 3 repairs. Further complicating the issue, these repairs are within patient occupied areas and would require swing space to complete the project that DSHNapa does not currently have available. Furthermore, recent storms have caused roof leaks that have damaged the cosmetic repairs already made. As such, the Department is cancelling remaining Project 3 deliverables.
- **Enhanced Treatment Program Staffing (-\$2.62 million and -7.1 positions in FY 2018-19 and -\$577,000 and 2.3 positions in FY 2019-20 one-time GF) (MR Issues 097 and 100)**The Enhanced Treatment Program (ETP) is a new enhanced level of care designed to treat patients who are at the highest risk of violence and who cannot be safely treated in a standard treatment environment. These units will provide improved treatment with a heightened secure setting to patients with a demonstrated and sustained risk of aggressive, violent behavior toward other patients and staff.

Construction and activation of the ETP units was delayed due to various reasons such as existing site conditions, code issues, and resulting change required by the State Fire Marshal. Further delays are due to unforeseen conditions such as unknown regular and low voltage electrical conduits and materials damages and unexpected ductwork. As a result of these delays, DSH anticipates a savings of \$2.62 million in current year and \$716,000 in budget year. Additionally, DSH proposes to redirect \$139,000 of the savings reported in FY 2019-20 to critical needs identified for DSH-Patton's ETP unit.

- **DSH-Metropolitan Increased Secured Bed Capacity (-\$3.4 million and -22.5 position in FY 2018-19 and -3.1 million and -20.1 in FY 2019-20 one-time GF) (MR Issue 096).** To provide additional capacity to address the ongoing system-wide forensic waitlist with a particular focus on the continuing IST waitlist, this expansion at DSH-Metropolitan is the final phase of the project. DSH has received

approval via past Budget Acts for positions and funding for Units 404, 406, and 408. Consistent with the previous units, DSH requested 119.3 partial year positions and \$18.6 million in 2019-20 for Units 412 and 414 in the 2019-20 Governor's Budget. The net impact of the Continuing Treatment West (CTW) Building and 100s Building renovations will be the activation of 236 additional beds at DSH-Metropolitan. As of the 2019-20 May Revision, there have been minor delays (two months) due to an initial delay in the contract award. In addition, there was a delay due to a new State Fire Marshal requirement for fire sprinkler pipe fitter companies to have certified workers. The delays resulted in DSH reporting a savings of \$3.4 million in FY 2018-19 and reduction of position authority by 22.5 for Units 406 and 408. For Units 412 and 414, DSH is reporting a reduction of funding by \$3.1 million and 21.6 positions in FY 2019-20.

- ***Telepsychiatry Resources (\$2.2 million and 11.0 positions in FY 2019-20, \$3.7 million and 21.0 positions in FY 2020-21 and \$3.5 million and 21.0 positions ongoing) (MR Issue 095).*** To expand the use of telepsychiatry and ensure appropriate delivery of care, DSH proposes to expand the current program to add clinical oversight and supervision, telepsychiatry coordinators, as well as sufficient information technology (IT) equipment and resources. To accommodate this expansion, DSH requests 11.0 positions and \$2,205,315 in FY 2019-20 and 21.0 positions and \$3,698,049 in FY 2020-21. The ongoing request starting in 2021-22 will be 21.0 positions and \$3.5 million.

Conditional Release Program (CONREP) Estimate (\$4.7 million in FY 19-20 and 11.6 million ongoing GF)

- ***CONREP SVP Program Update (-\$1.0 million in FY 2018-19 and -\$1.0 million in 2019-20 GF) (MR Issue 089).*** As of the 2019-20 May Revision, DSH assumes a caseload reduction of three SVPs in the current year from the total projected in the Governor's Budget, resulting in a total caseload of 18 SVP clients in CONREP by June 30, 2019. In FY 2019-20, an additional three SVPs are assumed to be released, for a total CONREP-SVP caseload of 21 by June 30, 2020. This projected population change results in a net decrease of two SVP clients from the total projected at Governor's Budget. The estimated caseload and budget are in accordance with the actual and updated schedule for release of SVP clients to CONREP. As such, DSH is reducing the request in FY 2018-19 by \$1,013,000 and by \$994,000 in FY 2019-20 and ongoing.

- **CONREP – Expand Continuum of Care: Step-Down Transition Program (\$5.7 million in 2019-20 and \$11.6 million in 2020-21 and ongoing GF) (MR Issue 093).** DSH proposes to expand its continuum of care for state hospital/CONREP patients via establishing a step-down program. DSH is requesting \$5.7 million in FY 2019-20 (\$11.5 million ongoing) to contract for a 78-bed vendor operated community step-down program to serve Mentally Disordered Offenders and Not Guilty by Reason of Insanity commitments who are preparing for conditional release from state hospitals within 18 to 24 months. This funding also includes expanding DSH's existing contract with Sylmar Health and Rehabilitation Center by four (4) beds for a total of 24 beds.

Contracted Patient Services Estimate (-\$725,000 in FY 2018-19 and -\$5.9 million in 2019-20 GF) (MR Issue 094)

- **Jail-Based Competency Treatment (JBCT) Existing Program Cost Decrease (-\$727,000 in FY 18-19 and -\$168,000 19-20 and ongoing GF).** As of the 2019-20 May Revision, DSH has identified cost savings totaling \$727,000 in 2018-19 and \$168,000 in 2019-20 and ongoing due to activation delays and changes to program capacity.
- **JBCT New Programs (\$2,000 in FY 2018-19, \$5.7 million in FY 2019-20 and \$9,000 ongoing GF)**
As of the 2019-20 May Revision, DSH has updated its assumptions commensurate with the timing of contract execution and program activation for the new programs identified in the 2019-20 Governor's Budget. As a result, DSH is adjusting its funding request by \$2,000 in 2018-19 and reporting a savings of \$5.7 million in 2019-20 and \$9,000 in ongoing to reflect the phased-in plan of new program activations.
- **Technical Adjustment—Interagency Agreement with HHS Agency (Issue 103)**—It is requested that Item 4440-011-0001 be decreased by \$222,000 to reflect an adjustment to the interagency agreement between the Department and the HHS Agency. Historically, the Department's budget has included funding for one HHS Agency position. In a companion proposal (see Issue 406 in the HHS Agency Finance Letter), the Agency is requesting a corresponding General Fund increase. This adjustment would properly align the funding with position authority in the HHS Agency budget.
- **Technical Adjustment—California State Lottery Education Fund (Issue 098)**—It is requested that the California State Lottery Education Fund under the Department of State Hospitals be increased by \$6,000 to reflect updated funding from the California State Lottery Education Fund.

STAFF COMMENTS/QUESTIONS

The Subcommittee heard the Governor's Budget DSH budget and January proposals on March 4, 2019.

The Subcommittee requests DSH highlight the key changes to the DSH budget in the May Revise, that are not described in more detail in a later issue in this agenda.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

**ISSUE 21: DISASTER PREPAREDNESS, RESPONSE AND RECOVERY BUDGET CHANGE
PROPOSAL (MR ISSUE 087)****PANELISTS**

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

This proposal is part of the Administration's larger Disaster Preparedness, Response and Recovery May Revision package. Based on lessons learned and due to the increased magnitude, frequency and complexity of recent disasters and those likely to come, the May Revision includes resources for various departments to enhance the State's disaster response preparedness and support the continuity of state government during disasters. These additional resources will provide necessary systems for employee emergency notification; temporary and mobile disaster operational facilities for hospital Emergency Operations Centers (EOC); increase the sphere of access to and utilization of satellite emergency communications phones; create an integrated, comprehensive and effective business continuity plan, training, and exercises; and designate specific personnel to manage the compliance with regulatory requirements for hospital emergency preparedness, and coordinate response, mitigation, patient movement, and recovery in the event of an actual emergency.

These additional system and personnel resources will enhance DSH's capability and capacity to more effectively care for patients and coordinate staff during future catastrophic natural or man-made disasters.

BACKGROUND

DSH manages the nation's largest inpatient forensic mental health hospital system. Its mission is to provide evaluation and treatment in a safe and responsible manner, seeking innovation and excellence in state hospital operations, across a continuum of care and settings. DSH is responsible for the daily care and provision of mental health treatment of its patients. DSH oversees five state hospitals and employs nearly 11,000 staff. Additionally, DSH provides services in jail-based competency treatment (JBCT) programs and conditional release (CONREP) programs throughout the 58 counties. In FY 2017-18, DSH served 11,961 patients within state hospitals and jail-based facilities, with average daily censuses of 5,897 and 227 respectively. The CONREP program maintains an

average daily census of approximately 654. DSH's five state hospitals are Atascadero, Coalinga, Metropolitan - Los Angeles, Napa and Patton. Pursuant to the Budget Act of FY 2017-18, the psychiatric programs operating at state prisons in Vacaville, Salinas Valley, and Stockton, where DSH treated mentally-ill prisoners, have been transferred to the responsibility of the California Department of Corrections & Rehabilitation (CDCR) as of July 1, 2017. In accordance with *Coleman v Brown*, a federal class action lawsuit, DSH continues to designate 336 beds at three of its state hospitals, Atascadero, Coalinga, and Patton for the treatment of mentally-ill prisoners for patients referred by CDCR.

The land mass size of DSH facilities is important to understanding the scope of the need for emergency preparedness. DSH's property portfolio encompasses more than 6.1 million gross square feet of building space in more than 474 buildings over approximately 2,600 acres of land.

DSH manages the nation's largest inpatient forensic behavioral health hospital system. More than 90 percent of DSH patients are forensic commitments. These patients are sent to DSH through the criminal court system and have committed crimes linked to their mental illness. This high-risk patient population and environment are important to consider so that effective emergency event planning, preparation and response can be organized with the tools and systems that support hospital employees, patients and the safety of the community.

Following the DSH "After Action Reports" of the October 2017 Atlas/Tubbs Fires that threatened Napa State Hospital, a 27-member multi-disciplinary team from across all state hospitals and headquarters was chartered to address the experiences and lessons learned from the disaster and provide recommendations for system improvements.

In 2018, the DSH Enterprise Emergency Management Assessment Team (EEMAT) was created and quickly organized into sub-groups that would specialize in developing recommendations to address:

- Medical and Nursing Care
- Patient Movement and Evacuation
- Hospital Police and Fire Coordination and Services
- Technology/Infrastructure/Communication Needs
- Administrative Services - Training, Fiscal, Staffing, FEMA requirements and reimbursement

From these teams, the following categories were identified that provide the framework for this Budget Change Proposal:

- Communications - lack of employee notification system and need for more satellite phones
- Training - establish a standard for those assigned to roles within the Emergency Operations Plans
- Data/Record Access - ability of clinical staff to have back-up systems for patient medical, treatment and pharmacy records in the event a disaster disables electricity and access to data, realization that patient manifests and charts need a redundancy system
- Regulatory Requirements - ensure compliance with the many oversight organizations
- Threats and Hazard Assessment Tools - utilize and monitor Hazard Vulnerabilities Assessments (HVA) created at each hospital for disaster planning and emergency preparedness
- Partnerships with local, state and federal agencies - document and strengthen relationships
- Standardization of emergency plans and tools - Hospital Emergency Operations Plans, Business Continuity Plans, Hospital Incident Command Systems (HICS) practices. After Action Reports, Organization of records and a refresh of Memorandums of Understanding (MOU) need to be collected, recorded and available to each hospital in advance of an event.

EEMAT also identified that emergency preparedness, response, mitigation, and recovery roles and responsibilities require extensive partnerships amongst hospital staff, but consistency in these roles is not defined and organized across the DSH. DSH facilities have a blend of emergency response staff assigned to support each site's Emergency Operations Plans (EOPs). Below is an outline of those resources:

- Atascadero State Hospital - The lead for the EOP is the Fire Chief.
- Coalinga State Hospital - The lead for the EOP is an Associate Governmental Program Analyst within the Health and Safety program.
- Metropolitan State Hospital - The lead for the EOP is the (A) Assistant Hospital Administrator.
- Napa State Hospital - The lead for the EOP is an Associate Governmental Program Analyst within the Health and Safety program.
- Patton State Hospital - The lead for the EOP is an Associate Governmental Program Analyst with Plant Operations.

As an outcome of the EEMAT team, DSH identified the need for specifically experienced, trained, and capable leads dedicated to emergency preparedness at each site to improve upon coordination, planning, documenting, training, and exercising emergency management practices across the department. A statewide coordinator would be dedicated to the headquarters office in Sacramento.

During a natural or man-made disaster, DSH is responsible for the lives, safety, care, and treatment of medically fragile, severely mentally ill, and forensic patients.

Each of the five DSH facilities have over 1,000 patients and employ thousands of staff who are responsible for the patients' 24/7/365 care. Hospital emergency preparedness, staff training, plan exercises, and mitigation to protect this fragile and high-risk population is critical to ensure healthcare personnel are ready to respond effectively to a crisis and keep patients safe from harm.

While DSH has demonstrated the ability to care for the patient population and communicate with staff and emergency management partners during a disaster, the October 2017 Atlas/Tubbs fire experiences - and the subsequent reviews by the DSH-EEMAT - have identified gaps in response capabilities. DSH is requesting funding and resources to address these gaps.

Expanded Emergency Notification System (\$50,000): DSH seeks to utilize the current partnership with DDS to expand the existing emergency notification system used for Sacramento employees into a statewide network. This system expansion would increase the number of employees who are able to receive emergency notifications from 515 in Sacramento to over 11,000 statewide. This system could also be used to notify and communicate critical information during an emergency event with the families and guardians of nearly 7,000 patients.

Emergency Satellite Phone Network Expansion for Hospitals (\$30,000 annually, \$20,000 onetime for hardware): Each DSH facility sits upon a large parcel of land, includes dozens of buildings, uses secure treatment areas with significant security and access restrictions, and services a variety of critical safety, treatment and infrastructure operations. Each hospital has four satellite phones currently, and this proposal would raise that number to nine satellite phones per site. DSH-Sacramento has four satellite phones. These phones and staff assigned are tested at least once each month with DSH-Sacramento.

Emergency Intermediate Operations Facility for Business Continuity (\$30,000): During the October 2017 Atlas-Tubbs fires impacting DSH-Napa State Hospital, the facility's power, cellular communications, access to the internet, DSH email, and patient data systems were disabled. DSH-Napa staff convened in the executive director's conference room and communicated with emergency responders and DSH Headquarters via a land-

line "red phone" emergency communications system. DSH proposes to contract services for mobile emergency operations facilities that would be delivered to a designated site and activated with office space, satellite links for technology and communications, power generators and experienced personnel to support activation and decommissioning of the facility. These facilities would service 20 Emergency Operations Center management and staff to administer life/safety decisions and business continuity administration.

Business Continuity Plan Statewide Consolidation Consultant (\$150,000 one-time): DSH currently conducts the emergency preparedness, response, and recovery activities with a 2016-2021 Business Continuity Plan and five hospital Emergency Operational Plans (EOP). This proposal would use expert consultant guidance to create, consolidate and coordinate existing plans into one statewide "Business Continuity, Response and Recovery Plan" for all six sites. The consultant would evaluate current plan connectivity, propose consolidation designs, draft the approved consolidation plan for review, and upon approvals would conduct training and hospital exercises at each site. Following the plan approval, training, and exercises, the consultant would provide an evaluation for future improvements to be addressed by DSH.

DSH Emergency Management Coordinators (\$716,000): DSH has identified the need for skilled, experienced and qualified civil service staff to guide the improvements identified by the EEMAT. DSH would recruit an Emergency Management Services Coordinator for each hospital, and one Senior Emergency Management Coordinator in Sacramento to organize and coordinate efforts statewide. These coordinators would be responsible for emergency preparedness coordination at each hospital and would work with headquarters to establish a standardized, consistent, and coordinated statewide emergency preparedness program. The coordinators would be responsible for integrating the needs and program deliverables of Fire/Police, Medical/Clinical, Administration/Health and Safety, Infrastructure/Plant Operations into the "Emergency Operation/Business Continuity Plan," and conduct training, exercises, and performance evaluations. The coordinators would work with subject matter experts to ensure compliance with regulatory/oversight agency requirements, including The Joint Commission. The coordinators would work with the senior management coordinator to improve existing systems, test those systems, and develop recommendations for improvements to meet DSH emergency response and management needs.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 22: PHASE 1 RELOCATION TO THE CLIFFORD L. ALLENBY BUILDING BUDGET CHANGE PROPOSAL (MR ISSUE 077)**PANELISTS**

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

The California Health and Human Services Agency (CHHS), Department of Developmental Services (DDS) and Department of State Hospitals (DSH) request \$23.9 million in General Fund authority as follows: \$8.3 million in fiscal year (FY) 2019-20, \$3.6 million in FY 2020-21, \$3.9 million in 2021-22 and 2022-23, and an ongoing amount of \$4.2 million. CHHS, DDS and DSH also request position authority for 1.0 permanent positions and 2.0 temporary help positions in FY 2019-20. This request addresses the services and equipment necessary for occupancy of the new building, but not funded through the capital outlay project. This augmentation is required for Phase 1 which includes initial funding for purchases and their corresponding on-going costs to relocate staff and operations to the new Department of General Services (DGS) Clifford L. Allenby Building to be located at 1215 C Street in Sacramento in January of 2021. Funding needed for costs to be incurred in other phases will be requested in a subsequent proposal.

This proposal includes the following proposed provisional language:

Add the following provision to Item 4440-011-0001:

11. Notwithstanding any other law, contracts entered into or amended for document imaging or archival services related to the relocation of the department's headquarters shall be exempt from the requirements of Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and from the Public Contract Code and the State Contracting Manual, and shall not be subject to the approval of the Department of General Services.

BACKGROUND

A 2015 study documented serious deficiencies with the Bateson Building currently occupied by CHHS, DDS and DSH. To address this and other state office infrastructure needs documented in the study, the 2016-17 Budget Act included a \$1.3 billion transfer over two years from the General Fund to a new State Project Infrastructure Fund to be used specifically for the renovation or replacement of state office buildings in the Sacramento area. One of the initial projects to be addressed was the construction of a new building on C Street in Sacramento to replace the vacant Department of Food and Agriculture Annex. Since that time, CHHS, DDS and DSH were chosen as the new building's future tenants and the building has been named the "Clifford L. Allenby Building (Allenby Building)." Construction of the Allenby Building is currently underway, and all three departments expect to occupy the building beginning in January of 2021.

The Allenby Building will contain around 360,000 square feet of total space and will house the three departments as well as commercial space and room for building support. The building was designed and will be constructed with sustainability in mind; the goals are to achieve Zero Net Energy (ZNE) and Leadership in Energy and Environmental Design (LEED) Platinum certifications. ZNE buildings are required to produce enough renewable energy to offset the entire building's energy use. LEED is the most widely used measure of green building rating in the world. DGS is helping the departments to reduce their footprints by designing the Allenby Building with modern efficiencies including smaller offices, collaborative work spaces, greatly reduced storage space, shared conference rooms and specialty meeting areas on each floor. The departments will have to greatly reduce their current space utilization and transition to the use of energy efficient devices and equipment. To achieve these two certifications, a sustainably designed building will have to be outfitted with resource-efficient mechanical and electrical systems and the building's occupants must alter their current behavior.

As previously mentioned, the three departments currently reside in the Bateson Building, a building deemed deficient by the state. The Bateson Building's Information Technology (IT) system consists of outdated equipment that requires a large amount of physical space to house and is not energy efficient. The building currently houses a combined estimate of 38 million pages of documents. This number is projected to be reduced to approximately 28 million pages by January of 2021 through a concentrated effort by all three departments to update retention schedules and eliminate unnecessary documents.

To physically move to, occupy and conduct business in the new Allenby Building, the departments must move some of the current office contents to the Allenby Building and decommission the Bateson Building, outfit the new building with necessary items and equipment not included in DGS' scope of work, and reduce the current Bateson Building document storage footprint to fit into the new storage space.

Moving costs include the physical relocation of office materials as well as the disposal and decommissioning required by DGS. The three departments are currently pursuing a shared contract for moving services to relocate each department's office contents and equipment from the Bateson Building to the Allenby Building. This contract will also include the disposal of surplus asset and equipment. Additionally, the Bateson Building will have to be decommissioned upon vacancy. This includes the removal of the data cables from all workstations and the disconnection of all hard-wired connections to existing furniture.

Finally, if the three departments are to physically fit their documents into the new building, the current document storage footprint will have to be reduced significantly. Part of the expectation of tenancy is a 50 to 70% reduction in storage needs. Each department is currently reviewing their respective document retention schedules and plan to update them before the end of FY 2018-19. This will be followed by the destruction of documents as permitted by the retention schedule and organization of the remaining documents into a system conducive for digitalization. Despite this effort, the departments anticipate a need to further reduce storage needs by January of 2021 to meet the Allenby Building's requirements.

Legislative Analyst's Concerns

The Governor proposes \$8.3 million from the General Fund in 2019-20 to move the California Health and Human Services Agency, the Department of Developmental Services, and the Department of State Hospitals into the new Clifford L. Allenby Building. Of this amount, \$4 million is being proposed to scan, archive, and destroy documents as the storage space in the new building is insufficient. In order to prevent the need to use the Department of General Services (DGS) for these services, which the administration reports would cost \$9 million, it is proposing budget bill language that would exempt the departments from (1) the requirement to use DGS and (2) various other contracting procedures and statutes, including the entire Public Contract Code. While we concur that DGS should not be used for these services given its high cost, it is unclear why the exemptions from the other contracting procedures and statutes are necessary. Accordingly, we recommend modifying the language to only exempt the departments from the requirement to use DGS for document scanning, archival, and destruction related to the move.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal and respond to the concerns raised by the LAO.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

ISSUE 23: STATEWIDE: ENHANCED TREATMENT PROGRAM CAPITAL OUTLAY PROPOSAL**PANELISTS**

- **Department of State Hospitals**
- **Department of Finance**
- **Legislative Analyst's Office**
- ***Public Comment***

PROPOSAL

It is requested that Item 4440-301-0001 be increased by \$2,387,000 to provide additional funding for the construction phase of the Statewide: Enhanced Treatment Program project at Atascadero and Patton State Hospitals. The project includes renovating existing facilities at two state hospitals in order to provide 49 Enhanced Treatment Units at Atascadero state hospital and Patton state hospital. Total project costs are estimated at \$15,957,000 (\$1,234,000 for preliminary plans, \$869,000 for working drawings, and \$13,854,000 for construction). The construction amount includes \$10,449,000 for the construction contract, \$731,000 for contingency, \$1,187,000 for architectural and engineering services, and \$1,487,000 for other project costs.

BACKGROUND

In accordance with AB 1340, Chapter 718, Statutes of 2014, DSH is constructing ETUs at Atascadero and Patton State Hospitals that will provide a more secure environment for patients that become psychiatrically unstable, resulting in highly aggressive and dangerous behaviors. Patients in this state of psychiatric crisis require individualized and intensive treatment of their underlying mental illness, while reducing highly volatile and violent behavior. The proposed ETUs will create secure locations within the existing hospitals to provide a safe treatment environment for both staff and patients. Patients will be housed individually and provided with the heightened level of structure necessary to allow progress in their respective treatment.

The DSH patient population has shifted over the past twenty years to a population that is more aggressive and committed via the criminal justice process. The shift to a greater forensic population has resulted in an increase in the rate of aggressive acts by patients towards other patients and staff. Aggressive acts can require first aid treatment, hospitalization, or result in death. At least two murders have occurred within the state hospital system since 2008, in addition to thousands of incidences of aggression. Additionally, DSH has seen an increase in aggressive acts for the civilly committed population that resides outside of secure treatment areas.

The DSH Enhanced Treatment Program Project will provide 39 secured Enhanced Treatment Unit beds (ETUs) at Atascadero State Hospital and 10 ETUs (female only) at Patton State Hospital. The Atascadero ETU project is currently under construction, and is approximately 25% complete. However, bids recently received for construction of the Patton project were significantly higher than the state's estimate. Increased costs are primarily related to an underestimation of the cost of installing fire sprinklers in an existing facility and for procurement of detention doors, coordination of construction activities of a phased project within a secured environment, and current conditions in the construction services market in San Bernardino. These issues have resulted in the need to provide additional funding of \$2,387,000 General Fund to complete construction of the project at Patton.

The completion of the Patton project is critical for DSH, and delaying the project for a year would result in:

- Continuation of inappropriate secured treatment space for the most violent patients in the DSH system.
- Further delay in the availability of secured treatment space specifically dedicated to the female population.
- Continued use of restraints and other securing procedures that are not suitable for this population.
- Continued behavioral threats toward patients and staff.
- Increased project costs related to a one year pause of the project.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DSH present this proposal.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

NON-DISCUSSION ITEMS

The Subcommittee does not plan to have a presentation of the items in this section of the agenda, unless a Member of the Subcommittee requests that an item be heard. Nevertheless, the Subcommittee will ask for **public comment** on these items.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 24: MISCELLANEOUS DHCS MAY REVISE ADJUSTMENTS (MR ISSUES 405, 313)

PROPOSALS

State Verification Hub Planning Activities (Issue 405)—It is requested that Item 4260-001-0001 be increased by \$78,000 and Item 4260-001-0890 be increased by \$77,000 on a two-year limited-term basis to support 1 position and consultant services to begin planning activities for a State Verification Hub to enhance eligibility verifications in public May 9, 2019 -2- assistance programs. See related issues in the California Health and Human Services Agency and Department of Social Services Finance Letters.

Title XXI (CHIP) Federal Funds Repayment—It is requested that provisional language be added to Item 4260-101-0001 to allow for an augmentation of up to \$479,557,000 General Fund for repayment of over-claimed Title XXI federal funds related to the Non-Optional Targeted Low Income Children's Program population of the Medicaid Program. This request includes the following provisional language:

Add the following provision to Item 4260-101-0001:

14. The Department of Finance may augment the amount appropriated in this item up to \$479,557,000 for repayment of over-claimed Title XXI federal funds related to the Non-Optional Targeted Low Income Children's Program population of the Medicaid Program. Repayment shall occur upon the final determination of the Centers for Medicare and Medicaid Services that associated Title XXI federal funds must be refunded by the State. The Department of Finance shall notify the Legislature within 10 days of authorizing an augmentation pursuant to this provision. The 10-day notification to the Legislature shall describe the reason(s) for the augmentation and the fiscal assumptions used.

Various Reappropriations (Budget Bill Act Issue 313)—It is requested that Item 4260-491 be amended to reappropriate \$7,385,000 in Item 4260-001-0001, Budget Act of 2018 included in state operations Issue 401, and up to \$808,000 in Item 4260-001-0001, Budget Act of 2018 for continued planning costs of the Comprehensive Behavioral Health Data Systems as reflected in the April 1 Finance Letter. It is also requested that the expenditure authority for the \$220 million appropriated in the 2018 Budget Act be extended until June 30, 2029 for the Proposition 56 Medi-Cal Physician and Dentist Loan Repayment Program per the following provisional language:

~~"4260-491—Reappropriation, Department of Health Care Services. The balances of the appropriations provided in the following citations are reappropriated. The amount specified in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2020, unless otherwise specified:~~

~~0001—General Fund~~

~~(1) Up to \$808,000 in Item 4260-001-0001, Budget Act of 2018 (Chs. 29 and 30, Stats. 2018) for continued planning costs of the Comprehensive Behavioral Health Data Systems.~~

~~(2) Up to \$7,385,000 in Item 4260-001-0001, Budget Act of 2018 (Chs. 29 and 30, Stats. 2018) for turnover and takeover of the Medi-Cal fiscal intermediary legacy contract.~~

~~3305—Healthcare Treatment Fund~~

~~(1) Provision 1 of Item 4260-102-3305, Budget Act of 2018 (Chs. 29 and 30, Stats. 2018). The balance of this appropriation shall be available for encumbrance or expenditure until June 30, 2029."~~

Trailer Bill

Extension of the Health Home Program Funding—Amendments to trailer bill language proposed at Governor's Budget are requested to extend the sunset date for the Health Homes Program to June 30, 2024 to align with the revised program implementation timeline.

In an effort to successfully implement the HHP, DHCS delayed program implementation from 2016 to 2018. HHP is currently in the process of being implemented in four waves over six-month intervals.¹ The first phase of implementation began on July 1, 2018 and the last implementation phase is set to begin January 1, 2020. Given the delay in HHP implementation, DHCS proposes to extend the sunset date that governs the HHP's ability to utilize funds from June 30, 2020 to June 30, 2024. This will allow the funds to be available for the duration of the program, in accordance with updated HHP implementation timelines, as well as to facilitate the completion of the HHP evaluation required pursuant to Welfare and Institutions Code Section 14127.5.

Staff Recommendation: Subcommittee staff recommends no action at this time to allow for additional debate and discussion.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 25: MISCELLANEOUS DPH MAY REVISE ADJUSTMENTS (MR ISSUES 401, 402, 403)**PROPOSALS**

- **California Home Visiting and Black Infant Health Programs (Issues 402 and 403)-** It is requested that Item 4265-001-0001 be amended by increasing reimbursements by \$3.3 million and Item 4265-111-0001 be amended by increasing reimbursements by \$31,519,000 to reflect reimbursements from the Department of Health Care Services for Medicaid-eligible activities previously not reflected in the Governor's Budget. Of this amount, \$22,869,000 will support the California Home Visiting Program and \$11,950,000 will support the Black Infant Health Program, including the California Perinatal Equity Initiative. These funds will allow the Department of Public Health to increase and improve participation in both programs. The reimbursements leverage \$30.5 million General Fund proposed in the Governor's Budget to expand the California Home Visiting and Black Infant Health Programs.
- **Proposition 99 Expenditure Adjustments (Issue 402)-** It is requested that Item 4265-001-0231 be increased by \$950,000, Item 4265-111-0231 be increased by \$500,000, Item 4265-001-0234 be increased by \$521,000, and Item 4265-001-0236 be increased by \$29,000 to reflect changes in Proposition 99 revenues. The increases in the Health Education Account will support state administrative activities and competitive grants. The increases in the Research Account and the Unallocated Account will support state administration activities.
- **2019 May Estimate: Genetic Disease Screening Program (Issue 402)-** It is requested that Item 4265-111-0203 be increased by \$1,799,000 to reflect increasing laboratory supply and equipment costs, and increasing case management and coordination services for newborn screening.
- **2019 May Estimate: Women, Infants, and Children (WIC) Program (Issue 403)-** It is requested that Item 4265-111-0890 be increased by \$2,557,000 and Item 4265-111-3023 be decreased by \$1,251,000 to reflect revised food expenditure projections based on a decline in caseload and updated expenditure projections for the transition to WIC Web Information System Exchange.
- **2019 May Estimate: AIDS Drug Assistance Program (ADAP) (Issue 401)-**It is requested that ADAP Rebate Fund expenditures be decreased by \$320,000. The decrease primarily reflects a projected decrease in medication expenditures for medication-only clients anticipated to transition to private insurance, or dis-enrollment from ADAP as a result of full-scope Medi-Cal eligibility.