AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER ELOISE GÓMEZ REYES, ACTING CHAIR

MONDAY, APRIL 29, 2019

2:30 PM OR UPON ADJOURNMENT OF FLOOR SESSION
STATE CAPITOL, ROOM 444

ITEMS TO BE HEARD

NON-DISCUSSION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: OVERVIEW OF DEPARTMENT BUDGET

PANELISTS

- **Brandon Nunes**, Chief Deputy Director of Operations, Department of Public Health
- **Susan Fanelli**, Chief Deputy Director of Policy and Programs, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

ISSUE 2: STD FUNDING (BCP)

PANELISTS

- **Gil Chavez, MD, MPH**, Deputy Director, Center for Infectious Diseases, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

ISSUE 3: ALZHEIMER'S DISEASE PROGRAM GRANT AWARDS AND GOVERNOR'S TASK FORCE ON BRAIN HEALTH (BCP) (SFL ISSUE 304)

PANELISTS

- **Mónica Morales, MPA**, Deputy Director, Center for Healthy Communities, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

ISSUE 4: CHILDHOOD LEAD POISONING PREVENTION PROGRAM INFORMATION TECHNOLOGY PROJECT IMPLEMENTATION (BCP)

PANELISTS

- **Mónica Morales, MPA**, Deputy Director, Center for Healthy Communities, Department of Public Health
- **Gary Nodine**, Deputy Director, Information Technology Services Division, Department of Public Health
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Rob Trojan**, IT Oversight Manager, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

ISSUE 5: HOME VISITING PROGRAM EXPANSION (BCP)

PANELISTS

- **Leslie Kowalewski**, Chief, Maternal, Child and Adolescent Health Division, Center For Family Health, Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center for Family Health, Department of Public Health
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

ISSUE 6: BLACK INFANT HEALTH PROGRAM EXPANSION (BCP)

PANELISTS

- **Leslie Kowalewski**, Chief, Maternal, Child and Adolescent Health Division, Center For Family Health, Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center for Family Health, Department of Public Health
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

ISSUE 7: LICENSING AND CERTIFICATION PROGRAM ESTIMATE

PANELISTS

- **Heidi Steinecker**, Deputy Director, Center for Health Care Quality, Department of Public Health
- **Scott Vivona**, Assistant Deputy Director, Center for Health Care Quality, Department of Public Health
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

ISSUE 8: L&C: LA COUNTY CONTRACT (BCP)

PANELISTS

- **Heidi Steinecker**, Deputy Director, Center for Health Care Quality, Department of Public Health
- **Scott Vivona**, Assistant Deputy Director, Center for Health Care Quality, Department of Public Health
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

ITEMS TO BE HEARD

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: OVERVIEW OF DEPARTMENT BUDGET

PANELISTS

- **Brandon Nunes**, Chief Deputy Director of Operations, Department of Public Health
- **Susan Fanelli**, Chief Deputy Director of Policy and Programs, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSED BUDGET

The Governor's proposed 2019-20 budget provides DPH approximately $3.2 billion overall, representing a small $41 million (total funds), or 1.3 percent, increase from the current year DPH budget. General Fund dollars of $184 million make up just 5.7 percent of the department's total budget while federal funds make up approximately 46 percent of the total department budget.

DEPARTMENT OF PUBLIC HEALTH
(Dollars In Thousands)

Fund Source	2017-18 Actual	2018-19 Projected	2019-20 Proposed	CY to BY $ Change	CY to BY % Change
General Fund	**$145,627**	**$177,280**	**$183,686**	**$6,406**	**3.6%**
Federal Funds	$1,432,465	1,540,352	$1,490,075	($50,277)	-3.3%
Special Funds & Reimbursements	$636,799	$643,277	$675,161	$31,884	5.0%
Licensing & Certification	$146,555	$163,942	$189,248	$25,306	15.4%
Genetic Disease Testing Fund	$128,138	$134,094	$141,176	$7,082	5.3%
WIC Manufacturer Rebate Fund	$233,196	$229,080	$214,929	($14,151)	-6.2%
AIDS Drug Assistance Program Rebate Fund	$287,780	$288,936	$323,747	$34,811	12.0%
Total Expenditures	**$3,010,560**	**$3,176,961**	**$3,218,022**	**$41,061**	**1.3%**
Positions	3,585.9	3,660.7	3,773.0	112.3	3.1%

The following table shows the proposed expenditures by program area.

DPH Program Expenditures (In Thousands)					
Program	**2017-18 Actual**	**2018-19 Estimate**	**2019-20 Proposed**	**CY to BY $ Change**	**CY to BY % Change**
Emergency Preparedness	$89,129	$100,364	$96,473	($3,891)	-3.9%
Healthy Communities	$514,061	$487,078	$499,088	$12,010	2.5%
Infectious Disease	$620,300	$667,287	$700,730	$33,443	5.0%
Family Health	$1,382,565	$1,442,197	$1,420,707	($21,490)	1.5%
Health Statistics & Informatics	$26,034	$30,902	$32,468	$1,566	5.1%
County Health Services	$126	$3,955	$174	($3,781)	95.6%
Environmental Health	$115,284	$138,707	$141,583	$2,876	2.1%
Health Facilities	$249,110	$291,351	$311,429	$20,078	6.9%
Laboratory Field Services	$13,951	$15,120	$15,370	$250	1.7%
Total Expenditures	**$3,010,560**	**$3,176,961**	**$3,218,022**	**$41,061**	**1.3%**

BACKGROUND

The Department of Public Health (DPH) is dedicated to optimizing the health and well-being of the people in California, primarily through population-based programs, strategies, and initiatives. DPH's goals are to achieve health equities and eliminate health disparities; eliminate preventable disease, disability, injury, and premature death; promote social and physical environments that support good health for all; prepare for, respond to, and recover from emerging public health threats and emergencies; improve the quality of the workforce and workplace; and promote and maintain an efficient and effective organization. The overall structure of DPH is as follows:

Department Director / State Public Health Officer

- Civil Rights
- California Conference of Local Health Officers
- Office of Health Equity
- Office of Quality Performance and Accreditation
- Administration and Public Affairs
- Center for Health Statistics and Informatics
- Emergency Preparedness Office
- Office of the State Public Health Laboratory Directors

Policy and Programs
- Emergency Preparedness Office
- Center for Health Statistics and Informatics
- Legislative and Governmental Affairs
- Office of State Laboratory Director
- Laboratory Field Services

Center for Chronic Disease Prevention and Health Promotion
- Chronic Disease and Injury Control
- Environmental and Occupational Disease Control
- Office of Problem Gambling
- Oral Health

Center for Environmental Health
- Environmental Management
- Food, Drug, and Radiation Safety

Center for Family Health
- Family Planning
- Genetic Disease Screening Program
- Maternal, Child, and Adolescent Health
- Women, Infants, and Children

Center for Health Care Quality
- Healthcare Association Infections Program
- Licensing and Certification

Center for Infectious Diseases
- AIDS
- Communicable Disease Control
- Binational Border Health
- Office of Refugee Health

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present an overview of the proposed department budget.

Staff Recommendation: Subcommittee staff recommends no action at this time as this is an oversight issue.

ISSUE 2: STD FUNDING (BCP)

PANELISTS

- **Gil Chavez, MD, MPH**, Deputy Director, Center for Infectious Diseases, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH requests $2 million General Fund in 2019-20 and annually thereafter for additional funding to local health jurisdictions for the prevention of sexually transmitted diseases (STDs). These efforts will be specifically targeted to the STDs causing the most severe consequences for the most vulnerable populations of California.

BACKGROUND

According to DPH, in California, STDs have been increasing dramatically. More than 750,000 new STD cases occur in California each year, not counting hundreds of thousands of new infections due to human papilloma virus. STD cases reached a record high for the third year in a row, with more Californians being diagnosed with chlamydia, gonorrhea, and syphilis in 2017 than ever before. In 2017, there were more than 300,000 reported STD cases in the state, a 45 percent increase since 2013. California ranks first among all states for the total number of cases of chlamydia, gonorrhea, and syphilis. Cases of congenital syphilis have also increased rapidly in recent years, from 33 in 2012 to 283 in 2017, with California leading the country in reported cases. Cases of congenital syphilis have also increased rapidly in recent years, from 33 in 2012 to 283 in 2017, with California now leading the country in reported cases.

STDs disproportionately affect populations that are vulnerable and living in poverty, and are associated with significant health disparities. STDs disproportionately affect African-Americans and men who have sex with men. African-American women have a disproportionately high rate of syphilis, which can cause the devastating condition of congenital syphilis, potentially resulting in deformities or still births. In addition, the largest proportion of congenital syphilis cases in California are born to Latina women. Importantly, these diseases are preventable and there are new opportunities to protect California residents from these diseases. Screening and treatment of STDs can prevent the spread of disease and long-term complications. Finally, STDs also increase the risk of contracting both the human immunodeficiency virus (HIV) and Hepatitis C (HCV), and together create a syndemic - a set of linked health problems that interact synergistically and exacerbate poor health outcomes. For example, having an STD increases the likelihood of acquiring HIV.

The administration indicates that they intend to distribute these funds to the local health jurisdictions with the highest need, defined by both STD rates as well as total cases. Los Angeles County receives separate funding for STD prevention directly from the Federal Centers for Disease Control and Prevention. DPH also states that they will explore distributing these funds on a regional basis, so that a collection of smaller counties could receive a larger grant.

STAFF COMMENTS/QUESTIONS

The Legislature initiated inclusion of $2 million one-time General Fund in the 2018 budget, and the administration indicates that this $2 million is the basis for the amount of their proposal for ongoing funding. DPH points out the need of local health jurisdictions to be able to use increased funding to hire additional staff which is not possible with one-time funds. Substantial evidence supports the need not only for ongoing funding, but for a much higher level of ongoing funding, and there are stakeholder proposals for more funding for this purpose than what the Governor has proposed. Subcommittee staff requested that DPH provide an impact analysis based on $2 million vs. $50 million in ongoing funding.

The Subcommittee requests DPH to present this proposal.

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

ISSUE 3: ALZHEIMER'S DISEASE PROGRAM GRANT AWARDS AND GOVERNOR'S TASK FORCE ON BRAIN HEALTH (BCP) (SFL ISSUE 304)

PANELISTS

- **Mónica Morales, MPA**, Deputy Director, Center for Healthy Communities, Department of Public Health
- **Sonal Patel**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH requests 2 permanent positions and $3 million General Fund in 2019-20 and annually thereafter to support Alzheimer's disease program grants focused on women and communities of color, and the creation and implementation of the Governor's Task Force on Alzheimer's Prevention and Preparedness. This proposal includes $2.7 million for local assistance and $0.3 million for state operations.

Spring Finance Letter (Issue 304) requests that an additional $0.3 million (one-time) from the $2.7 million in local assistance be added to state operations funding to support contracts needed to administer the proposed (and renamed) Governor's Task Force on Alzheimer's Prevention and Preparedness.

BACKGROUND

Alzheimer's Disease Program Statutory Authority and Description
The DPH Alzheimer's Disease Program was established through legislation in 1984 and expanded by subsequent legislation in 1988. The mission of the Alzheimer's Disease Program is to reduce the human burden and economic costs associated with Alzheimer's disease and related dementias, and ultimately to assist in discovering the cause and treatment of this disease. The program administers 10 California Alzheimer's Disease Centers at university medical centers. These Centers provide diagnostic and treatment services; professional training for medical residents, postdoctoral fellows, nurses, interns, and medical students, and community education such as caregiver training and support. The program also awards grants through a competitive process to scientists in California engaged in the study of Alzheimer's disease and related disorders.

Historical Funding
DPH states that California has been a national leader in Alzheimer's disease research, and since 1985 the state has invested more than $90.7 million in the California Alzheimer's Disease Centers, which have leveraged the funds to raise more than $544.5 million in federal and private research money (California State Plan for Alzheimer's Disease, 2011).

In 1987, the California Revenue and Taxation Code was amended to authorize taxpayers to contribute amounts on their tax returns, in excess of any tax liability, and to establish a fund for research related to Alzheimer's disease (Revenue and Taxation Code Sections 18761-18766), which is administered by DPH. From 1989 to 2009, the Alzheimer's Disease Research Awards were supported by both the General Fund and the Alzheimer's Disease and Related Disorders Research Fund. In 2009, funding to the Alzheimer's Disease Program was reduced and the program discontinued General Fund research activities. From 2009 to 2017, research awards received funding only from donations made by California taxpayers through a tax checkoff (received in the Alzheimer's Disease and Related Disorders Research Fund)—a checkoff that is scheduled to sunset on December 1, 2020.

Beginning in 2018-19, the Alzheimer's Disease Program includes $3.1 million General Fund to fund research in connection with Alzheimer's disease and related dementias, and their caregivers.

Research Grant Categories
The Alzheimer's Disease Program supports research that contributes to better understanding, care and support of patients and families affected by Alzheimer's disease and related disorders.

The 2018 research grant cycle Request for Applications included the following categories:

1. Caregiving: strengthening caregivers' health and effectiveness
2. Prevention: reducing risk for cognitive decline and dementia
3. Early Diagnosis and Detection: expanding early detection and diagnosis
4. Long-Term Services and Support Systems/Health Services: improving safety and quality of care for people living with dementia
5. Health Disparities: understanding the prevalence, policies, environmental and social determinants of health affecting California's diverse population

Disproportionate Impact on Women and Communities of Colors
Alzheimer's is the fifth most common cause of death for Americans ages 65 and older. According to federal Centers for Disease Control and Prevention data, California had 15,570 deaths attributable to Alzheimer's disease in 2016, which made it the 4th leading cause of death in the state.

Almost two-thirds of Americans with Alzheimer's disease or other dementias are women. While the prevailing view has been that the difference is due to the fact that women, on average, live longer than men and older age is the greatest risk factor for Alzheimer's, more research is needed to support the findings and understand the cause of this skew. Many researchers are questioning whether the risk of the disease is higher for women at any age due to biological or genetic variations, or due to differences in life experiences.

African-Americans are about two times, and Hispanics are about one and one-half times, more likely than older whites to have Alzheimer's. Among people ages 65 and older, African Americans have the highest prevalence of Alzheimer's disease and related dementias (13.8 percent), followed by Hispanics (12.2 percent).

Given that the Alzheimer's disease occurs in higher rates for women and communities of color, the grants will focus on research to understand the greater prevalence of Alzheimer's among these groups.

Governor's Task Force on Alzheimer's Prevention and Preparedness
This request also includes funding to develop and support the Governor's Task Force on Alzheimer's Prevention and Preparedness which will be operational for one year. The new task force will be co-chaired by the Governor and Maria Shriver. Members will be appointed by the Governor. The Governor's task force will hold listening sessions in different parts of the state and develop guidelines on brain health that can be shared with partners in the public, private, and non-profit sectors. Additionally the Governor's task force will look at the effects of Alzheimer's disease and policies that can point the way for brain-healthy families, workplaces, and communities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present this proposal, as modified by the Spring Finance Letter.

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

ISSUE 4: CHILDHOOD LEAD POISONING PREVENTION PROGRAM INFORMATION TECHNOLOGY PROJECT IMPLEMENTATION (BCP)

PANELISTS

- **Mónica Morales, MPA**, Deputy Director, Center for Healthy Communities, Department of Public Health
- **Gary Nodine**, Deputy Director, Information Technology Services Division, Department of Public Health
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Rob Trojan**, IT Oversight Manager, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH requests 8 permanent positions and $8.0 million in 2019-20, $9.3 million in 2020-21, $5.9 million in 2021-22, and $3.4 million annually thereafter to support the development and implementation of the Surveillance, Health, Intervention, and Environmental Lead Database (SHIELD) Information Technology (IT) Project. The proposed funding would come from the Childhood Lead Poisoning Prevention Fund.

BACKGROUND

Lead Pollution and Health Effects
Lead is a toxic heavy metal that persists as a legacy pollutant from leaded gasoline, leaded paint, smelting, mining, and manufacturing. The major health effects in children are typically neurological and include delayed learning, Attention Deficit Hyperactivity Disorder (ADHD), lower intelligence quotient (IQ) (impacting school performance and future earnings), and behavioral problems. In young children whose brains are still developing, even a small amount of lead can cause learning disabilities, behavioral problems, and anemia. At higher levels, lead exposure can result in seizures, coma, and even death. Childhood lead poisoning can also lead to health effects later in life, including hypertension, kidney disease, and reproductive problems.

Childhood Lead Poisoning Prevention (CLPP) Branch Description
California established a CLPP Program by legislation in 1991. The CLPP Branch is supported largely by fees collected from historic lead polluters (paint and petroleum industries and air emitters) deposited to the CLPP Fund. The bulk of these funds are distributed to local health departments to conduct lead poisoning prevention and case management. Health and Safety Codes (H&SC) §105275 and §124165 require the CLPP Program to perform multiple functions to reduce childhood lead exposure. In recent years, the CLPP Fund's expenditures have exceeded revenues, but the fund has had a positive balance due to legal settlements that provided additional dollars to the fund.

Young children enrolled in programs for low-income populations, or who live in deteriorated or recently renovated older housing with lead-based paint and lead-contaminated dust and soil are at the greatest risk for lead poisoning. These children are targeted by program activities and are required to be blood lead tested (California Code of Regulations, Title 17, Division 1, Chapter 9, §37000 et seq.). In an effort to reach this population and have them tested, outreach and educational materials are available in multiple languages. Families with young children receive guidance about preventing lead exposure during routine health care visits. Children identified with high blood lead levels (BLLs) are eligible for services regardless of income, health insurance, or documentation status.

In some local health jurisdictions, DPH provides direct services. However, the majority of direct services to children are provided by 50 local programs that contract with DPH (46 counties and 3 cities). Funding for local programs is provided based on the population of young low-income children, children with elevated lead levels, and children living in older housing. The CLPP Branch is responsible for: ensuring that public health nurses and environmental investigators in local programs provide appropriate services; providing lead tests results to the local programs; performing statewide surveillance, data analysis, oversight and outreach; lending technical assistance, and assisting programs with services not available locally.

All blood lead tests must be reported to the CLPP Branch (H&SC §124130). Approximately 700,000 tests are reported each year by over 300 laboratories, representing nearly 600,000 individual children. These reports are processed to assure accurate and complete information, including the identification of children with higher-level BLLs needing services. Test results are stored in the CLPPB's web-based data system and are accessible to local health jurisdictions.

Following the recommendation of the US Centers for Disease Control and Prevention (CDC), the CLPP Branch modified its case definition in 2016 to include additional children with lower lead levels. Children with high BLLs (> 15 micrograms per deciliter (mcg/dL) or persistent values of >10 mcg/dL) are currently defined as cases of lead poisoning requiring follow-up case management (BLLs rounded up to the nearest whole number). Children with elevated BLLs (>5 mcg/dL) who do not meet the case definition are eligible for certain public health services. Every year, approximately 650 children are identified as new cases, triple the volume prior to 2016. Given that each case is managed from two to four years, the CLPP Branch oversees an average of 1,800 cases annually.

New case alerts are sent via the CLPP Branch data system to local programs to initiate interventions for these children. Full case management includes the following:

1. Environmental investigations by environmental professionals to detect the sources of lead;
2. Home visits by public health nurses to educate families about reducing lead exposure, identify other at-risk family members, conduct nutrition and neurodevelopmental assessments; and

3. Ongoing follow-up and collaboration with the child's health care provider, including health care referrals, as needed.

Data System for Childhood Lead Exposure
Since 2006, Public Health has relied on the Response and Surveillance System for Childhood Lead Exposure (RASSCLE II, or R2) data system, to support receipt of laboratory test results, and provide case management and reporting functions performed by Public Health and local lead programs. Laboratories performing blood lead tests are required to electronically report test results to R2, and local and state staff use the system to manage cases. The R2 data system also serves to provide data for reporting and program evaluation and since 2006, the system has electronically processed over 8 million test results. Of this total number, approximately 9 percent required manual processing due to problems with laboratory data entry and with the R2 system. As of August 2018, the number of records awaiting processing in this queue is approximately 801,000. Workload due to increased case management has also expanded, with additional manual entry and review.

DPH explains that R2 is an aging system based on out-of-date technology, and is at risk of failure. When developing the R2 system in 2001, the CLPP Branch was required to adopt Public Health's enterprise reporting tool, Business Objects, for both Public Health and Department of Healthcare Services (DHCS). As a consequence of both CDPH and DHCS migrating away from the use of Business Objects in 2016 due to it being an outdated and no longer a cost effective product, the CLPP Branch lost the capacity to develop and run reports to fully meet programmatic needs, and local CLPP programs have been unable to use R2 for reporting purposes. The CLPP Branch and local health jurisdiction staff now use labor-intensive workarounds to identify children with elevated BLLs in need of services, perform manual processes for data entry, run routine reports, and evaluate program effectiveness.

DPH states that the current R2 data system no longer meets the needs of state and local lead programs and is at risk of failure. Given that R2 has lost its built-in reporting capacity, Public Health and local lead programs have limited capacity to provide complete, accurate and timely responses to questions from policy makers and the public. State and local health staff must rely on workarounds for analyses and oversight. If the system fails, providers and case managers will not have the information they need to ensure that lead poisoned children receive follow-up testing and proper clinical services, and that lead hazards in their homes are identified and eliminated. In a worst-case scenario, failure of R2 could result in delayed services to children in need of emergency chelation for dangerously high levels of lead poisoning.

The 2017 Budget Act included funding for DPH to begin the Project Approval Lifecycle as the first step in developing a new or improved data management system for the CLPP Branch (see 4265-002-BCP-2017-GB). The present proposal will provide funding to complete the process of developing and implementing SHIELD with specified IT expertise in state positions identified in the workload analyses. Beyond these core features, the system will enhance data security so that nurses and environmental professionals can

enter data from the field; track lead hazards and remediation in homes of lead-poisoned children; streamline support for mandated oversight functions and provide reporting and data warehouse capacity so that the CLPP Branch and local health jurisdictions can provide timely and accurate information to policy makers and the public.

LAO Concerns

The LAO has raised concerns with this (and several other) IT project included in the proposed budget due to the fact that the Project Approval Lifecycle (PAL) process, run through the California Department of Technology, does not always align with the state's annual budget process. For several of these IT projects, the budget includes multiple years of funding despite the fact that they are in various stages of the PAL process. The LAO is concerned that by approving of multiple years of funding, ahead of the full PAL process, limits the Legislature's opportunity to benefit fully from the PAL process. The LAO points out that if the Legislature approves the full multiyear funding in 2019-20, it makes the Legislature's oversight role more difficult.

Although the LAO is not especially concerned about this particular request for the SHIELD project, they have highlighted this issue more generally in a web post: https://lao.ca.gov/Publications/Report/3976.

In this case, the LAO recommends approving single year funding, and/or adding provisional language making DPH's funding contingent on approval of PAL documents by CDT and DOF, and notification to, and approval by, the Legislature. This would allow the Legislature to review any changes to the cost, schedule, or scope of the project.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal and LAO to explain their concerns with IT project proposals and the PAL process. The Subcommittee also requests DPH respond to the LAO concerns.

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

ISSUE 5: HOME VISITING PROGRAM EXPANSION (BCP)

PANELISTS

- **Leslie Kowalewski**, Chief, Maternal, Child and Adolescent Health Division, Center For Family Health, Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center for Family Health, Department of Public Health
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH requests 13 positions and $23 million in General Fund in 2019-20 and annually thereafter for the California Home Visiting Program (CHVP), to increase participation in current sites, add additional sites, and add new evidence-based home visiting models, with a focus on low-income, young mothers.

Requested Positions
The CHVP currently has 27 staff, and DPH requests:

- 1 Health Program Manager II,
- 2 Health Program Specialist Is,
- 2 Health Program Specialist IIs
- 1 Research Scientist Supervisor I,
- 3 Research Scientists IIs with a focus on informatics and epidemiology,
- 3 Associate Governmental Program Analysts, and
- 1 Office Technician.

BACKGROUND

Decades of research on home visiting show that home visits by a trained professional during pregnancy and in the first few years of life improves the lives of children and families. Specifically, home visiting has been demonstrated to lower rates of childhood injuries, child abuse and neglect, infant mortality, preterm birth, low birth weight, and smoking during pregnancy. Simultaneously, home visiting has been shown to increase immunizations, breastfeeding rates, and language development.

Research on the return on investment of the Nurse Family Partnership (NFP) programs (one model of providing home visiting) in California shows a 15 percent reduction in preterm births. Studies have also shown that exposure to adverse childhood experiences (ACEs), specific traumatic events that can occur in a child's life such as death of a parent,

divorce, exposure to intimate partner violence, is associated with increased morbidity and mortality from multiple diseases and life challenges across the life span. Home Visiting aims to reduce the risk of exposure to ACEs, to promote resiliency in both parent and child, and thus prevent the occurrence of associated long-term health impacts and associated treatment costs.

Housed within Public Health's Maternal, Child and Adolescent Health Division, CHVP is an evidence-based, voluntary program offered to pregnant women and their children. CHVP's focus is to provide comprehensive, coordinated in-home services to support positive parenting, and to improve outcomes for families who have one or more of the following risk factors: domestic violence, unstable housing, education of less than 12 years, child maltreatment, substance abuse, and depression and/or mental illness. Program goals include: (1) improved maternal and child health; (2) prevention of child injuries; (3) child abuse/maltreatment and reduction of emergency department visits; (4) improvement in school readiness and achievement; (5) reduction in crime or domestic violence; (6) improvements in family economic self-sufficiency; and (7) improvements in the coordination and referrals for other community resources and supports.

Existing County Sites and Home Visiting Models
Currently, CHVP has 23 county sites, which provide services using one of two evidence-based, nationally recognized home visiting models: Healthy Families America (HFA) and Nurse Family Partnership (NFP). Local Health Jurisdictions (LHJs) administer the home visiting program through their local department of public health, where they provide primary oversight of all home visiting activities.

The CHVP operates in the following counties: Alameda, Butte, Contra Costa, Del Norte, Fresno, Humboldt, Imperial, Kern, Los Angeles, Madera, Merced, Nevada, Riverside, Sacramento, San Diego, San Francisco, San Mateo, Shasta, Solano, Sonoma, Stanislaus, Tehama, and Yolo. Of these counties, 8 counties offer the HFA model and 15 operate a NFP model based on LHJ assessment of local needs. Los Angeles County is the only county that has both models. While both HFA and NFP leverage preventative interventions focused on promoting positive parenting and child development, the models vary based on enrollment eligibility and service provider types (see Table 1). As of December 10, 2018, CHVP has completed 185,422 home visits and served over 9,010 families at 23 local sites.

Table 1: Healthy Families America and Nurse-Family Partnership

	HFA	NFP
Enrollment Eligibility	Children: Up to age 5 (most children are 3 or younger). Women: Prenatally, up to 3 months after giving birth. Income-eligibility: HFA does not require that income be used as criteria as child maltreatment is the focus for eligibility. HFA uses Medicaid eligibility as guidance for agencies that want to use income.	Children: Up to age 2. Women: First-time mothers before the 29th week of pregnancy. Income-eligibility: NFP targets low-income participants. Local implementing agencies determine the specific criteria for defining low-income in consultation with the NFP National Service Office.
Service Provider Types	Home visits are provided by paraprofessionals known as family support and assessment workers. These workers typically have a social work, public health, or early childhood background.	Home visits are provided by public health nurses. Mothers are partnered with a registered nurse early in pregnancy and receive ongoing home nurse visits.

Expanding California Home Visiting Program Models

DPH states that expanding current sites into other counties, and model options, would help to meet current needs to support the most vulnerable families in California and promote improved health and resiliency in these populations.

For its current federally-funded program, California selected two of the federally-approved home visiting models (HFA and NFP) in order to simplify implementation, data collection, monitoring practices, and overall costs. While California has seen much success with the two home visiting models selected, other models have been added to the federally approved list, some more developed than others, each with different target populations and outcome goals. Most of the models are proprietary with additional associated costs. For example, the NFP model is very developed with not only a defined intervention, but a training program the model administrators provide, and a comprehensive database administrators maintain and report on. In contrast, HFA was selected by Public Health because it had a defined intervention but appeared more adaptable to California's rural counties. However, DPH had to design and provide all training for the HFA model, and design and maintain a data system for reporting of HFA outcomes. Currently, the following home visiting models meet the U.S. Department of Health and Human Services criteria for evidence of effectiveness according to the Home Visiting Evidence of Effectiveness project (HomVEE).

- Attachment and Biobehavioral Catch-Up (ABC)
- Child First
- Early Head Start Home-Based Option (EHS)
- Early Intervention Program for Adolescent Mothers
- Early Start (New Zealand)
- Family Check-Up (ECU)
- Family Connects
- Family Spirit
- Health Access Nurturing Development Services (HANDS)

- Healthy Beginnings
- Healthy Families America (HFA)
- HealthySteps
- Home Instruction for Parents of Preschool Youngsters (HIPPY)
- Maternal Early Childhood Sustained Home-Visiting (MECSH)
- Minding the Baby
- Nurse-Family Partnership (NFP)
- Oklahoma's Community-Based Family Resource and Support (CBFRS) Program
- Parents as Teachers (PAT)
- Play and Learning Strategies (PALS)
- SafeCare

DPH explains that examining and including new models as part of CHVP would add greater flexibility for LHJs to meet local needs. In order to allow for successful implementation, fidelity to the model, and accountability, Public Health requests $21 million General Fund in local assistance to provide additional resources to LHJs and $2 million in state operations to fund 13 positions. The resources would enable Public Health to examine and implement new models outside of HFA and NFP. As part of this expansion, Public Health would develop an approach to evaluate the various models including enhancing data collection and informatics for effective decision-making in choosing models. The start-up of new home visiting models requires new materials, trainings, data collection forms, and data system development. The number of new models adopted would vary depending on the models chosen based on local need, and the resources that are provided through existing model frameworks.

Expanding Participation
Across county sites, there are participant waitlists to access home visiting services. The requested resources would augment local capacity to expand participation in current models, increasing availability of service to more low-income, young women. Moreover, the funding would enable Public Health to expand CHVP's reach to additional counties it is not currently operating in.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal and respond to the following: Please confirm and explain the timeline for these funds, which DPH indicates as follows:

Year 1 -- Expansion of existing sites
Year 2 -- Expanding the number of sites by expanding into new counties
Year 3 -- Expanding the number of available models

Could these activities not overlap each other in year 1?

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

ISSUE 6: BLACK INFANT HEALTH PROGRAM EXPANSION (BCP)

PANELISTS

- **Leslie Kowalewski**, Chief, Maternal, Child and Adolescent Health Division, Center For Family Health, Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center for Family Health, Department of Public Health
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH requests 4 positions and $7.5 million in General Fund ($500,000 in state operations and $7 million in local Assistance) in 2019-20 and annually thereafter to expand the Black Infant Health (BIH) Program to improve African-American infant and maternal health.

BACKGROUND

The infant mortality rate in the United States is high relative to other developed countries at 5.8 deaths per 1,000 live births compared to Canada (4.5), United Kingdom (4.3), or Germany (3.4) (CIA World Factbook, estimates for 2017). For Black infants, the numbers are devastatingly high. In 2016, the White infant mortality rate in the United States was 4.9 per 1,000 live births—resembling other economically advanced nations. In contrast, the Black infant mortality rate in the US was 11.4 per 1,000 live births —a rate closer to that of lower income nations like Libya, Albania, and Tonga.

DPH explains that common public perception as to the causes of racial disparities is not consistent with the facts. Socioeconomic status certainly contributes to the health burden of many African-American families but studies on maternal morbidity and mortality demonstrate that insured, educated, or employed Black women with high levels of economic security continue to have higher rates of death or complications in pregnancy compared to matched women in other races. Risky health behaviors occur in all groups but Black mothers who do not smoke, a major risk for prematurity, have worse perinatal outcomes than White women who do smoke. Finally, prenatal care, while important, is not sufficient to narrow the disparity; the disparity persists even though over 90 percent of pregnant women in California get access to adequate prenatal care.

Legislation in 1989 established the BIH Program to more aggressively address the challenge of improving the health of African-American women, infants, and children by promoting health and health care during the prenatal and postpartum periods, and by providing services in a supportive and culturally competent manner. When BIH was started, its primary focus was to get African-American women into prenatal care.

However, over time, the data showed that access to prenatal care, while necessary, was not sufficient to narrow the disparity gap. Therefore, Public Health continued to look at ways to improve BIH with the ultimate goal of improving the health of African-American women, infants and children. In the fall of 2012, Public Health and the Maternal, Child and Adolescent Health (MCAH) Division developed an intensive single core model for BIH that addressed health promotion, social support, empowerment, and health education throughout a woman's pregnancy in order to help healthy women have healthy babies. The model was developed based on extensive review of the scientific literature and in consultation with experts in the field that suggested that on-going chronic stress due to social and historical constructs were likely contributing to worse health outcomes for African-American women and babies.

Based on some success with a group intervention approach, known as "Centering Pregnancy," the BIH intervention features 20 weekly group sessions held in culturally affirming environments. There are 10 sessions during pregnancy and 10 sessions postpartum, which are integrated with client-centered case management. Eligible participants are African-American women who are 18 years or older and up to 30 weeks pregnant at the time of enrollment. Participants learn proven strategies to reduce stress and develop life skills. This is accomplished through a group-based approach with complementary case management, including home visiting. Weekly group sessions help women build social support, access their strengths, make positive choices, and set health-promoting goals. Intermediary measures related to self-efficacy, social support, and empowerment are monitored in order to evaluate impact of the intervention.

BIH has been implemented in 15 local health jurisdictions (LHJs) which account for over 90 percent of all African-American births in California: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara and Solano counties and the cities of Long Beach and Pasadena.

By the mid-2000s BIH Program funding reached over $8 million dollars, including General Fund and federal funding from the Maternal and Child Health Services Block Grant (Title V) and Title XIX (Medicaid). In addition, LHJs were able to use local funding to leverage Title XIX (Medicaid) funding. However, in 2009-10, as the new group intervention approach was being implemented, all General Fund (and therefore matching Title XIX funds) was eliminated. Limited Title V funds became the only remaining funding source. This reduced staffing and lead to the closure of two large programs in high-risk communities, Riverside and San Bernardino counties. In 2014-15, $2 million General Fund was invested in the BIH Program.

The investment of General Fund in 2014-15 allowed LHJs to work toward the program as designed and Public Health/MCAH to provide the technical assistance needed to promote program fidelity and collect reliable data to measure intermediary outcomes. Participant recruitment and retention efforts were augmented and critical positions were re-established.

In addition, the 2018 Budget Act included $8 million General Fund ongoing for the Perinatal Equity Initiative, which provides funds for up to 15 county health departments to improve black infant birth outcomes and reduce the incidence of black infant mortality. This effort is currently in the planning and development stage.

The current BIH Program group model is near the end of a comprehensive evaluation for the years between 2015 and 2018 anticipated to be released in late 2019. DPH states that there are gains and areas that will need attention as the program goes forward, as follows:

- Gains in achieving intermediary outcomes:
  Early evaluation results indicate that women participating in the BIH Program have shown a number of positive short-term improvements. For example, women completing the BIH Program group model are 25 percent more likely to report high levels of social support; high social support is associated with a 5-fold decrease in depressive symptoms and a 6.7-fold decrease in tobacco use relative to women with low social support.

- Continued improvements in regards to participant recruitment and retention:
  Current BIH Program data reveals that once women attend one session, they report very positive experiences and ability to achieve intermediate goals. The gap between referral and participation has narrowed but remains. Local BIH programs have also been successful in addressing participant barriers to retention (e.g., transportation), and providing support such as maternity self-care (e.g., journals, pregnancy books, water bottles) and preparation for infant care (e.g., breastfeeding support items, infant care books). However, more support for retention efforts is needed.

Proposal Investments:
DPH explains that additional funding will support critical elements that are necessary to support an ongoing program that collects and analyzes all appropriate data, and learns and makes improvements based on a system of accountability. Examples of vital program support needed for the BIH Program are as follows:

- Complete an implementation evaluation to examine the contextual challenges to implementing the BIH Program in LHJs using existing reports and conducting key informant interviews; assess impact of quality improvement efforts.

- Improve data collection measures to capture key outcomes such as stress or baseline depression. The BIH Program uses the Efforts to Outcomes data system. To double the technical capacity of the current system it would cost approximately $150,000.

- Implement technical upgrades to the BIH data system in order to analyze:
  - Additional data not previously reported (e.g., depression, food insecurity, experiences of racism)

  - Participant satisfaction data
  - Outcomes as a function of group size and dosage of intervention
  - Associations between participation and birth outcomes
  - Comparison of outcome with other strategies such as home visiting, preconception counseling, fatherhood engagement

- Convene a state advisory group with representation of experts in health disparities and shared learning with other efforts, and with specific inclusion through authentic community engagement so that no decisions about Black family health be done without inclusion of Black families and community leaders.

- Assess alternative direct service models such as those outlined in the Perinatal Equity Initiative.

- Synthesize available information on BIH Program implementation and outcomes, make recommendations, identify areas to refine program goals and design, and consolidate findings from parallel programs and efforts to develop a summative report on achieving perinatal health equity in California.

- Expand BIH in existing counties according to numbers of African-American births.

- Support a version of intervention scaled for support to other counties where there may be fewer African-American births, but where pockets of need still exist.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present this proposal.

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

ISSUE 7: LICENSING AND CERTIFICATION (L&C) PROGRAM ESTIMATE

PANELISTS

- **Heidi Steinecker**, Deputy Director, Center for Health Care Quality, Department of Public Health
- **Scott Vivona**, Assistant Deputy Director, Center for Health Care Quality, Department of Public Health
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

L&C ESTIMATE

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

The federal Centers for Medicare and Medicaid Services (CMS) contracts with L&C to evaluate facilities accepting Medicare and Medicaid (Medi-Cal in California) payments to certify that they meet federal requirements. L&C evaluates health care facilities for compliance with state and federal laws and regulations, and it contracts with Los Angeles County to license and certify health care facilities located in Los Angeles County. L&C's field operations are implemented through district offices, including over 1,000 positions, throughout the state, and through a contract with Los Angeles County. In addition, L&C oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

As shown in the chart below, the Governor's budget proposes a 10.4 percent increase for L&C funding for 2019-20, primarily reflecting the proposed increase to the Los Angeles County contract (described in detail in the next issue in this agenda):

L&C Program Funding & Positions (Dollars in Thousands)			
Funding Source	**2018-19 Estimate**	**2019-20 Proposed**	**Current Year to Budget Year Change**
Federal Funds	$102,056	$99,349	-$2,707 (-2.7%)
Internal Department Quality Improvement Account	$2,600	$2,600	$0 (0%)

State Health Facilities Citation Penalty Account	$2,144	$2,144	$0 (0%)
Federal Health Facilities Citation Penalty Account	$398	$398	$0 (0%)
Reimbursements	$10,436	$12,187	$1,751 (16.8%)
L&C Program Fund	$162,883	$192,905	$30,022 (18.4%)
Total Funds	**$280,517**	**$309,583**	**$29,066 (10.4%)**
Field Positions – Health Facilities Evaluator Nurses	599.2	613.2	14 (2.3%)
Field Positions – Other	439.1	443.1	4.0 (0.9%)
Headquarters Positions	266.0	290.0	24.0 (9.0%)
Total L&C Positions	**1,304.3**	**1,346.3**	**42.0 (3.2%**

The Governor's budget includes the following estimates for key L&C accounts:

L&C Accounts Fund Conditions 2019-20			
	State Health Facilities Citation Penalties Account	**Federal Health Facilities Citations Penalties Account**	**Internal Department Quality Improvement Account**
Beginning Balance	$9,891,000	$16,851,000	$21,086,000
Revenues	$4,555,000	$4,040,000	$3,715,000
Total Resources	$14,446,000	$20,891,000	24,801,000
Expenditures	$3,346,000	$2,201,000	$2,600,000
Fund Balance	**$11,100,000**	**$18,690,000**	**$22,201,000**

State Health Facilities Citation Penalties Account - Used primarily to pay for temporary managers and/or receivers for skilled nursing facilities (SNFs). Funds from this account also have been used to support the Department of Aging's Long Term Care Ombudsman programs.

Federal Health Facilities Citations Penalties Account - Used to fund innovative facility grants to improve the quality of care and quality of life for residents of SNFs or to fund innovative efforts to increase employee recruitment or retention subject to federal approval.

Internal Departmental Quality Improvement Account - Used to fund internal L&C program improvement efforts. Funded by administrative penalties on hospitals.

Health Facility Licensing Fees

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

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

The fee rates are calculated as follows:

- Combining information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital).

- Calculating the state workload rate percentage of each facility type in relation to the total state workload.

- Allocating the baseline budget costs by facility type based on the state workload percentages.

- Determining the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.

- Dividing the proposed special fund cost per facility type by the total number of facilities within the facility type or by the total number of beds to determine a per facility or per bed licensing fee.

The following table shows the most up-to-date fees, as reflected in the 2019 Fee Report, including proposed supplemental fees for Los Angeles County facilities:

Table 1: Health Care Facility License Fee Table

Facility Type	Fee Per Bed or Facility	Number of Licensed Facilities/ Beds	Health Care Facility License Fees (rounded in nearest dollar)			
			2018-19		2019-20	
			Statewide	Los Angeles County Supplemental Fee	Statewide	Los Angeles County Supplemental Fee [2]
Acute Psychiatric Hospitals	Bed	8,190	$ 550.00	$ 55.00	$ 661.00	$ 156.00
Adult Day Health Centers	Facility	271	$ 6,242.00	$ -	$ 7,490.00	$ 365.00
Alternative Birthing Centers	Facility	12	$ 2,737.00	$ -	$ 2,914.00	$ -
Chemical Dependency Recovery Hospitals	Bed	412	$ 321.00	$ -	$ 321.00	$ 60.00
Chronic Dialysis Clinics	Facility	587	$ 3,431.00	$ 1,102.00	$ 3,431.00	$ 2,689.00
Primary Care Clinics - Community Clinics/Free Clini	Facility	1,449	$ 1,483.00	$ 78.00	$ 1,780.00	$ 328.00
Congregate Living Health Facilities	Bed	1,308	$ 644.00	$ 158.00	$ 773.00	$ 311.00
Correctional Treatment Centers	Bed	2,493	$ 1,185.00	$ -	$ 1,422.00	$ -
District Hospital Less Than 100 Beds	Bed		$ 550.00	$ 55.00	$ 661.00	$ 156.00
General Acute Care Hospitals	Bed	75,073	$ 550.00	$ 55.00	$ 661.00	$ 156.00
Home Health Agencies	Facility	1,727	$ 2,762.00	$ 908.00	$ 2,762.00	$ 1,061.00
Hospices (2-Year License Total)	Facility	1,242	$ 2,970.00	$ 884.00	$ 2,970.00	$ 1,150.00
Hospice Facilities	Bed	120	$ 524.00	$ -	$ 558.00	$ -
Intermediate Care Facilities (ICF)	Bed	5,235	$ 644.00	$ -	$ 773.00	$ 97.00
ICF/Developmentally Disabled (DD)	Bed	10,215	$ 1,199.00	$ 305.00	$ 1,438.00	$ 591.00
ICF/DD - Habilitative	Bed		$ 1,199.00	$ 305.00	$ 1,438.00	$ 591.00
ICF/DD - Nursing	Bed		$ 1,199.00	$ 305.00	$ 1,438.00	$ 591.00
Pediatric Day Health and Respite Care Facility	Bed	390	$ 311.00	$ -	$ 373.00	$ 46.00
Psychology Clinics	Facility	19	$ 2,853.00	$ -	$ 2,876.00	$ 480.00
Referral Agencies	Facility	3	$ 3,729.00	$ -	$ 3,729.00	$ 1,080.00
Rehab Clinics	Facility	12	$ 536.00	$ 119.00	$ 643.00	$ 241.00
Skilled Nursing Facilities [1]	Bed	119,495	$ 648.00	$ 158.00	$ 777.00	$ 312.00
Special Hospitals	Bed		$ 550.00	$ 55.00	$ 661.00	$ 156.00
Surgical Clinics	Facility	33	$ 5,136.00	$ 1,157.00	$ 6,163.00	$ 2,332.00

[1] SNF license fee inludes the statewide fee of $773 and the California Department of Aging SNF LTC Ombudsman program fee of $4.

[2] CDPH does not assess a supplemental fee on facilities that Los Angeles County Department of Public Health does not regulate.

Data Source: 2019-20 Licensing Fees Chart

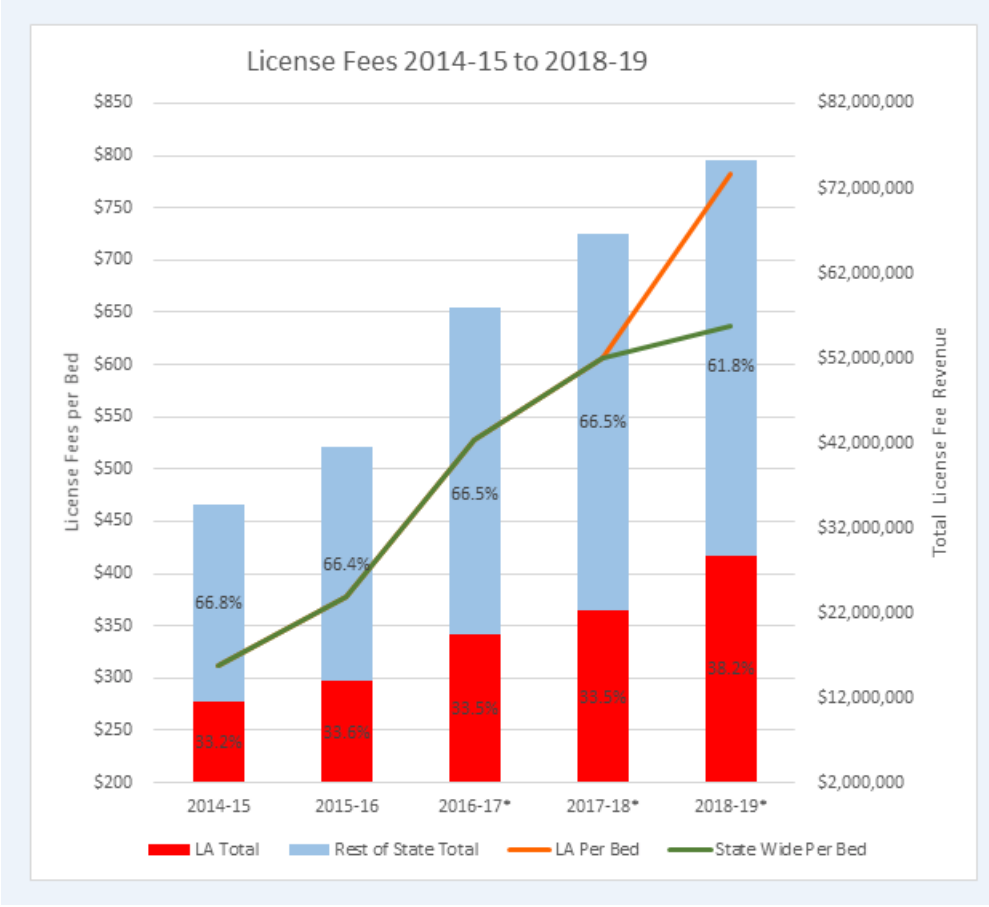
Stakeholder Response

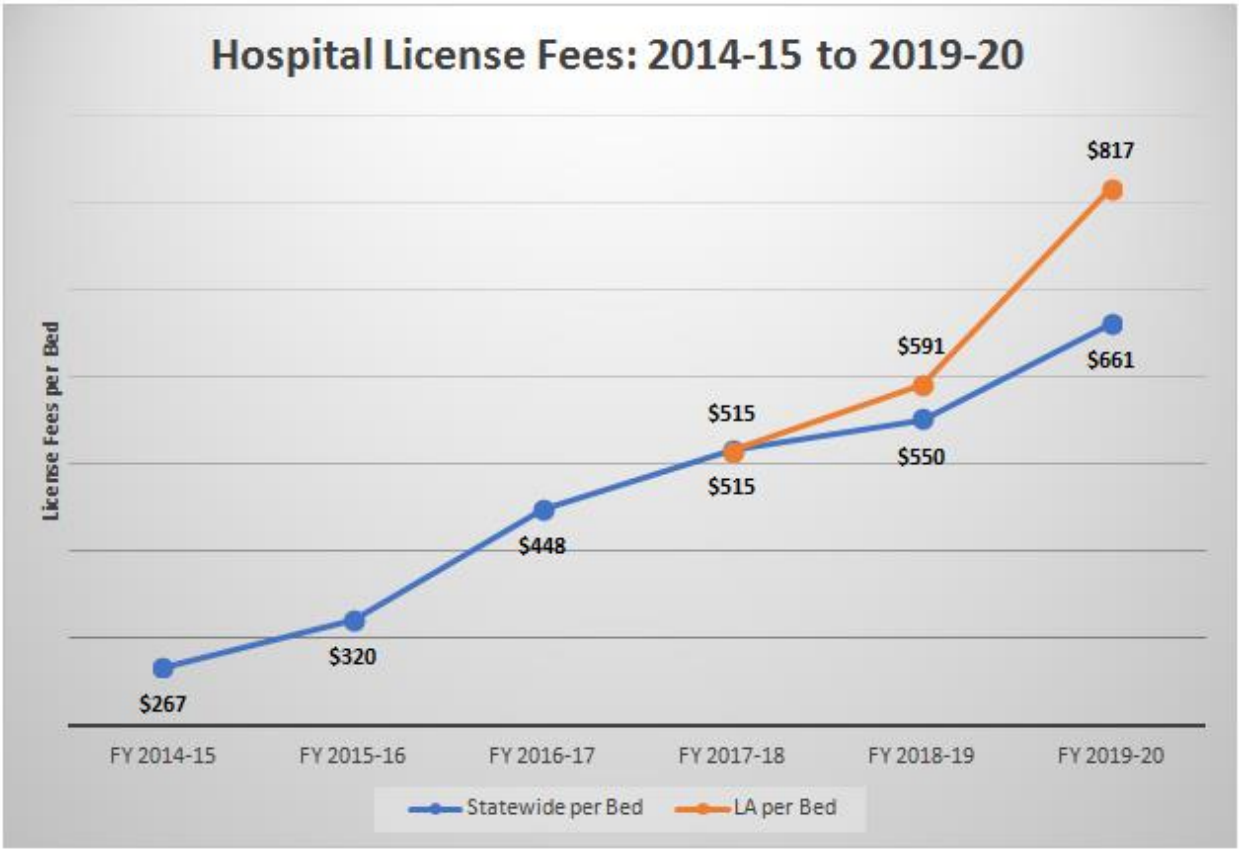
Generally, stakeholders (i.e., skilled nursing facilities and hospitals) have concerns with the amount of increases to the fees over the past several years and as reflected in this new fee schedule. These stakeholders have expressed to Subcommittee staff that they do not oppose the fee increases outright, however their concerns reflect the steady increases over the past many years coupled with alleged lack of progress on providing more timely service. The California Hospital Association (CHA) states that:

> The latest published data show that, as of June 30, 2018, CDPH has more than 20,000 open non-long-term care facility complaints and entity-reported events, of which hospitals represent the vast majority. Those data also find 61 percent (12,289) of those complaints and entity-reported events have been open for longer than 365 days. These data are consistent with FY 2016-17 and FY 2015-16

performance — 21,654 open complaints/events, with 61 percent open longer than 365 days, and 20,566 open complaints/events with 60 percent open longer than 365 days, respectively.

The California Association of Health Facilities and CHA provided the following charts to show the steady increase in licensing fees over the past four years:





STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present the Licensing and Certification Program estimate.

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

ISSUE 8: L&C: LA COUNTY CONTRACT (BCP)

PANELISTS

- **Heidi Steinecker**, Deputy Director, Center for Health Care Quality, Department of Public Health
- **Scott Vivona**, Assistant Deputy Director, Center for Health Care Quality, Department of Public Health
- **Hinnaneh Qazi**, Finance Budget Analyst, Department of Finance
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Senior Fiscal and Policy Analyst, Legislative Analyst's Office
- **Public Comment**

PROPOSAL

DPH requests $17.2 million in 2019-20, $38.2 million in 2020-21, and $57.3 million in 2021-22 from the State Department of Public Health Licensing and Certification Program Fund (Licensing and Certification Fund). The resources will fund an increase in costs associated with a new three-year contract with the Los Angeles County Department of Public Health (LAC) to transition the federal certification, state licensing, and investigation of complaints and reported incidents workload in Los Angeles County to LAC effective July 1, 2019, and move toward a pay-for-performance contract model. Over the course of the contract, LAC will increase to a staffing level that will enable LAC to assume the full workload for certification, licensure, and complaints in Los Angeles County. In addition to the increase in staffing over the three-year period, the increases include additional funding to account for potential increases in employee benefit rates, indirect costs, and/or personnel costs.

BACKGROUND

The DPH Center for Health Care Quality (CHCQ)
The CHCQ is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and quality of health care for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to ensure they comply with federal and state laws and regulations. Public Health receives funds through a grant from the Centers for Medicare and Medicaid Services (CMS) and licensing fees paid by health care facilities. Public Health/CHCQ licenses and certifies over 10,000 health care facilities and agencies in California in 30 different licensure and certification categories.

Approximately one third of licensed and certified health care facilities in California are located in Los Angeles County and 20 percent of the complaints and entity/facility-reported incidents received statewide each year are generated in Los Angeles County.

For over 30 years, DPH has contracted with LAC to perform a portion of workload for approximately 2,900 health care facilities in the Los Angeles County area. The total workload for Los Angeles County includes: 1) federal certification, 2) state licensing, and 3) investigation of complaints and entity/facility-reported incidents.

The 2015 Budget Act authorized an additional $14.8 million Licensing and Certification Fund in contract funding for LAC to conduct federal Tier 1 workload (long-term care recertification surveys/home health agency and hospice surveys/deemed facility validation surveys) and Tier 2 workload (non-long term care facility targeted and recertification surveys), investigation of long-term care complaints and entity/facility-reported incidents, and some initial licensing surveys. In July 2015, Public Health and LAC renewed the contract for a three-year term, for a total annual budget of $41.8 million to fund 224 positions. To fund increases in personnel costs, indirect cost rates, and lease costs, Public Health augmented the contract by $2.1 million in 2016-17, $1.1 million in 2017-18, and $3.4 million in 2018-19, and extended the contract one year (ending June 30, 2019).

The current contract with LAC does not require LAC to complete 100 percent of the Tier 3 and Tier 4 federal workload and state licensure activities, or investigate all complaints and entity/facility-reported incidents in Los Angeles County. Public Health acknowledged in 2015 that the requested expenditure authority would only fund a portion of the total workload in Los Angeles County, and that future requests for additional resources may be necessary to complete all mandated workload. Currently, Public Health/CHCQ uses state staff to address only the highest priority activities of this unfunded workload in Los Angeles County.

In 2015-16 Public Health established a Los Angeles County Performance Monitoring Unit. The Unit is staffed by a health facility evaluator nurse supervisor, two health facility evaluator nurse surveyors, and a retired annuitant to provide oversight and monitoring of LAC's performance, including on-site review, observation, data analysis, and audits.

Supplemental License Fees on Facilities Located in Los Angeles County

To address the higher cost of staff and workload in Los Angeles County, and the increasing costs of the contract with LAC, Public Health began assessing and applying a supplemental fee to its regulated health care entities located in Los Angeles County beginning in 2018-19. Assembly Bill 1810 (Committee on Budget, Chapter 34, Statutes of 2018) authorized Public Health to assess this supplemental fee on facilities LAC regulates. Current statute reads as follows:

> Health and Safety Code 1266(g): Commencing in the 2018-19 fiscal year, the department may assess a supplemental license fee on facilities located in the County of Los Angeles for all facility types set forth in this section. This supplemental license fee shall be in addition to the license fees set forth in subdivision (d). The department shall calculate the supplemental license fee based upon the difference between the estimated costs of regulating facility types licensed in the County of Los Angeles, including, but not limited to, the costs

associated with the department's contract for licensing and certification activities with the County of Los Angeles and the costs of the department conducting the licensing and certification activities for facilities located in the County of Los Angeles. The supplemental license fees shall be used to cover the costs to administer and enforce state licensure standards and other federal compliance activities for facilities located in the County of Los Angeles, as described in the annual report. The supplemental license fee shall be based upon the fee methodology published in the annual report described in subdivision (d).

Existing and Proposed LAC Contract
The current contract between Public Health and LAC, set to expire June 30, 2019, funds LAC staff to conduct a portion of the federal certification work and investigate a portion of complaints and entity/facility-reported incidents. It also funds LAC to conduct a specified number of initial state licensure surveys. The contract does not require LAC to complete all complaint investigations, state licensure work, or the lower tier federal certification work.

Public Health and LAC initiated contract negotiations for a new contract in August 2017. Contract negotiations stalled while addressing concerns over the contract's budget for 2018-19. Public Health and LAC reached agreement for 2018-19, and are currently negotiating a new contract for 2019-20 through 2021-22.

The new contract costs reflect a gradual increase for LAC workload (over three years) from the existing funding level of $48.4 million. To fund the new contract. Public Health requests an additional $17.2 million in 2019-20, $38.2 million in 2020-21, and $57.3 million in 2021-22. These resources will bring the total contract cost to $65.5 million in 2019-20, $86.5 million in 2020-21, and $105.6 million in 2021-22. This results in a total three-year cost of $258 million. This proposal includes funding to maintain the LAC contract costs at 2021-22 level, beginning 2022-23.

Changes in the LAC Contract
The increased funding will allow LAC to hire the staff necessary to move towards completing 100 percent of the workload, complete mandated workload timely, and address open long-term care complaints and entity reported incidents (ERI) received on or after July 1, 2015 and all new facility complaints and ERIs received after July 1, 2019. Completion of workload will occur over time as LAC hires, on-boards, and trains new staff. (Public Health will address open long-term care complaints and ERIs received prior to July 1, 2015 and non-long term care complaints and ERIs received prior to July 1, 2019.)

LAC Contract Positions
This proposal reflects funding for an additional 172 health facility evaluator nurse positions (and associated support and supervisory staff) for a total of 317 health facility evaluator nurse positions to accomplish 100 percent of the mandated workload in Los Angeles County. Public Health and LAC propose to phase-in these positions over the course of three years, hiring approximately 14 new health facility evaluator nurse positions per quarter. In addition to the increased costs associated with these positions,

this proposal requests an additional 3 percent funding in year one and year two to account for potential increases in employee benefit rates, indirect costs, and personnel costs.

Performance Metrics
The contract also will contain quality and customer service metrics. The proposed contract includes quantity (workload) metrics such as the percent of complaints and certification and licensing surveys required for completion within a given timeframe. The contract will also contain quality and customer service metrics that include, but are not limited to: regular State Observation Survey Analysis (SOSA) surveys for Skilled Nursing Facilities and Intermediate Care Facilities, yearly review of closed complaints and entity/facility-recorded files, average rating of 75% or higher on Provider Evaluation Surveys, timely scheduling and completion of initial and final letters to complainants, and timely scheduling and completion of informal conferences and dispute resolutions.

Financial Penalties, Corrective Action Plans, and Provisional Language
Public Health and LAC are still negotiating the details of the proposed contract's performance metrics and related incentives and penalties, but as of the Governor's Budget, both parties have reached substantial agreement that the contract will include financial penalties in the event that LAC does not achieve defined quantity metrics. Additionally, Public Health will only reimburse LAC for actual expenditures for verified contract costs. In the event that LAC does not meet quality or customer service metrics, LAC will be required to provide and implement written corrective action plans that address any identified deficiencies.

Moreover, the contract will contain provisions to allow for a reduction of the budget in FY 2021-22 in the event that the actual workload received does not align with the workload projections used as the basis for the third year budget.

Supplemental License Fees on Facilities Located in Los Angeles County
As a result of this proposal, Public Health will increase the supplemental license fee to reflect the contract expansion. The proposed 2019-20 supplemental license fee increase amount will be published in the CHCQ's annual fee report, which was released February 2019.

Public Health/CHCQ State Operations
These additional resources for LAC will enable CHCQ to direct state staff that are currently completing the highest priority complaint investigations and other licensure workload in Los Angeles County back to achieving workload in other areas of the state. This will allow CHCQ to more expediently address applications for initial licensure as well as more timely address and complete complaint/ERI investigations.

STAFF COMMENTS/QUESTIONS

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

1. What are the specific performance measures that will be included in the contract?

2. What is the justification for Health Facility Evaluator Nurses being paid significantly more in LA County than those employed by the state doing the same work?

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

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.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 9: CHILDHOOD LEAD POISONING PREVENTION PROGRAM REPORTING (SB 1097 AND SB 1041) (BCP)

PROPOSAL

DPH requests 6 permanent positions and $769,000 from the Childhood Lead Poisoning Prevention (CLPP) Fund in 2019-20 and annually thereafter to carry out specified blood lead screening data collection, analysis and reporting pursuant to Chapter 691 and 690, Statutes of 2018 (SB 1097 Hueso and SB 1041 Leyva, respectively).

To comply with SB 1097 and SB 1041, Public Health requests expenditure authority of $769,000 to support the following 6 positions:

- 2 Program Technicians II
- 2 Associate Governmental Program Analysts (AGPA)
- 2 Research Scientist III (Epidemiology/Biostatistics)

BACKGROUND

Lead Pollution and Health Effects

According to information provided by DPH, lead is a toxic heavy metal that persists as a legacy pollutant from leaded gasoline, leaded paint, smelting, mining, and manufacturing. The major health effect in children is typically neurological, including delayed learning, Attention Deficit Hyperactivity Disorder, lower IQ (impacting school performance and future learning), and behavioral problems. In young children whose brains are still developing, even a small amount of lead can cause learning disabilities, behavioral problems, and anemia. At higher levels, lead exposure can result in seizures, coma, and even death. Childhood lead poisoning can also lead to health effects later in life, including hypertension, kidney disease, and reproductive problems.

Childhood Lead Poisoning Prevention Branch Description

California established a CLPP Program by legislation in 1991. The CLPP Branch is supported largely by fees collected from historic lead polluters (paint and petroleum industries and air emitters) and deposited into the CLPP Fund. The bulk of these funds are distributed to local health departments to conduct lead poisoning prevention and case management. Health and Safety Code (H&SC) §105275 and §124165 require the CLPP

Program to perform multiple functions to reduce childhood lead exposure. The annual number of children identified with confirmed BLLs equal to or greater than 15 mcg/dL meeting case definition has decreased fivefold since the program began in the early 1990s and the percent of tested children identified with increased BLLs equal to or greater than 10 mcg/dL has decreased more than twofold since complete laboratory reports of these BLLs became available in 2007. In recent years the CLPP Fund's expenditures have exceeded revenues, but the fund has had a positive balance due to legal settlements that provided additional dollars to the fund.

Young children enrolled in programs (such as Medi-Cal) for low-income populations, or who live in deteriorated or recently renovated older housing with lead-based paint and lead-contaminated dust and soil, are at the greatest risk for lead poisoning. These children are targeted by program activities and are required to be blood lead tested (California Code of Regulations, Title 17, Division 1, Chapter 9, §37000 et seq.). In an effort to reach this population and have them tested, outreach and educational materials are available in multiple languages. Families with young children receive guidance about preventing lead exposure during routine health care visits with their Primary Care Provider (doctor, nurse practitioner, or physician's assistant). Children identified with high blood lead levels (BLLs) are eligible for services regardless of income, health insurance, or documentation status.

In some local health jurisdictions, Public Health provides direct services. However, the majority of direct services to children are provided by 50 local programs which contract with Public Health (47 counties and 3 cities). Funding for local programs is provided based on the population of young, low-income children; children with elevated lead levels; and children living in older housing. The CLPP Branch is responsible for ensuring home visits by public health nurses and environmental professionals, providing lead test results to the local programs, performing statewide surveillance, data analysis, oversight and outreach, lending technical assistance, and assisting programs with services not available locally.

All blood lead tests must be reported to the CLPP Branch (H&S Code §124130). Approximately 700,000 tests are reported each year by over 300 laboratories, representing nearly 600,000 individual children. These reports are processed to assure accurate and complete information, including the identification of children with higher-level BLLs needing services. Test results are stored in the CLPP Branch's web-based data system and are accessible to local health jurisdictions. Information about insurance status or Medi-Cal enrollment status is not reported.

Following the recommendation of the US Centers for Disease Control and Prevention, the CLPP Branch modified its case definition in 2016 to include additional children with lower lead levels. Children with high BLLs (> 15 micrograms per deciliter (mcg/dL) or persistent values of >10 mcg/dL) are currently defined as cases of lead poisoning requiring full follow-up case management (BLLs are rounded up to the nearest whole number). Children with elevated BLLs (>_5 mcg/dL) who do not meet the case definition are eligible for certain public health services. Every year, approximately 650 children are identified as new cases— triple the volume prior to 2016. Given that each case is

managed from two to four years, the CLPP Branch oversees an average of 1,800 cases annually. New case alerts are sent via the CLPP Branch data system to local programs to initiate interventions for these children.

Full case management includes the following:

- Environmental investigations by environmental professionals to detect the sources of lead;
- Home visits by public health nurses to educate families about reducing lead exposure, identify other at risk household members, and to conduct nutrition assessments; and
- Ongoing follow-up and collaboration with the child's health care provider, including health care referrals, as needed

Current Reporting

Public Health currently collects data on the blood lead levels and age groups by county and zip code. Laboratories that analyze blood lead are required to report all blood lead levels electronically to the state pursuant to H&SC §124130. This de-identified data is publicly available on the Public Health CLPP Branch website. The de-identified data Public Health currently reports on this website is broken out by county and includes:

- The number of cases per county;
- The number of cases within the reference level of BLLs at 4.5 mcg/dl to 9.5 mcg/dl; and
- The number of cases with BLLs above 9.5 mcg/dl

Data and Reporting Requirements Mandated by SB 1097 and SB 1041

SB 1097 and SB 1041 add to an existing mandated biennial report. The report describes the effectiveness of appropriate CLPP Program case management efforts.

SB 1097, among its provisions, requires the following activities from Public Health:

- Include the following data (identified by child's county and year of age) on the biennial report:
    - The total number of children tested for lead poisoning;
    - The results of blood lead testing by blood-lead-level range;
    - The number, by blood-lead-level range, who were referred for case management and environmental services and who received home visits, environmental investigations, family education and materials on lead, and nutrition assessment and education;
    - The identified sources of exposure for lead-exposed children and whether or not these lead hazards have been addressed by being removed, ameliorated, or abated.
- Post the biennial report on its website.
- Provide the data collected, along with the report, to Healthy Communities Data and Indicators Project for its use in planning healthy communities and evaluating the impact of plans, projects, policies, and environmental changes on community health. Current law already specifies that any material in the report comply with state and federal privacy laws.

This additional data is not electronically reported to the CLPP Branch. The data must be obtained from paper reports submitted by State staff and local jurisdictions, environmental lab and XRF sample analysis reports, and other sources and then manually entered into Public Health's Response and Surveillance System for Childhood Lead Exposure (RASSCLE II) system. The information requires time-intensive review, clarification and follow-up to ensure it is accurate and complete. In many cases, the sources are identified over an extended period of time or are not identified, and even when identified, it can take years to have them abated, ameliorated or removed. Once complete and accurate information is entered into RASSCLE II, a highly skilled analyst can then extract and analyze the data and create the mandated reports.

To meet the requirements of SB 1097, Public Health requests the following 5 positions to perform manual data processing and entry, extract and analyze data, and prepare the expanded report:

- 2 Program Technician IIs - to perform data entry and extraction of information collected from information gathered from the environmental investigations and nursing case management information.
- 2 Associate Governmental Program Analysts - to detect, analyze and validate the information that accompanies the data that may be incomplete, wrong, or duplicative. Additionally, the positions would collaborate with local health jurisdictions to help preserve the integrity of critical health data stored in the data systems.
- 1 Research Scientist III - to determine the number of children referred for and receiving home visits and environmental investigations, analyze the sources of lead-exposed children, and present the findings to the Healthy Communities Data and Indicators Project.

Medi-Cal Analysis and Reporting
SB 1041 requires Public Health to collect and analyze data on blood lead level screening tests for children enrolled in Medi-Cal. The data will be used to monitor appropriate case management efforts, to advance lead testing of children enrolled in Medi-Cal, and for public reporting.

Data systems that can be used to assess screening levels of children on Medi-Cal include the RASSCLE II database maintained by Public Health and the Management Information System/Decision Support System (MISDSS) database and Medi-Cal Eligibility Data System (MEDS) database that are maintained by Health Care Services.

The data systems are not connected to each other. RASSCLE II contains the most complete and accurate information about lead screening while the MISDSS and MEDS databases contain the most complete information about Medi-Cal participation and billing of services to Medi-Cal. The MISDSS and MEDS databases are very complex, and analysts require extensive training to use them reliably.

Health Care Services will need to provide Public Health with Medi-Cal eligibility data so that it can be linked with the RASSCLE II system. The data linkage will be based upon shared data elements that may include name, date of birth, social security number and other identifying data. Health Care Services can provide this patient-level Medi-Cal data to Public Health under an existing Interagency Agreement. To have the most complete and accurate results, the analysis must be done in collaboration with Health Care Services.

While the report is published biennially, the analysis of data for BLL testing would be continuous. To achieve this, Health Care Services and Public Health will need to produce data consistently, even in non-reporting years, to improve data quality and monitor performance in meeting BLL testing requirements for children enrolled in Medi-Cal.

To meet the requirements DPH requests:

- Research Scientist III to develop expertise in analyzing data collection from the MISDSS and MEDS systems. Additionally, the position will develop the protocols for matching data in those systems to data in RASSCLE II.

Health Care Provider Notification

The California Code of Regulations requires health care providers who perform periodic health assessments of children receiving services from a publicly funded program for low-income children (e.g. Medi-Cal) to order a lead toxicity screening. SB 1041 requires Public Health to notify health care providers who perform periodic health assessments for children about:

- The risks and effects of childhood lead exposure;
- The blood lead testing requirements for children enrolled in Medi-Cal; and
- The blood lead testing requirements for children not enrolled in Medi-Cal but with a high risk of exposure.

SB 1041 also requires health care providers to provide that information to parents and guardians.

Public Health does not currently anticipate additional resources will be needed to comply with this requirement. Public Health currently provides extensive outreach to health care providers and health programs about sources of lead, the effects of lead on the developing child, and state regulatory requirements for anticipatory guidance about lead and for blood lead testing. This outreach is conducted by the CLPP Branch and by the state-supported, local CLPP programs.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 10: MATERNAL, CHILD AND ADOLESCENT HEALTH: MEDI-CAL OVERSIGHT ACTIVITIES (BCP)

PROPOSAL

DPH requests 5 permanent positions and $656,000 ($328,000 General Fund and $328,000 in reimbursement authority) in 2019-20 and annually thereafter to comply with federal claiming and oversight requirements for expenditures of federal Title XIX (Medicaid) funds.

The resources would help avoid jeopardizing federal funding for DPH programs administered by local health jurisdictions (LHJs). The requested positions will address federal oversight requirements relating to time-study review, scope of work analysis, position reconciliation, contract management, processing of invoices, assistance with federally mandated audits, and fiscal tracking of Title XIX expenditures to meet federal requirements.

BACKGROUND

Federal Financial Participation funding, also known as Title XIX, is a Medicaid program that allows states and LHJs to draw down matching Title XIX reimbursements for activities that meet Title XIX objectives. Title XIX has two types of programs: Targeted Case Management and Medi-Cal Administrative Activities. DPH's Maternal, Child and Adolescent Health (MCAH) Division draws down matching Title XIX reimbursements for Medi-Cal Administrative Activities workload, which primarily assists individuals eligible for Medi-Cal with enrollment into programs and/or assists insured individuals with access to Medi-Cal providers, care, and services. Only General Fund or local funding (no federal funding) can be used as a match to draw down the Title XIX reimbursements to administer the program.

Title XIX provides variable federal matching rates for administrative functions in two ways - non-enhanced and enhanced:

- A non-enhanced reimbursement rate of 50 percent supports the majority of expenses needed to implement Title XIX activities, such as salaries, benefits, travel, training and other administrative expenses for non-skilled professional medical personnel including, but not limited to, administrators, associate staff, clerical staff not providing direct support to, or staff directly supervised by skilled professional medical personnel (SPMPs), and claims processing staff. Staff hired under contract, including SPMP staff, are to be charged at the non-enhanced rate.

- An enhanced reimbursement rate of 75 percent supports expenses of SPMP in the delivery of Title XIX activities such as salaries, benefits, training, and travel expenses for SPMPs who meet the federal education and training requirements and perform activities requiring specialized medical knowledge and skill, and for

the clerical staff who directly support and are supervised by a SPMP. Contract employees are exempt from claiming the enhanced rate.

LHJs are required to submit a time study and other documentation on a quarterly basis to CDPH/MCAH to draw down Title XIX reimbursements for activities that meet claiming requirements. Time studies are the primary documentation to determine the percent of personnel time eligible for Title XIX reimbursements. The time claimed to receive the Title XIX reimbursement must be spent performing Medi-Cal administrative activities that meet at least one of the following Federal Funding Participation objectives:

1. Assisting individuals eligible for Medi-Cal to enroll in the Medi-Cal program.
2. Assisting individuals on Medi-Cal to access Medi-Cal services.

DPH Interagency Agreement with the Department of Health Care Services (DHCS)
Since 2007, CDPH/MCAH has had an Interagency Agreement (IA) with the Department of Healthcare Services (DHCS) that allows DPH/MCAH and LHJs to match Title XIX reimbursements for MCAH programs that help eligible participants enroll In and access Medi-Cal services.

The 2019 Governor's Budget includes approximately $2 million General Fund for CDPH/MCAH to match Title XIX reimbursements. CDPH/MCAH works to improve the health and well-being of women, infants, children and adolescents throughout the state.

The following MCAH programs are administered by LHJs and receive federal Title XIX funding:

- Black Infant Health Program/California Perinatal Equity Initiative
- Adolescent Family Life Program
- MCAH Local Programs
  - Information and Education for Adolescent Health Program
  - Adolescent Sexual Health Program
  - Comprehensive Perinatal Services Program
  - Prenatal Care Guidance Program

Historically, Title XIX was managed by CDPH/MCAH as pass-through funding to LHJs with minimal processing. LHJs matched Title XIX funding with local dollars to support local MCAH programs. In 2017-18, DHCS reviewed the Title XIX IA with CDPH/MCAH and communicated oversight requirements that CDPH/MCAH did not provide in the past, but are important for federal auditing purposes. CDPH/MCAH oversight requirements include time-study and activity review, position reconciliation, and new invoicing requirements, such as secondary documentation. The oversight includes review of LHJ objectives, personnel duty statements, and scope of work activities to determine appropriate reimbursement claiming rates. Each additional requirement increases the need for MCAH personnel to carry out the required administrative oversight or risk jeopardizing federal funding.

Additional oversight includes submission of secondary documentation with every quarterly invoice submitted from CDPH/MCAH to verify the drawdown of Title XIX reimbursements. The collection of secondary documentation has been an existing contract requirement of LHJs; however, its submission to CDPH/MCAH for processing was not enforced. Examples of secondary documentation include daily logs, appointment books, event flyers, meeting agendas with minutes, calendars, journals, and day planners. This secondary documentation must also identify staff name(s), position(s), program(s), date and time span of activities, activities conducted and intent of activities, and number of clients seen or contacted (target audience). Additional oversight requirements also include greater analysis of personnel duty statements and scopes of work to determine appropriate claiming rates, in addition, when using a variable Medi-Cal Factor, verification and documentation of Medi-Cal enrollment is required.

Currently, CDPH/MCAH LHJs can draw down and match more than $35 million of Title XIX reimbursements to supplement local costs to administer CDPH/MCAH programs that link low-income Californians to Medi-Cal. Without Title XIX reimbursements, LHJs would have to reduce personnel staff that currently work to connect eligible MCAH program participants with Medi-Cal providers and services. LHJs rely on Title XIX reimbursements to leverage limited local resources. In addition, in the past two years, LHJs have been making a concerted effort to increase the amount of Title XIX reimbursements that is drawn down as a means to expand services to local clients in a more cost effective manner. Without CDPH/MCAH's administrative and programmatic oversight, LHJs would be unable to access the Title XIX reimbursements, thus reducing the effectiveness of their local agency and potentially services for Medi-Cal clients.

To continue Title XIX reimbursements for LHJs, CDPH/MCAH must develop additional administrative and programmatic guidance documents, such as policies, procedures, and templates, which detail the enforcement of primary documentation (time-study review), secondary supporting documentation, position reconciliation, and new invoice requirements.

DPH states that current staff will not be able to absorb these new duties without delaying MCAH allocation process and current invoicing requirements. Adding this additional work to this staff without assistance would not allow contract managers to plan for upcoming funding award cycles, process invoices within the 45-day requirement, or be able to provide the technical assistance LHJs require. Given that the requirement to perform these new duties began on June 4, 2018, DPH is redirecting the full-time equivalent of three staff from elsewhere in the department on a temporary basis. These staff will establish policies and procedures for the LHJs and will then meet on a monthly basis to process invoices, verify secondary documentation has been provided and submit reimbursement requests to DHCS. According to DPH, this piecemeal approach will not allow for any technical or programmatic consultation to the LHJs which is important given the new enforcement of procedures. Additionally, this approach is not sustainable beyond 2018-19 and jeopardizes CDPH's other administrative duties and priorities such as opioid overdoses and deaths, violence prevention initiatives, infectious disease outbreaks, and cannabis awareness. Also, the redirection approach does not take advantage of the

opportunity to leverage General Fund with Title XIX reimbursements for a 50/50 match. However, if CDPH is approved for 5 positions. Title XIX reimbursements can be used to support administrative staff at a 50/50 cost sharing.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 11: WIC ESTIMATE

WIC ESTIMATE

The WIC program is funded almost entirely with federal funds, including a Food Grant from the United States Department of Agriculture (USDA) as well as Nutrition Services and Administration (NSA) grant. The state also contracts for rebates from infant formula providers, which amounts to approximately 15 percent of the program funding.

As shown in the table below, the WIC estimate proposes total expenditures of $879 million in 2019-20, a $12.9 million (1.4%) decrease over the revised estimate for 2018-19.

WIC Expenditures

	2018 Budget Act	2018-19 Estimate	2018-19 Proposed	CYE to BY Change	% Change
Local Assistance	843,150,000	$828,388,000	$815,905,000	-$27,245,000	-3.23%
State Operations	$63,684,000	$63,684,000	$63,270,000	-$1,414,000	-2.22%
Total Expenditures	**$906,834,000**	**$892,072,000**	**$879,175,000**	**$12,897,000**	**-1.4%**

BACKGROUND

WIC provides supplemental food and nutrition for low-income families (185 percent of poverty or below) with pregnant women, breastfeeding and early postpartum mothers, infants, and children up to age five. WIC services include nutrition education, breastfeeding support, help finding health care and other community services, and checks for specific nutritious foods that are redeemable at retail food outlets throughout the state. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

DPH administers contracts with 84 local agencies (half are local government and half private, non-profit community organizations) that provide 650 locations statewide. Approximately 3,000 local WIC staff assess and document program eligibility based on residency, income, and health or nutrition risk, and issue 4.8 million food checks each month. Local WIC agencies issue WIC participants paper vouchers to purchase approved foods at authorized stores. Examples of WIC foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amounts and types of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support, and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged as being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

WIC Funding

DPH states that California's share of the national federal grant appropriation has remained at about 17 percent over the last 5 years. Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

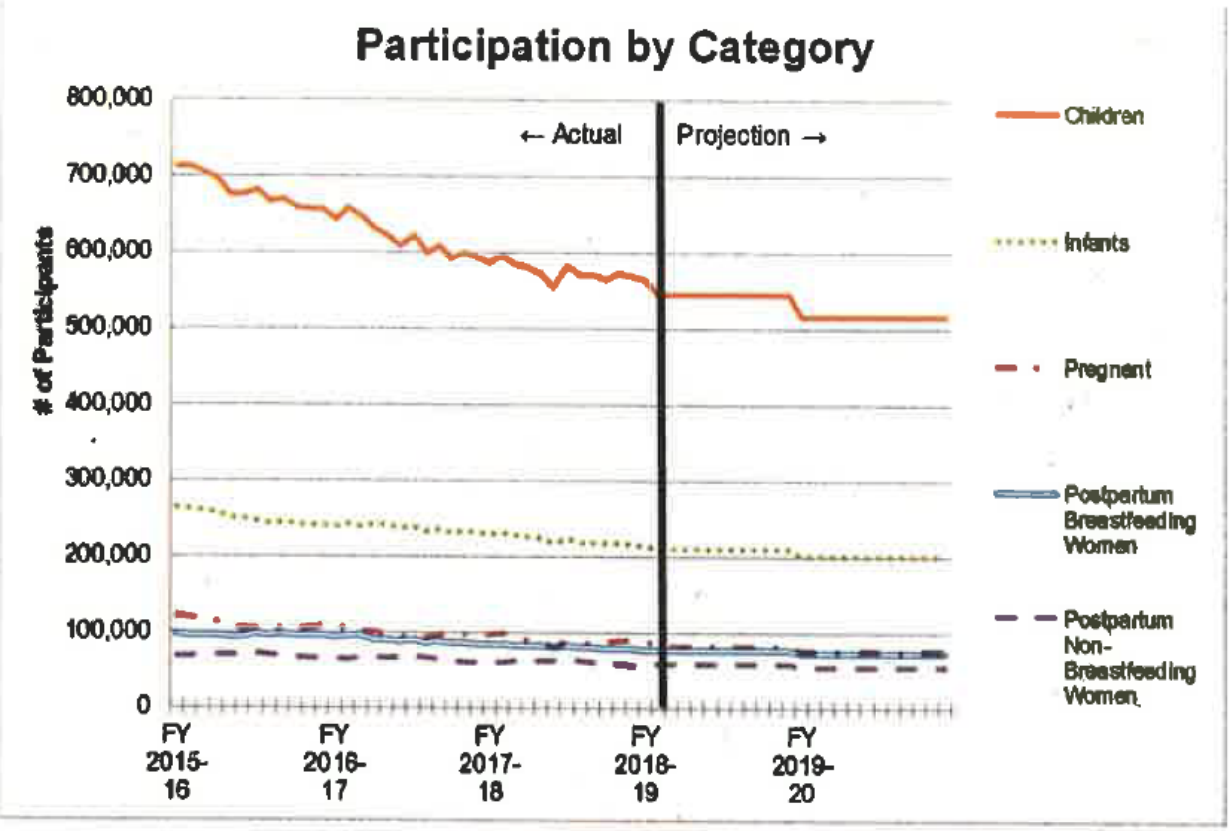
- **Food**. Food funds reimburse WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.

- **Nutrition Services and Administration.** Nutrition Services and Administration (NSA) Funds that reimburse local WIC agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition education, breastfeeding support, and referrals to health and social services, as well as support costs. States manage the grant, provide client services and nutrition education, and promote and support breastfeeding with NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.

- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with infant formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down Federal WIC food funds.

WIC Participation

Caseload (participation) in WIC has been decreasing since 2013, consistent with national trends, as can be seen in the chart below:



WIC Program staff note that although participation is decreasing in California and nationally, California's WIC program serves 76 percent of the eligible population, while the national average is 60 percent.

Electronic Benefit Transfer (EBT)

DPH is in the process of replacing the program's information technology system in order to be able to transition the program from paper vouchers to EBT cards. DPH anticipates issuing EBT cards during the summer of 2019, with full implementation by April 2020.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with the WIC estimate at this time.

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

ISSUE 12: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

GDSP ESTIMATE

The total GDSP proposed 2019-20 budget is $141.2 million, an $8.2 increase (6.2%) over the current year (2018-19) budget of $134.1 million. Of the proposed $141.2 million, $31.4 million is for state operations while $109.8 million is proposed for local assistance.

	Genetic Disease Screening Program Expenditures				
	2018 Budget Act	**2018-19 Estimate**	**2019-20 Proposed**	**CY to BY $ Change**	**CY to BY % Change**
NBS Local Assistance	$41,006,000	$41,006,000	$43,022,000	$2,016,000	4.9%
PNS Local Assistance	$35,022,000	$35,022,000	$36,459,000	$1,437,000	4.1%
Operational Support	$27,473,000	$27,473,000	$30,344,000	$2,871,000	10.5%
State Operations	$29,451,000	$30,593,000	$31,351,000	$1,900,000	6.5%
TOTAL	**$132,952,000**	**$134,094,000**	**$141,176,000**	**$8,224,000**	**6.2%**

BACKGROUND

The mission of the GDSP is "To serve the people of California by reducing the emotional and financial burden of disability and death caused by genetic and congenital disorders." California Health and Safety (H&S) Code sections 125000-125002, 125050-125119, and 124975-124996 require CDPH to administer a statewide genetic disorder screening program for pregnant women and newborn babies that is to be fully supported by fees.

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

Prenatal Screening Program (PNS). This program screens pregnant women who consent to screening for serious birth defects. The fee for this screening is $221.60; $211.60 is deposited into the Genetic Disease Testing Fund and $10 is deposited into the California Birth Defects Monitoring Program Fund. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests for pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester.

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

Newborn Screening Program (NBS). This program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee for this screening is $142.25. Where applicable, this fee is paid by prepaid health plans and insurance companies. Medi-Cal also covers the fee for its enrollees. The NBS screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions, and referral information is provided where applicable.

When the NBS Program began in October 1980, each newborn was screened for only three disorders; today, with the advent of new scientific findings, the NBS Program screens for more than 80 disorders in over 500,000 newborns and diagnoses more than 850 babies each year. California leads the nation in the number of disorders screened and provides the most comprehensive program in terms of quality control, follow-up services, genetic counseling, confirmatory testing, and diagnostic services.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with the GDSP estimate at this time.

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

ISSUE 13: L&C: CREATION OF A CENTRALIZED PROGRAM FLEX UNIT (BCP)

PROPOSAL

DPH requests 6 positions and $973,000 in 2019-20 and annually thereafter from the State Department of Public Health Licensing and Certification Program Fund (Licensing and Certification Fund) to shift health facility program flexibility application workload from 13 district offices and four Los Angeles County offices to a new centralized headquarters unit.

The resources would improve statewide consistency in program flexibility application decision-making by developing staff subject-matter expertise. The requested positions would also utilize a new electronic tracking system, funded from existing resources, to convert the application process from a paper-based system to an online platform system beginning summer of 2019.

BACKGROUND

Health and Safety Code (HSC) section 1276 provides Public Health the authority to grant facilities flexibility from regulatory requirements by using alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting pilot projects as long as the facility meets statutory requirements and has prior Public Health written approval. The approval provides the terms and conditions under which Public Health grants the exception. Written requests from applicants or licensees must include justification for the program flexibility request and adequate supporting documentation that the proposed alternative does not compromise patient care. After Public Health receives a complete application requesting program flexibility, Public Health has 60 days to approve, approve with conditions or modifications, or deny the application.

Currently, each of CHCQ's thirteen district offices and four Los Angeles County offices review program flexibility requests submitted by facilities and agencies in their designated area of oversight. Between 2013-14 and 2017-18, CHCQ received over 1,600 program flexibility requests. HSC 1276 requires the department to complete a review of a program flexibility request within 60 days; however, departmental data indicates that CHCQ is not meeting this requirement consistently. The number of program flexibility applications received between 2013-14 and 2017-18 increased by 193 percent (212 to 621) (see Workload History table). Qf the applications received in 2017-18, 50 percent were completed within the statutorily-required 60-day application review process. CHCQ projects the volume of requests will increase in the coming years, resulting in further impact to the existing workload of the district offices. While CHCQ reviews each request on a case-by-case basis, the reviews require program-wide consistency in applying regulations and standards of care. Because each district office handles the cases within their jurisdiction, inconsistency in the program flexibility review and approval process

exists. It is the intent of centralizing the review process for program flexibility requests to remedy this issue.

The transition to a centralized program flexibility model with clinical and administrative headquarter staff reviewing and responding to requests with approval, approval with conditions or modifications, or denial, will promote program-wide efficiency and consistency. Building a centralized team will promote development of subject matter expertise of those staff responsible for reviewing and responding to the requests and promote consistency in the evaluation of the requests. A centralized team will also allow for effective identification of trends, and reliable data documentation and report monitoring. Examining this data by a centralized team will support informed decisions on the need for future policy and/or regulatory changes.

Many providers and advocacy groups have expressed concerns and frustration having inconsistent decisions made on similar or identical program flexibility requests when reviewed by different district offices. For example, requests approved by one district office may be denied by another district office without differences in circumstance.

Public Health proposes to establish a centralized program flexibility unit with 6 staff with policy and clinical expertise to address consistency and efficiency in application of regulatory requirements.

Classifications include Health Program Manager II, Nurse Consultant II, Associate Governmental Program Analyst, and Office Technician (typing). These staff will review, process, and approve, approve with conditions, or deny program flexibility requests and work with the district offices to maintain and update program flexibility status in the existing licensing database as appropriate. These staff will also develop and maintain system requirements and business rules related to program flex, standardize program flex data, and prepare analytics and reports as needed. As a result of the workload shift, district-level supervisors will be able to redirect staff capacity to address backlogs relating to issuances, certifications, complaints, and citations.

In addition to the centralized review process, CHCQ will use existing resources to develop an Adobe Experience Manager electronic application for facilities to submit program flexibility requests online. Health care facilities are responsible for maintaining continuous, ongoing compliance with the licensing rules and regulations, while Public Health expeditiously reviews then approves, approves with conditions or modifications, or denies applications for program flexibility.

This solution will allow dedicated resources to effectively and efficiently apply the regulatory requirements when considering approval of requests, and additionally will support Public Health's intent of meeting the 60-day mandate for review and providing greater consistency for providers seeking flexibility across multiple district office jurisdictions.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 14: L&C: INCREASED INFORMATION TECHNOLOGY CUSTOMER SUPPORT (BCP)

PROPOSAL

DPH requests 6 positions and $911,000 in 2019-20 and annually thereafter from the State Department of Public Health Licensing and Certification Program Fund (Licensing and Certification Fund) to support increased information technology services workload associated with a new federally-required health facility survey automation system.

BACKGROUND

The Information Technology Services Division (ITSD) delivers services to Public Health programs by providing a range of centralized IT services through project management, information security, application development and support, business operations, information systems operations, and enterprise architecture. Within ITSD are the Applications Development and Support Branch (ADSB) and the Data Center Operations and Services Branch (DCOSB). The ADSB provides support for the development of new applications, as well as enhancements and maintenance of current applications. The ADSB supports several applications and systems, including the Automated Survey Processing Environment (ASPEN). ASPEN is a suite of software applications designed to help state agencies collect and manage healthcare provider data. DCOSB is responsible for developing and administering the information and technical architectural areas of ITSD through the establishment of reference models and processes needed to identify ITSD's current technical infrastructure standards and strategic direction. DCOSB also provides IT support, which includes IT maintenance and operational support for workstations, web sites, hardware, software, printers, network connections, servers, backup/recover, and storage.

CMS implemented the Long Term Care Survey Process (LTCSP) in November 2017 for skilled nursing facilities. The LTCSP is a resident-centered, outcome-oriented inspection that supports the accurate identification of quality of care and quality of life problems. The LTCSP required Public Health to use a single, software-based nationwide survey process rather than the paper reporting process that existed before. The new technology requires surveyors to complete in-depth on-site surveys and share in the field. CMS expects to add one to two facility types per year over the next several years to this new process. In addition, CMS will begin rolling out a federally-owned replacement system for ASPEN called the Internet Quality Improvement and Evaluation System (IQIES) by facility type beginning in spring 2019.

Transitioning Public Health staff to the new LTCSP process is the responsibility of the state. While CMS offers training programs to familiarize surveyors with the LTCSP, the implementation of the new process has placed increased demand on Public Health's Information Technology Services Division to address software and hardware issues for over 800 surveyors and 2,000 total users. The Division has experienced increased IT support tickets and slower response times for IT support tickets. Backlogged tickets

increased by 118 percent between 2013-14 and 2017-18. The lack of essential services (processing and maintaining requests for user's identification and password assistance related to the aforementioned systems, as well as provide expert assistance to users on installing, troubleshooting and transferring of such software) has put a burden on the program and caused multiple delays in completing workload and providing services.
Also, the current Public Health IT technician to surveyor ratio is 1:212. For the same ASPEN system, Texas has a 1:73 ratio and Florida has a 1:42 ratio.

This proposal will address the need for IT support designated to CHCQ for a growing number of digital platforms and reduce the amount of helpdesk tickets, allowing staff to address the ongoing, continuous, and increased workload. The requested 3 Information Technology Specialist I's in ADSB will focus on resolving tickets before a ticket reaches breach status, which is after three days. These staff will serve as the subject matter experts and provide problem resolution by responding to phone calls, emails, and monitoring helpdesk ticket requests on issues related to the ASPEN and other applications supported by ADSB.

To meet the growing application software and workstation hardware support needs, 3 additional Information Technology Specialist I's in DCOSB will support the surveyors with updating technologies, setting up workstations, and completing configuration and desktop support. The new federally mandated survey requirements necessitate resources for the following:

- Image configuration and setup of laptops/desktops/printers
- Router configuration
- Maintenance and warranty calls
- Re-Certification (iPad configuration and setup)
- IPhone support (configuration)
- Remote support with CITRIX and Virtual Private Network (VPN)
- New account setup (network, various applications)
- CId tablet exchange (Revolve replacement)
- File and print server and networking support
- Virtual Desktop Infrastructure (VDI) and application virtualization support

With the increase in support needs, current staff are receiving upwards of 90 open tickets per day. The backlog of support tickets prevents the team from documenting and improving processes and procedures. The backlog also prevents IT staff from having the time to develop and provide training to assist surveyors in performing their jobs more efficiently. If this proposal is not approved, helpdesk ticket response times will increase, resulting in an increase of support tickets escalating to breach status (not closed within three days), and delays in completion time of federal recertification surveys. Public Health receives federal funding from CMS and further delays in support could jeopardize Public Health's ability to meet the requirements established by the federal grant.

DPH states that permanent, as opposed to limited-term, resources for IT support are needed given the following:

- Future components to the electronic survey technology will be rolled out.
- CMS will expand the LTCSP to other health facility types.
- Frequency in updates to the ASPEN and LTCSP systems have increased, which results in an increase in the number of tickets.
- There has been an increase in the complexity of efforts needed to support surveyors and ASPEN users.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 15: ONLINE AND DISTANCE-LEARNING NURSE ASSISTANT TRAINING PROGRAMS (AB 2850) (BCP)

PROPOSAL

DPH requests 9 permanent positions and $1.2 million from the State Department of Public Health Licensing and Certification Program Fund (Licensing and Certification Fund) in 2019-20 and annually thereafter to review, approve, and monitor applications from new online and distance learning nurse assistant training programs (NATPs) and instructors, as required by Chapter 769, Statutes of 2018 (AB 2850 Rubio).

BACKGROUND

CHCQ issues nurse assistant certificates, to individuals 16 years of age and older, who complete a background check, finish a CHCQ-approved NATP, and successfully pass the required examination. Certified nurse assistants (CNAs) provide basic patient care services directed at the safety, comfort, personal hygiene, and protection of patients under the supervision of a registered nurse (RN) or licensed vocational nurse (LVN). CNAs cannot provide any services that require professional licensure and cannot perform tasks that require substantial scientific knowledge and technical skills, such as administering medications. Prior to the adoption of AB 2850, individuals were unable to complete their initial coursework online or in a distance learning center. Distance learning is a method of study where teachers and students do not meet in a classroom, but use the Internet, e-mail, mail, etc., to have classes. Trainees only had the option of receiving their training and education through skilled nursing facilities (SNFs) or intermediate care facilities (ICFs), or through local agencies or education programs such as a community college, or a regional occupational center in person.

CHCQ's Professional Certification Branch (PCB), amongst its various other tasks, enforces laws and regulations related to CNAs, and reviews and approves a NATP's proposed curriculum prior to its operation to verify that all required curriculum is included and complies with all relevant laws and regulations. PCB enforcement includes monitoring classes, assessing enrollment, and evaluating examination pass rates. CHCQ requires facilities to maintain a 60 percent pass rate to maintain their approval. PCB also oversees the approval of the CNA training programs, continuing education requirements, and the criminal record clearance of these health care paraprofessionals.

Chapter 52, Statutes of 2017 (SB 97), requires SNFs, except those that are a distinct part of a general acute care hospital or a state-owned hospital or developmental center, to provide a minimum of 3.5 direct care hours, with 2.4 of those hours being performed by CNAs. SB 97 required Public Health to develop emergency regulations in consultation with stakeholders to implement the statute's requirements. Prior to the statute, the staffing standard for SNFs was 3.2 nursing hours per patient day. The increased demand for

CNAs, due to the new staffing standards, necessitates expanding the training options for potential students, who will eventually become part of the CNA workforce.

In recognition of the need to expand CNA training options:

- The 2018 Budget Act provides $2 million in one-time General Fund to the Board of Governors of Community Colleges to expand CNA training as part of the Strong Workforce Program.
- Public Health awarded a $2.4 million state grant over two years (2018-19 and 2019-20) from the Federal Health Facilities Citation Penalties Account to the Quality Care Health Foundation to fund the CNA Kickstarter Project to increase the number of in-house CNA training programs.
- As part of the 2018 Budget Act, the Employment Training Panel also awarded $2.5 million from existing training programs to reimburse SNFs and other training providers for CNA training.

PCB data shows enrollment in NATPs decreased by approximately eight percent from January 2014 through January 2018. During this time, PCB reports enrollment in SNF- and ICF-based NATPs decreased 64 percent and enrollment in NATPs through local agency and educational institutions increased approximately 10 percent. This data suggests individuals are still seeking training, just not at the rates previously seen, and more often through local agencies and educational institutions.

AB 2850 authorizes SNFs, ICFs, educational institutions, and local agencies to offer the required 60 classroom hours of CNA precertification training through online or distance learning classes. The statute establishes minimum standards for operating online and distance learning NATPs, and requires online and distance learning NATPs to offer Public Health-approved curriculum.

Additionally, AB 2850 authorizes any LVN or RN with experience in providing care and services to chronically ill or elderly patients in an acute care hospital, SNF, ICF, home care, hospice care, or other long-term care setting to be eligible for approval as a NATP instructor at a SNF, ICF, educational institution, or local agency. Expanding the pool of potential qualified instructors will assist facilities, educational institutions, and local agencies to offer additional classes, thereby increasing the ability to train CNAs and address workforce shortages.

The requested resources are necessary to meet the mandated workload required by AB 2850 to provide the required levels of oversight of online and distance learning NATPs in SNFs, ICFs, educational institutions, and local agencies.

Public Health must review applications from prospective providers and instructors, review proposed curriculum, and monitor providers of online and distance learning NATPs for compliance with all laws and regulations pertaining to traditional NATPs. Applications are renewed every two years. CHCQ anticipates significant increases in workload resulting from new online and distance learning NATP applicants and new instructor applicants.

This will require 3 Associate Governmental Program Analysts (AGPAs) to review applications for accuracy and completion, prepare correspondence regarding approvals or deficiencies, and conduct regular reporting; and 3 Health Facility Evaluator Nurses (HFENs) to analyze applications, investigate complaints, and monitor and provide consultation to training programs. A Program Technician (PT) II will also be hired to sort and distribute mail, address inquiries, and prepare renewal notifications. Additionally, 1 Health Facility Evaluator Manager (HFEM) I will exercise oversight over the approval process of online CNA training programs.

DPH explains that, due to the technology associated with online and distance learning NATPs, staff need to possess information technology expertise. CHCQ requires 1 Information Technology Specialist (ITS) I. The ITS 1 will play a vital role in the enforcement of online training course requirements. The ITS 1 will also provide technical support to staff, assisting their efforts to monitor compliance with online CNA training program requirements.

To effectively provide oversight, and timely review and approval of both instructors and new online and distance learning programs, CHCQ will administratively establish positions and absorb costs with existing resources in 2018-19 in anticipation of the immediate workload that will result from the implementation of AB 2850, effective January 1, 2019.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 16: TIMELINES FOR HOSPITAL LICENSING APPLICATIONS (AB 2798) (BCP)

PROPOSAL

DPH requests 21 positions and $3.4 million from the State Department of Public Health Licensing and Certification Program Fund (Licensing and Certification Fund) in 2019-20 and annually thereafter to complete decisions on certain health facility licensing applications within new processing timelines, as required by Chapter 922, Statutes of 2018 (AB 2798 Maienschein).

Additionally, DPH requests trailer bill language to allow the Licensing and Certification Fund to support this mandated workload.

BACKGROUND

The Centralized Applications Branch (CAB) processes health care facility applications for CHCQ. CAB processes all of Public Health's applications for initial facility license, changes to existing licenses, and licensure renewals. CAB processes applications on a first-in, first-cut basis and often works with applicants to address incomplete or inaccurate application materials.

Public Health centralized the processing of health care facility applications for state licensure and federal certification to standardize the licensure application process and to create consistent application processing times. Following the development of CAB beginning in 2015-16, a significant backlog of applications resulted from personnel and process changes.

Since identifying their application backlog, CAB has increased staffing and instituted new processes to improve processing times and decrease the existing backlog. Between December 2017 and December 2018, CAB expanded from 25 to approximately 95 staff members and implemented new training and procedures. CAB has successfully decreased processing times for all applications. For performance metrics, please find the CAB performance metrics dashboard at:
https://www.cdph.ca.gcv/Prcgrams/CHCQ/LCP/Pages/CHCQPerfcrmanceMetrics.aspx

Pursuant to AB 2798, effective January 1, 2019, Public Health must review, and approve or deny all written applications submitted by general acute care hospitals (GACHs) and acute psychiatric hospitals (APHs) within 100 days of receipt. Public Health district offices (DQs) must complete all of their related tasks and report their findings to the CAB within 30 days of approval. DQs must meet the 30-day requirement within the 100-day mandated timeline for Public Health.

Additionally, Public Health must review and approve applications to expand existing services from GACHs and APHs within 30 days of receiving a written application, unless the hospital is cut of compliance with existing laws governing that service. Public Health

may authorize facilities to offer these expanded services for up to 18 months, and if needed, may extend authorization beyond the initial time period. If Public Health's review is not completed within 30 days, the application for the expanded services is automatically approved.

Additionally, CAB must develop an automated application system on or before December 31, 2019, and set up an advice program to assist applicants to complete their applications. Public Health is currently developing an automated application system using existing funding in the Internal Departmental Quality Improvement Account (IDQIA).

Public Health requests 21 positions and $3,386,000 from the Licensing and Certification Fund in 2019-20 and ongoing. These funds are necessary to meet the mandated workload related to the hospital licensing processing timelines established by AB 2798.

CHCQ anticipates increased pressure tc review and complete decisions for hospital applications due to the processing timelines established by AB 2798. In Quarter 1 of 2018-19, CAB's average application review period (from the date received through date of completion) for GACHs and APHs was 124 and 157 days, respectively. These do not include the time it takes for DQs to complete all of their related tasks and report their findings back to Public Health.

Effective January 1, 2019, Public Health must review and approve written applications submitted by a GACH or an APH within 100 days of receipt. In addition. Public Health DQs must complete any additional review and submit their findings to Public Health within 30 days from the date of approval. Since all review and approval-related work must be complete within the allotted time periods. Public Health needs additional staff at both headquarters and at DCs to perform the work.

CAB needs 3 Associate Governmental Program Analysts (AGPAs) positions to review incoming applications for completeness and accuracy, notify applicants of any missing documentation, and compile and monitor survey reports for tracking purposes. These positions will also assist CAB to develop the automated application system (funded through existing resources) by December 31, 2019, and establish an advice program to assist applicants to complete their applications.

Crucial to Public Health's ability to comply with AB 2798 is the hiring of 14 high-travel Health Facility Evaluator Nurses (HFENs) across DCs, and $199,000 to support the equivalent of two nurses through the Los Angeles County (LAC) contract. These staff will survey hospitals to assess compliance with regulations, prepare written analyses of findings, and provide technical assistance to healthcare facility administrators. The DQs also need 4 AGPAs to perform necessary licensing functions, timeline monitoring, and survey workload. Without these HFENs and support staff. Public Health DCs will be incapable of completing all mandatory work within the prescribed timeline by the new statute.

CHCQ will administratively establish positions and absorb costs within existing resources in the current year in anticipation of the immediate workload that will result from the adoption of AB 2798.

Trailer Bill Language

AB 2798 requires that resources necessary to implement AB 2798 be made available from the IDQIA, upon appropriation. The proposed trailer bill eliminates this requirement. DPH explains that ongoing licensing activities, such as the workload created by AB 2798, are more appropriately funded by the Licensing and Certification Fund. Fees deposited into the IDQIA are intended to fund typically limited-term internal quality improvement efforts.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 17: SOLICITING AND IMPLEMENTATION OF PROJECTS TO BENEFIT NURSING HOME RESIDENTS (SFL ISSUE 302)

PROPOSAL

DPH requests 1 position and $680,000 in 2019-20, $431,000 in 2020-21, and $149,000 annually thereafter from the Federal Health Facilities Citation Penalties Account (Account) to implement a project to benefit nursing home residents, and enhance the solicitation and monitoring of projects approved by the federal Centers for Medicare and Medicaid Services (CMS).

Additionally, provisional language is requested to authorize the Department of Finance to increase the expenditure authority for a CMS-approved project, upon request from Public Health and notification to the Legislature

BACKGROUND

CMS may impose monetary penalties against skilled nursing facilities (SNFs), nursing facilities (NFs), and dually-certified SNF/NF for either the number of days or for each instance a facility is not in substantial compliance with one or more Medicare and Medicaid participation requirements for Long-Term Care Facilities (Code of Federal Regulations (CFR) 42 Part 488.430). A portion of these Civil Money Penalty (CMP) Funds collected from nursing homes are returned to the states in which CMPs are imposed. State CMP funds may be reinvested to support CMS-approved activities that benefit nursing home residents that protect or improve their quality of life.

All states must submit to CMS an acceptable plan for the use of CMP funds for the upcoming calendar year. This plan must include available fund balances, current obligations, and plans for solicitation and review of future projects. CMS uses the data from California's CMP state plan to ensure that federal CMPs are being properly distributed. If states are unable to adequately plan for the use of their CMP funds, then CMS may withhold future disbursements of CMP funds to the state until the state has submitted an acceptable plan to comply with this section. Previous CMP projects include:

- In 2013-14, Public Health executed a three-year contract with the California Culture Change Coalition to reduce antipsychotic medication in SNFs in California.
- In 2015-16, Public Health executed a three-year contract with the California Association of Health Facilities (CAHF) for the Music and Memory program for improving dementia care.
- In 2017-18, Public Health executed a four-year contract with CAHF for a project to improve dietary services in California nursing homes.
- In 2018-19, Public Health executed a three-year contract with CAHF for the Volunteer Engagement project.
- In 2018-19, Public Health executed a two-year contract with Quality Care Health

Foundation for the Certified Nursing Assistant (CNA) Training Kickstarter Project

Health and Safety Code Section 1417.2 (a) establishes the Federal Health Facilities Citation Penalties Account (Account) into which moneys derived from CMPs for violations of federal law shall be deposited. Historically, Public Health's annual baseline expenditure authority for the Account has been $973,000, which limited CHCQ's ability to solicit CMP projects. The 2018 Budget Act includes $973,000 in expenditure authority. The 2018 Budget Act also includes one-time provisional language to authorize the Department of Finance to augment expenditures by an amount not to exceed $1.73 million after review of a request submitted by Public Health reflecting federal CMS approval to use the Account to implement the CNA Training Kickstarter Project. In fall 2018, the Department of Finance augmented the Account by $1.2 million to implement the CNA Training Kickstarter Project.

CHCQ's authorized and actual expenditures have consistently been significantly less than the revenues received for the Account. As a result, the Account fund balance has continued to increase. As of January 2019, the 2017-18 fund balance was approximately $15 million; the balance is projected to exceed $18 million by July 2019.

Nurse Leadership Project

Public Health provides contract management and oversight on behalf of CMS for all CMS-approved projects. CMS has recently approved a CMP grant for the Nurse Leadership Project. The total cost of this project is estimated to be $1.7 million over three fiscal years ($567,000 in 2019-20, $579,000 in 2020-21, and $592,000 in 2021-22).

Although Public Health can absorb a portion of the Nurse Leadership Project costs within existing Account expenditure authority, Public Health requests an increase in Account expenditure authority of $531,000 in 2019-20 and $282,000 in 2020-21 to implement the project. The implementation of the Nurse Leadership Project will help CHCQ promote the goal of improved nurse retention and improved quality of care.

More specifically, the project will concentrate on the development of nurse leaders, and focus on leadership abilities that affect engagement and retention of direct care staff, such as effective communication, managing expectations, accountability, delegation, and mentorship, with the goal of decreasing the turnover rate of direct care staff, which in turn will improve resident care, and lead to improved resident satisfaction. Consistent staffing and improved continuity of care are, in turn, expected to result in a reduction in undesirable resident outcomes such as the development of new pressure injuries, weight loss, confusion, medication errors, falls, and abuse.

1 Position Request to Enhance Solicitation and Implementation of Projects

Additionally, Public Health requests an increase of $149,000 from the Federal Health Facilities Citation Penalties Account in 2019-20 and annually thereafter, to support 1 Staff Services Manager I (Specialist) to continue the progress CHCQ has begun with soliciting CMP projects to benefit nursing home residents. This work is currently performed by Public Health/CHCQ branch chiefs. Each CMP project is assigned to a branch chief to manage the contract, scope of work, deliverables, etc. Solicitation is handled

predominately by CHCQ executive staff. This current arrangement does not provide continuity and consistency with project management and detracts from other CHCQ workload.

This position will verify that monies paid out for CMP projects are spent on the items identified by the CMP funds recipient, and will work as the project lead to monitor and track all project invoices. This position will develop and translate CMS-approved projects into individual contracts with scope of work activities and deliverables, will ensure project timelines and deliverables are met, and will intake and review CMP applications for completion and conformance with state laws and federal regulations. The criteria used to review CMP project applications will center on improvements to one or more of the following categories: culture change, residential or facility council, direct improvement to Quality of Care, consumer information, transition preparation for a nursing home resident, and training. The position will also post valuable, updated information regarding the solicitation process on the Public Health website, send quarterly emails to relevant associations with application templates and guidelines, work collaboratively with the district offices to post and distribute application solicitation notices to health care facilities, and will present impactful CMP projects and explain the application process (including an explanation of prohibited and permissible uses of CMP funds) to the nursing home provider community during their state conferences.

A dedicated position for this workload is critical given that Public Health expects a significant increase in projects beginning 2019-20. This is consistent with Public Health's CMS-approved state plan to expand outreach to stakeholders, which includes the recent launch of a webpage to promote project submittal. CMS allows the use of CMP funds for personnel to administer and monitor projects using CMP funds (CFR 42 Part 488.433).

Provisional Language
Since 2015-16, CHCQ has been actively soliciting CMP projects within the available resources. Additional funding for future CMS-approved projects can only be obtained upon appropriation by the Legislature. Due to recent guidance from CMS, the timing of the California budget process, and the project application approval process with CMS, Public Health requires the flexibility to augment the Account appropriation when necessary.

In February 2019, CMS requested states to obtain sufficient expenditure authority to timely and efficiently expend federal penalty funds. Under the existing expenditure authority level, there may be up to a one-year delay in project implementation, limiting timely benefits to nursing home residents. The delay may also discourage entities from submitting or implementing proposed projects. Additionally, CMS recently hired a vendor to expedite project application review (from 6 to 7 weeks to 2 to 3 weeks) to support faster project implementation. This is also likely to increase the volume of approved projects in 2019-20 and in coming years.

For any potential CMS-approved project that may exceed the existing Account expenditure authority. Public Health proposes provisional language to authorize the Department of Finance to increase the expenditure authority from the Account after review of a request submitted by Public Health that demonstrates a need for additional authority. Any augmentation shall be authorized not sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may determine.

As such, Public Health requests the following provision be added to Item 4265-115-0942:

> The Department of Finance may augment this item, after review of a request submitted by the State Department of Public Health reflecting federal approval to use this account. Any augmentation shall be authorized not sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may determine.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 18: ADAP ESTIMATE

ADAP ESTIMATE

The November 2018 ADAP Estimate provides a revised projection of Current Year (2018-19) local assistance costs for the medication and health insurance programs for ADAP, along with projected local assistance costs for the Budget Year (2019-20).

- For FY 2018-19, CDPH estimates that the ADAP budget authority need will be $407.9 million, which is a $26.2 million decrease in budget authority compared to the 2018 Budget Act. The decrease is primarily due to a decrease in projected medication expenditures and less than expected funding from the 2018 Ryan White Part B Supplemental grant.

  CDPH estimates ADAP revenue will be $325.6 million, which is an $830,000 decrease compared to the 2018 Budget Act. The decrease is primarily due to a decrease in projected medication expenditures.

- For FY 2019-20, CDPH estimates that the ADAP budget authority need will be $449.8 million, which is a $15.7 million increase in budget authority compared to the 2018 Budget Act. The increase is primarily due to an increase in projected medication and insurance premium expenditures.

  CDPH estimates ADAP revenue will be $379 million, which is a $52.5 million increase compared to the 2018 Budget Act. The increase is primarily due to an increase in medication expenditures.

California Department of Public Health
AIDS Drug Assistance Program
2019-20 November Estimate
Table 1: Local Assistance
(In Thousands)

Local Assistance	2018 Budget Act	Current Year FY 2018-19			2018 Budget Act	Budget Year FY 2019-20		
		2019-20 November Estimate	$ Change from 2018 Budget Act	% Change from 2018 Budget Act		2019-20 November Estimate	$ Change from 2018 Budget Act	% Change from 2018 Budget Act
Fund:								
Total Funds Requested	$434,076	$407,878	-$26,198	-6.0%	$434,076	$449,789	$15,713	3.6%
Federal Funds - Fund 0890	$132,438	$129,143	-$3,295	-2.5%	$132,438	$135,138	$2,700	2.0%
Rebate Funds - Fund 3080	$301,638	$278,735	-$22,902	-7.6%	$301,638	$314,650	$13,013	4.3%
Caseload	30,864	31,541	677	2.2%	30,864	33,457	2,593	8.4%

[1]Estimate numbers are rounded for presentation purposes; as a result, numbers may not total exactly.

Table 2: Rebate Fund Revenues (Fund 3080)
2019-20 November Estimate
(In Thousands)

Local Assistance	2018 Budget Act	Current Year FY 2018-19			2018 Budget Act	Budget Year FY 2019-20		
		2019-20 November Estimate	$ Change from 2018 Budget Act	% Change from 2018 Budget Act		2019-20 November Estimate	$ Change from 2018 Budget Act	% Change from 2018 Budget Act
Total Revenue Requested	$326,462	$325,632	-$830	-0.3%	$326,462	$378,988	$52,526	16.1%
Rebate Funds - Fund 3080	$324,462	$321,632	-$2,830	-0.9%	$324,462	$374,988	$50,526	15.6%
Interest Income	$2,000	$4,000	$2,000	100.0%	$2,000	$4,000	$2,000	100.0%

Caseload
The OA states that the overall number of clients receiving ADAP services is increasing and will continue to increase each year at rates similar to pre-ACA implementation due to persons becoming newly infected with HIV.

	2018-19 Estimate	2019-20 Proposed	CY to BY # Change	CY Act to BY % Change
Caseload	31,541	33,457	1,916	6.1%

BACKGROUND

ADAP provides access to life-saving medications for eligible California residents living with HIV, and assistance with covering costs related to HIV pre-exposure prophylaxis (PrEP) for clients at risk for acquiring HIV. ADAP services, including support for medications, health insurance premiums, and medical out-of-pocket costs, are provided to five groups of clients:

1. **Medication-only clients** are people living with HIV (PLWH) who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals. This group only receives services associated with medication costs.
2. **Medi-Cal share of cost (SOC) clients** are PLWH enrolled in Medi-Cal who have a SOC for Medi-Cal services. ADAP covers the SOC for medications for these clients. This group only receives services associated with medication costs.

3. **Private insurance clients** are PLWH who have some form of health insurance, including insurance purchased through Covered California, privately purchased health insurance, or employer-based health insurance; therefore, this group is sub-divided into three client sub-groups: Covered California clients, non-Covered California clients, and employer-based insurance clients. These groups receive services associated with medication costs, health insurance premiums, and medical out-of-pocket costs.

4. **Medicare Part D clients** are PLWH who are enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group receives services associated with medication co-insurance and Medicare Part D health insurance premiums. As of July 1, 2017, qualifying Medicare Part D clients have the option for premium assistance with Medicare Part B medical insurance and Medi-gap policies, which cover their medical out-of-pocket costs.

5. **PrEP clients** are individuals who are at risk for, but not infected with HIV, and have chosen to take PrEP as a way to prevent infection. This group receives services associated with medication costs and medical out-of-pocket costs.

ADAP collects full rebate for prescriptions purchased for all client types listed above except Medi-Cal SOC and PrEP clients. As the primary payer, Medi-Cal has the right to claim federal mandatory rebate on prescriptions for Medi-Cal SOC clients. In order to ensure duplicate rebate claims are not submitted to manufacturers by both programs, which is prohibited, ADAP does not invoice for rebates on these claims.

Historically, the majority of clients ADAP served were ADAP-only clients without health insurance, because PLWH were unable to purchase affordable health insurance in the private marketplace. However, with the implementation of the ACA, more ADAP clients have been able to access public and private health insurance coverage. ADAP clients are screened for Medi-Cal eligibility, and potentially eligible clients must apply. Clients who enroll in full-scope Medi-Cal are dis-enrolled from ADAP, because these clients have no SOC, drug co-pays, or deductibles, and no premiums. All clients who obtain health coverage through Covered California or other health plans can remain in ADAP's medication program to receive assistance with their drug deductibles and co-pays for medications on the ADAP formulary. Eligible clients with health insurance can co-enroll in ADAP's health insurance assistance programs for assistance with their insurance premiums. Assisting clients with purchasing health insurance is more cost effective than paying the full cost of medications. In addition, assisting clients with purchasing and maintaining health insurance coverage improves the overall health of Californians living with HIV because clients have comprehensive health insurance and access to the full spectrum of medical care, rather than only HIV outpatient care and medications through the Ryan White (RW) system.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with the ADAP estimate at this time.

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

ISSUE 19: RICHMOND: VIRAL RICKETTSIAL DISEASE LABORATORY ENHANCED UPGRADE CAPITAL OUTLAY (SFL)

PROPOSAL

The administration requests $1,080,000 for construction project enhancements to the Viral Rickettsial Disease Laboratory to ensure that CDPH retains its BSL-3 Certification. Total project costs are $6,953,000 ($241,000 for preliminary plans, $830,000 for working drawings, and $5,882,000 for construction). The construction amount includes $4,714,000 for the construction contract, $335,000 for contingency, $471,000 for architectural and engineering services, and $362,000 for other project costs. The preliminary plans began in July 2007 and were completed in April 2008. The working drawings began in May 2008 and were completed in August 2018. Construction is scheduled to begin in August 2019 and be completed in August 2020.

BACKGROUND

Select agent viruses that require BSL-3 facilities include, but are not limited to, hantavirus, poxviruses, novel influenza (e.g. avian influenza viruses), Middle East Respiratory System (MERS)- CoV, Severe Acute Respiratory System (SARS), Chikungunya virus, Japanese encephalitis virus, and West Nile virus. An operational BSL-3 laboratory is needed to be able to identify these viruses to prepare and respond to deadly emerging viral diseases.

When the Richmond Campus VRDL laboratory was constructed in 2000, it was designed to meet the existing BSL-3 requirements as determined by the Centers for Disease Control (CDC) and the National Institute of Health (NIH). In 2006, because of world health concerns, the CDC and NIH implemented enhanced requirements for BSL-3 certified labs. In response to this, DPH was provided funding of $482,000 General Fund in 2007-08 for the preliminary plan and working drawing phases for a project to upgrade the VRDL BSL-3 suite to conform to the new requirements. Construction funding of $4,333,000 General Fund was provided in 2015-16, and was reappropriated in 2016-17.

In August 2017, the Department of General Services (DGS) bid the construction contract, but only received one bid. The bid was $3,445,000, which was 23 percent, or $649,000, above the estimated $2,796,000 construction contract cost.

DGS evaluated the bid, contacted interested bidders, and concluded:

- There was limited interest by other bidders due to the current strength of the Bay Area construction market.
- The specialty nature of a laboratory project further limited potential bidders.
- The original construction estimate did not adequately reflect the Bay Area construction market conditions.

- Although only one bid was received, the bid was competitive and reflected the current construction market.

As a result, in 2018-19 the authority for the project's construction phase was reverted, and a new construction appropriation of $4,866,000 was provided to fund the associated cost for DGS to update the drawings, rebid the project, and the estimated increased construction cost.

In October 2018, DGS bid the project again. In January 2019, DGS received one qualified bid of $4,714,000, which exceeded the construction contract cost of $3,709,000 by $1,005,000, or 21 percent. The reasons for the increase include an overall tightening of the bay area construction market combined with the specialty nature of the project.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 20: IMPROVING VITAL RECORDS INTEROPERABILITY AND DATA QUALITY (BCP)

PROPOSAL

DPH requests 3 permanent positions and $1.2 million in 2019-20 and 2020-21, $1.3 million in 2021-22 and 2022-23, $1.4 million in 2023-24, and $21,000 in 2024-25 and ongoing from the Health Statistics Special Fund. The resources would allow for continued investments in the development and upgrades of vital record registration systems and would support a significant transfer of data reporting responsibility to Public Health staff.

BACKGROUND

Public Health's Center for Health Statistics and Informatics (CHSI) is responsible for the registration of vital events, the issuance of legal vital record documents, and the collection and management of public health and vital statistics data. Public Health/CHSI compiles vital statistics data from birth, death, and fetal death certificates for more than 750,000 Californians annually. These data are foundational to the federal government, state agencies, local government agencies, policy makers, and researchers for measuring population health, conducting research on health outcomes, and for purposes of state and local public health reporting and surveillance.

By statute, the State Registrar operates under the authority of Division 102 of the Health and Safety Code (HSC). Division 102 makes the State Registrar responsible for registering each live birth, fetal death, death, and marriage that occurs in California, and for providing certified copies of vital records to the public. HSC Section 102230 requires the State Registrar to permanently preserve vital records in a systematic manner and to prepare and maintain a comprehensive and continuous index of all registered certificates.

Registration of births, deaths, and fetal deaths are done through electronic web-based registration systems where data necessary for the legal registration of births, deaths, and fetal deaths are entered by key stakeholders, such as hospitals, funeral homes, attending physicians, and medical-examiner/ coroners. Demographic and medical information captured during the registration process provide the foundational health data used for measurement of population health, identification of disparities, and assessment of program effectiveness.

Public Health's vital records registration and reporting systems are housed and managed through two Interagency Agreements (IAs) with the University of California (UC), one with UC Davis, and the other with UC Santa Barbara. The current IA with UC Davis expires December 31, 2019, and is proposed for renewal. The existing UC Santa Barbara IA will expire June 30, 2019, and will not be renewed.

A majority of the request reflects the modification and renewal of an IA with UC Davis and the remainder reflects a shift of activities from an IA with UC Santa Barbara to Public Health staff.

Modification and Renewal of IA with UC Davis

The resources requested reflect a renewed and modified five-year IA with UC Davis ($3.9 million in 2019-20 and 2020-21, 4.0 million in 2021-22 and 2022-23, and $4.1 million in 2023-24 from the Health Statistics Special Fund) offset by base funding for the existing IA with UC Davis ($2.7 million Health Statistics Special Fund) set to expire December 31, 2019. The total requested funding to support the IA with UC Davis is $1.2 million in 2019-20, $1.1 million in 2020-21, $1.3 million in 2021-22 and 2022-23, and $1.4 million in 2023-24 (see Table 2).

The current five-year IA is estimated to cost $11.9 million Health Statistics Special Fund. The proposed renewed five-year IA with UC Davis is for $20 million Health Statistics Special Fund. The increased costs reflect the hiring of four new UC Davis positions to oversee vital records system modifications, and adjustments for higher salary and benefits rates, data storage, equipment, and facility costs.

Table 2

Fiscal Year	Base Funding for UC Davis IA[1/]	Proposed Total Cost of UC Davis IA	BCP Request for UC Davis IA[2/]
2019-20	$ 2,740,000	$ 3,942,000	$ 1,202,000
2020-21	$ 2,740,000	$ 3,880,000	$ 1,140,000
2021-22	$ 2,740,000	$ 4,046,000	$ 1,306,000
2022-23	$ 2,740,000	$ 4,027,000	$ 1,287,000
2023-24	$ 2,740,000	$ 4,134,000	$ 1,394,000
2024-25	$ 2,740,000	$ -	$ -

[1/] Amount based on the annualized 2018-19 cost of the existing IA with UC Davis, sheduled to end 12/31/19.

[2/] IA with UC Davis is proposed to end 6/30/24.

UC Davis maintains the California Integrated Vital Records System (Cal-IVRS) platform. Cal-IVRS is the term used by Public Health to refer to applications developed for use over the secure internet by funeral directors, coroners, medical examiners, local registration districts, hospitals, physicians, counties and Public Health to facilitate the registration and reporting of vital events in California. It is comprised of the following systems, bringing birth, death, and fetal death registration systems together onto a single platform:

- The California Electronic Birth Registration System (EBRS)
- The California Electronic Death Registration System (EDRS)
- The California Fetal Death Registration System (FDRS) • The Vital Records Business Intelligence System (VRBIS)

These resources are needed for continued development (dev-ops) of vital records operating systems to implement interoperability solutions to make data capture more efficient, thereby continuing California's capability for electronic vital records registration and data reporting to our many federal, state, county partners and researchers, contractors and stakeholders. The versioning upgrades are needed to improve the quality of data at the time of capture and to implement solutions designed to speed the

transmission of data to internal and external partners. More specifically, proposed system upgrades include (see Table 3):

Table 3

System and Description	Proposed Enhancements and Benefits
California Electronic Birth Registration System (EBRS) EBRS is the new birth registration software that will replace the legacy birth registration system (the Automated Vital Statistics System, or AVSS) developed by UCSB in the 1980s, and set to retire June 2019. Statewide deployment of EBRS is expected to be complete by June 2019.	• Continue development of EBRS, which will allow Public Health to house the birth registration system on the same platform as other vital records systems. • Add functionality to register amendments of birth records. The existing process for amendments is a largely manual, time-consuming process that is not integrated into AVSS. • Create functionality to query birth records registered in the legacy AVSS system, enable replacement certificates to be created in EBRS, and update existing records in the VRBIS database with new certificates.
Electronic Death Registration System (EDRS) EDRS is California's system for electronic death certificate origination and registration. The web-based CA-EDRS system provides the ability for coroners, funeral directors, doctors, and hospitals to submit electronic death certificates for registration 24 hours a day.	• Streamline transfer of data from provider-based Electronic Health Records (EHRs), and improve interoperability between Medical Examiner/Coroner case management systems and the EDRS to improve the timeliness of registration and cause of death data. • Develop technical requirements to integrate a Centers for Disease Control and Prevention (CDC) web service system to improve the quality of cause of death reporting. • Increased interoperability and streamlined data transfer would reduce staff time and duplication of data entry by end users, and would make more timely and accurate death data available for public health uses. • Implement upgrades against ransomware attacks and other security threats.
Fetal Death Registration System (FDRS) FDRS is the state's system for electronic fetal death certificate origination and registration.	• Revise the current fetal death certificate form and upgrade the FDRS user interface necessary to bring California's fetal death certificate and registration system into compliance with national standards, which Public Health is contractually bound with the National Center for Health Statistics (NCHS) to fulfill. • Incorporate fetal death data as a component of the VRBIS as Public Health lacks a data repository and reporting system for these registered records.

Vital Records Business Intelligence System (VRBIS) VRBIS is the Public Health database and reporting system which works with vital records data to allow county health departments to access the data certified by county health staff for public health uses.	• Include fetal death data as a component of the VRBIS, building functionality in VRBIS to produce data files for reporting to the NCHS and automating a largely manual process. • Align enhancements to EBRS, EDRS, and FDRS with VRBIS, allowing all systems to function on an integrated, interoperable platform. Synchronization is needed to guarantee that access to essential public health data is uninterrupted.

Shift of Activities from IA with UC Santa Barbara to Public Health Staff The resources requested also include 3 permanent positions and $427,000 in 2019-20 and ongoing for Public Health to transition workload activities currently performed by UC Santa Barbara. These activities include data file creation, vital record file distribution, and analyses of data quality issues. The requested amount is offset by existing base funding for the IA with UC Santa Barbara ($406,000 Health Statistics Special Fund ongoing), as the UC Santa Barbara IA is set to expire June 30, 2019. The total requested funding to shift these activities is therefore $21,000 Health Statistics Special Fund in 2019-20 and annually thereafter (see Table 4).

Table 4

Fiscal Year	Base Funding for UCSB IA[1/]	Proposed Total Costs of Shifting Activities to CDPH Staff	BCP Request for Shifting Activities to CDPH Staff
2019-20	$ 406,000	$ 427,000	$ 21,000
2020-21	$ 406,000	$ 427,000	$ 21,000
2021-22	$ 406,000	$ 427,000	$ 21,000
2022-23	$ 406,000	$ 427,000	$ 21,000
2023-24	$ 406,000	$ 427,000	$ 21,000
2024-25	$ 406,000	$ 427,000	$ 21,000

[1/] IA ends 6/30/19.

Automated Vital Statistics System (AVSS) is the legacy birth registration system developed by UC Santa Barbara in the 1980s, and is set to retire upon completion of the IA with UC Santa Barbara. It supports only the birth registration process. The system is best described as semi-automatic, in that it produces a paper certificate for signature that must be routed first to the local registration district and then to the state. The paper certificates are scanned and imaged by Public Health for issuance. To replace AVSS, Public Health's existing IA with UC Davis includes the ongoing development of the EBRS. However, some key system functionality has not been completed and would be funded with the proposed renewed IA with UC Davis.

Although the UC Santa Barbara workload associated with birth registration system maintenance would to be shifted to UC Davis, existing UC Santa Barbara workload associated with data file generation, submission, and quality assurance would be transitioned to Public Health staff. The shift in workload from UC Santa Barbara to Public Health would include the following:

- Creation and distribution of birth files to meet contract requirements with the NCHS and Social Security Administration (SSA);
- Creation and distribution of custom birth source files related to public requests, including researchers; • direct communication with providers, hospitals, and coroners to validate data quality issues; and,
- Research and analyses of data quality issues.

Increasingly, Public Health is experiencing more requests for near real-time data to support program surveillance, governmental analysis, and research projects, as there is growing recognition that near real-time birth and death data can be more effectively used for surveillance and population health monitoring. Because vital records data files were historically only made available about nine months after the close of a calendar year, they have limited value for surveillance.

Public Health also has limited resources to evaluate missing, incomplete, improbable, and/or impossible data elements reported in birth and death registration. Therefore, Public Health is seeking additional staff resources to support the delivery of more timely data files, monitor data quality, perform follow up, and support outreach and education efforts with certifiers, medical examiners/coroners, and facilities. With the implementation of the above enhancements and the hiring of three new Public Health positions, Public Health can implement solutions designed to speed the transmission of data to internal and external partners, improve the quality of data, and avoid risk of failing to meet contract deliverables.

Privacy protections and security requirements are also constantly evolving. New policies and procedures have been created to comply with statutory changes and include the Public Health Minimum Data Necessary Policy, and the CHHS Data De-Identification Guidelines. These new procedures require a more stringent review of each data application and the creation of custom data files of only the data fields required for the specified purpose. The review time of data applications has risen from a few hours in the past to an average of sixteen hours. As a result, staff time has increased a total of 4,800 hours annually for review and processing of data applications. This is compounded by the staff time required to prepare custom data files as opposed to making a copy of a static CD.

The requested 3 permanent positions would perform workload associated with data file creation and distribution for all vital records systems (birth, death, and fetal death systems) housed in the Cal-IVRS platform. Centralizing all data file creation and distribution activities will allow Public Health to have inhouse expertise in such workload.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 21: PUBLIC HEALTH CRISIS RESPONSE GRANT (SFL ISSUE 305)

PROPOSAL

lt is requested that provisional language be added to Items 4265-001-0890 and 4265-111-0890 to allow the Department of Public Health to quickly accept public health emergency funding pursuant to Centers for Disease Control and Prevention (CDC) Public Health Crisis Response Grant requirements. In February 2018, the Department received approval to be placed on an "Approved-But-Unfunded" list of grantees, which stipulates its recipients have certified that they can submit to CDC an amended budget within 14 days of notice of CDC's intent to make an award, and complete hiring and execute contracts within 30 days of the notice. The Department's "Approved-But-Unfunded" application status was set to expire January 31, 2019, but the Department received confirmation from CDC in January 2019 that it will continue to be placed on the "Approved-But-Unfunded" list through August 1, 2020. The proposed provisional language will allow the Department to meet these requirements in response to public health emergencies and is consistent with the provisional language used for the same purpose in the 2018 Budget Act.

Add the following provision to Item 4265-001-0890:

> 3. Notwithstanding any other law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by the State Department of Public Health that additional funds are available pursuant to a United States Department of Health and Human Services, Centers for Disease Control and Prevention Cooperative Agreement for Emergency Response: Public Health Crisis Response grant. Within 10 working days of authorizing that augmentation, the Department of Finance shall provide written notification of the augmentation to the chairpersons of the fiscal committees in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee.

Add the following provision to Item 4265-111-0890:

> 3. Notwithstanding any other law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by the State Department of Public Health that additional funds are available pursuant to a United States Department of Health and Human Services, Centers for Disease Control and Prevention Cooperative Agreement for Emergency Response: Public Health Crisis Response grant. Within 10 working days of authorizing that augmentation, the Department of Finance shall provide written notification of the augmentation to the chairpersons of the fiscal committees in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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

ISSUE 22: ELECTRONIC VISIT VERIFICATION PHASE II PLANNING (SFL ISSUE 303)

PROPOSAL

It is requested that Item 4265-001-0001 be increased by $15,000 and reimbursements be increased by $132,000 to support planning activities to comply with federal electronic visit verification requirements related to Department of Public Health personal care services authorized per the California Section 1915(c) Home and Community-Based Services Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome Waiver. See related issue in the California Health and Human Services Agency, Department of Health Care Services, and Department of Developmental Services Finance Letters.

This request represents the DPH component of a larger, multi-department proposal which is being overseen by the California Health and Human Services Agency. The full proposal will be heard by Sub 1 on May 1, 2019.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff has no concerns with this request at this time.

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