AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MAY 7, 2018

2:30 P.M. - STATE CAPITOL, ROOM 444

VOTE ONLY ITEMS

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VOTE ONLY ITEMS

4700 DEPARTMENT OF COMMUNITY SERVICES AND DEVELOPMENT

ISSUE 1: BUDGET CHANGE PROPOSAL (BCP): LOW-INCOME WEATHERIZATION PROGRAM (LIWP) REAPPROPRIATION

BCP REVIEW

The Administration requests reappropriation of any unexpected balances of 2015-16 local assistance appropriations received from the Greenhouse Gas Reduction Fund (GGRF) to be available for encumbrance until the end of 2018-19, and available for liquidation until the end of 2018-19. The proposal includes budget bill language.

Launch of the LIWP 2015-16 Single-Family program was delayed following protests to the competitive bid process identifying Regional Administrator awardees. Due to this delay, contracts were not finalized until June 2017. When factoring in ramp-up activities such as the renegotiation of project implementation plans, implementation of outreach strategies, and seasonal factors during winter months that limit project completions, liquidation of all the funds by the end of 2017-18 seems unrealistic. If the reappropriation authority is not granted, CSD anticipates reverting a total of $57 million in GGRF.

Staff Recommendation:

Approve the BCP. This subcommittee heard and discussed this item during its April 11, 2018 hearing. No concerns have been raised.

ITEMS TO BE HEARD

SPECIAL ORDER ON HEALTH CARE

ISSUE 2: SPECIAL ORDER ON HEALTH CARE IN CALIFORNIA

PANELISTS

- **Assemblymember Dr. Joaquin Arambula**
- **Assemblymember Dr. Jim Wood**

Public Comment

PROPOSAL

As Co-Chairs of the Select Committee on Health Care Delivery Systems and Coverage, Assemblymembers Arambula and Wood will present a proposal to Assembly Budget Subcommittee #1 that includes a comprehensive set of reforms to California's health care system, reflecting the goals of increasing insurance coverage and access to care, improving quality of care, and making health care more affordable in California.

BACKGROUND

In 2017-18, the Select Committee on Health Care Delivery Systems and Universal Coverage (Select Committee) conducted several hearings on a variety of topics, including in-depth discussions of California's current healthcare delivery systems, examined universal coverage in other countries, discussed the cost-containment efforts of other states, and explored options and implementation considerations for universal coverage.

The passage of the federal Patient Protection and Affordable Care Act (ACA) reduced the number of uninsured in California in half from seven million to three million. Under the ACA's Medicaid expansion, low-income single adults (at or below 138% of the federal poverty level (FPL)) without dependent children became eligible for Medi-Cal. As of October 2017, about 3.8 million Medi-Cal enrollees gained coverage under this expansion. Today, Medi-Cal enrollment is closely approaching 14 million.

As part of the ACA, California also created Covered California (CC), the state's marketplace exchange. Californians became eligible for federal premium subsidies if their household income is at or below 400% of the FPL ($48,240 annually for a single individual or $98,400 for a family of four). Additionally, federal financial assistance was provided to lower copays, deductibles, and other out-of-pocket costs. Total enrollment in CC has held steady at between 1.2 to 1.4 million, with about 85% of enrollees receiving federal subsidies. All these efforts reduced the number of Californians in the individual market who reported spending more than 10% of their family income on premiums and out-of-pocket costs from 43% in 2013 to 34% in 2015. It should be noted that individuals with incomes above 400% of the FPL receive no affordability assistance.

The hearings of the Select Committee revealed that employment-based coverage, Medi-Cal, and Medicare remain the dominant sources of coverage for Californians, and most of health care is delivered through managed care arrangements. Additionally, many of California's low income residents or those without coverage rely on community or county health clinics as a source of care. Difficulty affording premiums and concerns about coverage comprehensiveness are factors for many Californians who remain uninsured.

Additionally, even among people with coverage, some remain underinsured, facing substantial financial barriers to access. Underinsurance, defined as having high cost burden or exposure to high health cost sharing, affects 21% of insured Californians using Commonwealth Fund criteria. The most affected by underinsurance are those in Medicare and the individual market.

Another potential source of disruption in care is the upheaval referred to as churn which occurs when individuals have a change in their health insurance status, which could occur due to a change in job status or financial eligibility for public programs. A change in health insurance coverage can result in change in health plan, which can disrupt care and relationships between patients and providers.

Californians also experience marked differences in their ability to access medical care and some of this disparity is related to the availability of physicians who are not distributed equally throughout the state. Many rural areas suffer from physician shortages, with the physician-to-population ratios below established federal benchmarks in some of these areas.

Testimony at the Select Committee hearings also revealed that in California, as in the rest of the U.S., average prices for most healthcare services are much higher than in other developed nations, and that prices vary substantially by type of coverage. In addition, administrative costs, such as billing and insurance related costs, contribute to overall higher healthcare spending in the state.

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 3: STAKEHOLDER PROPOSAL ON SUICIDE HOTLINE FUNDING

PANELISTS

- **Kita S. Curry**, PhD, President/CEO, Didi Hirsch Mental Health Services
- **Lyn Morris,** Senior Vice President, Clinical Operations, Didi Hirsch Mental Health Services

Public Comment

PROPOSAL

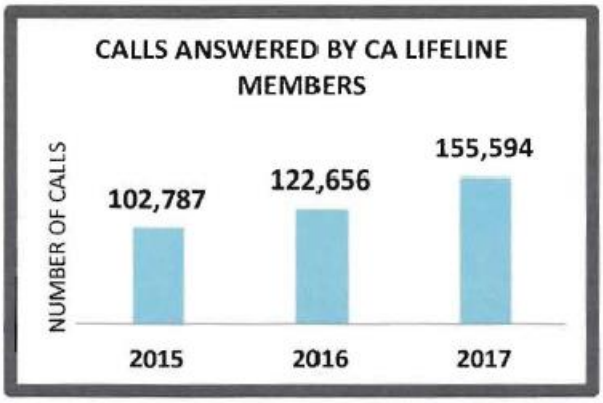
Didi Hirsch requests an ongoing allocation of $4.8 million for FY 18-19 and future years to fund California's 11 Suicide Prevention Lifeline (Lifeline) network members. This represents a $500,000 increase over the FY 17-18 allocation of $4,297,867. They also request that the oversight for this program be transferred from the Department of Health Care Services to the Mental Health Oversight and Accountability Commission.

BACKGROUND

Didi Hirsch provided the following background information:

California, along with the rest of the nation, has embraced the Lifeline as its safety net for residents in emotional distress or a suicidal crisis, as well as for those concerned about a friend or loved one. The counties have invested millions of dollars advertising the Lifeline number, as have universities, insurance companies, etc. In addition:

- Any Google search that is suicide-related brings up the Lifeline number;
- Facebook responds with the number when posts contain key words associated with suicide;
- When iPhone's Siri hears suicide mentioned, "she" refers the speaker to the Lifeline;
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires all facilities to give it to every suicidal person they serve.



Launched by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2005, the National Suicide Prevention Lifeline is a network of 165 suicide crisis lines in the U.S. that must be accredited and adhere to specific standards and best practices. The federal government supports Lifeline's infrastructure, which includes a telecommunications system that links callers to the closest line and rolls calls over to a back-up line if the closest line is busy or has lost power. However, states are expected to fund direct services; SAMHSA provides individual lines with nominal stipends up to $1,500 per year.

The Lifeline network also is able to link callers to services provided by larger crisis lines that would be far too costly for every Lifeline member to provide, such as 24/7 bilingual Spanish counselors and a Disaster Distress Helpline. Similarly, California's network of Lifeline members ensure 24/7 coverage for counties without a Lifeline crisis center. Many take calls outside their home counties, and the largest of the State's Lifeline centers answers calls from all 58 counties. Didi Hirsch is submitting this request on behalf of all 11 lines. Didi Hirsch states that the funding is needed to cover the rapid increase in calls to the line. California's Lifeline members answered more than 155,000 calls in calendar year 2017, an increase of 27% over the previous year.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Didi Hirsch present this proposal.

Staff Recommendation: No action is recommended at this time.

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 4: MEMBER PROPOSAL ON TULARE REGIONAL MEDICAL CENTER

PANELISTS

- **Assemblymember Devon Mathis**

Public Comment

PROPOSAL

Assemblymember Mathis requests $22 million one-time for emergency funding to the Tulare Regional Medical Center.

BACKGROUND

Assemblymember Mathis provided the following background information:

The Tulare Local Healthcare District operates the Tulare Regional Medical Center, located within the City of Tulare, in one of the poorest counties in the state. There are currently over 70,000 people in its service area with no access to local hospital services. Until recently, the Healthcare Conglomerate Associates (HCCA) has been the management firm of the medical center. When they contracted with a previous Board of Directors, the contract which they negotiated paid HCCA an exorbitant annual amount. The Board of Directors mismanaged funds received through a 2005 General Obligation Bond. These actions ultimately led to the removal of the old Board of Directors, and the eventual closure of the hospital itself. Since then, a new Board of Directors has taken over management of the hospital and seeks to re-open the doors to service the people of Tulare.

While audits are currently being conducted by both the State Auditor and the Tulare County District Attorney on the possible wrongdoings that led to the hospital's closure, the current Board of Directors has taken on the arduous task of settling past debts to preserve the hospital itself. This new board has worked diligently to address the mismanagement of funds by the previous board, and has worked to re-open the doors to the medical center. Despite best efforts, the board has entered Chapter 9 bankruptcy. It faces a loss of cash and losing the staff currently preparing to reopen the hospital.

The pressure to re-open the medical center is mounting at a rapid pace because of the extreme healthcare needs beset upon the community. Tulare residents are suffering greatly without access to healthcare: already, two residents have died in the streets due to a lack of access. Assemblymember Mathis states that "While the use of previous funds are deliberated and investigated, I must take a proactive approach to re-open the medical center and ensure that it continues providing vital healthcare services. Without these funds, more people will continue to die. This cannot be allowed to happen."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Mathis present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 5: MEMBER PROPOSAL ON FRIDAY NIGHT LIVE PARTNERSHIP

PANELISTS

- **Assemblymember Devon Mathis**
- **Jim Kooler,** Administrator, California Friday Night Live Partnership

Public Comment

PROPOSAL

Assemblymember Mathis requests $6 million General Fund annually to the Department of Health Care Services (DHCS) for the purpose of providing supplemental funding to the California Friday Night Live Partnership (CFNLP) at the Tulare County Office of Education (TCOE).

BACKGROUND

Assemblymember Mathis provided the following background information:

The Friday Night Live (FNL) program was established in California in 1984 as a high school program to reduce underage drinking and driving and to promote a teenage lifestyle free of alcohol and other drugs. The mission of FNL is to build partnerships for positive and healthy youth development that engage youth as active leaders and resources in their communities. Youth involved in FNL have the opportunity to develop skills and plan activities in concert with their peers and adult advisors. FNL programs are youth-driven, providing meaningful roles for youth in the program. FNL builds community partnerships that support youth, helping to foster a sense of autonomy and power, and promote the belief in a young person's capacity to contribute.

The FNL program grew from a pilot program in 3 counties to a statewide movement that, at its peak, operated in 55 of the 58 counties and had just over 1,000 FNL chapters at schools and community sites. Since 1996, statewide support and coordination of the FNL program have been provided by the CFNLP at the TCOE. The CFNLP has provided leadership, innovation, training, technical assistance, and served as an intermediary to provide local project funding on specific issues. With the framework of the CFNLP, local programs have the ability to design their efforts to meet their specific needs.

Over the last ten years, since the downturn of the economy, the FNL programs at the state and local levels have seen dramatic reductions in funding, resulting in less capability to serve young people when the need continues to grow. One program that was decimated with the elimination of funding was the Friday Night Live Mentoring (FNLM) program. The FNLM program is a cross-age mentoring program that connects high school students as positive role models for middle school students to prepare them

for a successful transition to high school. Today the FNL program continues to operate in 50 of the 58 counties with just over 500 chapters.

While the program has been able to retain some of its original services, the benefits offered to the students should be expanded to their original levels. These programs have a proven track record of benefiting their participants, especially with regards to reducing abuse of alcohol, tobacco, drugs, and violence. This program helps young people stay in school, increasing school's average daily attendance and helps promote a safe school environment. As such, Assemblymember Mathis asserts that the state should expand the capacity of the FNL system in the 50 counties by providing additional resources to support and enhance the quality of local program implementation.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Assemblymember Mathis present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 6: STAKEHOLDER PROPOSAL ON BREAST AND CERVICAL CANCER TREATMENT PROGRAM TREATMENT CAPS

PANELISTS

- **Angela Blanchard**, Legislative Advocate, Susan G. Komen
- **Kelly MacMillan**, Executive Director, Norther/Central Affiliate, Susan G. Komen

Public Comment

PROPOSAL

Susan G. Komen requests $8.4 million General Fund and trailer bill to eliminate treatment caps in the Breast and Cervical Cancer Treatment Program (BCCTP).

BACKGROUND

The Komen Foundation provided the following background information:

Breast Cancer affects far too many Californians – it is estimated that approximately one in every eight women in the U.S. will have breast cancer during their lifetime.

The BCCTP provides necessary cancer treatment to low-income, uninsured or underinsured individuals diagnosed with breast and/or cervical cancer. Under current law, the state-only-funded BCCTP is not aligned with the federally-funded BCCTP, causing gaps in service and treatment for women diagnosed and treated through the state-funded program. Under the state BCCTP, treatment coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. It is also important to note that, currently no other health insurer imposes treatment caps.

The state-only BCCTP provides services to three important groups of women – those who have purchased insurance but are underinsured, women regardless of their documentation status, and women newly employed and in the probationary period of their health insurance.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Susan G. Komen present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 7: STAKEHOLDER PROPOSAL ON COVERAGE OUTREACH AND ENROLLMENT

PANELISTS

- **Lucy Quacinella**, Consultant to Maternal and Child Health Access

Public Comment

PROPOSAL

Maternal and Child Health Access, leading a coalition of approximately 40 organizations, requests $26.5 million in State General Fund ($53 million total with federal match) over two years to be used by community-based organizations statewide, not only to help consumers enroll in and retain health coverage but also to access medical services. Current funding for this type of consumer assistance under AB 82 and SB 18 runs out June 30, 2018.

BACKGROUND

Maternal and Child Health Access (MCHA) provided the following background information:

At present, there is unfortunately an exploding demand from consumers for education and accurate information about eligibility as well as for help sorting out options and deciding whether to apply or continue receiving Medi-Cal, Covered California, or other health programs. This is due to the many and ongoing federal administrative changes to Obamacare, the upcoming end of the federal individual mandate to purchase health insurance, and pervasive fear and confusion among immigrant families about accepting any kind of assistance, including medical care, given the attacks coming from the federal level and the overall national discourse on immigration; many people are asking: If we try to sign up for coverage, will the federal government find out? How will my private information be used if I sign up? Could they take my green card away if I use Medi-Cal? If my citizen kids get medical care, with or without insurance, does anyone in my family risk being deported? Are we even eligible for anything at all these days?

MCHA states that, in the current environment, outreach and education about health coverage and access to care remain extremely important, and now is not the time to let Medi-Cal funding end for the help that these organizations provide. These organizations are known and trusted in the community, flexible and able to address priority needs as new challenges arise. Moreover, as the Governor regularly warns, an economic downturn could happen again at any time; the current needs for outreach, education and the other types of assistance provided (described below) would increase exponentially. The present budget request would help these organizations address the current significant needs as well as prepare for new challenges.

Enrollment and Retention Services

In Los Angeles County alone, these organizations have enrolled 27,000 people and provided information about health coverage programs to over 90,000 just during FY 2016-17. The California Coverage and Health Initiatives, which operate in 41 counties, assisted 215,956 individuals in 2016 (most recent available, with 35 counties reporting to date).

Retention rates for individuals receiving help in Los Angeles County are in the high 80-90% range. In contrast, the statewide rate in 2015 was just 81%, and, for individuals in Los Angeles who did not receive help from a community-based organization, only 65%. Just one organization alone, MCHA, is on track to have helped over 5,000 individuals in L.A. keep their Medi-Cal or other health coverage during the 12-month period from July 2017 through June 2018.

The retention assistance provided by these organizations is considered indispensable during the annual Open Enrollment period for Covered California, when new applicants are also reviewed for Medi-Cal eligibility and when many of Medi-Cal's 13.3 million beneficiaries reach their annual eligibility redetermination dates. The redetermination process brings the risk that eligible children and adults will be cut off due to complicated and burdensome documentation requirements, computer problems, or other barriers.

This work, helping to prevent this "churning" in the Medi-Cal caseload, not only promotes continuity of care for consumers but also helps the state save on the administrative costs associated with re-enrollment; such costs were estimated at $180 per beneficiary in 2005 and therefore would be even higher now. Retention services are also key throughout the year and in every county: this is because any time a change that could affect eligibility—such as a reduction or increase in income for low-wage working poor families following new work hours or wages-- is reported to the system, the whole family's case is re-reviewed, raising the risk of disenrollment despite eligibility.

These efforts involve far more than assistance with enrollment and retention in coverage programs. These community-based organizations also provide extensive assistance so that a person can actually use his or her health insurance benefits. In 2015, 79% of applicants that these organizations helped enroll in Los Angeles County had utilized their medical benefits, based on the six-month follow up call. Today, MCHA alone is on track to have helped over 6,300 individuals get access to medical care during the 12-month period from July 2017 through June 2018. The following are but a few of the many types of access problems that community-based organizations help consumers resolve:

- Long waits to see health plan specialists, beyond safe timelines;
- Disruption in continuity of care when an individual's Covered California or Medi-Cal eligibility changes to the other program and the existing provider does not participate in both;
- Dangerous delays in accessing care when having to obtain prior plan authorization to receive services out of network, or state approval to leave a plan and use Medi-Cal in fee-for-service, when the plan's own network lacks the specialty care the person needs;

- Navigating services when the individual is debilitated by mental health issues, faces domestic violence, lives on the streets, has just been released from a long period of incarceration, or has other complicated personal or medical conditions and a plan's case management services fall short;
- Accessing dental or mental health services through Pregnancy-Related Medi-Cal, which many providers perceive as unavailable to women who are not in Full Scope Medi-Cal;
- Accessing Medi-Cal services when a child beneficiary has a medical support order but the private, primary coverage is not actually available or doesn't otherwise include the Medi-Cal-covered services that the child needs;
- Getting newborns access to the pediatricians and/or pediatric specialists they need after being defaulted into the mother's Medi-Cal plan without notice to the family;
- Removing improper "share of cost;"
- Filling medically necessary prescription medications that are not on the Medi-Cal Drug Formulary;
- Accessing Medi-Cal's transportation benefits to medical services; and
- Accessing translation services and locating culturally appropriate providers.

The need for post-enrollment assistance has increased dramatically in recent years: in Los Angeles, for example, over 33% of the total issues addressed since 2003 occurred from 2014-2017. The health access barriers these community-based organizations help consumers address are far from isolated incidents. As this 2015 report on *Improving Medi-Cal Managed Care Plan Quality* from the Legislative Analyst's Office shows, quality of care has been a significant challenge affecting millions of consumers. The Health Consumer Alliance (HCA), which is a collaborative of legal services organizations assisting low-income people throughout the state with complex legal problems, reports that 25% of the assistance it provided to individuals referred by Covered California in 2016 (most recent available) was for post-enrollment access issues. For 2017, HCA data for the Department of Managed Health Care shows that a substantial proportion of opened cases-- about 41%-- involved health care access barriers, as distinct from the remaining 59% involving problems with enrollment and retention.

Getting people into coverage and helping them keep and use it is cost-effective. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases, like asthma, diabetes, high blood pressure, heart disease, and cancers. When a person gets so sick they can no longer avoid trips to the doctor or hospital, treatment becomes far more expensive, including for Medi-Cal if the individual does eventually enroll. Addressing health issues sooner rather than later is also vital for being able to work and support oneself and family.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Maternal and Child Health Access present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 8: STAKEHOLDER PROPOSAL ON ADULT DAY HEALTH CARE RATE INCREASE

PANELISTS

- **Mollie Tobias**, Executive Director, SteppingStone Adult Day Health Care

Public Comment

PROPOSAL

SteppingStone Adult Day Health Care, Self-Help for the Elderly, Bayview Senior Services, and L'Chaim Adult Day Health Care Jewish Family and Children's Services request an 20% increase in the Medi-Cal rate for adult day health care (ADHC) in San Francisco and a corresponding budget allocation of $4 million.

BACKGROUND

SteppingStone Adult Day Health Care provided the following background information:

SteppingStone states that: "One of San Francisco's most valuable and cost-effective programs to assist frail elders and disabled adults is being starved because of a Medi-Cal rate for adult day health care (ADHC) that has not increased in eleven years."

In 2015, 20% of San Francisco's population was over the age of 60, some 161,000 individuals. Of these, 1/3 were over age 75 and 17,000 individuals were 85 or older. It is expected that the senior population will continue to grow, reaching 25% of San Francisco's population by 2030, with the fastest growing segment being those over age 85. In addition, in 2015, 4% of San Francisco adults under age 60 were disabled, some 35,000 individuals.

Together seniors and disabled adults include many thousands of very vulnerable San Franciscans. For most, one of their most fundamental concerns is to not be forced into a skilled nursing facility, but to maintain their health sufficiently to remain in their homes and with their families. This is where adult day health care agencies play a role with an effective and cost-efficient program to help frail elders and disabled adults maintain their health.

Adult day health care is a half-day program that provides participants with multiple therapies, health oversight, recreational activities and an opportunity to socialize in a safe environment. In this way, clients can maintain their health and care givers receive a vital respite while knowing that their loved ones are safe. Clients stay in these programs for an average of four years with some participating for over a decade. The value of this time being well enough to remain at home and with their families is immense. In maintaining the health of participants, ADHC reduces unnecessary emergency room and hospital admissions for this population. In addition, ADHC delays or prevents admission to skilled nursing facilities, a much more expensive method of care. Estimates from the 2016 Genworth Financial Cost of Care Study show that adult day

health care is generally 1/5 the cost of skilled nursing care. To summarize, the benefits of Adult Day Health Programs are:

- Reduced hospital readmissions and emergency room visits
- Participants stay healthier and are less lonely in the daily presence of their families
- Provide supervised care while individuals can still stay at home with their family/caregivers
- Daily social and therapeutic activities provide stimulation and improve mental cognition
- Enhance the quality of life of participants and their families
- Decreases cost by avoiding full time institutionalization while still providing consistent health monitoring and socialization

Since 2007 the Medi-Cal rate for adult day health care has been frozen despite enormous increases in the cost of providing this service in San Francisco. San Francisco is one of the most expensive cities in the United States. Overall the consumer price index for the Bay Area has gone up over 30% since 2007 and medical care specifically has risen 43.9%. Salaries have also increased dramatically including the minimum wage which has risen from $9.14 an hour in 2007 to $14 in 2018.

Even with the use of aggressive fundraising and cost constraints, it is simply not viable for any organization to have annually increasing costs, but a flat fee for over a decade. These agencies are straining, particularly in attracting and retaining the skilled health care workers required to do this work at salaries they can afford. SteppingStone argues that it makes no sense to starve adult day health care organizations to the point that they must begin to decline clients, resulting in the use of more expensive interventions including emergency room visits, hospital admissions and skilling nursing care. They state that the state needs to be expanding capacity to meet the growing need for ADHC in San Francisco, not struggling to maintain current levels of service.

In 2007 there were six nonprofit adult day health care agencies in San Francisco. There are now only four remaining, and they are struggling to maintain services. This request is for an increase in the Medi-Cal ADHC rate in San Francisco of at least 20%, putting that rate close to what is currently paid for ADHC services by the Veterans Administration.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests SteppingStone Adult Day Health Care present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 9: STAKEHOLDER PROPOSAL ON PEDIATRIC FREE-STANDING SUBACUTE FACILITIES RATE INCREASE:

PANELISTS

- **Michelle Nydam**, Chief Operating Officer, Sun Valley Specialty Healthcare

Public Comment

PROPOSAL

Sun Valley Specialty Healthcare requests $4 million General Fund to increase rates for the four pediatric free-standing subacute facilities in California.

BACKGROUND

Sun Valley Specialty Healthcare provided the following background information:

Sun Valley Specialty Healthcare, a stand-alone pediatric subacute facility that cares for children who are dependent on technology for their survival. These services include long-term care and rehabilitation programs for newborn to 21 years. Their staff is specifically trained to care for children who have experienced catastrophic illnesses, injuries resulting from Congenital Birth Defects, Neurologic Injuries, Cardiac & Respiratory disorders, Seizure disorders, and premature birth complications among others. Their staff specializes in technologies such as mechanical ventilation, Gastric tube dependence, Total parenteral nutrition, central line care, and IV therapy. These are examples of the services provided under a Skilled Nursing Licensure but are referred to as pediatric subacute services due to the specialized and more intensive nursing needs of the children.

The daily rate for these subacute pediatric services has not increased in 10 years. As a result, providers are facing ongoing and growing shortfalls that threaten their ability to continue providing services. Because these free-standing subacute services are much more cost-effective than acute facilities – they are up to five times less expensive than their acute care counterparts – increasing their daily rate will help preserve this important step-down level of care for medically-fragile children.

Most children requiring subacute pediatric care come from an intensive or natal intensive care unit. This level of acute care is reimbursed at a daily rate at a minimum of $3,000. In contrast, the daily rate of a free-standing pediatric subacute facility is approximately $750 a day. This rate has been effectively frozen since 2008.

During the last 10 years, the costs of operating these kinds of facilities continue to rise steadily. The labor market has become more competitive, requiring higher wages, increasing overtime, and lowering staff retention. Moreover, these facilities continuously integrate the most effective new technology into their patient services, and unfunded local and state mandates impose additional fiscal pressures.

Until 2017, subacute pediatric facilities were able to provide and bill for supplemental therapy for patients assessed with medical necessity. Supplemental therapy provides valuable therapies to our patients and a solid source of additional revenue to bridge the shortfall in our subacute rate. The Department of Health Care Services recently reinterpreted the eligibility criteria for supplemental therapy to effectively eliminate this therapy for children as well as the operating revenue that has helped providers backfill the completely insufficient daily rate.

The current reimbursement structure – the 2008 daily rate unsupported by supplemental therapy billing – sets up an annual financial shortfall of more than half a million dollars for Totally Kids Sun Valley, which is a devastatingly precarious financial position for a small facility. Many other similar facilities face the same severe shortfalls. Sun Valley states that: "Uncorrected, the state's insufficient reimbursement rate will be the undoing of a fiscally and medically sound model that has fulfilled its policy objectives for over two decades. Low daily rates without any adjustment or restructuring is certain to render the subacute pediatric model unsustainable, and the state will be confronted with a growing population of medically fragile, technologically dependent children "trapped" in expensive acute facilities."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Sun Valley Specialty Healthcare present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 10: STAKEHOLDER PROPOSAL ON CCS OUT-PATIENT RATE INCREASE

PANELISTS

- **Mike Odeh**, Director, Health Policy, Children Now
- **Erin Kelly**, Executive Director, Children's Specialty Care Coalition

Public Comment

PROPOSAL

Children Now and the Children's Specialty Care Coalition request use of a portion of Proposition 56 funds to increase the California Children's Services (CCS) rate for CCS outpatient physician services. By increasing the CCS rate for outpatient services, it allows the funds to be targeted to pediatric specialty physicians that serve the state's children with serious, complex and chronic health care needs.

BACKGROUND

Children Now provided the following background information:

Voters passed Proposition 56 authorizing Medi-Cal supplemental payments with the goal of increasing provider participation in the Medi-Cal program and increasing access to services for Medi-Cal beneficiaries, including the 5.7 million children in Medi-Cal who need access to a full range of preventive, dental, and specialty services. For the inaugural year, the Department of Health Care Services (DHCS) worked diligently to secure federal approval for an initial list of CPT billing codes for physician and dental services eligible for one year of supplemental payments using Proposition 56 funds. These payments provided additional funding to support episodic and acute problem-oriented care services that will benefit children.

Children Now asserts that, while it is still very early in the Proposition 56 experience, there are hundreds of millions of additional dollars to invest in Medi-Cal Supplemental Payments and thus presents an important opportunity to focus a significant portion of that investment on addressing the most critical access areas for children in California. Building on DHCS' approach of supplementing payment rates for specific service codes, California should consider additional targeted Proposition 56 Supplemental Payments in a three-pronged approach to address the key access areas affecting children:

1. pediatric preventive services, such as well-child visits and developmental screenings;

2. children's fluoride varnish application and preventive dental services; and

3. pediatric specialty care services, provided as part of the California Children's Services (CCS) Program

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Children Now and the Children's Specialty Care Coalition present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 11: STAKEHOLDER PROPOSAL ON CONTINUATION OF CALIFORNIA COMMUNITY TRANSITIONS PROGRAM

PANELISTS

- **Ana Acton**, Executive Director, FREED Center for Independent Living

Public Comment

PROPOSAL

Disability Rights California, Justice in Aging, East Bay Innovations, and Choice in Aging request $19 million General Fund annually for the California Community Transitions Program.

The Governor's proposed budget reduces the CCT program from $19.1m ($2.5 GF) in 2017-18 to $8m ($1.8 GF) in 2018-19 due to a phase out of federal funds (FFP), which ends September 30, 2020 when the program expires. These organizations propose that on-going program costs budgeted at the 2017-18 appropriated amount ($19m) continue in 2018-2019 and thereafter. After September 30, 2020, no FFP would be available unless the federal Money Follows the Person Demonstration Program is reauthorized. General Fund would replace the loss of the FFP at the expiration of the federal program. Total program savings in 2018-2019 are estimated to be $28.2m ($14.1 GF). Continuing the program with GF beyond September 2020 will allow the program to continue in 18-19 and the first quarter of 19-20 without program reductions and FFP and continue to fund the Program thereafter and realize the full estimated savings to the GF from program continuation.

BACKGROUND

Disability Rights California provided the following background information:

History
In January of 2007, the California Department of Health Care Services (DHCS) was awarded a special grant to participate in the Money Follows the Person Rebalancing Demonstration, known in California as the California Community Transitions (CCT) project. The goal of this project is to transition long-term nursing home residents back to community settings. The federal program expires September 30, 2020.

CCT Accomplishments
This project successfully demonstrated that the State is able to accomplish three goals simultaneously: (1) Medi-Cal beneficiaries living in skilled nursing institutions for longer than 90 days can be transitioned back into community living; (2) California can comply with the Olmstead decision requiring the State to enable people with disabilities to live in the most integrated setting possible; and (3) the State can realize savings since community living is more cost effective for the State.

To date, the CCT program has successfully transitioned 3,629 individuals from institutional settings to the community resulting in an average of approximately $60,000 in savings per participant per year.

CCT Termination
Beginning in January 2017, DHCS began implementing a two-year effort to terminate the CCT program. The last long-term care resident transitions will occur in December 2018. After that, post-transition work will continue in 2019 and end in 2020.

Separately from the CCT process, DHCS has renewed the Nursing Facility Acute Hospital (NF/AH) waiver, newly renamed the Home and Community Based Alternatives (HCBA) waiver, and intends to delegate administration of the waiver to contracted non-state providers called Waiver Agencies.

DHCS asserts that the new HCBA Waiver will serve to replace the CCT program. However, the HCBA waiver cannot truly replace the CCT program. The HCBA waiver is neither capable of serving all those in need of transition services currently served by the CCT program or of providing the same level of services. The CCT program offers transitions services to all eligible individuals who utilize IHSS and other non-waiver services as well as those enrolled in all HCBS waivers in the community. In contrast, the HCBA waiver limits transition services to only those individuals enrolled in the HCBA waiver. Additionally, the transition services the HCBA waiver offers to this limited population are not at the same level as those offered by the CCT program as described below:

- Staffing Costs Higher: The HCBA requires that nurses fill care management positions and masters level social workers at a significantly higher cost than that required under the current CCT model, which allows transition coordinators without degrees with supervision from nurses or other clinical professionals to provide services. CCT has effectively used this model to transition individuals to the community so there is no demonstrated need for higher-level staff.
- Ratio Requirement is Too High: As structured, the caseload to staff ratio is too high under the HCBA waiver to adequately provide for the services necessary during the height of a transition.
- Restricts Reimbursement for Pre-Transition Work: Unlike the CCT program, the HCBA waiver only allows for reimbursement for pre-transition work if the transition to the HCBA Waiver takes place. If the individual dies, transitions to non-HCBA Waiver services, or otherwise does not complete the transition, there is no reimbursement for pre-transition work.
- Unable to achieve required 60/40 ratio: The HCBA waiver requires a 60 (institutional placements)/40 (community applicants) ratio for entrance from the waitlist. While this is intended to encourage transitions from institutions, the barriers to transition described here will in fact slow such transitions, which will impede entrance to the Waiver for all applicants who need Waiver services to be safe at home.
- Limits Access to Transition Services: The HCBA waiver only allows for transition service provision for 60% of waiver eligible participants at any given time. This limitation will slow the rate in which these services can be provided in sharp

contrast to the CCT program, which provides transition services to individuals as soon as they are eligible for the program.

- Reduces the Reimbursement for Transition Costs: The HCBA waiver provides for just $5,000 in actual transition costs compared to $34,500 currently available under the CCT program

STAFF COMMENTS/QUESTIONS

The Subcommittee requests FREED present this proposal and requests DOF to clarify and confirm what they estimate net savings would be to the state based on continuing to fund this program with state General Fund per this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 12: STAKEHOLDER PROPOSALS ON DIABETES PREVENTION PROGRAM

PANELISTS

- **Flojaune G. Cofer**, PhD, MPH, Director of state Policy & Research, Public Health Advocates

Public Comment

PROPOSAL

Public Health Advocates submitted the following two proposals related to the Diabetes Prevention Program (DPP), a Medi-Cal benefit approved through the 2017 health budget trailer bill:

1. A one-time allocation of $500,000 (total funds) to the California Department of Health Care Services (DHCS) to obtain certified translation services for the CDC-approved DPP curriculum in all threshold languages. Translated curricula will be made publicly available on the DHCS website for all California DPP Providers to use; and

2. Trailer bill to make technical corrections to the statute in order to better align the DPP program with the Centers for Disease Control and Prevention program specifications.

BACKGROUND

Public Health Advocates provided the following background information:

In 2017, the California legislature approved Medi-Cal funding for the DPP, a lifestyle change program proven to prevent or delay type 2 diabetes among people who have prediabetes and women with a previous diagnosis of gestational diabetes. The legislation states that DHCS must "require Medi-Cal providers offering DPP services to use a CDC-approved lifestyle change curriculum."

Translation Services

DHCS has cultural and linguistic requirements to provide Medi-Cal services in threshold languages. A threshold language is defined as a language identified on the Medi-Cal Eligibility Data System (MEDS) as the primary language of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. In 2016, 38% (4,483,455) of Medi-Cal eligible persons state-wide reported a language other than English as their primary language that met criteria for a threshold language. Thirteen distinct languages meet the criteria for a threshold language: Arabic, Armenian, Cambodian, Cantonese, other Chinese, English, Farsi, Hmong, Korean, Russian, Spanish, Tagalog, and Vietnamese.

CDC-approved DPP curricula are only available in English and Spanish. The CDC will not provide curricula in additional languages, though they do have a process to approve curricula translated elsewhere. To prevent DPP providers from individually translating materials—which is costly, burdensome, unstandardized and duplicative—the DHCS should translate materials to ensure that persons speaking threshold languages receive appropriate services.

Technical Trailer Bill

In the process of preparing for DPP implementation, several concerns were raised by the DPP providers and program administrators about the bill language misalignment with the Centers for Disease Control and Prevention program specifications; ideally, amendments to program requirements should occur prior to the benefit start date in 2019, as follows:

Proposal 1: Remove the 5 percent weight loss requirement for ongoing maintenance sessions:

Revise Article 4.11 Section 14149.9 (i) of the Welfare and Institutions Code to read: "*A beneficiary who participates in the DPP shall be allowed to participate in 22 peer coaching sessions over a period of at least one year. Thereafter, the department shall provide a participating beneficiary* ~~***who achieves and maintains a required minimum weight loss of 5 percent from the first core session, in accordance with CDC standards,***~~ *with less intensive, ongoing maintenance sessions to help the beneficiary continue healthy behaviors.*"

Rationale: Because a significant reduction of diabetes risk may occur in weight loss targets less than 5 percent, the specification in statute of this requirement is concerning. DPP research found a significant clinical benefit from at least 3 percent weight loss. The 5 percent minimum weight loss standard has been currently implemented for CDC Diabetes Prevention Recognition Program (DPRP) recognition, but there are hints that CDC may be revising its weight target goal. Public Health Advocates recommend not specifying a standard that may be higher than CDC and result in participants who meet a revised CDC standard not being eligible for ongoing services.

Proposal 2: Remove the eligibility criteria and align with the CDC Diabetes Prevention Recognition Program (DPRP) program eligibility.

Revise Article 4.11 Section 14149.9 of the Welfare and Institutions Code to read: *"(f) A Medi-Cal provider may identify and recommend participation in the DPP to a beneficiary who meets the CDC Diabetes Prevention Recognition Program (DPRP) program eligibility requirements.* ~~***Following requirements:***~~

~~***(1) The beneficiary is at least 18 years of age.***~~

~~***(2) As of the date of the provider recommendation, the beneficiary has a body mass index (BMI) of at least 25 if the beneficiary is not self-identified as Asian, or a BMI of at least 23 if the beneficiary is self-identified as Asian.***~~

~~***(3) Within the 12-month period prior to the provider recommendation, the beneficiary has had one of the following:***~~

~~***(A) A hemoglobin A1c test with a value between 5.7 and 6.4 percent.***~~

~~***(B) A fasting plasma glucose of 110-125 mg/dL.***~~

~~***© A two-hour plasma glucose of 140-199 mg/dL.***~~

~~***(4) The beneficiary has no previous diagnosis of type 1 diabetes or type 2 diabetes, with the exception of gestational diabetes.***~~
~~***(5) The beneficiary does not have end-stage renal disease.***~~***"***

Rationale: As written, there are several instances where the Medi-Cal eligibility criteria are more restrictive than the CDC standards (e.g. Body Mass Index, Fasting Glucose, no mention of risk score assessment enrollment eligibility). There does not appear to be a rationale for these restrictions and, as a result, they render Medi-Cal beneficiaries who are at risk for diabetes ineligible for the program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Public Health Advocates present these proposals.

Staff Recommendation: No action is recommended at this time.

ISSUE 13: STAKEHOLDER PROPOSAL ON HEALTHY START RE-CREATION

PANELISTS

- **Anna Hasselblad**, Manager, Public Policy, United Ways of California

Public Comment

PROPOSAL

A coalition of the following organizations has submitted this proposal:

1. United Ways of California
2. Children's Defense Fund – California
3. The Children's Partnership
4. California Coverage & Health Initiatives
5. Children Now
6. Partnership for Children & Youth
7. Maternal and Child Health Access
8. RYSE Center
9. Coalition of California Welfare Rights Organizations, Inc.
10. California Council of Community Behavioral Health Agencies
11. California Food Policy Advocates

This coalition requests $480,000 total funds for positions at DHCS to support the reestablishment of the Healthy Start Initiative, which provides for the coordination of support services for children and families that address the social determinants of health. This proposal includes additional components that request resources for the California Department of Education, that have been submitted to Assembly Budget Subcommittee #2 on Education Finance.

BACKGROUND

United Ways of California provided the following background information:

Starting in 1992, California funded the Healthy Start Initiative, which coordinated comprehensive, school-community integrated services and activities to improve the health and wellness of children, youth, and families including: health, dental, and vision care; mental health and substance use disorder counseling; family support and parenting education; academic support; health education; safety education and violence prevention; youth development; employment preparation; and more. Evaluation of the program showed that the physical, mental, and emotional health of the students and their families were measurably enhanced, and the child's academic success improved greatly.

In fact, a statewide evaluation found that test scores for the lowest performing Healthy Start schools improved substantially, with reading scores increasing by 25 percent and math scores by 50 percent. Other positive changes were reported as well, like decreased drug use, fewer behavioral problems in the classroom, and greater parent involvement at Healthy Start schools. And Healthy Start helped more kids get the medical care they needed. The report documented a 50 percent increase in access to needed healthcare and a 50 percent reduction in the use of emergency rooms for non-urgent care. While each local Healthy Start was unique to their community, all were designed to do the following:

- Ensure that each child receive the physical, emotional, and intellectual support that he or she needed — in school, at home, and in the community — to succeed in school and in life;

- Build the capacity of students and parents to be participants, leaders, and decision-makers in their communities; and,

- Support child and family-serving public and nonprofit agencies to streamline and integrate their programs to provide more effective prevention and early intervention supports to children and their families.

However, in 2002, as a response to the recession and state deficit of $24 billion, California's state-supported Healthy Start program was largely defunded and shuttered completely in 2007 despite evidence of its effectiveness and strong support from local communities. Much has changed since then. Thanks to the Affordable Care Act, Medi-Cal expansion, and the extension of full-scope Medi-Cal coverage to all low-income California children and youth regardless of immigration status, all children have access to health coverage. This coverage should equal access to care and services, but too often does not. Additionally, numerous public health and human services should be delivered by local county and district based providers, funded through the Local Control Funding Formula (AB 97, 2013), the Mental Health Services Act (Prop 63, 2004), Educationally-Related Mental Health Services (AB 114, 2011), the Safe Neighborhoods and Schools Act (Prop 47, 2014), among others. Add to this the prospects of the Adult Use of Marijuana Act – Youth Education, Prevention, Early Intervention and Treatment Account (Prop 64, 2016) and the wide range of supports for children and families should be robust.

Unfortunately, the increasing numbers of Californians experiencing poverty, housing insecurities, the challenges of adequate workforce, and the overall lack of coordination of the numerous health and human service programs results in children and families being lost in the cracks and not accessing the care they need and deserve. A compounding factor for streamlining access across services is that often the delivery of these benefits depends on separate local planning processes and the ability of local leaders to work together and to prioritize the growing range of local funding sources, rather than the needs of children and their families. The success of the Healthy Start Initiative was predicated on the need for the siloed services to be more uniformly coordinated and leveraged in the most efficient and effective way, and for remaining

gaps to be identified. Support of local community and multi-disciplinary collaboration is sorely missing from California's funding streams and is needed now more than ever.

This proposal would reestablish the Healthy Start Initiative within the State Departments of Education and Health and Human Services to oversee a competitive grant program to fund local collaboratives between schools, communities, parents, county health and human service agencies, and other nonprofit health and social service providers to support students and their families in accessing the health, behavioral health, screenings, and other child and family supports needed for the students and their families to thrive. Statewide demonstration grants should target school districts serving a large proportion of disenfranchised students, due to poverty, isolation, immigration status or other combinations of deficits in the social determinants of health. To ensure sustainability and scalability, the Healthy Start program would also provide technical assistance to grantees, including training on how to implement best practices and robust evaluation and outcomes reporting on programs, locally, and collectively.

While school districts and the diverse planning collaborative would determine their own priorities and use their local funds to supplement the projects, the state Healthy Start program would provide a technical support center, trainings, share best practices, and evaluate the effectiveness of the program for student success.

Reinvestment Recommendations: The initial planning initiative would cost up to $20 million over two years and would include:

- DHCS and CDE staff time and administration to establish the grant program and obtain any necessary federal or state approvals.

- 25 two-year planning grants to local collaboratives (grants up to $250,000/year).

- A technical assistance (TA) and evaluation component to gather outcomes data and assess the program's impact on supporting local coordination to improve the lives of children, families, and communities. Additionally, TA could help local grantees in developing funding sustainability plans and establish best practices to be modeled as the program progresses. The departments could contract with a state university or qualified research entity to perform the evaluation.

Further, the following recommendations focus on program changes that would improve Healthy Start's ability to spark efforts that eventually go to scale districtwide and represent genuine systems change among the partner agencies. In addition to changes, these recommendations also contain references to elements of the original program that helped make it successful and should be preserved:

- In order for a local collaborative to receive a planning grant they must show in their grant application a clear commitment to sustainability and long-term financial planning, including how they will leverage Medi-Cal Administrative Activities (MAA) and Local Education Agencies (LEA) funding, along with the blending other funding sources such as the Mental Health Services Act funds,

realigned public safety and social services, Special Education Local Planning Area (SELPA) Allocation, and city and county discretionary funds, among others.

- Use of grant funds should be limited to expenses associated with planning activities and, once a program graduates to the operational phase, coordination activities (at both the school site and community/district level). Grant funds should not go to supplant direct services that have other funding sources but may be used to leverage other funding streams.
- Given that strong partnerships are key and the process for building partnerships and a diverse collaborative is incremental, the emphasis on grants supporting planning and having an operational phase should be preserved.
- While the inability to obtain explicit commitment from a county should not keep a school district from being competitive for a grant, MOUs with local government agency partners should be required as a critical part of grant applications. Applicants should be required to include in their applications/plans how they will integrate their Healthy Start planning and programs with other Health and Human Services initiatives at the district and county level.
- For local collaboratives that are already working to coordinate services and funding streams and can substantiate their progress, or for LEAs that have previously received Healthy Start grants and can demonstrate their readiness to move more rapidly into operational phases, there should be consideration for grant funding that is not explicitly for planning and may be used for program implementation or expansion.
- The Departments should provide technical assistance to grantees regarding planning, governance, partnerships, funding, and evaluation.

Despite a reinvestment in schools and underserved student groups through the Local Control Funding Formula (LCFF), it is clear that many students are not receiving the well-being and health services they need to be successful in the classroom. There is evidence in too many districts that improved or increased services outside of the classroom are not being funded or met. And in most cases these services should not be funded out of LCFF, but rather braided with health and social service funding streams. The problem is districts need a funding stream and directive to elevate sustainable coordination and building the necessary infrastructure to leverage the array of funds to support the well-being of children and families.

Further, until recently the importance of mental health services for children experiencing trauma was intuitive and anecdotal. Now, neuroscience supports the importance of healing and building resiliency following traumatic experiences and toxic stress as a critical service for preventing short and long-term mental and physical health problems. Treating trauma and building resiliency is essential for children to learn and build successful futures. Untreated trauma is linked to increases in depression, obesity, diabetes, and asthma. By viewing many behavioral problems with a trauma-informed lens, children and youth can be treated for mental health challenges, substance use disorders, among other developing needs, rather than suspended and expelled. Preventing and treating trauma is also linked to fewer contacts with the juvenile justice system. Healthy Start is an important first step in translating emerging science into public policy to benefit California's children and youth.

The Healthy Start program was estimated at a statewide level to leverage four dollars in otherwise untapped local and federal funds for every one dollar invested by the state. The sources for these additional funds included LEAs maximizing MAA funding, First 5 support, Mental Health Services Act, Early Periodic Screening Diagnosis, and Treatment (EPSDT), city and county discretionary funds, and private donor and foundation supports. Now, with even more resources available at the local level along with the disparate coordination of those services, the reestablishment of the Healthy Start Initiative could ensure an even more dramatic return on investment for the state, in addition to the improvement in the social determinants of health for millions of students.

Although 97 percent of children are enrolled in health coverage, disparities in health outcomes persist, and children and families too often lack access to the care and services they are eligible for. Ensuring that children and families access the supports and services which they need or are eligible for is a core component to promoting the healthy development and educational success of California's youth.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests United Ways of California present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 14: STAKEHOLDER PROPOSAL ON CHIS CHILDREN'S DATA REQUEST

PANELISTS

- **Kristen Golden Testa**, California Health Director, The Children's Partnership

Public Comment

PROPOSAL

The California Children's Health Coverage Coalition requests $750,000 one-time funding to implement a pilot expansion for the California Health Interview Survey (CHIS) to strengthen data collection efforts on California's children and youth.

The California Children's Health Coverage Coalition includes:

The Children's Partnership
Children Now
Children's Defense Fund California
California Coverage & Health Initiative
United Ways of California)
California Children's Hospital Association
American Lung Association in California
Children's Specialty Care Coalition
Community Health Initiative of Orange County
Maternal and Child Health Access
Asian American Advancing Justice in Los Angeles
National Health Law Program
California Pan Ethnic Health Network
California School-Based Health Alliance
Regional Asthma Management and Prevention

BACKGROUND

The California Children's Health Coverage Coalition provided the following background information:

Since 2001, the California Health Interview Survey (CHIS) has served as a vital data resource for the state and California counties, tracking the population health needs of California's children and families. Policymakers, researchers, health experts and advocates, members of the media and others depend on CHIS for credible and comprehensive data on the health of Californians. CHIS data are the foundational resource for tracking the number of uninsured children in California on children and adolescents have been used to inform numerous policies and programs for children's health, ranging from children's health coverage and health reform efforts such as eligibility for Medi-Cal and the implementation of Health for All Kids Act and Affordable Care Act. In addition, CHIS data on children has informed research on utilization and

access to other social services, such as evaluations of SNAP education's effects on children's physical activity, and monitoring the impact of First Five California's "Talk, Read, Sing" Campaign.

Unfortunately, efforts to collect data from children and adolescents have declined in the last ten years due to length of interview time and outdated methods. If the trends in declining response rates continue, the CHIS may not be able to release data each year below the state level for children and teens.

In order to counter trends of declining child response, the CHIS is experimenting with alternative modes of data collection, including a Spring 2018 test with an online survey. The use of an online response is expected to yield more child and teen interviews due to the fact that younger households tend to be more likely to respond online. However, due to funding limitations, online questionnaire will only be available in English (leaving speakers of other languages to respond by telephone).

This proposal seeks $750,000 in additional funding to conduct a second test in the fall of 2018 that would accomplish the following:

- Add a Spanish version of the online CHIS questionnaire, which will increase the data we collect about teens and children in Spanish-speaking households;
- Experimentally reversing the questionnaire sequence to ask questions first about the selected child, followed by questions about the selected adult;
- Measure the impact of such a design change across the state, and inform future decisions about the need for customized approaches in different parts of the state; and
- Refine methods for encouraging adolescence to participate in survey interviews.

Funding this proposed additional CHIS testing in the fall of 2018 will position the CHIS to determine the design of the CHIS in 2019 and beyond. Therefore, this one-time investment of additional funding for the CHIS will positively impact the quality of CHIS data for adults, teens, and children for years to come.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests The Children's Partnership present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 15: STAKEHOLDER PROPOSAL ON ALCOHOL MISUSE SCREENING AND COUNSELING

PANELISTS

- **Paula Wilhelm**, Senior Policy Analyst, County Behavioral Health Directors Association

Public Comment

PROPOSAL

County Behavioral Health Directors Association (CBHDA), which represents the public mental health and substance use disorder program authorities in counties throughout California, requests $8.4 million ($2.58 million SGF/$5.82 million FFP) for the Department of Health Care Services (DHCS) to expand the Medi-Cal benefit for adult Alcohol Misuse, Screening and Counseling (AMSC) to include screening for misuse of opioids and other illicit drugs.

BACKGROUND

CBHDA provided the following background information:

California has taken meaningful action to combat the national opioid crisis by developing innovative treatment programs like the Drug Medi-Cal Organized Delivery System and the California Hub and Spoke system. Strengthening screening and referral pathways between primary care and specialty substance use disorder (SUD) treatment is an important next step to ensure that even more Medi-Cal beneficiaries access life-saving care.

The benefits of routine screenings for alcohol misuse, followed by brief intervention or counseling and referral to treatment as needed, are well-documented. This approach is commonly referred to as SBIRT, for Screening, Brief Intervention and Referral to Treatment. SBIRT for alcohol use has been endorsed by the U.S. Preventive Services task force (USPSTF) and has consistently been shown to reduce hazardous drinking across diverse populations when implemented according to established best practices. SBIRT for alcohol became part of the Medi-Cal managed care benefits package for adults over 18 years of age in 2014 and is now referred to as AMSC. AMSC has been widely implemented across the state in safety net primary care settings like public hospitals and federally qualified health centers.

SBIRT for illicit drug use has received less attention from researchers than SBIRT for alcohol, and study results have been mixed. However, the U.S. Department of Health and Human Services (HHS) describes SBIRT for drug use as a “promising” practice, and the USPSTF is in the process of re-visiting its recommendations on this topic. Evaluators of a comprehensive, national SBIRT grant program administered by the Substance Abuse and Mental Health Services Administration recently reported that drug screening using the SBIRT model was associated with positive outcomes – namely, a

75 percent reduction in illicit drug use. This finding is consistent with other evidence that has linked screening and brief intervention to reductions in the use of marijuana, cocaine, amphetamine-type stimulants, and opioids.

Research also indicates that the extent to which SBIRT can prompt reductions in substance use or increase referrals to specialty SUD treatment depends on how it is implemented. Working on behalf of DHCS, researchers with the University of California at Los Angeles' Integrated Substance Abuse Program (UCLA-ISAP) have studied statewide implementation of SBIRT/AMSC. They have identified key strengths and challenges in the approach to date, as well as promising models from around the country that might be adapted to improve outcomes in California.

To maximize the potential benefits of screening for drug misuse, CBHDA strongly recommends that any appropriation to expand the Medi-Cal AMSC benefit be contingent upon continued quality improvement and evaluation efforts like those DHCS has undertaken in partnership with UCLAISAP. The intent of this proposal is to strengthen linkages and referral pathways between primary care and specialty SUD treatment. Because SBIRT for drug misuse has not yet been consistently shown to achieve such results, ongoing evaluation will be critical to determine whether the expanded benefit produces desirable outcomes. And with treatment rates for alcohol misuse estimated to be as low as 7.2 percent of people who need care, it is important to improve the efficacy of alcohol screening even as we seek to better detect drug use.

Making thoughtful investments now to help more Californians access SUD care can generate long-term economic benefits. According to the U.S. Surgeon General, the combined economic costs of alcohol and drug misuse are around $442 billion each year. Cost-benefit analyses have repeatedly shown that spending on SUD treatment is offset not only by reduced expenditures on other health care services, but also by significant reductions in drug-related crimes and their societal costs. One recent study found that providing treatment for just 10 percent of currently untreated individuals in New England could generate over $550 million in savings. SBIRT itself been shown to reduce public costs: a study of SBIRT drug and alcohol screening for workingage Wisconsin Medicaid beneficiaries found that screening alone was associated with a $391 per-beneficiary reduction in health care spending.

To fully confront an opioid crisis that claimed the lives of more than 2000 Californians in 2016, this state's publicly funded health systems must identify more people with SUDs and connect them to care. Expanding adult alcohol screening to detect misuse of opioids and other drugs is one strategy to achieve these goals.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests County Behavioral Health Directors present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 16: STAKEHOLDER PROPOSAL ON MOBILE OPTOMETRY SERVICES FOR CHILDREN IN MEDI-CAL

PANELISTS

- **Ann Hollister**, Chief Executive Officer, Vision to Learn

Public Comment

PROPOSAL

Vision To Learn requests $5 million in one-time Department of Health Care Services (DHCS) funding to support the operation of Vision to Learn, a mobile vision services provider that offers vision services (vision screenings, eye examinations, and glasses) at no out-of-pocket cost to children in low-income communities throughout the state. This funding is available for encumbrance or expenditure until June 30, 2020.

BACKGROUND

Vision to Learn (VTL) provided the following background information:

VTL has thus far provided glasses to 58,505 kids from low-income and disadvantaged communities in Los Angeles alone, and 76,141 statewide.

This proposal is to support VTL's efforts for the next year while DHCS designs a workable mechanism to allow Medi-Cal reimbursement for these vital services in 2019. The $5 million will be spent to reimburse VTL for Medi-Cal eligible students in Title 1 schools that need this important care brought to them because of the endless obstacles they face in getting to an optometrist's office. This money will allow VTL to offer these services statewide wherever a district and VTL enter into an agreement. To be clear, VTL will provide services to all kids that have parental authorization regardless of Medi-Cal eligibility or citizenship status.

Medi-Cal provides vision coverage for kids living in poverty, but most of these kids are not getting the care they need. The unmet need for vision services in low-income schools is enormous. Researchers estimate that 1 in 5 students need glasses – and more in low-income communities. In fact, through the LA County Pilot, VTL found that 70% of the students who needed glasses did not have them before VTL provided services to that population.

VTL states that, "The sheer quantity of students served by VTL and other nonprofit mobile vision service providers using philanthropic funding to serve a primarily Medi-Cal eligible population is a sad testament to the need for the Legislature to continue to address this issue." In the last four years, VTL alone has provided over 95,000 California children living in communities of need with eye exams and over 75,000 with glasses. Specific data on the problem:

- Glasses are critical for students' educational achievement as 80% of all learning during a child's first 12 years is visual.
- National estimates find 250,000 to 400,000 of California students lack the glasses they need to see.
- Kids in low-income communities and minorities are disproportionately affected.
- In LA County 9 out of 10 kids that have been served by VTL were going to school without the vision services they needed. VTL's electronic medical records found about 66% of students provided glasses by VTL did not already have glasses. Another 23% had glasses with an incorrect prescription. Together, 89% of students provided glasses by VTL did not have a working pair of glasses.
- An impact analysis conducted by the UCLA Mattel Children's Hospital found that 92% of teachers and 90% of parents felt most of the children at their schools would not have had access to glasses without VTL's public private partnership.
- UCLA's study also found significant improvement in test scores and classroom behavior as determined by year-over-year math and reading scores as well as school staff interviews.

Vision To Learn partners with each school through a Memorandum of Understanding (MOU) to deliver its vision services to students in schools and targets Title I schools in the delivery of its services. This one-time funding is intended to temporarily address an ongoing need for and access to vision services for children in low-income communities until a permanent Medi-Cal funding solution can be pursued. The proposal would also direct DHCS to ensure that no later than 7/1/2019, the department develops a mechanism for direct Medi-Cal reimbursement for qualified mobile vision services providers, like VTL.

> *(NOTE: Qualified mobile vision service providers are those providers who meet the standards and participation criteria that were developed pursuant to subdivision (b) of Section 14087.9730.)*

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Vision to Learn present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 17: STAKEHOLDER PROPOSAL ON TRANSFER OF SCHOOL FUNDS TO DEPARTMENT OF EDUCATION OFFICE OF SCHOOL HEALTH

PANELISTS

- **Hellan Roth Dowden**, Project Manager, Teachers for Healthy Kids

Public Comment

PROPOSAL

A Coalition of the following organizations has submitted this proposal:

1. California School Nurses Organization
2. Teachers for Healthy Kids
3. California Teachers Association
4. Los Angeles Unified School District
5. National Association of Social Workers
6. California School-Based Health Alliance
7. Children Now
8. California School Boards Association
9. San Diego Unified School District

This coalition requests trailer bill to authorize DHCS to withhold $500,000 in funds from California schools and transfer these funds to the Department of Education.

BACKGROUND

The coalition provided the following background information:

School districts and advocacy groups are requesting that a small portion of funds, received as reimbursements to school districts through the Local Education Agency (LEA) Billing Option Program that provides a 50-50 federal match for direct services to children with Individual Education Plans (IEP), instead be sent to the Department of Education to support an office for school-based health services. The proposed language would establish a transfer mechanism for these funds from DHCS to CDE upon agreement by DHCS, CDE and Department of Finance. DHCS would not lose funds for any of their administrative activities since the amount would be additive and taken from LEA reimbursements. DHCS and the federal Centers for Medicare and Medicaid Services (CMS) are in the last stages of agreeing on a State Plan Amendment that should be completed in July that will allow school districts to bill for services to all children on Medi-Cal not just those with IEPs. Currently, Special Education staff at CDE work with DHCS. With the expansion, CDE will need to change its structure to address health and wellness issues of students beyond those receiving services through special education. This office will help schools to implement this change by providing guidance and technical assistance to LEAs.

In the last year reported* (2014-15), the 536 Local Education Agencies participating in the LEA Billing Option program received $149.5 million in reimbursement from CMS based upon annual cost report submitted by DHCS. Of this amount, $1.5 million, as per Section 14115.8(g)(1), remained with DHCS to fund a contract with Navigant Consulting that provides program support. What is being proposed is to take an additional $500,000 in funds (which is about .033 of total reimbursements) being returned to LEAs (i.e. school districts and county offices of education) and send it to CDE to support the office. The amount would be capped at $500,000 and split between the participating LEAs for an annual cost per LEA of $933.

The proposed trailer bill is as follows:

1) amend the Welfare and Institutions Code Section 14115.8

(g)(1) These activities shall be funded and staffed by proportionately reducing federal Medicaid payments allocable to LEAs for the provision of benefits funded by the federal Medicaid program under the billing option for services by LEAs specified in this section. Moneys collected as a result of the reduction in federal Medicaid payments allocable to LEAs shall be deposited into the Local Educational Agency Medi-Cal Recovery Fund, which is hereby established in the Special Deposit Fund established pursuant to Section 16370 of the Government Code. These funds shall be used, upon appropriation by the Legislature, only to support the department to meet all the requirements of this section. If at any time this section is repealed, it is the intent of the Legislature that all funds in the Local Educational Agency Medi-Cal Recovery Fund be returned proportionally to all LEAs whose federal Medicaid funds were used to create this fund. The annual amount funded pursuant to this paragraph shall not exceed ~~**one million five hundred thousand dollars ($1,500,000).**~~ **two million dollars ($2,000,000). Of this amount, five hundred thousand dollars ($500,000) shall be provided, through an interagency transfer, to the State Department of Education, for the support of school-based Medi-Cal programs, upon agreement of the Department of Finance, the Department of Health Care Services, and the State Department of Education.**

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Teachers for Healthy Kids present this proposal.

Staff Recommendation: No action is recommended at this time.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 18: OSHPD OVERVIEW AND PROPOSED BUDGET

PANELISTS

- **Fran Mueller**, Chief Deputy Director, Office of Statewide Health Planning and Development
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSED BUDGET

For 2018-19, the Governor's Budget proposes $145 million for the support of OSHPD. The proposed budget reflects a 14 percent ($23 million) decrease from the current year budget, primarily reflecting the completion of funding for the Mental Health Services Act (Proposition 63) Workforce, Education and Training ("WET") program.

OSHPD Budget
(Dollars in Thousands)

Fund Source	2016-17 Actual	2017-18 Projected	2018-19 Proposed	CY to BY $ Change	% Change
General Fund	-	$33,334	$33,333	($1)	0%
Hospital Building Fund	47,349	63,485	63,521	$36	0.1%
Health Data & Planning Fund	31,830	31,388	31,752	$364	1.2%
Registered Nurse Education Fund	2,113	2,179	2,180	$1	0%
Health Facility Construction Loan Insurance Fund	5,564	4,939	4,943	$4	0.1%
Health Professions Education Fund	5,777	1,099	1,099	$0	0%
Federal Trust Fund	1,482	1,572	1,464	($108)	-6.9%
Reimbursements	4,141	868	868	$0	0%
Mental Health Practitioner Education Fund	397	395	395	$0	0%
Vocational Nurse Education Fund	212	224	224	$0	0%
Mental Health Services Fund	33,613	26,086	2,808	($23,278)	-89.2%
Medically Underserved Account For Physicians, Health Professions Education Fund	4,708	2,399	2,399	$0	0%
TOTAL EXPENDITURES	**$137,186**	**$167,968**	**$144,986**	**($22,982)**	**-13.7%**
Positions	447.2	433.5	430.5	(3)	-0.7%

BACKGROUND

The Office of Statewide Health Planning and Development (OSHPD) develops policies, plans and programs to meet current and future health needs of the people of California. Its programs provide health care quality and cost information, ensure safe health care facility construction, improve financing opportunities for health care facilities, and promote access to a culturally competent health care workforce.

The Facilities Development Division (FDD):

1. Reviews and inspects health facility construction projects.
2. Has projects, currently under plan review or construction, valued in excess of $20 billion.
3. Enforces building standards, per the California Building Standards Code, as they relate to health facilities construction.
4. Is one of the largest building departments in the State of California.

The Healthcare Information Division (HID) collects and disseminates healthcare quality, outcome, financial, and utilization data, and produces data analyses and other products. The Division collects and publicly discloses facility level data from more than 5,000 CDPH-licensed healthcare facilities - hospitals, long-term care facilities, clinics, home health agencies, and hospices. These data include financial, utilization, patient characteristics, and services information. The Division produces more than 100 data products, including maps and graphs, summarizing rates, trends, and the geographic distribution of services. Risk-adjusted hospital and physician quality (outcome) ratings for heart surgery and other procedures are also published. The Division provides assistance to the members of the public seeking to use OSHPD data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments and stakeholders.

The Healthcare Workforce Development Division (HWDD) supports healthcare accessibility through the promotion of a diverse and competent workforce while providing analysis of California's healthcare infrastructure and coordinating healthcare workforce issues. The division's programs, services and resources address, aid and define healthcare workforce issues throughout the state by:

1. Encouraging demographically underrepresented groups to pursue healthcare careers.

2. Identifying geographic areas of unmet need.

3. Encouraging primary care physicians and non-physician practitioners to provide healthcare in health professional shortage areas in California.

HWDD staff collect, analyze and publish data about California's healthcare workforce and health professional training, identify areas of the state in which there are shortages of health professionals and service capacity, and coordinate with other state

departments in addressing the unique medical care issues facing California's rural areas.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD to provide an overview of the department and its proposed budget, and to provide any significant program updates within OSHPD.

Staff Recommendation: No action is recommended at this time.

ISSUE 19: COST TRANSPARENCY RX IMPLEMENTATION PLAN (SB 17) BUDGET CHANGE PROPOSAL

PANELISTS

- **Scott Christman**, Deputy Director, Chief Information Officer, Office of Statewide Health Planning and Development
- **Noah Johnson**, Finance Budget Analyst, Department of Finance
- **Brian Metzker**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

OSHPD requests 3.0 positions and $500,000 expenditure authority in Fiscal Year (FY) 2018-19, 5.5 positions and $850,000 in FY 2019-20, and 5.5 positions and $800,000 expenditure authority ongoing from FY 2020-21 to implement the new program created by this bill. The Department of Managed Health Care's (DMHC) Managed Care Fund and the Department of Insurance's (DOI) Insurance Fund are the identified fund sources to pay for the costs of the bill and the transfer will be based on the ratio of covered lives regulated by the department. All penalties received by OSHPD will be deposited into the Managed Care Fund.

BACKGROUND

Chapter 603, Statutes of 2017, Senate Bill 17 (SB 17) requires prescription drug manufacturers to give a 60-day notice to state purchasers, healthcare service plans, health insurers, and pharmacy benefit managers if the cumulative increase of the wholesale price of a drug over the last two calendar years is over 16 percent. This bill also requires drug manufacturers to report certain information related to these price increases and related to the introduction of new drugs that exceed the Medicare Part D threshold for a specialty drug to the Office of Statewide Health Planning and Development (OSHPD). OSHPD is required to publish the information on its website at a minimum of a quarterly basis and within 60 days of receipt from a manufacturer for price increases and new drugs. Failure by the prescription drug manufacturers to report this information to OSHPD is subject to a civil penalty of $1,000 per day.

OSHPD is the central repository for healthcare data in California. OSHPD collects facility-level financial, utilization, and services inventory data reported by over 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics (primary care and specialty), home health agencies, and hospices. OSHPD also collects approximately 16 million individual confidential patient records annually regarding hospital inpatient discharges, emergency department encounters, ambulatory surgery encounters, and coronary artery bypass graft surgeries.

OSHPD's Accounting and Reporting Systems Section (ARSS), where this program will primarily reside, currently receives, reviews, and makes available to the public various healthcare data, including financial and utilization data from licensed California hospitals, long-term care facilities, clinics, home health agencies, and hospices. ARSS also maintains licenses for all licensed healthcare facilities in California in addition to providing public information about nonprofit hospital community benefit plans and hospital discount payment policies.

OSHPD issues regulations that govern the reports submitted by health facilities. All the reports submitted to OSHPD undergo a review process, to check for compliance and accuracy. Data from these reports are made available to the public as data products and public reports, which are posted to OSHPD's public website and the California Health and Human Services' Open Data Portal. OSHPD also produces special studies and custom data runs using public data, upon request.

OSHPD does not currently collect data on drug prices or work closely with the drug manufacturer industry. This is an entirely new business for OSHPD and resources are needed to build and maintain a new program. A comprehensive list of drug manufacturers is not available, and it is unknown how many exist, though it is estimated to be over several hundred. Additionally, companies are often changing through new startups and consolidations, as well as frequent selling of drug manufacturing operations to other companies. Since there are over eighty thousand unique prescription drug products, managing the association of these products to drug manufacturers will require extensive work to track drug manufacturing companies.

Ongoing resources are needed to develop appropriate systems to receive reports and data of any size from drug companies, track an ever-changing list of drug manufacturers, issue regulations, enforce, compliance, provide technical assistance, and manage the ongoing new workload created by this legislation.

An online web portal has been created to collect the registration information for drug manufacturers. These entities will then submit the required information and notifications regarding price increases through the web portal. OSHPD used existing information technology systems to develop this web portal. An approved 81 BA has been filed with the California Department of Technology, which reflects the resources requested in this budget change proposal.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests OSHPD present this proposal.

Staff Recommendation: No action is recommended at this time.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 20: STAKEHOLDER PROPOSAL ON CALIFORNIA SURVEILLANCE GATEWAY

PANELISTS

- **Vanessa Cajina**, Legislative Advocate, Mosquito and Vector Control Association of California

Public Comment

PROPOSAL

The Mosquito and Vector Control Association of California requests $500,000 General Fund annually to support the California Surveillance Gateway (CalSurv).

BACKGROUND

The Mosquito and Vector Control Association of California (MVCAC) provided the following background information:

CalSurv is a program that is jointly managed by three entities: the MVCAC, the California Department of Public Health (CDPH), and the Center for Vectorborne Diseases at the University of California at Davis. This centralized data allows these three partners to provide and receive real-time reporting as to where mosquitoes might emerge so that they can use the best means to combat them and prevent their reproduction. California mosquito control programs already employ cutting-edge technology to combat the spread of disease, but this funding would greatly improve the state's ability to get ahead of costly mosquito-borne diseases, which continue to affect hundreds of people around the state each year.

CalSurv's Structure and Funding Allocation: This proposal is for an ongoing appropriation from the General Fund of five-hundred thousand dollars ($500,000) to be allocated to the California Vector-borne Disease Surveillance (CalSurv) system. As described above, CDPH, UC Davis, and MVCAC members work cooperatively on this program – UC Davis would continue to manage the day-to-day operations of the database, but this funding would allow CalSurv to hire additional research and programming staff. This would allow UC Davis to expand CalSurv's functions and help combat the spread of mosquito-borne illnesses. It would also provide certainty for a program that is critical in protecting public health across the state.

In terms of operations and cooperative agreements, CalSurv is operated by UC Davis; local mosquito control agencies can upload data when they detect mosquitoes that can transmit diseases, which CalSurv loads into the database and can overlay with climate information to predict where invasive mosquitoes might be detected next, and the

California Department of Public Health (CDPH) coordinates appropriate responses to epidemiological threats.

California Has Supported Mosquito Research, But CalSurv Funding Sustainability Is a Concern: From 1972 to 2008, the state provided funding to the University of California for state-based mosquito research, which was also disseminated for more localized research. However, in 2008 at the height of the state's budget deficit, the University absorbed the funding into other operations. Since then, there has been no state support for mosquito research, which is a critical component of protecting the public health. Providing state and local funding is especially important as mosquito reproduction is closely associated with climate and geography variations, meaning mosquito control programs deal with different reproduction and abatement issues but can learn from their colleagues in different regions.

After that state support vanished, researchers and professors at UC Davis established CalSurv, which performs the functions described above. This system has become an indispensable weapon in the fight against mosquito-borne illness, as our three partners share data and collaborate on best practices to manage mosquito populations. This database allows MVCAC members to better visualize and predict where disease-spreading and nuisance mosquitoes will emerge so that they can be abated early and with the least harmful techniques available.

CalSurv funding is tenuous. It is supported by academic research grants, as well as a climate change focused NASA grant, which is currently in jeopardy. The importance of coordinated surveillance of mosquito-borne diseases has been recognized time and time again since California first dealt with the outbreak of West Nile virus in 2003. Expanded surveillance programs require enhanced data management, spatial and temporal visualization, and computational tools to assess risk and recommend appropriate intervention.

In 2017, the federal Centers for Disease Control and Prevention (CDC) provided funding to CDPH that included support for local mosquito control agencies that monitor for and/or combat the invasive mosquito species that can carry Zika. Eradication of invasive Aedes is a costly endeavor and extremely labor intensive. However, this year the same funding will not be available. As such, this is a timely point to provide additional support for ongoing statewide surveillance that can benefit all parts of the state.

The Growing Threat and Impacts of Mosquito-Borne Illness: Mosquito surveillance is crucial for tracking, eliminating, and preventing the spread of mosquitoes and the diseases they carry. Even though it has been present in California since 2003, West Nile virus continues to affect costs to the state's healthcare system, including health insurance, public payers such as Medi-Cal, healthcare facilities that treat patients, lost productivity, and the costs to control mosquitoes. A study of the 2005 season in Sacramento County counted 163 cases in the county, amounting to a treatment cost of over $18,000 per infected individual.

Statewide and in Sacramento County, the number of West Nile cases has fluctuated since then, but the growth in the number of cases has been remarkable. For example, there were 158 human cases in 2011 statewide with 58 cases in Los Angeles County. From there, the numbers of human cases have trended upward, then more than doubling in 2012 with 479 cases and skyrocketing to a high of 801 cases in 2014 with 253 of those in Los Angeles County. Using the 2005 Sacramento projection, that is a statewide cost of $14.4 million and $4.5 million to Los Angeles. Providing mosquito control professionals with the best aggregated data possible will help them bend the prevention curve and protect the populations they serve.

Due to effective mosquito surveillance, efforts to limit the spread of West Nile were successful. However, mosquitos adapt quickly by becoming resistant to pesticides, alter their feeding and biting patterns, and infest geographic regions they have never before been detected. In fact, the Culex species that transmits West Nile virus has been known to travel 25 miles or more per day, making real-time surveillance a critical tool in fighting mosquito-borne illness.

More recently new invasive species have been detected in California such as the Aedes Aegypti. The Aedes Aegypti is the mosquito known to transmit the Zika virus as well as dengue, chikungunya and yellow fever. As of March 24, 2017, CDPH reports there have been 527 Zika cases acquired overseas and 5 infants born with Zika-related birth defects. While the state has thus far avoided any local transmission of Zika, the potential for an outbreak in California does exist and a robust surveillance system can help with prevention efforts.

As climate change continues to affect our planet, higher temperatures and dryer climates help with the increase in diseases such as West Nile. It also creates climates that more suitable to invasive species like the Aedes mosquitos. Additionally, after a particularly wet season, like last year, mosquito abatement agencies are gearing up for a particularly high mosquito season.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the Mosquito and Vector Control Association of California present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 21: STAKEHOLDER PROPOSAL ON DIABETES AWARENESS CAMPAIGN

PANELISTS

- **Flojaune G. Cofer**, PhD, MPH, Director of state Policy & Research, Public Health Advocates

Public Comment

PROPOSAL

Public Health Advocates requests $10 million General Fund one-time for the Department of Public Health (DPH), Division of Chronic Disease & Injury Control, Chronic Disease Control Branch to be spent over 24 months to plan and implement a Diabetes Awareness Outreach Campaign.

Campaign Overview. The campaign will employ a multi-pronged approach combining traditional media, social media, clinical referrals and targeted grassroots messaging to achieve three key aims:

1. Increased awareness of the problem: e.g. prevalence of diabetes and pre-diabetes in the state/local area, the link between diabetes and heart disease;
2. Understanding of personal risk: e.g. knowledge of the risk factors for diabetes and personal risk score assessment, preventability of diabetes (even with a family history); and,
3. Increased awareness of prevention and treatment resources: e.g. Diabetes Prevention Program and Diabetes Treatment and Management Programs.

Additional Staffing. The Chronic Disease Control Branch shall hire two full time staff for 24 months to perform internal administrative duties related to the campaign. Hired staff shall have experience in public health and/or communications and shall be employed in the state classification of Health Program Specialist II or higher.

Public/Private Advisory Committee. The Chronic Disease Control Branch shall establish an advisory committee endowed with decision-making powers for the campaign. The advisory committee shall be a public-private partnership composed of representatives from the Chronic Disease Control Branch, the Department of Health Care Services Benefits Division, local health departments, marketing and advertising firms; health care practitioners, pharmacists, promotores and community health workers; and experts in behavioral modification, behavioral economics, social media marketing, and multi-cultural/multi-lingual messaging. The chair of the advisory committee shall be a representative from a non-state entity. The advisory committee shall be established by no later than October 1, 2018, and shall meet, at a minimum, on a quarterly basis.

BACKGROUND

Public Health Advocates provided the following background information:

The Diabetes Epidemic. Like much of the nation, California is facing a diabetes epidemic of almost unimaginable proportions. The majority (55%) of California adults, and almost one quarter (23%) of teens, now have either Type 2 diabetes or prediabetes. In the next five years, 1.9 million *more* Californians are expected to be diagnosed with diabetes—an 80% increase – costing California an additional $15 billion in annual health care costs. The burden of diabetes falls overwhelmingly on low-income communities; at 20%, diabetes rates are four times higher among adults living below the federal poverty level than for those in families earning over $75,000, at 5%. Thus, much of the increased treatment costs will be paid by Medi-Cal.

Investments in Diabetes Prevention and Treatment. In 2017, the California legislature approved Medi-Cal funding for the Diabetes Prevention Program (DPP), a lifestyle change program proven to prevent or delay type 2 diabetes among people who have prediabetes and women with a previous diagnosis of gestational diabetes. For California, this was the first ever investment of state funds for diabetes prevention. Prior to the Medi-Cal funding, DPP coverage was approved for Medicare (beginning April 1, 2018), CalPERS (beginning January 1, 2017) and many private insurers. For Californians with a diabetes diagnosis, evidence-based management programs to prevent complications are included benefits for public and private insurance.

Ongoing Needs: Medical coverage for treatment is an important aspect of health care, but is often underutilized. Traditional barriers to health care utilization include convenient access to services including virtual programs, ancillary supports for in-person services (e.g. transportation and childcare) and respectful and culturally appropriate delivery models, many of which are being prioritized in the implementation of diabetes treatment and prevention programs; however, one of the costliest remaining barriers to health care utilization is outreach. To increase utilization for covered diabetes prevention services, beneficiaries must be aware: 1) they have a health care need; 2) covered services exist to address their need; 3) the process to access services, 4) how the services will be useful in improving their health.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Public Health Advocates present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 22: STAKEHOLDER PROPOSAL ON ALL CHILDREN THRIVE

PANELISTS

- **Flojaune G. Cofer**, PhD, MPH, Director of state Policy & Research, Public Health Advocates
- **Harold Goldstein**, DrPH, Executive Director, Public Health Advocates

Public Comment

PROPOSAL

Public Health Advocates (PHAdvocates) and the UCLA Center for Healthier Children, Families, and Communities request a one-time allocation of $15 million in Proposition 63 administrative funds to establish All Children Thrive / California (ACT/CA), a three-year initiative to develop and pilot test in 12 California cities or counties a public health approach to preventing childhood trauma, countering its effects, and fostering individual, family, and community healing and resilience. Under the auspices of Community Partners, the UCLA Center for Healthier Children, Families and Communities and Public Health Advocates (PHAdvocates) will do the following:

Objective 1. Establish an ACT/CA Equity Advisory Group (Months 1-2). To ensure that ACT/CA meets the needs of participating low-income communities of color, they will establish an advisory group of state and local experts in trauma- and equity-informed community programming to guide the initiative's design and implementation. The advisory group will ensure that ACT/CA nurtures the wisdom and creativity within participating communities; addresses overt and systemic racism and oppression; and promotes safety, trust, transparency, collaboration, and empowerment. They will convene the group quarterly to get their feedback on activities and progress, and to solicit input on future direction.

Objective 2. Identify the most effective public health approaches for preventing childhood trauma, diminishing its risks, and improving child, family, and community wellbeing (Months 1-9). They will conduct an exhaustive review of the scientific literature. They will identify model programs through outreach to trauma prevention and intervention experts around the world, conducting structured interviews with leaders and participants from the most effective programs. With particular attention to approaches developed with a high degree of community input, community co-design, and a focus on equity and inclusion, they will use findings to identify programs with the greatest impact, sustainability, ease of implementation, and prospect for scaling. They will determine the local commitment, tools and resources, coaching, and other support communities will need to launch, implement, and sustain the strategies. Based on these findings, along with guidance from the ACT/CA Equity Advisory Group, they will establish a detailed framework for the initiative.

Objective 3. Review and analyze data infrastructures currently in use around the world to monitor and improve the performance of efforts to ensure child health, development, and wellbeing (Months 1-9). They will identify best practices in data and information systems for monitoring child adversity, health, development, and wellbeing, including the array, presentation, and use of child and community trauma-related data for program improvement and building community support. They will develop a model data system and dashboard to track outcomes, trends, and impact to share and revise based on feedback from ACT/CA communities.

Objective 4. Develop a toolkit for cities and counties describing model public health approaches to ACEs and data infrastructure to monitor child wellbeing (Months 10-12). Based on results from Objectives 1 and 2, they will develop and share with cities and counties an All Children Thrive Toolkit with model public health strategies for addressing ACEs in their communities. The toolkit will include best practices from around the world for promoting equity, lessons learned, and implementation options, ensuring community participation in program design, and supporting community leadership in program implementation. Rather than mandating strategies, the toolkit will broaden the sense opportunity and help communities to envision desirable alternatives to the status quo.

Objective 5. Recruit 12 low-income California cities and counties to develop and implement ACT/CA (Months 9-12). Using a simple application process, they will recruit three large (pop. >250K), three medium (pop. 50-249K), and three small (<50K) cities and three small rural counties (pop. <100K). Jurisdictions will be selected by the Equity Advisory Group based on criteria such as per capita income, ethnic composition, child health status, and commitment from elected officials, community-based organizations, and residents.

Objective 6. Provide technical assistance (TA) to help participating communities select, develop, and implement public health strategies to prevent childhood trauma, counter its effects, and foster individual, family, and community healing and resilience (Years 2-3). TA will include one-on-one coaching and group facilitation and support to promote collaborative learning and creativity, a web-based learning community sharing best practices, and assistance with data collection strategies to monitor impact and for quarterly reporting.

a) Local Advisory Group. Each city or set of conjoining jurisdictions will establish an advisory group of local elected officials, community leaders, and resident champions to guide their ACT/CA initiative.
b) Listening Sessions. With guidance and support from their local advisory group, cities will hold community listening sessions to share information about trauma and resiliency and to learn about trauma-related needs and priorities of youth and adult residents.
c) Implementation Strategies. Based on findings from listening sessions, advisory groups will select and prioritize policies, programs, and practices for implementation. They will establish a coalition of individuals and organizations enthusiastic about helping to carry out those strategies, developing detailed timelines and workplans, assigning tasks, defining benchmarks, and planning for the collection of process and outcome measures.

Objective 7. Support an All Children Thrive/CA Learning Network (Years 2-3). They will establish a peer learning network to provide facilitated, structured opportunities for participating cities to share collaboration and mobilization strategies, policy and program innovations, measurement and reporting templates, and other lessons learned. The Learning Network will adopt an all teach, all learn approach, helping communities build their own local learning system to continuously evaluate, learn, adapt, and scale their efforts at the local level.

Objective 8. Evaluate impact, identify best practices, and develop options to spread and scale ACT/CA throughout California. (Months 34-36). With help from the Equity Advisory Group, and based on input from local participants, we will assess the impact of each community initiative and of ACT/CA as a whole. They will identify best practices for key strategies such as public education, resiliency building, family support, building safer and more cohesive neighborhoods, ensuring access to care and support, promoting dignity and respect, ensuring access to resources and opportunities, and engaging and empowering affected youth and families. They will identify and share with the Proposition 63 Commission and the legislature the viability of and options for expanding ACT/CA statewide for broadest impact.

BACKGROUND

Public Health Advocates provided the following background information:

Adverse childhood experiences (ACEs) are a fundamental contributor to many of California's most urgent and costly social problems, including violence, poor academic performance, homelessness, drug addiction, mental illness, and chronic health conditions like heart disease and diabetes. Sources of trauma and toxic stress, ACEs are so damaging— and their causes so deeply woven into our social fabric—that their prevention and intervention have become top public health priorities.

A century ago, germ theory transformed our ability to treat illness and prevent death from infectious disease. Now, we know childhood trauma's central role in our most pressing public health challenges. Focusing attention at the traumatic roots of these challenges can help California to reduce the prevalence of physical and behavioral health problems and their resulting impact on health care, social service, and criminal justice costs.

All Children Thrive / California (ACT/CA) is a three-year, equity-focused, community-driven initiative to develop, test, and refine the tools and support our diverse communities need to *prevent* ACEs, *counter* their effects, *promote* healing, and *foster* individual and community resilience, giving all California children the opportunity to thrive. They will gather best practices from around the world and, together with leaders and residents from 12 low-income California cities and counties, establish and evaluate groundbreaking prevention and intervention strategies. By the end of the initiative, they will demonstrate measurable outcomes in pilot communities and will have evidence-based models ready to scale throughout the state. ACT/CA builds on the ACT national

initiative that supports transformative innovation and improvement to prioritize children's health and development in more than a dozen cities around the country.

Sources of Childhood Trauma. Strong, frequent, and/or prolonged adversity without adequate adult support can activate a child's stress response, alter brain development, and increase risk for stress-related disease and cognitive impairment. Trauma at the family, community, and social levels has been shown to profoundly affect a child's ability to thrive physically, emotionally, socially, academically, and economically later in life.

Nearly two-thirds (62%) of California adults have experienced at least one adverse childhood event; 18%—more than 1.5 million children—have experienced at least two and 17% have experienced four or more ACEs. Low-income people and people of color are at increased risk for trauma because they are more likely to face severe economic hardship, poor housing quality, greater social isolation, and inadequate community infrastructure. They are also more likely to face institutional racism, concentrated poverty, and other barriers, perpetuating a traumatic cycle from which escape is often difficult.

Consequences of Childhood Trauma. Childhood trauma and its lasting impacts pose significant threats to physical and behavioral wellbeing throughout the lifespan. Children with two or more ACEs are nearly four times more likely to repeat a grade in school than students with none. Youth with four or more ACES are almost 13 times more likely to be convicted of a felony. Adults who experienced trauma as children have significantly higher rates of depression, alcoholism and drug use, homelessness, and chronic diseases like heart disease and diabetes (Figure 2). ACEs increase the risk of dropping out of high school, criminal justice system involvement, lower lifelong earnings, and higher health care costs. Adults with six or more ACEs die 20 years earlier on average than those with none, living on average 60 versus 80 years. Unaddressed childhood trauma costs California untold billions in avoidable expenditures for health care, criminal justice, child welfare, family services, and income support. Additional costs accrue from the lost productivity (and resulting lost income taxes) of millions of adults whose traumatic early experiences—and lack of help to overcome them—keep them from meeting their potential.

Condition	Increased Rate	Condition	Increased Rate
Alcoholism	7.4 x	Heart Attack	2.3 x
Arthritis	2.3 x	Injection Drug Use	10.3 x
Asthma	2.3 x	Juvenile Arrest	12.9 x
Depression	4.6 x	Stroke	2.8 x
Diabetes	2.0 x	Suicide Attempts	12.2 x

Figure 2. Increased incidence for those with 4+ vs. no ACEs

Reducing Childhood Trauma: A Public Health Approach. An effective public health response to ACEs must include individual, family, and community strategies to prevent trauma, provide compassionate and culturally appropriate care to young people who have experienced trauma, and equip children to respond to traumatic experiences. Programs from around the world show that effective prevention and intervention strategies include the following:

1. ***Public education*** to create a shared understanding about trauma's harmful effects and the importance of preventing trauma, promoting resiliency, and reducing trauma-related stigma.
2. ***Individual resiliency building*** to help children gain coping skills, build self-efficacy, succeed academically, set and reach personal goals, have hope for their future, and gain confidence in their ability to overcome hardships.
3. ***Family support*** to ensure that caregivers have effective parenting skills, strong relationship and communication skills, stable employment, needed behavioral health services, and a supportive community network.
4. ***Neighborhood support*** to create safe, engaged, and cohesive social networks that build trust and increase connectedness, identify and address trauma risk factors, reduce exposure to toxic stress, and provide timely services to children and families affected by trauma.
5. ***Broader community support,*** where policies, programs, and practices make educational and employment opportunities widely and equitably available; dismantle systemic racism; promote dignity, respect, and understanding of all people; and ensure that health, education, housing, and social services are reimbursed and trauma-informed.
6. ***Community driven processes*** that ensure trauma prevention and intervention efforts meet the needs and priorities of residents and engage and empower affected youth and families.
7. ***Evaluation*** to promote continuous quality improvement and ***data collection*** to understand program effectiveness and differences in community outcomes to inform later replication.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests Public Health Advocates present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 23: STAKEHOLDER PROPOSAL ON LEAD CONSTRUCTION PROGRAM

PANELISTS

- **Jose Mejia**, Director, California State Council of Laborers

Public Comment

PROPOSAL

The Laborers' International Union of North America requests trailer bill to do the following:

1. Authorize the Department of Public Health Lead Construction Certification Program to raise program fees (currently $75) by a sufficient amount (estimated to increase by $10-$12) to increase sufficient revenue to the program to fund an additional full-time position, in order to expedite the program's workload and issue certifications on a faster time-line; and

2. Reduce the statutorily-mandated application processing timeline from 120 to 60 days.

BACKGROUND

The following background information on the program was taken from the DPH website:

California's lead accreditation and certification program began in June 1994. At that time, new childhood lead poisoning prevention legislation (codified in Health and Safety Code Section 105250 et seq.) required the California Department of Public Health (CDPH) to create a program to certify lead-related construction trades-people and accredit lead-related construction training providers. Final regulations establishing this program took effect April 5, 1995. Revisions to these regulations that established work practice standards for lead-related construction and amended the previously established accreditation and certification requirements went into effect in January 1999. These regulations were updated in April 2008.

Certification means that CDPH has evaluated and approved a person's qualifications to perform lead-related construction work in residential and public buildings. CDPH evaluates applicants to make sure they have completed State-approved training and have relevant experience and education to perform lead work.
CDPH grants five kinds of certificates:

- Lead Inspector/Assessor
- Lead Project Monitor
- Lead Sampling Technician
- Lead Supervisor
- Lead Worker

Each certificate has different training, education, and experience requirements. Certificates are granted to individual people, not to companies or businesses. Candidates for full lead Inspector/Assessor, Supervisor, and Project Monitor certification must also pass a State certification exam (in addition to the "end of course" exam). There are currently many situations which require lead-related construction professionals to be certified.

- State law requires certification for anyone doing lead hazard evaluations (inspections), lead clearance testing, lead abatement project design, or lead abatement work, in residential and public buildings in California.
- State law requires certification for workers conducting lead abatement activities in public elementary and pre-schools or public daycare centers.
- California OSHA regulations require training and certification for lead-related construction workers and supervisors who are exposed to airborne lead at or above the 8-hour permissible exposure limit (PEL) of 50 µg/m3.
- The U.S. Department of Housing and Urban Development (HUD) requires certification for those conducting pilot lead abatement projects.
- Lead inspections that are done to comply with the Federal real estate disclosure rules must be done by State certified inspector/assessors.

The Childhood Lead Poisoning Prevention Branch (CLPPB) staff manages a program to ensure that construction activities involving lead are performed in a manner to eliminate existing lead hazards, and to avoid creating new lead poisoning hazards for children and other occupants, as well as the workers themselves. The primary activities include:

- Evaluating and accrediting training providers who teach lead specialists how to find and abate lead hazards.

- Evaluating the qualifications of applicants for lead certification, and granting certification to those qualified to perform lead-related construction work in an effective and lead-safe manner.

Assembly staff has received complaints from labor about the amount of time it takes DPH to certify individuals, thereby allegedly leading to significant delays in construction projects. According to DPH, the current average application turn-around time is approximately 60 days, while state regulations allow for up to 120 days. DPH also states that the program has 4.0 full-time equivalent positions and 3.0 full-time-equivalent contract positions, and no vacancies. The Subcommittee first heard this issue at its hearing on Monday, February 26, 2018, but had not received this proposal at that time.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the California State Council of Laborers present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 24: STAKEHOLDER PROPOSED TRAILER BILL ON LICENSING AND CERTIFICATION DATA SHARING

PANELISTS

- **Barbara Glaser**, Senior Legislative Advocate, California Hospital Association

Public Comment

PROPOSAL

The California Hospital Association requests trailer bill language requiring the California Department of Public Health (CDPH) to publicly post information on the Centralized Applications Unit's (CAU) on workload volume and timeliness of processing health facility applications.

BACKGROUND

The California Hospital Association provided the following background information:

Hospitals continue to experience long wait times for CDPH's CAU to complete and approve applications. The CAU processes applications for many changes, including initial application for licensure, change of ownership, change of location, change of name, change of services and reports of changes (of governing board, administrator, director of patient care services, beds, geographical service area, indirect ownership change or stock transfers).

Currently, it takes approximately eight to 10 months for an application to reach the top of the queue to be assigned to a CAU analyst. It takes an additional four and a half months after the application is complete to receive approval for the new or expanded services. CHA believes the public disclosure of metrics related to the CAU's workload would inform the public, providers and policy makers about its performance.

Delays in approving these applications mean that patients lack access to critical — sometimes life-saving — services. One Northern California hospital waited six months for CDPH to approve a new MRI, and was forced to transport ill, worried patients via ambulance to a distant facility — simply because CDPH had not completed its review. A Southern California hospital waited over nine months to add two additional beds to its existing cardiac catheterization program. A patient with a blocked coronary artery needs cardiac catheterization immediately; ambulances had to bypass this hospital, although it had cardiac catheterization beds available, because the application had not reached the top of the queue for CAU evaluation. The backlog in CAU has reached the point of endangering the health of California's citizens.

CDPH has undertaken several improvement activities to increase the CAU's efficiency, including hiring additional permanent staff and several temporary staff and working toward automating the application process. Much of this is supported by the following budget actions:

- The 2015-16 budget provided CDPH funding to purchase software to automate the processing of forms in CAU and the Professional Certification Branch.

- The 2016-17 budget authorized CDPH to use $1.5 million to redesign CAU information technology systems, including replacing substantially paper-based processes with information technology solutions as well as online applications and reporting features.

- The 2017-18 budget provided CDPH with a multi-year expenditure authority from its Internal Department Quality Improvement Account for contacted services, including the continued redesign of the CAU information technology system.

CHA asks the budget committee to consider mandating public metrics on the workload volume and timeliness of the CAU across all facility and application types. Specifically, CHA requests the following language be adopted:

> *Beginning October 2018, the State Department of Public Health shall, on a quarterly basis, report to the fiscal and appropriate policy committees of the Legislature and post on its website data related to the workload volume and timeliness of the CAU across all facility and applications types.*

This language is similar to uncodified budget trailer bill language adopted in 2014 (Chapter 31) that required the department to report workload and performance metrics related to complaint investigations, entity-reported incidents, recertification surveys and other information.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the California Hospital Association present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 25: STAKEHOLDER PROPOSED TRAILER BILL ON HOSPITAL INSPECTIONS

PANELISTS

- **Marcus McKinney**, Legislative Advocate, California Nurses Association

Public Comment

PROPOSAL

The California Nurses Association requests trailer bill intended to increase the integrity of hospital inspections performed by the California Department of Public Health (CDPH).

BACKGROUND

The California Nurses Association (CAN) provided the following background information:

Under current law, the CDPH is mandated to deploy "Hospital Inspectors" in order to conduct the inspection of hospitals for specified purposes. The purpose of these inspections is for Inspectors to make findings, as well as respond timely and appropriately to issues identified during the inspections process. However, the presence of management during these inspections has had a stifling effect on hospital personnel, often times intimidating personnel so much that they are deterred from providing meaningful feedback. The presence of management during these inspections has no correlation to improved quality or outcomes, has a chilling effect on personnel, and if anything has only resulted in the omission of potentially important issues personnel may seek to have addressed.

Under existing law, Labor Code Section 6314, an employee or authorized representative is afforded the right to speak privately with inspectors to discuss safety or health violations during the course of an investigation or inspection conducted by Cal/OSHA. Therefore, CAN is requesting the adoption of language which would help improve the integrity and effectiveness of inspections at the California Department of Public Health by ensuring that employees are able to speak privately with CDPH inspectors, just like Cal/OSHA employees are allowed to speak privately with inspectors. However, CAN is not seeking any additional changes to the scope or nature of the inspections as currently conducted by CDPH, other than the removal of management from the process.

Specifically, CNA requests the following language amending Health and Safety Code section 1278.5 to read:

> *"(n) Any employee, or his or her authorized representative, shall have the right to discuss possible regulatory violations or patient safety concerns with the inspector privately during the course of an investigation or inspection by the department."*

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the California Nurses Association present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 26: LICENSING AND CERTIFICATION FEDERAL STANDARDS TRAILER BILL

PANELISTS

- **Jean Iacino**, Deputy Director, Center For Health Care Quality, Department of Public Health
- **Phuong La,** Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The Department of Public Health is seeking to reinstate specific statutory authority to use federal certification standards for state licensure for ESRDs, CORFs, and ASCs. The UC Davis study determined that federal regulatory standards are sufficient for state standards for ESRDs, CORFs, and ASCs. Public Health concurs with the findings of the study and recommends granting permanent authority to use federal regulations as licensure standards for ESRDs, CORFs, and ASCs.

Public Health is also seeking to reinstate specific statutory authority to use federal standards during the rulemaking process for ICF/DD regulations. The regulations for ICF/DDs are anticipated to be released in 2018.

BACKGROUND

Until January 1, 2018, California statute authorized Public Health to use federal regulatory standards as the state licensing standards for chronic dialysis clinics (ESRD), rehabilitation clinics (CORF), and ambulatory surgical clinics (ASC). The purpose of the sunset date was to allow Public Health to conduct a study to determine whether the federal regulations adequately protect the health and safety of patients. Public Health contracted with the Institute for Population Health Improvement (IPHI) at UC Davis to conduct the study. Public Health was required to conduct at least one public hearing and submit a report to the Legislature regarding how the ESRDs, ASCs, and CORFs meet the federal certification standards as a basis for state licensing standards and making recommendations for any California-specific standards that may be necessary.

In December 2015, UC Davis published the report, titled: “A Review of Regulatory Standards, Quality of Care Concerns, and Oversight of Ambulatory Surgery Clinics, Comprehensive Outpatient Rehabilitation Facilities, and End-Stage Renal Disease Facilities” (study). The study concludes that federal regulations are sufficient for regulating these specialty clinics and that expanded state-specific regulations would be of uncertain, marginal value. In addition, ESRD, CORF, and ASC clinics must currently meet federal certification standards in order to participate in Medicare and Medicaid.

The law also authorized Public Health to use federal certification standards for the regulation of Intermediate Care Facilities/Developmentally Disabled (ICF/DD) nursing and ICF/DD continuous nursing until January 1, 2018. ICF/DD nursing and ICF/DD continuous nursing facilities were not included as part of the study because Public Health is currently developing regulations for these categories of ICF/DDs.

When the sunset took effect on January 1, 2018, Public Health and the Department of Developmental Services will not have specific statutory authority to use the federal certification standards as state licensure standards, which qualify these programs for Medicare and Medicaid.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 27: HEALTH CARE LICENSING AND OVERSIGHT SPRING FINANCE LETTER

PANELISTS

- **Jean Iacino**, 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
- **Cj Howard**, Chief, Policy And Planning, Center For Health Care Quality, Department of Public Health
- **Phuong La,** Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

The California Department of Public Health (CDPH) requests 22 positions and expenditure authority of $2.4 million from the Licensing & Certification Program (L&C) Fund (Fund 3098) and $294,000 from the Internal Departmental Quality Improvement Account (IDQIA) in Fiscal Year (FY) 2018-19 and ongoing to improve core operations and effectiveness, foster quality improvement projects, and address workforce needs.

Position Requests	2018-19
Research and Evaluation Unit	
Health Program Manager II	1.0
Research Analyst II	2.0
Research Program Specialist II	1.0
Information Technology Specialist II	1.0
Continuous Quality Improvement	
Health Program Manager II*	1.0
Research Program Specialist II*	1.0
Professional Certification Branch	
Aide and Technical Certification Section	
Program Technician II	4.0
Criminal Background Section	
Associate Governmental Program Analyst	4.0
CNA Training Program Review	
Associate Governmental Program Analyst	2.0
Program Technician II	2.0
New 3.5 and 2.4 Staffing Standards Waiver Review	
Health Facilities Evaluator Nurse	1.0
Associate Governmental Program Analyst	1.0
Program Technician II	1.0

*IDQIA funded positions.

BACKGROUND

The CDPH, Center for Health Care Quality (CHCQ), is responsible for three significant functions that ensure health care facilities and professionals can provide safe, effective, and quality health care for all Californians. The three functions include the following.

1. The Licensing & Certification Program is responsible for regulatory oversight of licensed health care facilities and fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to oversee compliance with federal and state laws and regulations and issues state citations and Administrative penalties for facilities out of compliance. CHCQ licenses and certifies over 10,000 health care facilities and agencies in California in 30 different licensure and certification categories.

2. The Professional Certification Branch administers the certification of certified nurse assistants (CNAs), home health aides (HHAs), certified hemodialysis technicians (CHTs), and the licensing of nursing home administrators (NHAs). The branch oversees the approval of the CNA, HHA, and CHT training programs and continuing education, and the criminal record clearance of these four health care professional types,

3. The Healthcare Associated Infections Program (HAI) improves quality of care and patient safety through the prevention of infections in California health care facilities. HAI accomplishes this through assistance with prevention activities, development of infection prevention recommendations, and implementation of mandatory public reporting of healthcare-associated infection data.

CHCQ's funding sources are the State Department of Public Health Licensing and Certification Program Fund (Fund 3098), federal funds (Title XVIII and Title XIX Grants), reimbursements associated with interagency agreements with the Department of Health Care Services, and General Fund to support survey activities in state-owned facilities.

Over the past three years, CHCQ has engaged in numerous business process improvement projects to: reduce processing time for new licensure and change of ownership applications, more timely address complaint investigations, and use difficult-to-recruit and retain health facility evaluator nurse (HFENs) positions in a more focused manner for activities that require their clinical expertise. Since 2015, CHCQ has used the IDQIA to:

- Purchase hardware and software to develop internal and external performance dashboards;
- Automate key business practices;
- Streamline data collection from regulated entities;
- Execute contracts to successfully improve CHCQ's hiring, onboarding, and retention practice;

- Redesign the Centralized Applications Unit's IT systems and the Health Facilities Consumer Information System;

- Provide leadership training programs for staff; and
- Facilitate stakeholder forums to discuss process improvements and other program updates.

Also within existing resources, CHCQ has achieved significant improvement in the processing time for CNA certifications (less than 5 business days), secured a call tracking/measurement system, and significantly improved its ability to respond to the 15,000 monthly incoming CNA call inquiries. Additionally, and within existing resources, CHCQ has begun to transition to electronically enabled survey and investigation fieldwork by initiating an innovation project to pilot point-of-service technology coupled with a user-centered designed electronic system for investigating adverse events involving retained foreign objects. In addition, CHCQ has transitioned to a point-of-service electronic survey process (ASPEN) for federal long-term care surveys as mandated by the Centers for Medicare and Medicaid Services (CMS). Conducting the federally mandated work electronically requires significant transformation of state licensing work to reduce duplication and improve efficiency.

Despite significant advances and progress in CHCQ's survey and certification operations, there remains work to be done to implement technology solutions that improve efficiency and effectiveness and respond to new and emerging issues in the field. CHCQ needs to build a data infrastructure that will enable a more strategic and coordinated approach to implement technology solutions and quality improvement projects.

In FY 2015-2016, CDPH received an additional 237 positions to address licensing and certification workload. The CHCQ health facility evaluator nurse vacancy rate increased from less than 5 percent to more than 20 percent with the addition of these positions. However, CHCQ has made progress in decreasing the vacancy rate and filling positions. As of January 2018, the HFEN vacancy rate is 10 percent. The 2018-19 Governor's Budget estimate indicated an increase of 147 HFENs and 57 support and supervisory positions (204 total) would be required to meet the current workload as it relates to licensing, survey, and complaint investigations. CHCQ is not requesting these additional positions at this time, as CHCQ continues to focus on identifying efficiencies and reducing the vacancy rate. The positions requested in this proposal are not fieldwork positions. Instead, they will provide critically needed backbone functions to support fieldwork positions and operations.

In June 2012, CMS required CDPH to assess its survey and certification operations. CDPH contracted with Hubbert Systems Consulting to perform this assessment. In August 2014, Hubbert Systems Consulting issued a final report containing 21 recommendations. CHCQ has completed five recommendations and continues to work diligently to implement the remaining recommendations to "allow for meaningful, measureable improvements in the Programs' performance." The Hubbert report and recommendations and CHCQ's implementation work plan and progress are documented on our stakeholder website at:

https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/WorkPlanUpdatesGoalCompletionReports.asp

In addition to ongoing quality improvement needs, recent legislation has created new and increased workload for the Center. Effective July 1, 2018, all freestanding skilled nursing facilities (SNFs), excluding distinct parts of general acute care hospitals, state-owned hospitals, or developmental centers, are required to increase staffing from the current 3,2 nursing hours per patient day requirement to 3.5 direct care service hours per patient day, with CNAs performing a minimum of 2.4 hours per patient day.

This requirement will create a demand for more CNAs to enable facilities to meet the staffing requirements and a commensurate demand for more CNA training programs. CDPH anticipates an increase in the number of applications for approval of new training programs as well as applications for individuals seeking CNA certification.

Additionally, the new staffing standard requires CHCQ to develop two waiver processes. One waiver is for SNFs seeking to waive the 3.5 direct care service hours requirement and/or the 2.4 CNA hours requirement due to a workforce shortage. A facility with an approved workforce shortage waiver may not staff below 3.2 direct care hours. The other waiver is for SNFs to staff at lower levels of CNAs while maintaining the overall 3.5 direct care service hours requirement based on the resident acuity. A SNF seeking either waiver must submit a waiver application to CDPH for review, and approval or denial. Review of these waivers represents a new workload for CHCQ. In the 2017-18 fiscal year, CHCQ received funding for one position to draft emergency regulations and all facility letters

Legislative Analyst's Office

The LAO provided the following analysis and comments:

DPH is requesting 22 positions and expenditure authority of $2.7 million (from special funds) in its Center for Health Care Quality (CHCQ) in 2018-19 and ongoing, to improve core operations (7 positions) and address professional certification workload (15 positions). We will make comments regarding the 15 professional certification positions (in CHCQ's Licensing and Certification Program), which primarily address increased workload associated with certified nursing assistants (CNAs) and skilled nursing facilities (SNFs). DPH's 15 proposed positions are part of a larger package of proposals by the administration that affect labor agencies, Medi-Cal, higher education, and DPH, and respond to recently enacted CNA-related staffing requirements at skilled nursing facilities (SNFs).

LAO Bottom Line. We are tracking the entire package of proposals related to SNF staffing requirements and CNA training and certification. Our soon-to-be-released analysis will include a comprehensive overview of the package and its component parts as well as several recommendations. We do not believe the Legislature should make decisions about any one proposal in a silo, but consider them as a whole, aligning funding, program, and staffing decisions. For example, our recommendations—if taken—could affect the number of positions DPH needs to address anticipated workload.

Preliminary Comments on DPH Proposal. While we recommend consideration of the package of proposals as a whole, we have some preliminary concerns about DPH's

component of the package. Ultimately we think it lacks a complete justification of why 15 full-time permanent positions are needed. For example:

- Fifteen may not be the right number of positions. In light of recent improvements in application processing times and in light of the online submission system DPH hopes to roll out this calendar year, some of the requested positions may be unnecessary.

- Some of the positions may not need to be permanent. Some of the functions that would be performed by the requested positions appear limited-term in nature, such as processing waivers of SNF staffing requirements.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH present this proposal and requests LAO present their analysis and concerns.

Staff Recommendation: No action is recommended at this time.

ISSUE 28: BABYBIG/INFANT BOTULISM TREATMENT AND PREVENTION PROGRAM SPRING FINANCE LETTER

PANELISTS

- **Drew Johnson,** Assistant Deputy Director, Center for Infectious Diseases, Department of Public Health
- **Lina Grant,** Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

lt is requested that provisional language be added to Item 4265-001-0272 to provide the Department the flexibility to meet manufacturing costs for the next production cycle of BabyBIG® (Human Botulism Immune Globulin), should the production timeline shift into fiscal year 2018-19. BabyBIG® is an orphan drug, and is the only treatment of infant botulism in the United States. The Department is the only producer of BabyBIG® in the world, with only one facility approved by the Food and Drug Administration for production of the drug, located in Los Angeles, California: Shire Biotechnology. The production of BabyBIG® is difficult to schedule. Currently, the Governor's Budget assumes a 2019-20 production timeline. The proposed language would allow the Department to adjust expenditure authority to meet the uncertain timing for manufacturing.

Add the following provision to Item 4265-001-0272:

1. In the event the production schedule for BabyBIG® Lot 7 is accelerated and begins in the 2018-19 fiscal year, the Department of Finance may augment this item in the amount necessary to support these production costs. Any augmentation shall be authorized no sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or no 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 requests DPH present this proposal.

Staff Recommendation: No action is recommended at this time.

ISSUE 29: EMERGENCY RESPONSE: PUBLIC HEALTH CRISIS RESPONSE GRANT SPRING FINANCE LETTER

PANELISTS

- **Barbara Taylor,** Deputy Director, Emergency Preparedness Office, Department of Public Health
- **Lina Grant,** Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

lt is requested that provisional language be added to Items 4265-001-0890 and 4265-111-0890 to allow the Department to quickly accept public health emergency funding pursuant to a new Centers for Disease Control and Prevention (CDC) Public Health Crisis Response Grant. In February 2018, the Department received approval to be placed on an "Approved-But-Unfunded" list of grantees, which stipulates that 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 proposed provisional language will allow the Department to meet these requirements in response to public health emergencies.

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

> 3. Notwithstanding any other provision of law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by Public Health of available funds by the Centers for Disease Control and Prevention's Cooperative Agreement for Emergency Response: Public Health Crisis Response Grant. Within 10 working days of authorizing such an 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 provision of law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by Public Health of available funds by the Centers for Disease Control and Prevention's Cooperative Agreement for Emergency Response: Public Health Crisis Response Grant. Within 10 working days of authorizing such an 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 requests DPH present this proposal.

Staff Recommendation: No action is recommended at this time.