April 24, 2024

The Honorable Akilah Weber, M.D.
Chair, Assembly Budget Committee No. 1 on Health
1021 O Street, Room 4130
Sacramento, CA 95814

RE: Child Health and Disability Prevention (CHDP) Program Transition – CONCERNS
Hearing on April 29, 2024 – Assembly Budget Subcommittee No. 1

Dear Assembly Member Weber,

The undersigned organizations, representing California's local health departments, social services agencies, their workforce, and impacted children and families, write to express concerns with the Department of Health Care Services' (DHCS) transition of the Child Health and Disability Prevention (CHDP) Program.

Pursuant to SB 184 (Chapter 47, Statutes of 2022), CHDP will become inoperative and the Health Care Program for Children in Foster Care (HCPCFC) will become a standalone program as of July 1, 2024, or the date that DHCS certifies all transition-related steps have been completed. SB 184 required DHCS to conduct an extensive stakeholder engagement process to inform a final transition plan.

DHCS issued its final transition plan and certification at the end of March 2024, leaving little time for local health departments to effectively close out the CHDP Program and establish HCPCFC as a standalone program. While our coalition has appreciated the engagement with DHCS on the transition, we continue to have the following concerns:

HCPCFC Budget Allocation & Methodology

As proposed in the Governor's January Budget, DHCS intends to split the entire $34 million CHDP budget between: 1) $13.1 million for standalone HCPCFC, and 2) $20.8 million for the DHCS California Children's Services (CCS) Monitoring & Oversight Initiative.

Eliminating CHDP, according to DHCS in 2022, was not intended to be a cost-saving or cost-neutral proposal. Our organizations believe that the proposed amount for standalone HCPCFC, with the additional requirements in the newly released program guide, is inadequate. Based on engagement with local programs, our coalition proposes the following staffing structure and methodology needed to establish HCPCFC as a standalone program.

Staff Position	Ratio	FTEs Needed	Salary	Benefits	Total
Nurse Manager	1 Nurse Manager per 6 SPHNs	6.96 FTEs	$214,855	$133,210	$2,421,228
Supervising Public Health Nurse	1 SPHN per 8 PHNs	41.74 FTEs	$169,609	$105,158	$11,468,070
Public Health Nurse	1 PHN per 150 cases	333.90 FTEs	$150,695	$93,431	$81,513,638
Public Health Assistant	.025 FTE per 1 PHN	8.35 FTEs	$60,467	$37,490	$817,692
Data Analyst	.025 FTE per 1 PHN	8.35 FTEs	$123,288	$76,439	$1,667,217
Fiscal Staff	.025 FTE per 1 PHN	8.35 FTEs	$80,283	$49,775	$1,085,663
Administrative Staff	.05 FTE per 1 PHN	16.70 FTEs	$66,731	$41,373	$1,804,800

Note: This methodology utilizes a caseload of 50,085 children which is the five-year average foster care caseload between 2020-2024. Salary and benefit data was sourced from Los Angeles County. Benefits are calculated at 62 percent of salaries.

Our coalition seeks to lower the ratio of public health nurses to cases to account for case review and reporting requirements under standalone HCPCFC, as well as increased case acuity of foster children and youth. Moreover, additional duties set forth by the Administration, including performance measure tracking, prompt the need for data analyst positions to support the program.

Taken together, our coalition anticipates the total amount of personnel resources needed to establish standalone HCPCFC to be approximately $100.8 million. Currently, HCPCFC allocations issued to jurisdictions total $54.7 million (HCPCFC base allocation, Psychotropic Medication Monitoring & Oversight allocation, and caseload relief allocation). Based on our proposed methodology above, we estimate the additional need to be approximately $46.1 million to adequately resource this program.

Our coalition requests $46.1 million to establish standalone HCPCFC. However, recognizing the available resources from CHDP, as well as the state's current budget climate, our coalition seeks a minimum of $34 million (entire CHDP budget amount) for standalone HCPCFC.

Jurisdiction Flexibility

Given the incredible diversity of California's population and varying structures of jurisdictions, local health departments request flexibility in staffing the standalone HCPCFC to sufficiently address needs of their foster children and youth populations. The methodology above is intended to estimate the total statewide need for all the local HCPCFC programs statewide. However, recognizing that the total available funds from CHDP only amounts to $34 million, we request that DHCS allow local jurisdictions the flexibility to use their additional allocations as needed locally for the most effective administration of standalone HCPCFC.

For example, jurisdictions with complex foster care caseloads may need to assign a physician or other clinician to oversee clinical and administrative aspects of standalone HCPCFC. Jurisdictions may enlist an epidemiologist to conduct data analysis and may utilize various support staff to support other administrative-related functions of the standalone HCPCFC.

Our coalition requests jurisdiction flexibility in utilizing their HCPCFC administrative allocation to staff their standalone program to best meet local needs.

CCS Monitoring & Oversight Initiative

At the time our coalition reached agreement with the Administration on the sunset of CHDP via SB 184 (Chapter 47, Statutes of 2022), at no point was there consideration of reallocating CHDP resources to the CCS Monitoring & Oversight Initiative. Moreover, throughout DHCS' extensive CHDP stakeholder engagement process that occurred in 2023, our organizations consistently expressed concerns with redirecting these funds to the CCS Monitoring & Oversight Initiative. Despite these objections, DHCS has continued to propose reallocating a disproportionate share of the existing CHDP budget to this new and unrelated initiative.

The CCS Monitoring & Oversight Initiative seeks to establish and implement a variety of performance, quality, and reporting standards for county CCS programs. While local programs do not oppose this additional monitoring and oversight, our coalition expresses significant concerns with existing, long-standing issues with the fundamental budget and fiscal administration of the program. The CCS program, as it stands today, is woefully underfunded and administratively complex. Prior to establishing new requirements on top of the core CCS program, our coalition urges DHCS to work with CHEAC to improve the fiscal administration and operations of the program and to seek a separate funding source to resource the new CCS Monitoring & Oversight Initiative.

Our coalition requests that the CCS Monitoring & Oversight Initiative be delayed indefinitely and that all CHDP funds are made fully available to establish standalone HCPCFC programs.

Our organizations remain committed to working with the Legislature and Administration to ensure a seamless transition of these programs while preserving local health department staff to support the health of children and families in their communities. Thank you for your time and attention to this important matter.

Respectfully,

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cc: Honorable Members, Assembly Budget Subcommittee No. 1
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