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

SUBCOMMITTEE NO. 3 Agenda

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

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

Consultant: Scott Ogus

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0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Electronic Visit Verification Phase II Planning

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

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

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

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

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

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

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

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

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

Electronic Visit Verification Phase II Programs

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

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

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

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

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

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

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

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

The requested position equivalents are as follows:

OSI (Three position equivalents)

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

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

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

DHCS (Two position equivalents)

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

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

DDS (Three position equivalents)

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

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

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

DPH (One position equivalent)

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

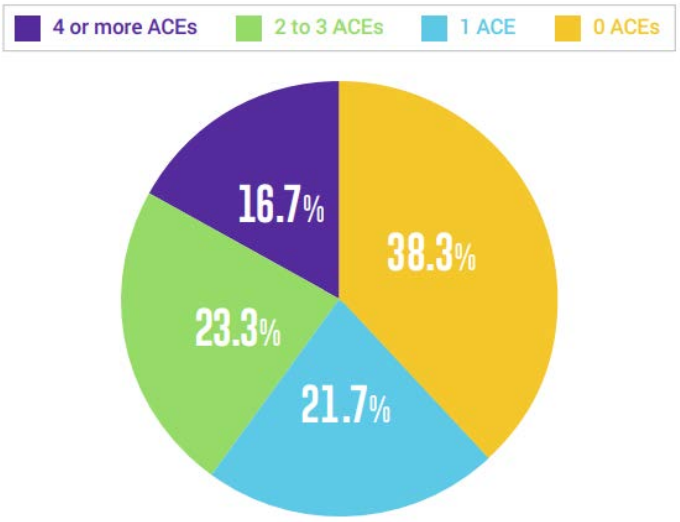
- Raising public awareness on and coordinating policies governing scientific screening and treatment for toxic stress and adverse childhood events.
- Advising the Governor, the Secretary of the California Health and Human Services Agency, and policymakers on a comprehensive approach to address health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

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

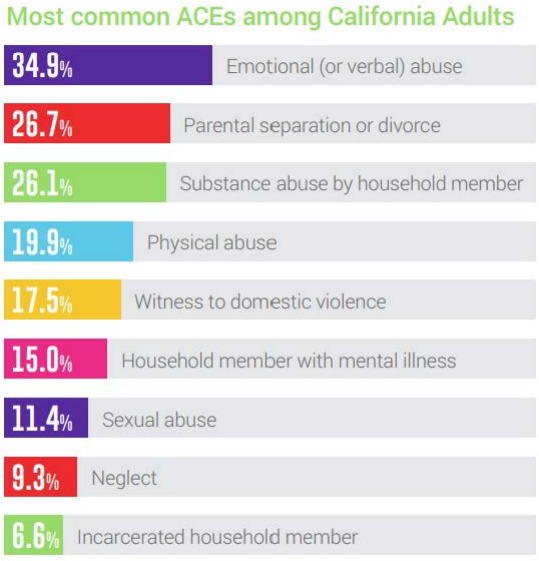
[2] Felitti V., Anda R., Nordenberg D., Williamson D., Spitz A., Edwards V., Koss M., Marks J. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Deaths in Adults". Am J Prev Med 1998;14(4) 245-258.

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

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



Prevalence of number of ACEs among California adults



Most common ACEs among California adults

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

Issue 3: Center for Data Insights and Innovation

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

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

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

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

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

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

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

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

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

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

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

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

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

	Victim Compensation Board

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

Issue 4: Office of Health Care Affordability

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

Issue 5: Proposals for Investment

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

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

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

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

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

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

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

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

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

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

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

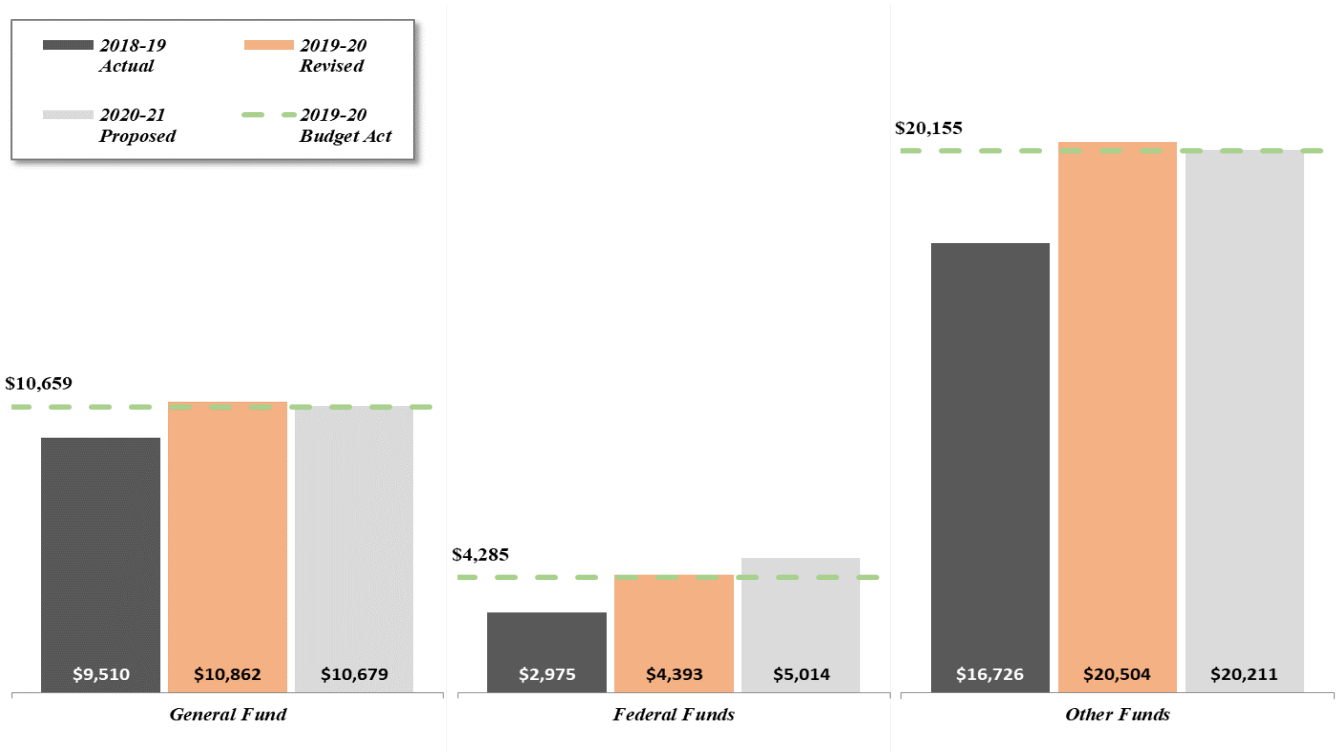
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

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

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Overview

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



(dollars in thousands)

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

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

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

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

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

Subcommittee Staff Comment. This is an informational item.

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

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

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

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

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

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

* Resources ongoing after 2021-22.

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Emergency Medical Dispatch (SB 438)

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

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

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

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

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

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

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

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

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

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

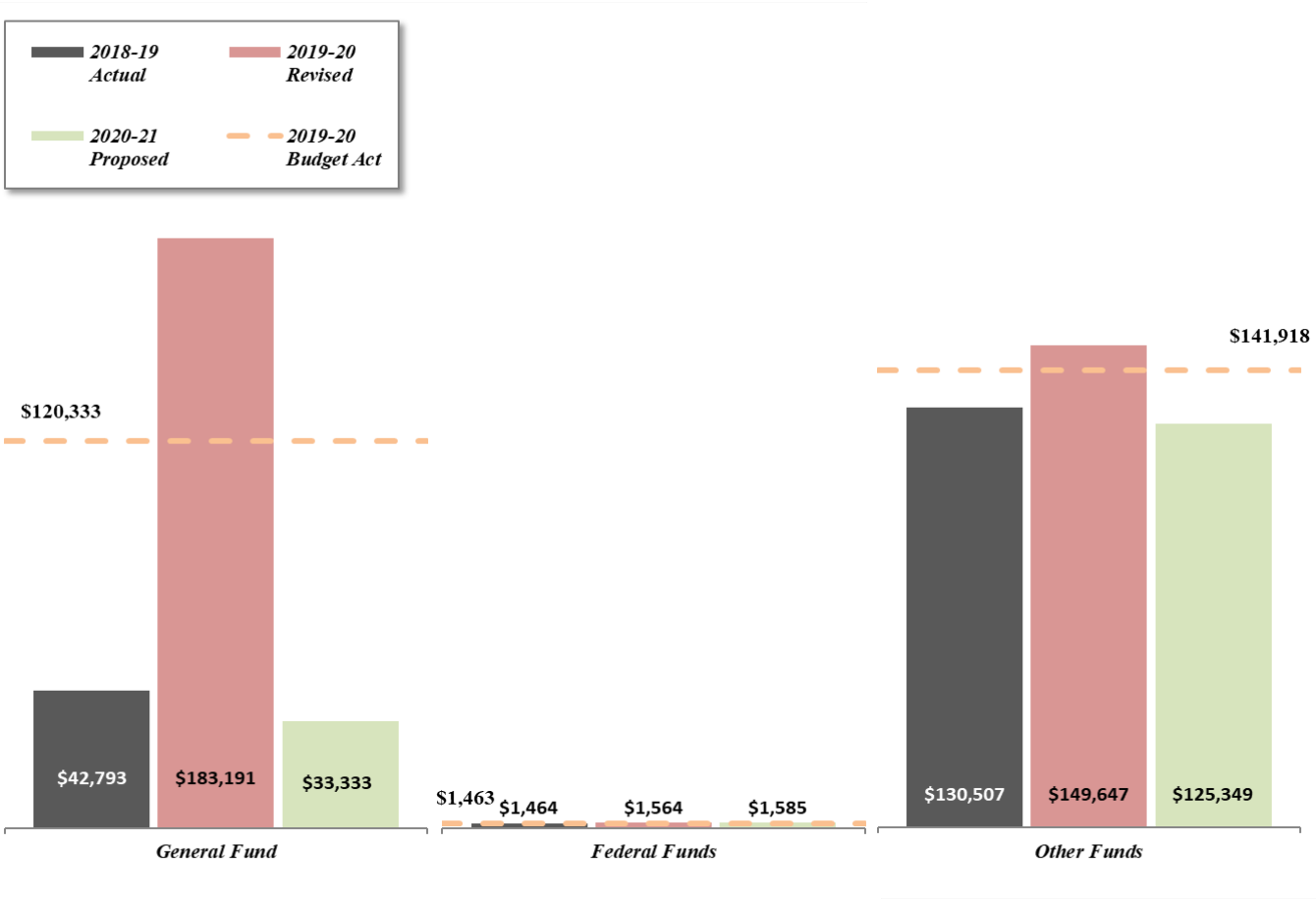
Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Overview

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Song-Brown: Teaching Health Center Awards – September 2019

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

* FM = Family Medicine, Peds = Pediatrics

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

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

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

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

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

Goals

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

Objectives

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Issue 2: County Medical Services Program Loan Repayment Administration

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

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

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

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

Figure 1. County Medical Services Program Counties

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Healthcare Data Disclosure (SB 343)

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

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

* Position and Resources ongoing after 2021-22.

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

* Positions and resources ongoing after 2021-22.

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Hospital Procurement Contracts Reporting (AB 962)

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

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

* Positions and resources ongoing after 2021-22.

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 6: Proposals for Investment

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

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

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

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

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

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

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

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

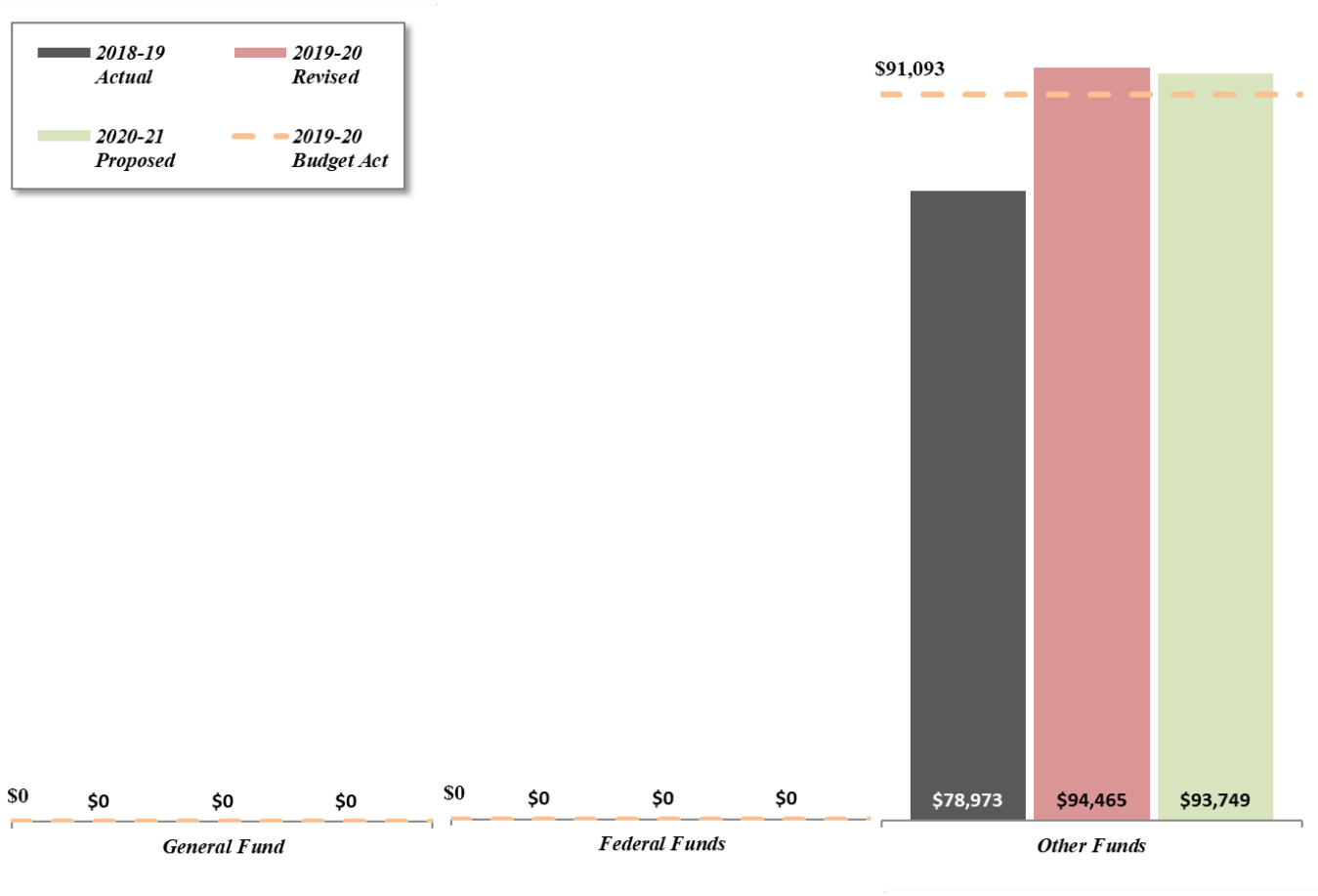
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

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

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview

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



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

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

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

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

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

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

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

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

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

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

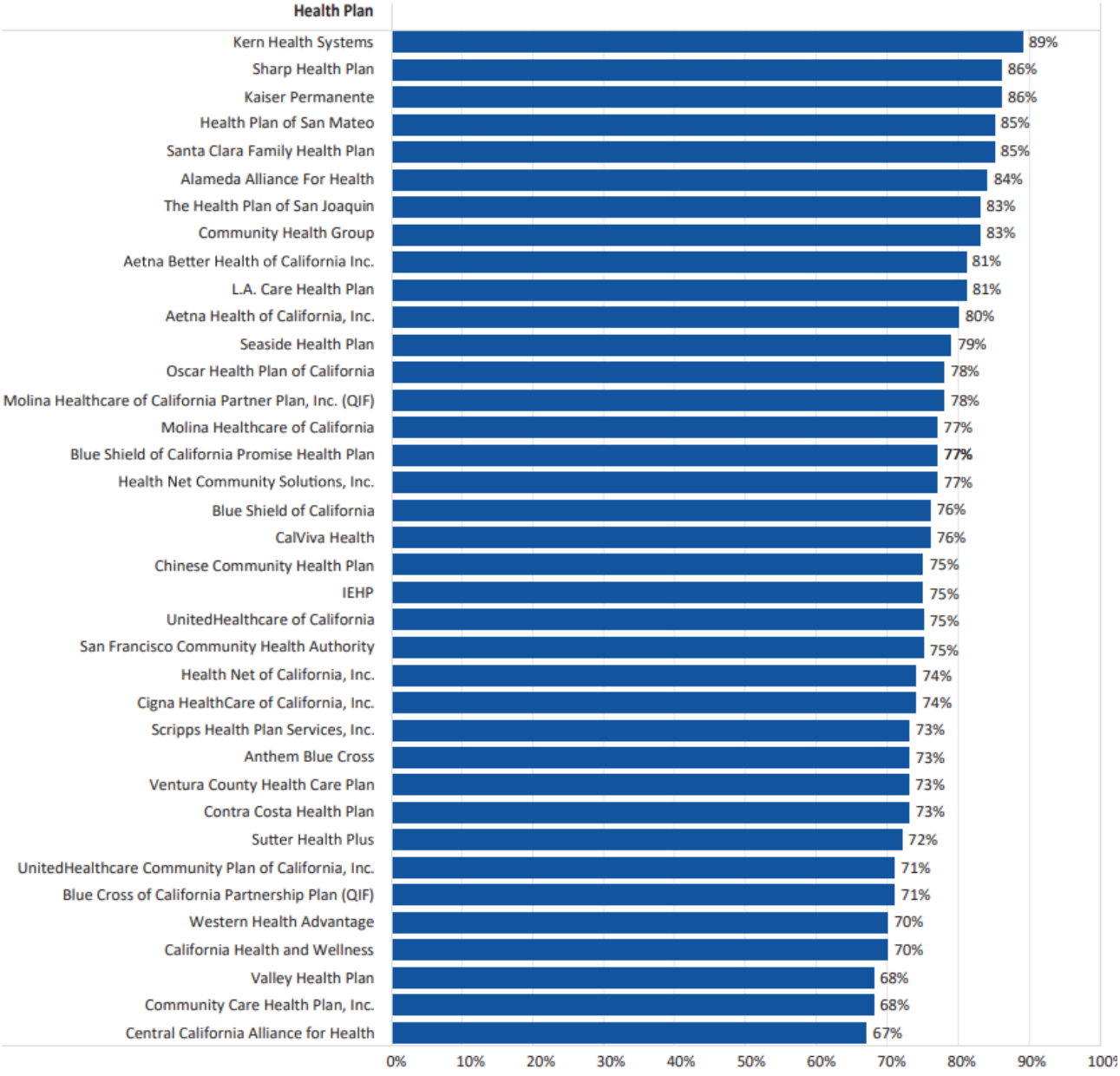
Full-Service Health Plans:

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

Behavioral Health Plans:

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

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



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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment. This is an informational item.

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

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

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

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

Issue 2: Information Security Resources

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Large Group Rate Review (AB 731)

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

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

* Positions and resources ongoing after 2021-22.

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

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

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

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

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

Office of Financial Review

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

Office of Legal Services

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

Office of Technology and Innovation

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

* Positions and resources ongoing after 2021-22.

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

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

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

Office of Financial Review

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

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

Office of Plan Licensing

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

Office of Financial Review

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

Office of Legal Services

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

Help Center

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

Office of Technology and Innovation

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

Office of Plan Licensing

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

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

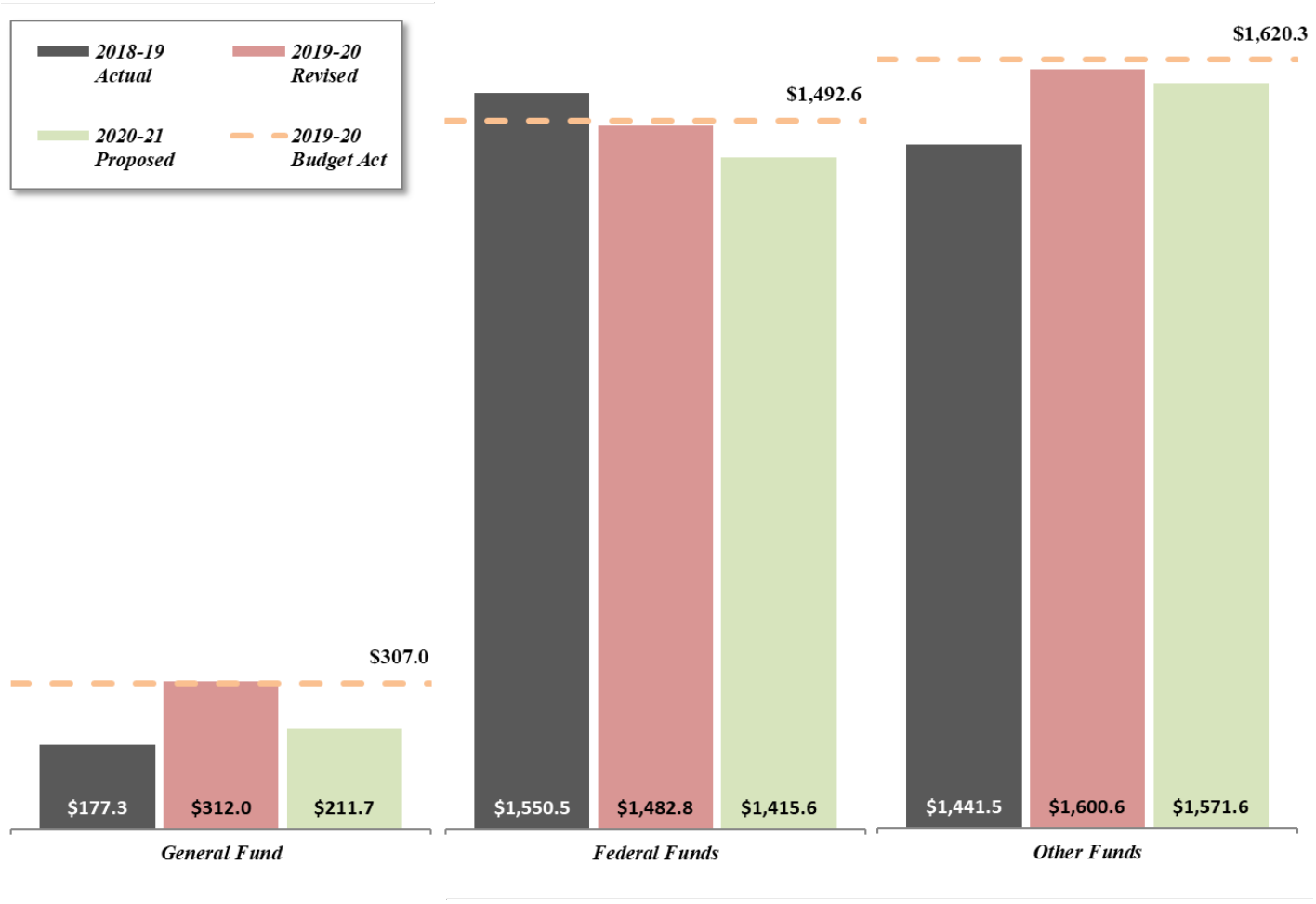
Questions. The subcommittee has requested DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Overview

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



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

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

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

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

According to DPH, their goals include the following:

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

The department is composed of seven major program areas:

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

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

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

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

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

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

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

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

Item 4265-001-0001—Department of Public Health

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

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

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

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

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

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

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

Informational Issue. The state of California, like much of the rest of the United States and the world, is responding to an outbreak of novel coronavirus (COVID-19), which causes mild-to-moderate respiratory illness with symptoms similar to the flu, including fever, cough, and shortness of breath. COVID-19 can also cause more severe respiratory illness. The California Office of Emergency Services (CalOES), DPH, and local health departments are leading the public response to the outbreak with containment and mitigation strategies to slow the spread of COVID-19 and avoid overwhelming the health care system.

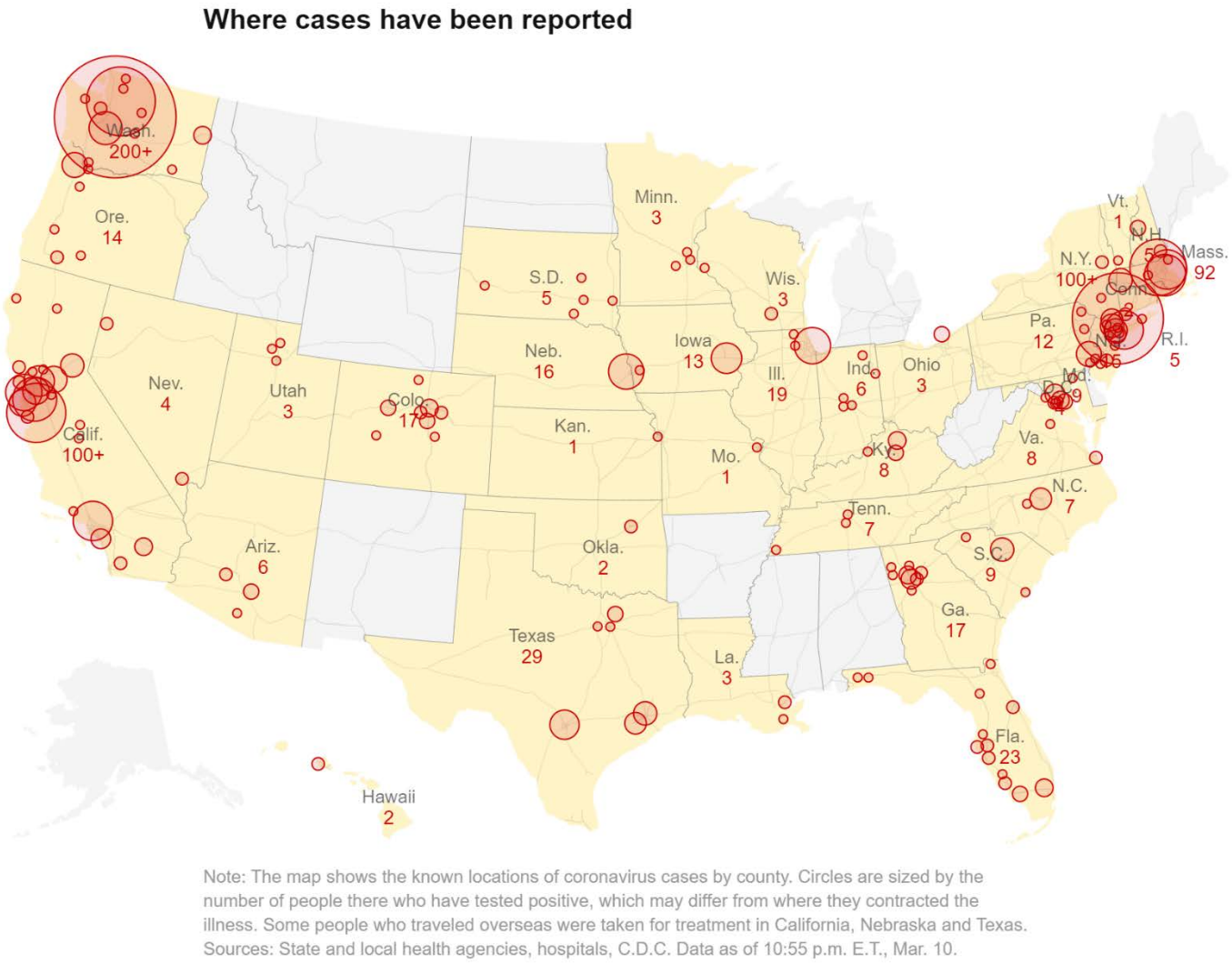
Outbreak Origin and Transmission. COVID-19 was first identified in Wuhan, Hubei Province, China. However, cases of COVID-19 have been reported in several countries internationally, including the United States. According to DPH, California is actively working with the White House, Centers for Disease Control and Prevention (CDC), local governments, health facilities, and health care providers across the state to prepare and protect Californians from COVID-19.

According to the CDC, coronaviruses are a large family of viruses that are common in people and many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with MERS-CoV and SARS-CoV.

COVID-19 is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir.

Early on, many of the patients at the epicenter of the outbreak in Wuhan had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside Hubei and in countries outside China, including in the United States. Some international destinations now have apparent community spread with the virus that causes COVID-19, as do some parts of the United States. Community spread means some people have been infected and it is not known how or where they became exposed.

Epidemiological studies of the initial stages of the outbreak in Wuhan suggest that COVID-19 may have an extremely high transmission rate for infected individuals. The initial studies estimated infected individuals transmitted COVID-19 to an average of 2.5 additional people. For reference, the equivalent transmission rate of influenza A is 1.1 to 1.5. DPH reports that, according to available international data, of those who have tested positive for COVID-19, approximately 80 percent do not exhibit symptoms that would require hospitalization.



Note: The map shows the known locations of coronavirus cases by county. Circles are sized by the number of people there who have tested positive, which may differ from where they contracted the illness. Some people who traveled overseas were taken for treatment in California, Nebraska and Texas. Sources: State and local health agencies, hospitals, C.D.C. Data as of 10:55 p.m. E.T., Mar. 10.

Current Status of Individuals Affected in California. DPH reports that, as of the morning of March 10, 2020, there are a total of 157 confirmed, positive cases in California. 24 cases are from repatriation flights, and the other 133 confirmed cases include:

- 50 travel related cases
- 30 person-to-person transmission
- 29 community transmission
- 24 cases currently under investigation
- 2 death

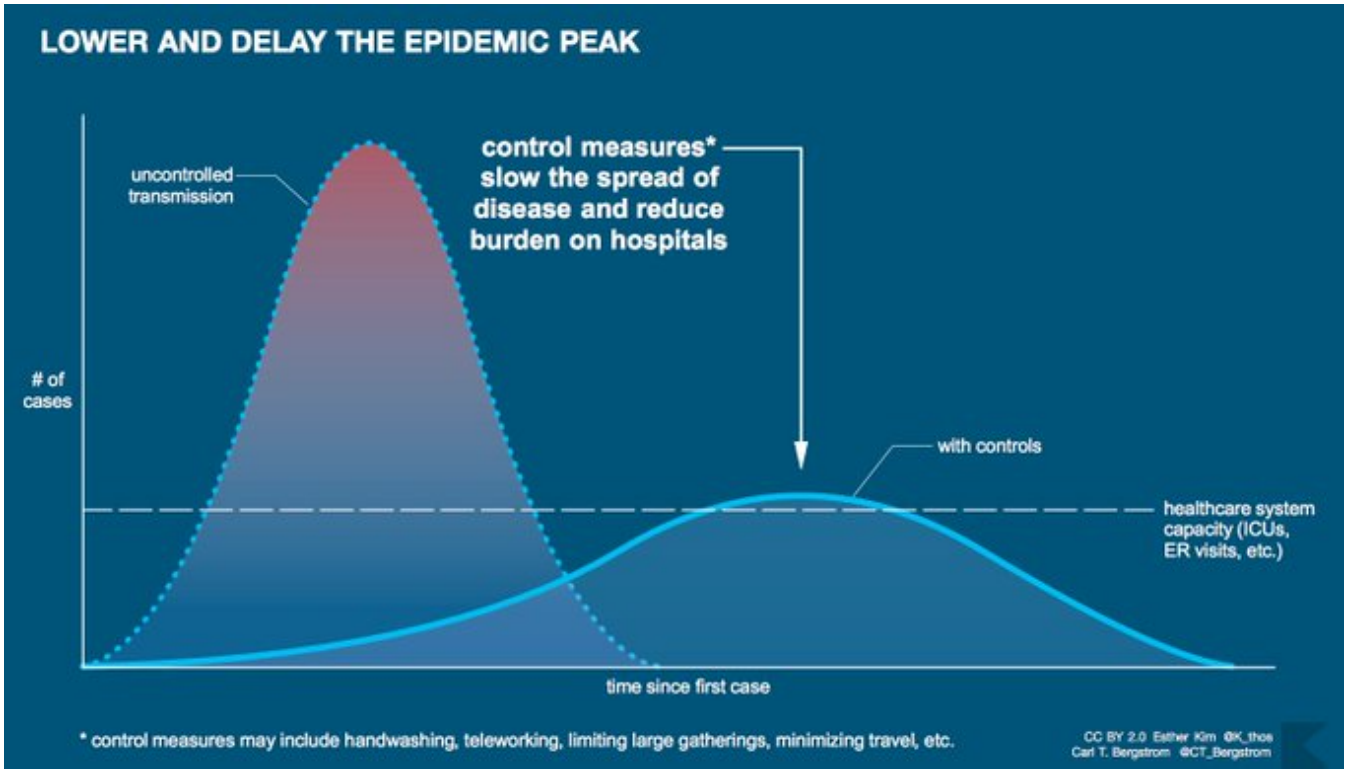
Nationwide, there have been 25 deaths reported from COVID-19, with positive cases reported in 36 states, including the District of Columbia.

More than 10,320 individuals who traveled on commercial flights through San Francisco International Airport or Los Angeles International Airport are self-monitoring across 49 local health jurisdictions. This self-monitoring is precautionary, and these individuals are not currently displaying symptoms.

22 individuals have tested positive that were aboard the Grand Princess cruise ship returning from Hawaii to San Francisco.

Status of Testing Capabilities. According to DPH, 18 public health laboratories in California are testing for COVID-19. These labs include the DPH State Laboratory in Richmond, and county public health laboratories in Alameda, Contra Costa, Humboldt, Los Angeles, Monterey, Napa-Solano-Yolo-Marin (located in Solano), Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, Santa Clara, Shasta, Sonoma, Tulare and Ventura. The Richmond Laboratory will provide diagnostic testing within a 48-hour turnaround time. More public health labs will soon be able to test for COVID-19, which will improve testing response time. Quest Laboratories is also now online and capable of processing 1,200 tests daily. DPH reports two additional commercial labs will begin testing March 24.

Containment and Mitigation Strategies. The potentially significant rate of transmission poses risks of overwhelming the health care system's capacity if a significant number of people are infected with COVID-19 simultaneously. During the initial stages of the worldwide outbreak, DPH and local health departments were conducting disease surveillance, implementing local testing, managing suspect and confirmed cases, and conducting contact tracing to track and contain the potential spread of the outbreak. With the significant incidence of community transmission of COVID-19 among individuals with no history of travel to affected regions or known contact with positive individuals, much of the state and local response has turned to mitigation, including expanded testing, encouraging hygiene, and social distancing.



DPH and the CDC currently estimates the health risk of COVID-19 to the general public remains low. DPH guidance to the general public includes the following recommendations:

1) Wash hands with soap and water
2) Avoid touching eyes, nose or mouth with unwashed hands
3) Avoid close contact with people who are sick
4) Follow guidance from public health officials
5) Individuals experiencing symptoms of COVID-19 (fever, cough, and shortness of breath) should contact their health care provider first before seeking medical care so appropriate precautions may be taken
6) Individuals experiencing symptoms of COVID-19 should stay away from work, school, or other people.

While DPH is not currently recommending the cancellation of public events, or other restrictions on public gatherings, several instances of social distancing actions have been occurring throughout the state and across the nation. For example, several California universities, including many University of California campuses, Stanford University, the University of Southern California, among others, have modified academic schedules and implemented flexibility for classes to be conducted online or remotely for the remainder of the academic term. The Elk Grove Unified School District closed its schools and accelerated its spring break to begin March 9. The state of Washington, which has also experienced a significant number of positive COVID-19 cases, announced restrictions on gatherings of more than 250 people. Certain high-profile public events, such as a management conference for the biotechnology company Biogen, have resulted in an alarming rate of transmission of COVID-19 among participants.

DPH has issued guidance on responses to the outbreak for health care facilities (hospitals and long-term care facilities), community care facilities (assisted living and child care facilities), schools and institutes of higher education, event organizers, first responders, employers, health care plans, and laboratories. DPH also has issued guidance on home, school, and child care facility cleaning for those testing positive for COVID-19.

Local Health Officers and Health Facilities COVID-19 Response Panel. The subcommittee has requested the following panelists to discuss the local health department and health facility response to the COVID-19 outbreak:

- Kat DeBurgh, Executive Director, Health Officers Association of California
- Amanda Willard, Sr Program Coord – Dental/Emergency Preparedness, CA Primary Care Association
- Carmela Coyle, President and CEO, California Hospital Association
- Jackie Bender, Vice President of Policy, CA Association of Public Hospitals and Health Systems
- Amy Blumberg, Director of Legislative Affairs, and Jason Belden, Director of Disaster Preparedness, California Association of Health Facilities

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

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

1. Please provide a brief overview of the current incidence, morbidity, and mortality statistics for COVID-19 infection in California and the United States.

2. Please provide a brief overview of the state's coordinated prevention and response activities for COVID-19.

3. What should the public expect in the coming weeks and months regarding the spread of COVID-19? How should the public prepare?

4. Is the department sufficiently resourced to respond to the spread of COVID-19? What additional resources might be needed to support prevention and response efforts?

5. Are local health jurisdictions sufficiently resourced to respond to COVID-19?

6. Has the current COVID-19 response highlighted any gaps in readiness that might help the state and DPH to prepare for the next infectious disease crisis? What would constitute an adequately resourced preparedness effort?

7. How does DPH or the state more broadly plan for the need for public health surge capacity during outbreaks such as COVID-19? What percentage of the current public health workforce is currently engaged in response to COVID-19?

The subcommittee has also requested local health officers and health facility panelists to respond to the following:

1. Local Health Officers – How are local health officials coordinating with DPH and other state entities to manage the COVID-19 outbreak? Do local health departments have any current resource needs to address the outbreak? Has the response identified any gaps in readiness or resources that should be addressed once the current outbreak is under control?

2. Hospitals/Public Hospitals/Clinics - How have your facilities/clinics been impacted by the COVID-19 outbreak? How would your facilities and clinics manage a potential surge in intensive care needs if the outbreak continues to spread rapidly? What is the capacity of the health system to respond to the outbreak? How many high-intensity cases could the health system absorb?

3. Skilled Nursing Facilities – COVID-19 appears to have a significantly higher mortality rate among seniors and unchecked transmission within skilled nursing facilities or other facilities for seniors has had catastrophic results in other states. How are skilled nursing facilities responding to the COVID-19 outbreak? What protective measures have been implemented? Is there any general guidance skilled nursing facilities are following regarding family visitors or employees of facilities?

Issue 3: Master Data Management Sustainability

Budget Issue. DPH requests ten positions and expenditure authority from the Health Statistics Special Fund of $1.5 million annually. If approved, these positions and resources would allow DPH to increase department-wide analytics for public health decision-making, to continue implementing master data management strategies, and implementation of data-driven community interventions.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0099 – Health Statistics Special Fund	$1,500,000	$1,500,000
Total Funding Request:	**$1,500,000**	**$1,500,000**
Total Requested Positions:	**10.0**	**10.0**

* Positions and Resources ongoing after 2021-22.

Background. In 2018-19, grant funding provided by an Emergency Response: Public Health Crisis Response Cooperative Agreement with the federal Centers for Disease Control and Prevention allowed DPH to establish the Analytic Services Unit (ASU) within the Center for Health Statistics and Informatics (CHSI). The ASU assists with implementation of an enterprise-level data governance structure, implementation of standard processes and procedures for master data management within DPH programs, and to provide advanced descriptive and predictive analytics services to DPH programs. The ASU consists of six positions and worked with a health information management lead within CHSI to procure advanced analytics software and actively developed a menu of analytics services DPH programs may request. According to DPH, the ASU and health information management lead have been receiving informal requests for analytics since March 2019. The federal grant that funded the ASU positions expired on November 30, 2019, and the federal Public Health and Health Services Block Grant that funds the health information management lead will expire on June 30, 2020.

The analytic services provided by the ASU and health information management lead have included various data operations. For example, the ASU provided consultation to the DPH Center for Health Communities to: 1) conduct data dictionary assessments of possible opioid-related data sources for cross-analysis; 2) collect requirements for a technical infrastructure capable of automated ingestion, integration, and cross-analysis of multiple opioid-related data sources; and 3) develop a system design blueprint for software development of a surveillance system capable of performing these automated processes. These analyses allow DPH to produce data visualizations and reports to show a more complete picture of opioid overdoses in California to support data-driven, science-based decision-making and interventions for opioid overdose prevention.

DPH also reports the addition of the ASU positions and others to its Informatics Branch within CHSI have led to increasing needs for administrative workload that are currently supported by part-time redirection of two CHSI staff members. These staff members provide training and travel coordination, timekeeping, meeting coordination, notetaking, policy analysis, and legislative analysis.

DPH requests ten positions and expenditure authority from the Health Statistics Special Fund of $1.5 million annually to allow DPH to expand provision of department-wide analytics for public health

decision-making, continue implementing master data management strategies, and implementation of data-driven community interventions. These resources would fund the following positions:

- **One Research Data Supervisor II position, two Research Data Specialist II positions,** and **one Research Data Analyst II position** would provide the analytics services to support DPH programmatic needs.
- **Three Information Technology Specialist II positions** would act as liaisons for communicating with DPH programs that include assistance with mature data collection or storage systems, data management services and implementation of data management practices. One of these positions would serve as the health information management lead.
- **One Associate Governmental Program Analyst, one Staff Services Analyst,** and **one Office Technician** would provide administrative support to the ASU and the Informatics Branch within CHSI.

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

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

1. Please provide a brief overview of this proposal.

2. Please describe some of the analytics that have been performed by the ASU for DPH programs.

3. What other programs does DPH expect to benefit from these analytics capabilities and how?

Issue 4: AIDS Drug Assistance Program (ADAP)

Background. The Office of AIDS within DPH administers the AIDS Drug Assistance Program (ADAP), which provides access to life-saving medications for Californians living with HIV and assistance with costs related to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for Californians at risk for acquiring HIV. Clients are eligible for ADAP services if they meet the following criteria:

1. are HIV infected;
2. are a resident of California;
3. are 18 years of age or older;
4. have a Modified Adjusted Gross Income that does not exceed 500 percent of the Federal Poverty Level; and
5. are not fully covered by or eligible for Medi-Cal or any other third-party payer.

ADAP Programs. ADAP provides services to its clients through support for medications, health insurance premiums and out-of-pocket costs. Participating clients generally fall into one of five categories:

1. *Medication-only clients* are people living with HIV who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals, who only receive services associated with medication costs.
2. *Medi-Cal Share of Cost clients* are persons living with HIV enrolled in Medi-Cal who have a share of cost for Medi-Cal services. ADAP covers the share of cost for medications for these clients, who only receive services associated with medication costs.
3. *Private insurance clients* are persons living with HIV who have some form of health insurance, including through Covered California, privately purchased health insurance, or employer-based health insurance and who receive services associated with medication costs, health insurance premiums and medical out-of-pocket costs.
4. *Medicare Part D clients* are persons living with HIV enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group of clients receives services associated with medication co-pays, medical out-of-pocket costs, Medicare Part D health insurance premiums, and has the option for premium assistance with Medigap supplemental insurance policies, which cover medical out-of-pocket costs.
5. *Pre-exposure prophylaxis (PrEP) clients* are individuals who are at risk for, but not infected with, HIV and have chosen to take PrEP as a way to prevent infection. For insured clients, the PrEP Assistance Program (PrEP-AP) pays for PrEP-related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's co-payment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP-related medical costs, as medication is provided free by the manufacturer's medication assistance program.

ADAP is funded by federal funds and the ADAP Rebate Fund (Fund 3080). The federal government began funding state programs to assist people living with HIV to purchase antiretroviral medications in 1987. Since 1990 with the passage of the Ryan White Comprehensive AIDS Resources Emergency Act,

now known as the Ryan White Program, the federal Health Resources and Services Administration (HRSA) provides funding to states for ADAP programs. In addition to federal funds, ADAP receives significant funding from mandatory and voluntary manufacturer rebates for ADAP drug expenditures.

ADAP Local Assistance Estimate. The November 2019 ADAP Local Assistance Estimate reflects revised 2019-20 expenditures of $431.3 million, which is a decrease of $18.2 million or four percent compared to the 2019 Budget Act. According to DPH, this decrease is primarily due to reduction in medication expenditures partially offset by an increase in private insurance medical out-of-pocket expenditures. DPH indicates these offsetting changes are partially due to the success of the Access, Adherence, and Navigation (AAN) Program transitioning medication-only clients to private insurance or Medi-Cal and partially due to projections of higher insurance premium costs that will be updated at May Revision. For 2020-21, DPH estimates ADAP expenditures of $467.5 million, an increase of $18 million or four percent compared to revised expenditures for 2019-20. According to DPH, this increase is similarly attributable to the transition of medication-only clients to private insurance or Medi-Cal and higher insurance premium cost projections.

ADAP Local Assistance Funding Summary		
Fund Source	**2019-20**	**2020-21**
0890 – Federal Trust Fund	$116,571,000	$113,259,000
3080 – AIDS Drug Assistance Program Rebate Fund	$314,709,000	$354,205,000
Total ADAP Local Assistance Funding	**$431,280,000**	**$467,464,000**

ADAP tracks caseload and expenditures by client group. DPH estimates ADAP caseload and expenditures for 2019-20 and 2020-21 will be as follows:

Caseload by Client Group	**2019-20**	**2020-21**
Medication-Only	12,307	12,580
Medi-Cal Share of Cost	107	136
Private Insurance	10,170	10,687
Medicare Part D	7,627	7,683
PrEP Assistance Program	2,412	3,542

Expenditures by Client Group	**2019-20**	**2020-21**
Medication-Only	$304,049,841	$310,204,641
Medi-Cal Share of Cost	$1,049,441	$1,180,878
Private Insurance	$87,428,538	$112,917,214
Medicare Part D	$23,457,664	$26,910,401
PrEP Assistance Program	$6,069,446	$7,868,071

In addition, enrollment costs are estimated to be $7.9 million in 2019-20 and $8.4 million in 2020-21. Beginning in 2017-18, ADAP introduced a new reimbursement methodology for enrollment sites which

includes a payment floor and variable payments dependent on new client medication enrollment, client bi-annual self-verification, client annual re-enrollment, client insurance assistance enrollment and re-enrollment, and PrEP client enrollment and re-enrollment.

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

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

1. Please provide a brief overview of the major changes to the ADAP Estimate.

Issue 5: ADAP Modified Adjusted Gross Income (MAGI) Information

Trailer Bill Language Proposal. DPH proposes trailer bill language to allow for electronic retrieval of AIDS Drug Assistance Program clients' modified adjusted gross income data from the California Franchise Tax Board.

Background. The AIDS Drug Assistance Program (ADAP) provides access to life-saving medications for Californians living with HIV and assistance with costs related to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for Californians at risk for acquiring HIV. Clients are eligible for ADAP services if they meet the following criteria:

1. are HIV infected;
2. are a resident of California;
3. are 18 years of age or older;
4. have a Modified Adjusted Gross Income that does not exceed 500 percent of the Federal Poverty Level; and
5. are not fully covered by or eligible for Medi-Cal or any other third-party payer.

Currently, ADAP receives adjusted gross income information from the Franchise Tax Board FTB under a three-year agreement. According to DPH, state law only allows FTB to provide the adjusted gross income, which does not include household data necessary to calculate modified adjusted gross income (MAGI), which forms the basis of determinations of ADAP client eligibility. DPH reports enrollment workers receive tax returns from potential clients and calculate MAGI separately, following up with FTB staff if additional calculations or information is necessary.

DPH proposes trailer bill language to amend state law to use federal definitions of "household" and "family size" and changes references from "taxpayer" to "taxpayer household". These changes would allow FTB to provide sufficient information to ADAP to determine client eligibility, streamlining data collection, reducing administrative burdens and eliminating conflicts in current law.

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

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

1. Please provide a brief overview of this trailer bill language proposal.

Issue 6: PrEP Assistance Program – 30 Day Initial Supply of PrEP and PEP Medication

Trailer Bill Language Proposal. DPH proposes trailer bill language to allow the Pre-Exposure Prophylaxis Assistance Program to pay for an initial 30-day supply of pre-exposure prophylaxis and post-exposure prophylaxis medication.

Background. AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018, authorized the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) to provide assistance with medical out-of-pocket costs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), as well as access to medications on the PrEP-AP formulary for the prevention of HIV. However, AB 1810 limited the quantiy of prescriptions as follows:

- PrEP-AP may furnish up to 14 days of PrEP and PEP medication to clients.
- PrEP-AP may furnish up to 28 days of PEP medication to clients who are victims of sexual assault.

Currently, the combination medication tenofovir disoproxil fumarate and emtricitabine, marketed under the brand name Truvada by Gilead Sciences, is the only FDA-approved medication for PrEP and is a component of the recommended PEP regimen. According to DPH, Gilead Sciences only packages Truvada in bottles containing 30 tablets, enough for a 30-day supply. The package insert specifically instructs providers to dispense only in the original container and Gilead Sciences has been explicitly instructing providers that bottles of Truvada may not be split. Due to these restrictions, DPH has experienced barriers to compliance with the 14-day and 28-day limits imposed by AB 1810 for the provision of PrEP and PEP medication to PrEP-AP clients.

DPH proposes trailer bill language to allow ADAP to furnish an initial 30-day supply of PrEP and PEP medication to PrEP-AP clients, consistent with the current packaging practices of the manufacturer. According to DPH, this change would impact approximately 400 PrEP-AP clients and would result in increased ADAP Rebate Fund costs of between $830,000 and $1.7 million annually, depending on whether the client is insured or uninsured or if they are eligible for the manufacturer's medication assistance program.

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

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

1. Please provide a brief overview of this trailer bill language proposal.

2. Is there any clinical relevance to the manufacturer guidance that bottles containing 30 tablets of Truvada not be split?

Issue 7: ADAP Enrollment System Maintenance and Operations Support

Budget Issue. DPH requests nine positions and expenditure authority from the ADAP Rebate Fund of $4.8 million annually. If approved, these positions and resources would allow DPH to support ongoing maintenance and operations of the ADAP Enrollment System, which manages eligibility determinations, enrollment, and medication access for clients of the ADAP program.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
3080 – AIDS Drug Assistance Program Rebate Fund	$4,750,000	$4,750,000
Total Funding Request:	**$4,750,000**	**$4,750,000**
Total Requested Positions:	**9.0**	**9.0**

* Positions and resources ongoing after 2021-22.

Background. Prior to July 2016, ADAP's pharmacy benefits manager (PBM) contract included both pharmaceutical and enrollment services. After the expiration of the PBM contract, the 2016 Budget Act approved contract resources to separate these functions into two contracts: a PBM contract with Magellan and a new enrollment benefits manager (EBM) contract with A.J. Boggs & Company. A.J. Boggs, under the terms of the contract, was required to provide a web-based eligibility portal that would allow local enrollment sites and other Ryan White programs to simplify enrollment and access to services. In November 2016, the enrollment portal was unexpectedly unavailable for enrollment worker and client use. DPH identified security vulnerabilities in the new system and identified two breaches of confidential client information. After the portal became unavailable, DPH took several actions to address the problems with enrollments and eligibility determinations:

- Enrollment workers were instructed to fax client applications directly to A.J. Boggs
- Eligibility was extended until the next reenrollment or recertification period after June 2017
- Paper applications were shortened to streamline the faxed application process
- DPH staff actively worked with enrollment sites, clients, and advocates to monitor problems and ensure continued access to medications and health insurance
- DPH provided semi-weekly updates on the issue with enrollment workers and stakeholders
- ADAP ceased secondary, state-level review of new applications to expedite access to medications.

DPH staff also engaged consultants at Deloitte to provide an independent assessment of the security issues and future viability of the enrollment portal.

DPH terminated its EBM vendor relationship with A.J. Boggs in March 2017, citing material breach of contract. A.J. Boggs ceased processing applications and DPH began processing applications received by fax. At the same time, DPH began implementation of a new enrollment system developed in consultation with Deloitte since the failure of the A.J. Boggs enrollment portal. DPH staff provided training and access to the new system for enrollment workers and redirected 21 staff positions from other divisions to support these efforts.

The 2018 Budget Act included 15 positions and expenditure authority from the ADAP Rebate Fund of $2.7 million annually to manage the workload of transitioning eligibility and enrollment services to the interim ADAP Enrollment System (AES) within the Office of AIDS.

The interim AES was built as a custom web-based solution with approximately 600 users, which include DPH staff and enrollment workers at approximately 193 certified enrollment sites throughout California. Working with the California Department of Technology through the Project Approval Lifecycle (PAL) Stage Gate process, DPH completed eight enhancements to the interim AES to transition the system to serve as a long-term solution for ADAP enrollment benefit management and system integration.

DPH requests nine positions and expenditure authority from the ADAP Rebate Fund of $4.8 million annually to support ongoing maintenance and operations of the permanent AES solution. Specifically, these resources would support the following positions in the following DPH divisions:

Office of AIDS

- **Two Research Scientist II positions** would manage advanced analytical and statistical work needed to integrate eligibility enrollment, clinical, demographic, and drug and service utilization, drug spend, premium payment, and out-pocket claim records; oversee development of data created from routine data exchange workflows; lead analyses of medication adherence and client health outcomes using transactional data and laboratory results; develop, implement, and monitor quality improvement metrics and projects.
- **One Health Program Specialist I position** would support non-technical programmatic functions, coordinate completion of vendor risk questionnaire and coordinate data submissions in response to federal reporting requirements.
- **Two Associate Governmental Program Analysts** would perform the following functions related to the Pre-Exposure Prophylaxis Assistance Program (PrEP-AP): 1) review and track clinical provider applications for providers and entities wanting to join the PrEP-AP networks; 2) manage contracts associated with PrEP-AP clinical provider and PrEP-AP enrollment site networks; 3) perform secondary review of PrEP-AP applications; 4) provide technical assistance to clinical providers, enrollment workers, and clients; and 5) assist in implementation and administration of recently authorized PrEP-AP service enhancements.

Information Technology Services Division

- **One Information Technology Specialist II position** would build, configure, and provide technical support for all AES servers and database environments; participate in database maintenance, change management, and documentation standards; provide oversight and technical support in the maintenance of operational data stores, data warehouse, and data marts; provide high-level technical expertise in the maintenance of business architecture, information architecture, application architecture, networking architecture, and technology architecture; and ensure enterprise and architectural requirements, strategies, standards, plans, and policies are met.
- **One Information Technology Specialist I position** would assist and facilitate maintenance to standards for applications and systems; serve as a subject matter expert and lead on application maintenance, system administration, and security; provide technical consultation to customers, staff, and management as necessary; provide recommendations regarding application or system issues in

support of strategic planning, goals, and operations; develop and revise various documents including different phases of the Software Development Life Cycle (SDLC), migration plans, task checklists, installation and configuration procedures, disaster recovery manuals, software evaluation reports, data history logs, and upgrade proposal presentations.

Office of Compliance

- **One Associate Management Auditor** and **one Staff Services Management Auditor** would ensure compliance with contract requirements, state and federal laws, federal Health Resources and Services Administration programmatic, fiscal, and monitoring requirements, and assist in maintaining fiscal integrity.

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

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

1. Please provide a brief overview of this proposal.

Issue 8: Immunization Medical Exemption Program

Budget Issue. DPH requests 15 positions and General Fund expenditure authority of $3.4 million in 2020-21, and $3.1 million annually thereafter. If approved, these positions and resources would allow DPH to standardize processes for immunization medical exemption requests and build new capacity into the California Immunization Registry.

Program Funding Request Summary		
Fund Source	**2020-21**	**2021-22***
0001 – General Fund	$3,400,000	$3,100,000
Total Funding Request:	**$3,400,000**	**$3,100,000**
Total Requested Positions:	**15.0**	**15.0**

* Positions and resources ongoing after 2020-21.

Background. Health and Safety Code Section 120372 requires DPH to develop, by January 1, 2021, a standardized medical exemption form to be used statewide by physicians and surgeons for a child for whom a physician does not recommend immunization. The form, which must be transmitted electronically to the California Immunization Registry (CAIR), must include physician contact information, child and parents' names, a statement certifying physical examination of the child, and a description of the medical reason for which the exemption is required. DPH is required to establish a system to monitor immunization rates at schools and institutions, review these rates annually, and review medical exemptions for any schools or institutions with immunization rates of less than 95 percent, schools or institutions that do not report, or of physicians who have submitted five or more medical exemptions in a calendar year. If medical exemptions do not meet applicable Centers for Disease Control, Advisory Committee on Immunization Practices, or American Academy of Pediatrics criteria, or are found to be otherwise invalid, the State Public Health Officer or designee must review and may revoke the exemptions. Parents may appeal an exemption revocation to the Secretary of the California Health and Human Services Agency. DPH is also required to report physicians that meet certain criteria to the medical licensing boards of California.

DPH requests 15 positions and General Fund expenditure authority of $3.4 million in 2020-21, and $3.1 million annually thereafter to implement standardized medical exemption electronic reporting to the CAIR, monitoring of immunization rates and review of provider medical exemption requests, manage the medical exemption appeals process, and reporting of providers to medical licensing boards. Specifically, these resources would support the following staff and consulting services:

- **Database Development** – **Two Information Technology Technicians** would build functionality into CAIR to support the online submission of medical exemption requests, develop and test these functionality enhancements, manage ongoing maintenance and operations, and train new and existing users on the new functionality.
- **Medical Exemption Review – One Public Health Medical Officer III-Supervisor, two Public Health Medical Officer III,** and **two Nurse Consultant III Specialists** would provide first-level review of medical exemption requests that meet the review criteria, as well as additional review of more complex requests and second-level review of denied exemption requests. According to DPH, first-level review would be required for 9,468 exemptions, 947 exemptions would exhibit sufficient

complexity to require additional review, approximately 4,000 denied exemption requests would require second-level review, with approximately 1,000 requiring final review by the expert review panel.

- **Medical Exemption Review Support - Two Associate Governmental Program Analysts** would support clinical staff within DPH in reviewing medical exemptions submitted to CAIR for any schools or childcare institutions with immunization rates less than 95 percent or who do not report, or of physicians who have submitted five or more medical exemptions in a calendar year.
- **Program Activities - Three Office Technicians, one Research Scientist III, and one Staff Services Analyst** would serve as liaisons with other state agencies and stakeholders; provide consultation on development of and updates to the exemption form; provide technical assistance to physicians, local health departments, schools, and childcare facilities; develop a communications plan, educational materials, and a training module on how to complete the exemption process; respond to inquiries about the exemption requirements; track the status of exemptions under review; send communications about revocations to parents, schools, childcare facilities, medical licensing boards, issuing physicians, and local health officers; analyze exemption data; and prepare ad hoc reports regarding the program and exemption rates and trends.
- **Legal Support – One Attorney III position** would provide support for legal challenges to the new review requirements, consult with legal staff on issues related to protection of health information for children with exemptions, public-facing program materials, and program procedures and guidelines.
- **Medical Consultants** – UC Davis would provide consulting services of $10,000 annually to provide medical expertise regarding immunization contraindications and precautions.
- **Expert Review Panel Consultants** – Three medical consultants at a cost of $507,200 annually would support the expert review panel, which would meet at designated times each year to review revoked exemptions under appeal. Costs would support the consultants, travel, and other support costs.

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

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

1. Please provide a brief overview of this proposal.

Issue 9: Proposals for Investment

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

End the Epidemics Coalition Proposals. The End the Epidemics Coalition has proposed the following seven investments in ending the epidemics of human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexually transmitted diseases (STDs):

- Master Plan on HIV, HCV, and STDs – The End the Epidemics coalition requests General Fund expenditure authority of $2 million one-time for the Secretary of Health and Human Services and the Chief of the Office of AIDS to develop a Master Plan on HIV, HCV, and STDs. This proposal would provide HHS and OA with resources to convene a stakeholder advisory committee and work with relevant state agencies to set targets for ending the HIV, HCV, and STD epidemics and identify recommended programs, policies, strategies, and funding for achieving these targets. This proposal is consistent with SB 859 (Wiener).
- Increase ADAP Eligibility Levels – The End the Epidemics coalition requests expenditure authority from the ADAP Rebate Fund to increase ADAP and PrEP-AP eligibility from 500 percent to 600 percent of the federal poverty level to align with the new state subsidies for individuals enrolled in Covered California. ADAP rebates can be used to fund this increased eligibility limit. This proposal would be implemented by the Office of AIDS.
- Expand Family PACT Eligibility to Address Rising STD Rates – The End the Epidemics coalition is requesting an ongoing General Fund expenditure authority of $12 million to support policy changes outlined in SB 885 (Pan) to expand access to sexually transmitted disease (STD) services covered by the Family Planning, Access, Care, and Treatment program (Family PACT) to help address California's STD public health crisis. Family PACT already covers STD services for low-income and uninsured Californians, but only within the context of a family planning visit. Individuals not at risk for experiencing or causing an unintended pregnancy – including many LGBT patients – are currently forced to pay out of pocket for STD services, or forgo care – fueling rising STD rates.
- Hepatitis C Prevention, Linkage to and Retention in Care Services – The End the Epidemics Coalition is requesting ongoing General Fund expenditure authority of $15 million for HCV prevention, linkage to and retention in care services, with a focus on those at greatest risk, people who are using drugs. California has invested in the relatively inexpensive, simple, tolerable and extremely effective HCV cure, ensuring that most who need it will get the medication if they know their status and can navigate their health care systems or services. However, the state has provided very little to fund the prevention and linkage services that are necessary to address the barriers faced by most people living with and at risk of HCV, including stigma, homelessness, drug use, mental health challenges and other social determinants. As a result, the HCV epidemic is growing at alarming rates in California, particularly among young people.
- HIV Prevention Funding – The End the Epidemics coalition requests ongoing General Fund expenditure authority of $15 million to address HIV health inequities, particularly among communities of color. While new HIV cases declined roughly 9 percent from 2014 to 2018, progress has been uneven and Black and Latinx communities remain disproportionally impacted by the epidemic. The proposed funding would support biomedical and structural interventions to improve HIV health outcomes among the state's most underserved residents, particularly Black and Latinx people living

with and vulnerable to HIV. Funding would be distributed by the Office of AIDS through a competitive grant process to local health jurisdictions and community-based organizations.

- Addressing the STD Public Health Crisis – The End the Epidemics coalition is requesting an additional ongoing General Fund investment of $3 million – for a total of $10 million for the Department of Public Health's STD Control Branch to dispense throughout the state to support a comprehensive, evidence-informed approach to STD prevention and improve the capacity of local health jurisdictions to address rising STD rates in their region. Funding would be prioritized to serve communities disproportionately impacted by STDs, and would be distributed through a competitive grant process to local health jurisdictions (LHJs). Once the funds are received, LJHs would be required to sub-grant out at least 50 percent of the funding to community-based organizations.
- Increase Investment in the California Supply Clearinghouse – In order to reduce the rate of overdose deaths, as well as rates of HIV and viral hepatitis among people who inject drugs, the End the Epidemics Coalition respectfully urges the Legislature to increase the annual budget for the State Office of AIDS Syringe Exchange Supply Clearinghouse from the current $3 million to $8 million per year. This change is urgently needed to meet the rapid expansion of programs, and the increased number of people seeking assistance to prevent fatal overdose and the transmission of potentially deadly infections. These funds would provide hundreds of thousands of Californians with the tools they need to protect themselves and their families.

Sexually Transmitted Disease (STD) Navigators. The County Health Executives Association of California requests General Fund expenditure authority of $20 million annually to be allocated to all 61 local health departments to provide services to 1) individuals who are experiencing reinfections of syphilis, chlamydia, and gonorrhea; 2) individuals who are diagnosed with more than two STDs at the same time; and 3) individuals diagnosed with HIV and STDs. The services would include the following:

1) Assess the health and social needs of the client.
2) Identify and resolve client risk factors and obstacles to care.
3) Establish routine contact with clients, including those who may be difficult to locate.
4) Coordinating referrals and connections to address health and social needs, including behavioral health services, housing, homelessness assistance, and harm reduction counseling and services.
5) Ensure clients receive care and follow-up in a timely manner including follow-up with primary care providers.
6) Provide outreach and navigation services to the client's sexual partners.
7) Routine follow-up education and access to prevention and screening services.

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

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