Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Susan Talamantes Eggman, Ph.D., Chair
Senator Melissa Melendez
Senator Richard Pan, M.D.

Thursday, February 3, 2022
1:00 pm
State Capitol – Room 4203

Consultant: Scott Ogus

Item **Department** **Page**

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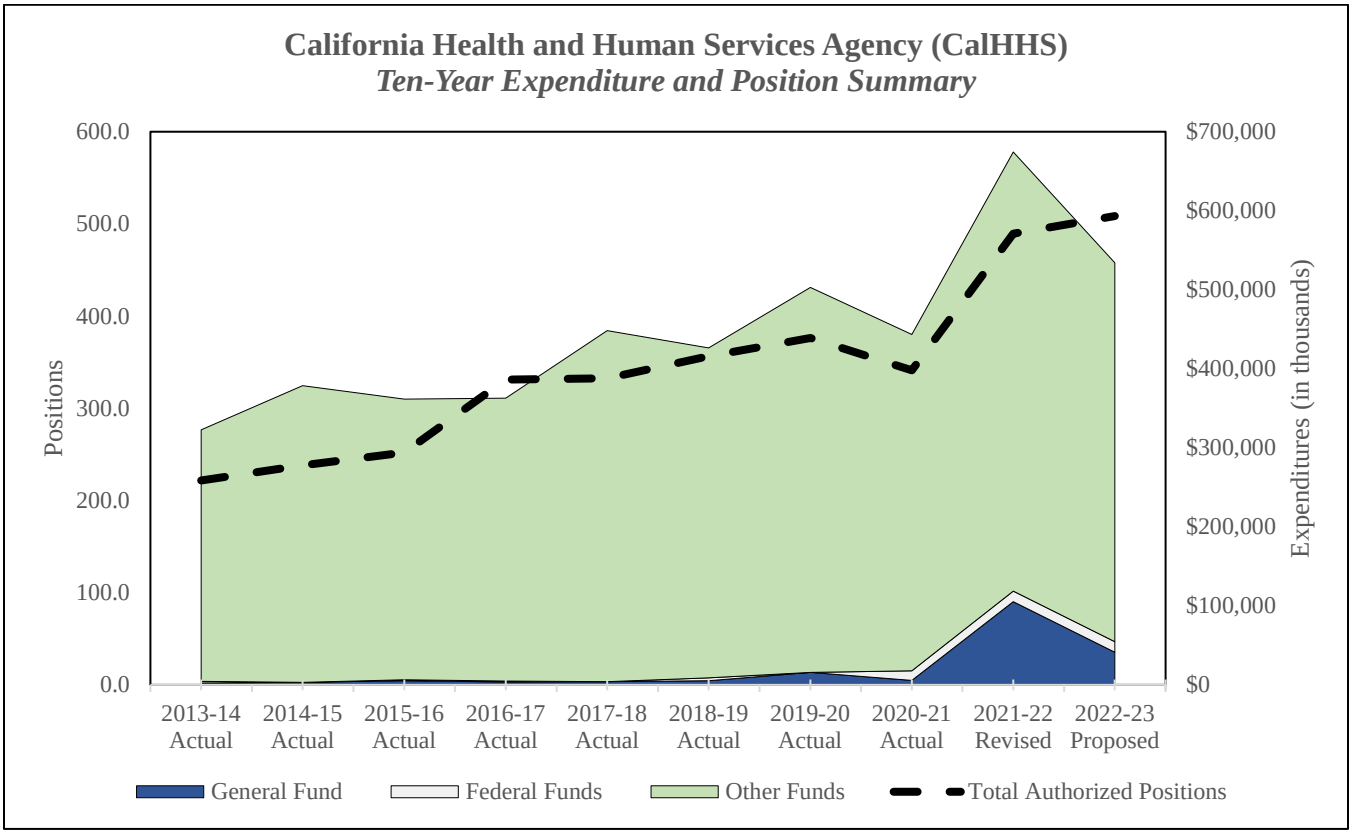
0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Overview



California Health and Human Services Agency- *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2020-21 Actual**	***2021-22 Budget Act***	***2021-22 Revised***	***2022-23 Proposed***
General Fund	$5,628	$22,493	$105,254	$41,202
Federal Funds	$12,236	$13,415	$13,415	$13,446
Other Funds	$425,728	$488,472	$555,674	$479,480
Total Department Funding:	**$443,592**	**$524,380**	**$674,343**	**$534,128**
Total Authorized Positions:	**341.3**	**376.7**	**489.5**	**508.5**
Other Funds Detail:				
Reimbursements (0995)	*$5,050*	*$4,131*	*$4,978*	*$4,185*
Office of Patient Advocate Trust Fund (3209)	*$1,971*	*$2,205*	*$2,236*	*$2,231*
Data Insights and Innovation Fund (3377)	*$0*	*$443*	*$443*	*$443*
Central Service Cost Recovery Fund (9740)	*$5,105*	*$5,105*	*$5,135*	*$2,894*
California HHS Automation Fund (9745)	*$413,602*	*$476,588*	*$542,882*	*$469,727*

Background. The California Health and Human Services Agency (CalHHS) oversees twelve departments and five offices 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. CalHHS is administered by a cabinet-level Secretary of Health and Human Services, appointed by the Governor and confirmed by the California State Senate. According to CalHHS, its primary mission is to provide policy leadership and direction to the departments, boards, and programs it oversees, to reduce duplication and fragmentation among departments in policy development and implementation, to improve coordination among departments on common programs, to ensure programmatic integrity, and to advance the Governor's priorities on health and human services issues.

The departments and other entities within CalHHS include:

- Department of Aging (CDA)
- Department of Public Health (DPH)
- Department of Child Support Services (DCSS)
- Department of Community Services and Development (CSD)
- Department of Developmental Services (DDS)
- Emergency Medical Services Authority (EMSA)
- Department of Health Care Services (DHCS)
- Department of Managed Health Care (DMHC)
- Department of State Hospitals (DSH)
- Department of Rehabilitation (DOR)
- Department of Social Services (DSS)
- Department of Health Care Access and Information (HCAI)

Within CalHHS there are several other entities administered by appointed commissions or governing boards, including:

- State Council on Developmental Disabilities
- Commission on Aging
- California Senior Legislature
- California Children and Families Commission
- California Health Benefit Exchange (Covered California)
- State Independent Living Council

CalHHS also oversees the allocation of funds to local governments under 1991 and 2011 State-Local Realignment.

Within the organizational structure of CalHHS are five offices and the Center for Data Insights and Innovation.

Office of the Secretary of Health and Human Services. The Office of the Secretary formulates and coordinates policy among the Agency's departments, and communicates with the Legislature, stakeholders, and the public about issues relating to the state's health and human services programs. The Office of the Secretary is composed of six distinct offices or units, including:

- Office of Legislative Affairs – The Office of Legislative Affairs provides coordination, oversight, and management of proposed legislation and ensures the Administration's legislative priorities are developed and implemented. The office provides policy guidance, instruction, and direction to health and human services departments and entities, and coordinates with the Governor's Office on legislative positions.
- Office of External Affairs – The Office of External Affairs manages ongoing public information and public affairs functions and provides guidance and direction to public information officers in health and human services departments and entities. The office serves as the official Agency spokesperson to respond to media inquiries, and coordinates with the Governor's Office communication staff on significant and sensitive media issues.
- Office of the Agency General Counsel – The Office of the Agency General Counsel provides legal counsel to the Office of the Secretary and senior Agency staff, coordinates with the Governor's Office of Legal Affairs and with the Chief Counsels in health and human services departments and entities.
- Office of Program and Fiscal Affairs – The Office of Program and Fiscal Affairs is responsible for formulating, analyzing, revising, and evaluating the program and fiscal impacts of major health and human services policies of the Administration. This work includes assessment of all policy, legislative, fiscal, and other issues that have implications among health and human services departments and agencies, as well as other state agencies.
- Administration Unit – The Administration Unit manages personnel, human resources, training, and internal budget issues.
- Office of the Agency Information Officer – The Office of the Agency Information Officer supports health and human services departments and entities to successfully deliver data and technology solutions through portfolio support, enterprise architecture, information security, agency governance, and horizontal integration activities.
- Office of Policy and Strategic Planning – The Office of Policy and Strategic Planning is responsible for driving measurable outcomes on CalHHS guiding principles and strategic priorities through system alignment and program integration across the agency's departments and offices. The Office works on a set of initiatives to advance equity, address the social determinants of health, and ensure a whole person approach.

Office of Systems Integration (OSI). The Office of Systems Integration (OSI) procures, manages, and delivers technology systems that support the delivery of health and human services to Californians. OSI manages a portfolio of large, complex information technology (IT) projects, providing project management, oversight, procurement, and support services for these projects and coordinating communication, collaboration, and decision-making among project stakeholders and program sponsors. After the procurement phase, OSI oversees the design, development, governance, and implementation of IT systems that support the administration of health and human services programs in California.

Office of the Surgeon General (OSG). The Office of the Surgeon General (OSG) was established in 2019 to advise the Governor, serve as a leading spokesperson on matters of public health, and drive solutions to the state's most pressing public health challenges. The OSG, led by California's first Surgeon General, Dr. Nadine Burke Harris, has established early childhood, health equity, adverse childhood experiences (ACEs), and toxic stress as key priorities. The Surgeon General has set a goal to reduce ACEs and toxic stress by half in one generation.

Office of Law Enforcement Support (OLES). The Office of Law Enforcement Support (OLES) was established in 2014 to provide monitoring and oversight of law enforcement personnel serving in the Office of Protective Services at DSH and DDS. OLES develops training protocols, policies, and procedures for law enforcement officers operating at DSH and DDS, and investigates incidents involving law enforcement personnel at state hospitals or developmental centers.

Office of Youth and Community Restoration (OYCR). The Office of Youth and Community Restoration (OYCR) supports the transition of justice involved youth being served in local communities by promoting a youth continuum of services that are trauma responsive and culturally informed, using public health approaches that support positive youth development, building the capacity of community-based approaches, and reducing the justice involvement of youth. The OYCR also assesses the efficacy of local programs, provides technical assistance and support, reviews local Juvenile Justice Realignment Grants, fulfills statutory obligations of an Ombudsperson, and develops policy recommendations.

Center for Data Insights and Innovation (CDII). The Center for Data Insights and Innovation (CDII) was established in 2021 to advance CalHHS data initiatives and help turn data into insights, knowledge, and action. The Center combines functions from the previous Office of Health Information Integrity (CalOHII), Committee for the Protection of Human Subjects (CPHS), Office of the Patient Advocate (OPA), and Office of Innovation. These functions include ensuring state department compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other related state and federal privacy laws, health plan and medical group report cards evaluating health care quality and the patient experience, and reporting on health care consumer and patient assistance centers by state agencies (Department of Managed Health Care, Medi-Cal, Department of Insurance, and Covered California). CDII also administers the CalHHS Open Data Portal, which provides public access to non-confidential health and human services data.

2021 BUDGET ACT INVESTMENTS – IMPLEMENTATION UPDATES

The 2021 Budget Act included several important investments in the CalHHS budget. The subcommittee is monitoring implementation of the following investments:

Children and Youth Behavioral Health Initiative – Statewide Coordination and Oversight. The 2021 Budget Act included expenditure authority of $1.4 billion ($1 billion General Fund, $100 million Coronavirus Fiscal Recovery Fund or CFRF, $222 million federal funds, and $105 million Mental Health Services Fund) in 2021-22, $1.3 billion ($769.2 million General Fund, $429 million CFRF, and $124 million federal funds) in 2022-23, $275.2 million ($175.2 million General Fund and $100 million federal funds) in 2023-24, $262.1 million ($156.1 million General Fund and $106 million federal funds) in 2024-25, and $227.1 million ($121.1 million General Fund and $106 million federal funds) in 2025-26, to support the Children and Youth Behavioral Health Initiative and other interventions to support behavioral health services for students. The total investment over five years is $3.5 billion and includes the following components for implementation by CalHHS:

- *Coordination, Subject Matter Expertise, and Evaluation.* $10 million General Fund in 2021-22, $20 million General Fund in 2022-23, $10 million General Fund in 2024-25, and $10 million General Fund in 2025-26 for the California Health and Human Services Agency (CalHHS) for coordination, subject matter expertise, and evaluation of the initiative.

- *ACEs and Toxic Stress Awareness Campaign.* $25.1 million General Fund in 2021-22 and $100,000 General Fund in 2022-23 through 2025-26 for the Office of the Surgeon General (OSG) to conduct a public education campaign to raise awareness about prevention, signs, and self-care strategies for adverse childhood experiences (ACEs) and toxic stress.

Implementation Updates

- *Coordination, Subject Matter Expertise, and Evaluation.* On October 26, 2021, the Governor appointed Melissa Stafford Jones as the Director of the Children and Youth Behavioral Health Initiative at CalHHS. The Director will also be supported by an Assistant Secretary for the initiative. CalHHS reports it has accomplished the following activities in support of the initiative over the past three months:
  - Drafted an initial governance model for the initiative.
  - Drafted an initial landscape analysis focused on state children and youth behavioral health efforts.
  - Launched initial input gathering across several types of stakeholders, including education partners and youth. These efforts have included listening sessions, digital diaries, engagement in selected working sessions, and youth engagement expert interviews.
  - Released an initiative program brief, and drafted additional standard communications materials.
  - Shared initiative priorities and five-year milestones with the CalHHS Behavioral Health Task Force.
  - Drafted scope of work and explored procurement of external subject matter expertise for strategic communications, marketing, and landscape analysis.

- *Aces and Toxic Stress Awareness Campaign.* According to CalHHS, the Office of the Surgeon General has promoted the initiative via multiple media outlets, podcasts, and presentations to stakeholder groups.

Equity and Language Access Proposals. The 2021 Budget Act included several investments to achieve more equitable outcomes in health and human services programs. These initiatives were as follows:

- *Equity Dashboard.* The 2021 Budget Act included three positions and General Fund expenditure authority of $3.2 million in 2021-22 and $1.1 million annually thereafter for CalHHS; and five positions and expenditure authority of $967,000 ($484,000 General Fund and $483,000 federal funds) in 2021-22 and $922,000 ($461,000 General Fund and $461,000 federal funds) annually thereafter for DHCS, to develop and release an equity dashboard to better understand disparities among programs and services in health and human services departments and entities. The dashboard will be part of CalHHS' Open Data Portal and will identify data gaps by race, ethnicity, sexual orientation, and gender identity.

- *Workforce Equity Training.* The 2021 Budget Act included General Fund expenditure authority of $2.5 million in 2021-22 and 2022-23 to expand training opportunities in health and human services departments and other entities to identify and eliminate barriers to an inclusive, just and sustainable society. Staff will receive racial equity training to ensure state programs and services are respectful and mindful of the communities being served.

- *Language Access Resources.* The 2021 Budget Act included General Fund expenditure authority of $307,000 in 2021-22 and 2022-23 to develop and implement an agency-wide language access policy and protocol framework that considers legal compliance; operational aspects of translation and interpretation; bilingual staff testing, classification, and related human resources requirements; and engagement with community stakeholders and partners.

- *Language Access Services.* The 2021 Budget Act included General Fund expenditure authority of $20 million, available until June 30, 2024, for activities to improve and deliver language access services in health and human services program. Prior to expenditure of these funds, CalHHS is required to complete a language access framework and a report to the Legislature detailing the framework components and how these additional resources will be utilized in health and human services departments to support language access planning and implementation.

- *Post-COVID Equity Analysis.* The 2021 Budget Act included one position and General Fund expenditure authority of $1.7 million in 2021-22 and $154,000 annually thereafter to conduct a retrospective analysis of the intersection of the COVID-19 pandemic and health disparities and inequities.

Implementation Updates

- *Language Access Framework.* On August 31, 2021, CalHHS submitted its Language Access Framework and Spending Plan Report. The report indicates CalHHS will adopt a Language Access Policy that applies to CalHHS departments and offices and will consider the following:

    - The ability to translate and/or adapt vital documents intended for statewide use into the top 15 to 20 languages spoken by Californians with limited English proficiency.
    - The provision of essential website content intended for a statewide audience in the top 15 to 20 languages and American Sign Language.
    - The provision of free oral and sign language interpretation services upon request for all public contacts.
    - The process of noticing to the public of the availability of free language assistance services.
    - The development of department-level language assistance plans that address federal and state language access requirements, including guidance under Title VI of the Civil Rights Act of 1964 and the requirements of the Dymally-Alatorre Bilingual Services Act.
    - Permanent establishment of the agency's Language Access Work Group, composed of representatives from CalHHS departments and offices, as a standing internal work group to further engage on language access policy and process development.
    - Participation in the statewide Language Access Task Force co-chaired by the Department of Human Resources (CalHR) and the Department of Social Services (DSS).
    - Review of available data on languages spoken by limited English proficiency Californians to generate a list of threshold languages for vital document and essential website content translation and adaptation.
    - Facilitate streamlining of interpretation and translation/adaptation functions currently housed within CalHHS departments or offices.
    - Continue to explore how state and federal laws and regulations align to promote policies and practices that ensure language access.

- *Language Access Services – Spending Plan.* In its Language Access Framework and Spending Plan Report, CalHHS also indicated how it intends to allocate the $20 million included in the 2021 Budget Act to improve language access. CalHHS will transfer the majority of these funds to the Department of Social Services to lead agency-wide implementation of the Framework. $2.9 million will be spent in 2021-22, and $8.6 million in 2022-23 and 2023-24. DSS will continue to lead the Language Access Work Group and will establish 22 positions to coordinate language access activities, with 20 at DSS and one each at DPH and DHCS. These positions will do the following:

  - **One Attorney III** position will provide legal support and advice to CalHHS and DSS on language access issues, including the interplay of federal and state legal and regulatory frameworks, rulemaking, and contracting requirements.
  - **One Staff Services Manager (SSM) II** position will oversee translation and adaptation functions to support expanded translation and adaptation capacity and quality control available to all CalHHS departments.
  - **One SSM II** position will serve as CalHHS Language Access Coordinator, leading the Language Access Work Group and the development, adoption, implementation, and monitoring of the CalHHS Language Access Policy. The position would also coordinate agency-level stakeholder engagement, and supervise and coordinate the work of department-level Language Access Coordinators.
  - **Three SSM I Specialist** positions will serve as the Language Access Coordinators for the three largest CalHHS departments (DSS, DHCS, and DPH). These coordinators will lead development and oversee implementation of each department's Language Assistance Plan, including collaborating with programs to identify vital documents and website content for translation and adaptation, as well as points of public contact in need of oral and sign language interpretation services, and periodic program-specific language needs assessments.
  - **Two SSM I Specialist** positions will serve as Language Access Coordinators for small- and medium-sized CalHHS departments, providing coordination and technical assistance to support the development and implementation of department-level Language Assistance Plans.
  - **Two SSM I** positions will oversee an additional translation and adaptation unit and an interpretation unit within DSS, creating added capacity to be made available to other CalHHS departments.
  - **Five Associate Governmental Program Analysts (AGPAs)** will serve as translators and translation/adaptation contract liaisons, adding capacity and enhancing quality of translated or adapted materials for CalHHS departments.
  - **Four AGPAs** will serve as Spanish language and ASL interpreters, providing interpretation for CalHHS departments' stakeholder meetings and other public events, and coordinate provision of contract interpreters.
  - **One AGPA** will serve as a contract analyst, expanding administrative capacity of DSS to request bids, execute, and manage consolidated agency-wide language services vendor contracts.
  - **One Office Technician** will provide administrative and clerical support.
  - **One Accounting Officer** will support processing and payment of vendor invoices and other accounting functions.

  In addition, funds will be allocated to contracts to provide CalHHS and its departments and offices with expanded translation, adaptation, field testing, interpretation, and language access technical assistance.

According to CalHHS, between September and December 2021, CalHHS and DSS planned to recruit and hire the language access staff, reconvene the Language Access Work Group, define the initial baseline list of languages for translation and adaptation, and execute interagency agreements.

Between January and June 2022, CalHHS and DSS plan to brief legislative staff on the CalHHS Language Access Policy prior to adoption and after review by stakeholders, adopt the Language Access Policy, develop department-level Language Assistance Plans, develop and refine the methodology for determining and updating the baseline list of languages, build and expand DSS translation/adaptation/interpretation processes to offer to CalHHS departments, and provide ongoing technical assistance to department Language Assistance Plans through the Language Access Work Group.

Between July 2022 and July 2024, CalHHS and DSS plan to implement department-level Language Assistance Plans, provide ongoing translation/adaptation/interpretation services to CalHHS departments, provide ongoing technical assistance for Language Assistance Plan implementation, conduct ongoing stakeholder engagement to support continuous quality improvement, continue updating and improving language data and baseline list of languages, review Language Access Policy implementation across CalHHS departments and determine necessary permanent resources, and provide updates to legislative staff on progress through budget briefings.

Health Information Data Exchange Framework. The 2021 Budget Act included General Fund expenditure authority of $2.5 million in 2021-22, and the Legislature approved trailer bill language to establish a California Health and Human Services Data Exchange Framework to include a single data sharing agreement and common set of policies and procedures to govern the exchange of health information among health care entities and state departments and agencies.

Implementation Updates

- In August 2021, the Secretary appointed an expert stakeholder advisory group to inform development of the CalHHS Data Exchange Framework. The stakeholder advisory group includes representatives of health care payers, hospitals, physicians, clinics, nonprofit organizations, counties, consumer groups, organized labor, and information exchange organizations.
- The stakeholder advisory group has met five times since its establishment, with four additional meetings scheduled monthly until July 2022.
- According to CalHHS, the state will establish a single data sharing agreement by July 1, 2022.
- By January 31, 2023, CalHHS and the California State Association of Counties will encourage as many county health, public health, and social services providers to connect to the Data Exchange Framework to exchange health information in real time with participating health care entities. In addition, the Data Exchange Framework data sharing agreement will be executed by general acute care hospitals, physician organizations and medical groups, skilled nursing facilities, health care service plans and disability insurers, Medi-Cal managed care plans, clinical laboratories, and acute psychiatric hospitals.
- By January 31, 2024, all participating entities will exchange health information or provide access to health information to and from every other entity in real time for treatment, payment, or health care operations.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of the CalHHS mission and its oversight of key departments and other entities.

2. Please provide an update on implementation of the following 2021 Budget Act investments:

    a. Children and Youth Behavioral Health Initiative – Statewide Coordination and Oversight
    b. Equity and Language Access Proposals
    c. Health Information Data Exchange Framework

Issue 2: California Healthcare, Eligibility, Enrollment, and Retention System

Budget Change Proposal – Governor's Budget. The CalHHS Office of Systems Integration (OSI) requests six positions and expenditure authority from the California Health and Human Services Automation Fund of $1.3 million annually. If approved, these positions and resources would allow OSI to support the stabilization of critical services within the California Healthcare, Eligibility, Enrollment, and Retention System (CalHEERS).

Program Funding Request Summary (CalHHS-OSI)		
Fund Source	**2022-23**	**2023-24***
9745 – CHHS Automation Fund	$1,300,000	$1,300,000
Total Funding Request:	**$1,300,000**	**$1,300,000**
Total Requested Positions:	**6.0**	**6.0**

***** Positions and resources ongoing after 2023-24.

Background. Established by AB 1602 (Perez) and SB 900 (Alquist), Chapters 655 and 659, Statutes of 2010, the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) serves as the consolidated system support for eligibility, enrollment, and retention for the Covered California health benefits exchange and the Medi-Cal program. Sponsored by Covered California, the Department of Health Care Services (DHCS), and 13 program partners, CalHEERS streamlines resources from which individuals and small businesses are able to research, compare, check their eligibility for, and purchase health coverage. CalHEERS supports the maintenance, operations, and ongoing business of both Covered California and DHCS by supporting account creation, consumer application, eligibility rules, and health plan selection for insurance affordability programs. CalHEERS also interfaces via the Electronic Health Information Transfer (eHIT) with the Statewide Automated Welfare Systems (SAWS) for Modified Adjusted Gross Income (MAGI) Medi-Cal eligibility, enrollment, and reporting; and provides data for potential eligibility to other programs, such as non-MAGI Medi-Cal, CalFresh, and California Work Opportunities and Responsibility for Kids (CalWORKs).

To implement the CalHEERS system, Covered California and DHCS selected Accenture, LLP, as the prime vendor in June 2012, with the system going live to the public 15 months later on October 1, 2013. The Accenture contract expired in June 2020 and, after a three-year competitive procurement process, the CalHEERS project awarded a new systems integrator (SI) contract for ongoing system development, maintenance, and operations to Deloitte, LLC.

Resource Request. OSI requests six positions and expenditure authority from the California Health and Human Services Automation Fund of $1.3 million annually to support the stabilization of critical services within the California Healthcare, Eligibility, Enrollment, and Retention System (CalHEERS). Specifically, OSI requests positions and resources for the following purposes:

User Acceptance Testing (UAT) Unit

- **One Information Technology (IT) Supervisor II** and **two IT Specialist I** positions would provide leadership and support to the User Acceptance Testing (UAT) Unit, which supports the CalHEERS portal, change and configuration management system, SharePoint collaboration sites, system testing, integration testing, regression testing, smoke testing, user acceptance testing, Americans with Disabilities Act compliance testing, mobile testing, advocate testing, data warehousing, automation,

disaster recovery, incident triage, and daily incident and problem management. According to OSI, the UAT unit was originally established to only perform UAT functions. However, the scope of testing has continued to change since CalHEERS went live in 2013 and now includes testing related to defect fixes, and testing and oversight of the SI vendor, Deloitte.

Functional Business Analysis (FBA) Unit

- **One IT Specialist I** position would provide state oversight, expertise, and knowledge of system functional design for major releases, minor releases, monthly releases through Waterfall, and a new collection of principles with HCD and Agile methodology. According to OSI, changes to state and federal funding for Affordable Care Act programs has resulted in additional change requests for system enhancements. In 2021-22, the Functional Business Analysis (FBA) unit is expecting to design approximately 90 sponsor-requested system enhancements, an increase of 26 percent compared to 2020-21.

Operational Readiness Unit

- **One IT Supervisor II** position would provide state oversight for incident management, production system monitoring, Help Desk, carriers, security and cyber security, configuration management operations, responding to and tracking systems and application errors, lead post releases command center, and monitor bridge to field questions and issues. This position would oversee the Operations team and be responsible to plan, organize, and direct the activities of the state and the SI, ensuring CalHEERS system and technical operations management activities are conducted in accordance with project management plans, industry standards, and OSI best practices.

Enterprise Infrastructure Team

- **One IT Specialist II** position would serve as the technical lead for the CalHEERS cloud migration, ensuring the state moves in the direction of industry best practices, drives the strategic direction of all cloud transformation and enhancements, as well as assessing all change requests and technical requests.

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.

Issue 3: Electronic Benefit Transfer Project

Budget Change Proposal – Governor's Budget. The CalHHS Office of Systems Integration (OSI) requests three positions and expenditure authority from the California Health and Human Services Automation Fund of $480,000 in 2022-23 and 2023-24. If approved, these positions and resources would allow OSI to effectively manage three new electronic benefit transfer (EBT) projects, meet stakeholder demands, and maintain the level of operations required for the state's benefit recipients.

Program Funding Request Summary (CalHHS-OSI)		
Fund Source	**2022-23**	**2023-24**
9745 – CHHS Automation Fund	$480,000	$480,000
Total Funding Request:	**$480,000**	**$480,000**
Total Requested Positions:	**3.0**	**3.0**

Background. The California Electronic Benefit Transfer (EBT) Project is responsible for automating the issuance, delivery, redemption, settlement, and reconciliation of California's public food and cash program benefits. The EBT Project supports the CalFresh program, the Women, Infants, and Children (WIC) Program, the California Work Opportunity and Responsibility to Kids (CalWORKs) Program, the Refugee Cash Assistance Program, the State Utility Assistance Subsidy (SUAS, formerly LI-HEAP), the Cash Assistance Program for Immigrants, and General Assistance/General Relief. The California EBT system provides recipients with electronic access to food, cash and WIC benefits using magnetic-strip cards at point-of-sale (POS) terminals and automated teller machines (ATMs). California EBT issues close to $12 billion annually in food and cash aid benefits to more than two million EBT cardholders enrolled in California public benefit programs.

According to OSI, the California EBT Project has evolved from a maintenance and operations organization to being a multi-service organization for automated benefit issuance, complex data analytics on benefit redemption, and stakeholder management. In addition, the project now supports three new programs: Online Purchasing, Pandemic EBT (P-EBT), and Summer EBT.

Online Purchasing enables individuals and families to purchase groceries online using their EBT card at participating retailers. Implemented as a pilot project in a few states prior to the pandemic, California implemented Online Purchasing, including Amazon and Walmart, within weeks of federal expansion of authority during the pandemic. Online Purchasing is now a permanent program for EBT services and, according to OSI, is rapidly expanding to include other retailers.

P-EBT and Summer EBT were implemented during the pandemic by the Department of Social Services (DSS), the Department of Education (DOE), and the California EBT Project to enable children who would otherwise receive free or reduced-price meals at school to receive extra food benefits when schools are closed. P-EBT provides the benefit during the regular school year, while Summer EBT provides the benefit during the summer months. According to OSI, P-EBT has served nearly 7.5 million children since it was implemented in May 2020, and the program was expanded and extended by the federal American Rescue Plan Act of 2021 to include Summer EBT.

Resource Request. OSI requests three positions and expenditure authority from the California Health and Human Services Automation Fund of $480,000 in 2022-23 and 2023-24 to manage the three new

electronic benefit transfer (EBT) projects, meet stakeholder demands, and maintain the level of operations required for the state's benefit recipients. Specifically, OSI requests positions and resources for the following purposes:

Online Purchasing Coordinator

- **One IT Specialist I** position would serve as the Online Purchasing Coordinator, acting as the lead technical specialist responsible for complex activities related to EBT Online Purchasing. The position would coordinate and participate in testing activities, and coordinate all Online Purchasing communications with stakeholders, such as retailers, the United States Department of Agriculture Food and Nutrition Service, counties and the state.

P-EBT and Summer EBT Lead

- **One IT Specialist I** position would serve as P-EBT and Summer EBT Lead, acting as the lead technical specialist for complex activities related to P-EBT and Summer EBT. The position would coordinate and participate in testing activities, and coordinate all P-EBT and Summer EBT communications with stakeholders.

P-EBT and Summer EBT Testing Lead

- **One IT Specialist I** position would serve as P-EBT and Summer EBT Testing Lead, working with the EBT Test Manager to test EBT system changes in the test environment for P-EBT and Summer EBT, ensure system requirements related to these two programs are testable, consistent, and traceable, and track and test bug fixes and software releases.

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.

Issue 4: California Health and Human Services – Cybersecurity Program Augmentation

Budget Change Proposal – Governor's Budget. The CalHHS Office of Systems Integration (OSI) requests two positions and expenditure authority from the California Health and Human Services Automation Fund of $993,000 annually. If approved, these positions and resources would allow OSI to respond to cybersecurity attacks and address security and privacy risks identified by state and other security assessments.

Program Funding Request Summary (CalHHS-OSI)		
Fund Source	**2022-23**	**2023-24***
9745 – CHHS Automation Fund	$993,000	$993,000
Total Funding Request:	**$993,000**	**$993,000**
Total Requested Positions:	**2.0**	**2.0**

***** Positions and resources ongoing after 2023-24.

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 addition to requirements under AB 670, 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.

AB 2813 (Irwin), Chapter 768, Statutes of 2018, established the California Cybersecurity Integration Center (Cal-CSIC) within the Office of Emergency Services (CalOES). Cal-CSIC's primary mission is to reduce the likelihood and severity of cyber incidents that could damage California's economy, its critical infrastructure, or public and private sector computer networks. Cal-CSIC serves as the central organizing hub of state government cybersecurity activities and coordinates information sharing with local, state, and federal agencies, tribal governments, utilities and other service providers, academic institutions, and nongovernmental organizations. CalHHS is one of 12 federal, state, and higher education entities that comprise the governance structure of Cal-CSIC.

Within CalHHS, the Office of the Agency Information Officer (OAIO) supervises all information technology and telecommunications activities within the agency, including information security, technology, and telecommunications personnel, contractors, systems, assets, projects, purchases, and contracts. The OAIO supports agency departments to enhance programs through successful delivery of data and technology solutions through portfolio support, enterprise architecture, agency information security, and agency governance activities. The OAIO also monitors agency departments' compliance with state and federal information security and privacy regulations.

Resource Request. OSI requests two positions and expenditure authority from the California Health and Human Services Automation Fund of $993,000 annually to respond to cybersecurity attacks and address

security and privacy risks identified by state and other security assessments. Specifically, OSI requests the following positions and resources:

Deputy Agency Information Officer

- **One IT Specialist II** position would serve as Deputy Agency Information Security Officer to assist CalHHS and agency departments with cybersecurity tasks and efforts, and serve as the specialized technical expert to assist with agency oversight responsibilities and compliance activities with state and federal information security and privacy regulations.

Cal-CSIC Representative

- **One IT Specialist III** position would serve as a specialized technical expert advisor on cybersecurity threats and provide guidance and advice on methods to investigate, document, and report on cybersecurity issues and emerging trends. The position would provide actionable technical and tactical cyber information and intelligence to federal, state, local, tribal, and territorial governmental and private sector partners. This position would also provide backup to the Agency Information Security Officer representing CalHHS at the Cal-CSIC.

Consulting Services

- $600,000 annually would support consulting services to engage with agency departments to create more standardization and identify opportunities for collaboration on implementation of cybersecurity efforts.

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.

Issue 5: Electronic Visit Verification Phase II

Budget Change Proposal – Governor's Budget. The Office of Systems Integration (OSI), the Department of Health Care Services (DHCS), and the Department of Developmental Services (DDS) request 16 positions (six at OSI, six at DHCS, and four at DDS) and total expenditure authority of $13 million ($3 million General Fund and $10 million federal funds) in 2022-23, $11.3 million ($3 million General Fund and $8.2 million federal funds) in 2023-24, $9.3 million ($2.5 million General Fund and $6.8 million federal funds) in 2024-25, $9.4 million ($2.6 million General Fund and $6.8 million federal funds) in 2025-26, and $9.1 million ($2.5 million General Fund and $6.7 million federal funds) in 2026-27. If approved, these resources would continue the multi-departmental effort for the second phase (Phase II) of implementation of Electronic Visit Verification for personal care services and home health care services.

Program Funding Request Summary (CalHHS-OSI)		
Fund Source	**2022-23***	**2023-24****
9745 – CHHS Automation Fund	$10,342,000	$9,240,000
Total Funding Request:	**$10,342,000**	**$9,240,000**
Total Requested Positions:	**6.0**	**6.0**

***** Transfers from other Departments (included below): DHCS: $5,171,000; DDS: $5,171,000
** Additional fiscal year resources requested for OSI: 2024-25: $7,567,000; 2025-26: $7,665,000; 2026-27: $7,413,000

Program Funding Request Summary (DHCS)		
Fund Source	**2022-23**	**2023-24****
0001 – General Fund	$710,000	$590,000
0890 – Federal Trust Fund*	$9,972,000	$8,240,000
Total Funding Request:	**$10,682,000**	**$8,830,000**
Total Requested Positions:	**6.0**	**6.0**

***** Federal Trust Fund appropriation includes transfer of federal Medicaid matching funds to DDS, reflected below as Reimbursements.
** Additional fiscal year resources requested for DHCS: 2024-25: $7,247,000; 2025-26: $7,323,000; 2026-27: $7,128,000

Program Funding Request Summary (DDS)		
Fund Source	**2022-23**	**2023-24****
0001 – General Fund	$2,335,000	$2,424,000
0995 – Reimbursements*	$3,574,000	$2,934000
Total Funding Request:	**$5,909,000**	**$5,358,000**
Total Requested Positions:	**4.0**	**4.0**

***** Reimbursements are the result of federal matching funds transferred from DHCS and are included in the totals attributed to the DHCS request.
** Additional fiscal year resources requested for DDS: 2024-25: $4,521,000; 2025-26: $4,570,000; 2026-27: $4,444,000

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 for all 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

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

location of service delivery, the individual providing the service, and the time the service begins and ends. Programs serving Medi-Cal beneficiaries 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, the 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 included 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. DSS reported that, as of October 2020, 95 percent of IHSS and Waiver Personal Care Services providers and recipients were enrolled in the EVV system.

Phase II includes 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
DHCS	Waiver Personal Care Services Agency Model		X	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 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, the state's failure to implement EVV by January 1, 2021, will result in the following reductions in federal matching funds for Medi-Cal services:

Electronic Visit Verification Delay – Federal Matching Fund Penalties by Department		
Department	**2020-21**	**2021-22**
Department of Social Services	($14,781,000)	($42,649,000)
Department of Developmental Services	($5,219,000)	($10,144,000)
Department of Health Care Services	($417,000)	($761,000)
Department of Aging	($31,000)	($55,000)
Department of Public Health	($11,000)	($20,000)
TOTAL	**($20,459,000)**	**($53,629,000)**

EVV Phase II Implementation Progress. According to OSI, the EVV Phase II project has been working towards implementation by January 1, 2022. The project completed its selection process for an EVV Solution contractor in May 2021 and submitted its Implementation Advanced Planning Document (IAPD) and draft EVV contract to the federal Centers for Medicare and Medicaid Services (CMS) for approval in June 2021. The project also submitted its Stage 4 Project Readiness and Approval documentation to the California Department of Technology, as part of its Project Approval Lifecycle (PAL) process, in June 2021. According to a presentation made by OSI and the affected departments to stakeholders, the EVV portal (CalEVV) is available for personal care services providers to register. All PCS providers must use either the CalEVV system or an alternate EVV system by January 1, 2022. HHCS providers will be required to use CalEVV or an alternate EVV system by January 1, 2023.

Resource Request. OSI, DHCS, and DDS request 16 positions (six at OSI, six at DHCS, and four at DDS) and total expenditure authority of $13 million ($3 million General Fund and $10 million federal funds) in 2022-23, $11.3 million ($3 million General Fund and $8.2 million federal funds) in 2023-24, $9.3 million ($2.5 million General Fund and $6.8 million federal funds) in 2024-25, $9.4 million ($2.6 million General Fund and $6.8 million federal funds) in 2025-26, and $9.1 million ($2.5 million General Fund and $6.7 million federal funds) in 2026-27, to continue the multi-departmental effort for the second phase (Phase II) of implementation of Electronic Visit Verification for personal care services and home health care services.

The resources included in this request are comprised of a conversion of 16 of 19 existing position equivalents to permanent, a continuation of three existing position equivalents at DHCS, as well as new contract and solution vendor resources for the project. The allocation of funds and position equivalents in this request for each of these departments are as follows:

Department/Office	General Fund	Federal Funds/ Reimbursements	TOTAL FUNDS	Permanent Positions
OSI*	[$-]	[$-]	[$10,342,000]	6.0
DHCS	$710,000	$6,398,000	$7,108,000	6.0
DDS	$2,335,000	$3,574,000	$5,909,000	4.0
Total	**$3,045,000**	**$9,972,000**	**$13,017,000**	**16.0**

* OSI Allocation is non-add, as this allocation is the result of a transfer from DHCS and DDS of $5,171,000 each for a total of $10,342,000 of the approved funding to OSI to fund contract costs and six positions. The remaining funds in these departments

($1.9 million at DHCS and $738,000 at DDS) support the requested positions and positions equivalents for 2022-23 (six positions and three position equivalents at DHCS, and four positions at DDS). In addition, the DDS federal funds are reflected as reimbursements from DHCS, the single state Medicaid agency, which claims federal matching funds on behalf of DDS.

Project Team Staff Resources – $2.9 million. The Project Team is composed of a mix of state and consultant staff, including six positions at OSI, six positions and three position equivalents at DHCS, and four positions at DDS. These positions are conversions or extensions of resources received in the 2018-19, 2020-21, and 2021-22 fiscal years. Specifically, the positions and position equivalents requested by department/office are as follows:

OSI

- *Project Director.* **One IT Manager II** position would serve as Project Director, providing leadership and strategic direction to the project.
- *Technical Manager.* **One IT Manager I** position would serve as technical manager for the project, managing technical details of prime and ancillary contracts, reviewing contract deliverables, overseeing contractor implementation performance and other processes, and facilitating collaboration on security matters with internal and external stakeholders.
- *Fiscal and Budget Specialist.* **One Staff Services Manager (SSM) I** position would serve as fiscal and budget specialist, processing and tracking invoices and expenditures, and monitoring and documenting various fiscal activities.
- *Contracts and Procurement Lead.* **One IT Specialist I** position would serve as contracts and procurement lead, helping develop solicitation and other procurement documents, and managing and monitoring consultant contracts.
- *Procurement Analyst.* **One IT Specialist I** position would serve as a procurement analyst, providing technical expertise to the project on competitive IT procurements, and state and federal approval documentation.
- *Project Support/Librarian.* **One IT Associate** would serve as project support and librarian, acting as the project's document management specialist, managing project documents, administering the project's document and content management application, supporting review of contract deliverables, and otherwise supporting the project management team.

DHCS

- *Program Manager.* Resources equivalent to **one SSM II** position would serve as Program Manager for the EVV Unit within the Health Care Delivery Systems Division, acting as the primary point of contact between executive management and stakeholders, and managing and administering the EVV Training Program.
- *Program Specialist (HPS I).* **One Health Program Specialist (HPS) I** position would serve as program specialist, developing and maintaining policy and planning documents, participating as program subject matter expert, developing project and other reports, developing training and technical assistance materials, conducting needs assessments and performing utilization reviews of the EVV system.
- *Program Specialists (AGPA).* **Two Associate Governmental Program Analysts (AGPA) and** resources equivalent to **one AGPA** would serve as program specialists, coordinating stakeholder meetings, developing and maintaining policies and procedures, helping to prepare and develop

department bulletins and other notices, responding to inquiries from state departments and stakeholders, and supporting and monitoring contracts and other documents.

- *Project Manager.* Resources equivalent to **one IT Specialist II** position would serve as project manager, providing project management functions, facilitating meetings and reporting to the California Department of Technology, reviewing standards and programming for IT solution, and ensuring compliance with state and federal privacy laws.
- *Technology Specialist/Lead.* **Three IT Specialist II** positions would serve as technology specialist/lead (one in the CA-MMIS Division, one in the Information Management Division, and one in the Enterprise Technology Services Division), documenting systems architecture and interfaces, identifying and tracking technical issues and risks, maintaining the Information Systems Security Plan and other information assessments, participating in risk management activities and review activities, and reviewing deliverables.

DDS

- *Program Manager.* **One Community Program Specialist IV** position would serve as Program Manager for the EVV Unit, overseeing development of EVV regulations and procedures, serving as subject matter expert on EVV regulations and procedures, handling sensitive legislative or regulatory issues, coordinating stakeholder engagement, and managing the EVV Training Program.
- *Project Manager.* **One IT Specialist II** position would serve as project manager, facilitating meetings and reporting to DDS management, performing business analysis of federal EVV legislation, ensuring compliance with state and federal privacy laws, and reviewing programming results.
- *Technical Architect/Analyst.* **One IT Specialist II** position would serve as technical architect/analyst, documenting systems architecture and interfaces with the EVV system, identifying and tracking technical issues and risks associated with the EVV system, advising the project team on enhancements and changes, completing and maintaining the Information Systems Security Plan and other information security assessments, and acting as the departmental technical liaison to the EVV project.
- *Program Specialist.* **One AGPA** would serve as program specialist, coordinating and assisting with EVV implementation planning, working with the solution contractor to develop or amend the EVV training plan and other materials, analyzing and evaluating progress and completion of projects and assignments, and compiling data for use in reports and other tracking activities.

Consultant Contracts - $2.9 million. In addition to the positions and positions equivalents, OSI and DHCS are requesting $2.9 million consultant contracts for project management, business analysis, testing, technical support, solution certification services, independent verification and validation services, and interdepartmental consulting costs for the California Department of Technology Office of Statewide Project Delivery project oversight.

EVV Solution Vendor Services - $6.3 million. OSI is requesting $6.3 million to continue support for the EVV Phase II Solution contractor, which began implementation of the EVV Phase II project in September 2021. According to OSI, the amount requested is based on the vendor's proposed solution, implementation, and service operation costs for a five year contract.

Operating Expenses and Equipment (OE&E). OSI, DHCS, and DDS are also requesting $937,000 for other operating expenses and equipment, including general expenses, printing, communications, travel,

training, facilities, and administrative support costs. Of this amount, OSI would receive $651,000, DHCS would receive $198,000, and DDS would receive $88,000.

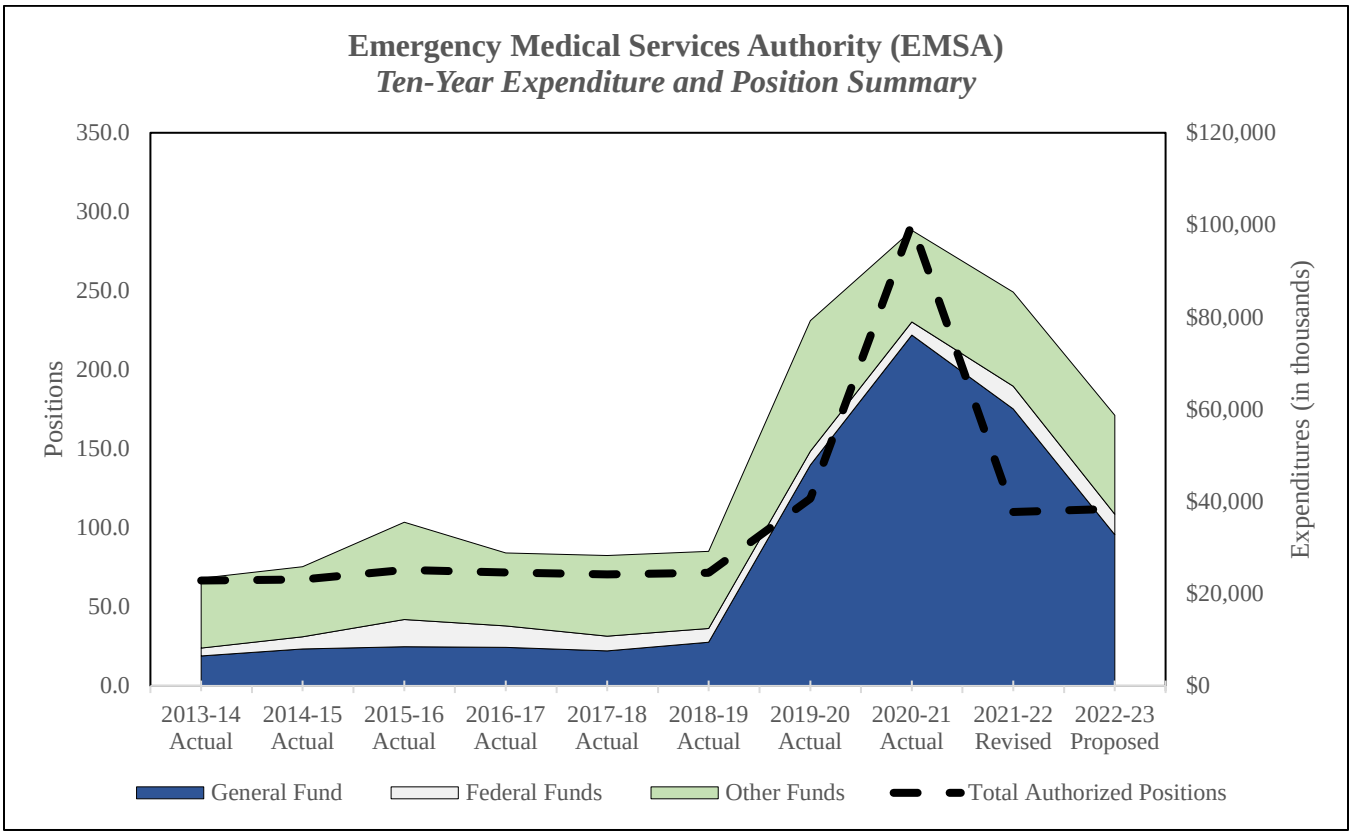
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested OSI, DHCS, and DDS to respond to the following:

1. Please provide a brief overview of this proposal.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Overview



Emergency Medical Services Authority - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2020-21 Actual**	***2021-22 Budget Act***	***2021-22 Revised***	***2022-23 Proposed***
General Fund	$76,092	$12,154	$60,098	$32,790
Federal Funds	$2,854	$4,861	$4,946	$4,466
Other Funds	$19,888	$20,353	$20,349	$21,436
Total Department Funding:	**$98,834**	**$37,368**	**$85,393**	**$58,692**
Total Authorized Positions:	**292.3**	**74.8**	**110**	**112**
Other Funds Detail:				
EMS Training Prog. Approval Fund (0194)	*$82*	*$150*	*$158*	*$241*
EMS Personnel Fund (0312)	*$2,633*	*$2,796*	*$2,645*	*$3,644*
Reimbursements (0995)	*$15,774*	*$15,738*	*$15,832*	*$15,837*
EMT Certification Fund (3137)	*$1,399*	*$1,669*	*$1,714*	*$1,714*

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 prevention, 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.

2021 BUDGET ACT INVESTMENTS – IMPLEMENTATION UPDATES

The 2021 Budget Act included several important investments in the EMSA budget. The subcommittee is monitoring implementation of the following investment:

California Physician Orders for Life Sustaining Treatment (POLST) eRegistry Act. The 2021 Budget Act included General Fund expenditure authority of $10 million in 2021-22 and $750,000 annually

thereafter, and the Legislature approved trailer bill language, the California POLST eRegistry Act, for EMSA to implement a statewide electronic registry system to collect information about Physician Orders for Life Sustaining Treatment (POLST) received from health care providers.

Implementation Update

- Under the provisions of the California POLST eRegistry Act, EMSA will adopt regulations for operation of the POLST eRegistry System, including standards and procedures for submission and dissemination of electronic POLST information, user identity verification, and standards to ensure accuracy and protect confidentiality.
- The POLST eRegistry system will incorporate the authority's existing Advance Health Care Directive Registry and will be implemented in conjunction with the proposed California Emergency Medical Services Data Resource System (CEDRS), EMSA's emergency medical services data interoperability system project.

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 the Authority's mission and programs.

2. Please provide an update on implementation of the following 2021 Budget Act investments:

    a. California Physician Orders for Life Sustaining Treatment (POLST) eRegistry Act

Issue 2: Replacement and Upgrade of Aging Vehicle and Radio Fleet Assets

Budget Change Proposal – Governor's Budget. EMSA requests General Fund expenditure authority of $8.7 million in 2022-23 and $50,000 annually thereafter. If approved, these resources would allow EMSA to replace and upgrade emergency medical response fleet equipment and radio assets.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$8,644,000	$50,000
Total Funding Request:	**$8,664,000**	**$50,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2023-24.

Background. The EMSA Disaster Medical Services (DMS) Division is tasked with disaster medical response planning, preparedness, and mitigation to quickly mobilize to support federal, state, regional, and local stakeholders. During disasters, the DMS Division is responsible for coordinating and deploying assets and personnel, including EMSA staff, California Medical Assistance Teams (CAL-MAT), Mission Support Teams (MST), mobile medical shelters, DMS vehicles, medical caches and other supplies, biomedical equipment (e.g. ventilators, intravenous infusion pumps, hospital beds, oxygen cylinders), pharmaceuticals, and communication equipment caches.

According to EMSA, over the past several years the DMS Division has responded to an increasing number of statewide disaster responses, including extreme weather events, drought, wildfires, earthquakes, and infectious disease outbreaks. EMSA reports these response efforts have tested the limits of its vehicle and radio equipment, with old and ineffective equipment, inappropriate supplies, and inadequate communications tools placing EMSA and CAL-MAT logistics and field staff in unsafe and compromising conditions.

Resource Request. EMSA requests General Fund expenditure authority of $8.7 million in 2022-23 and $50,000 annually thereafter to replace and upgrade emergency medical response fleet equipment and radio assets. EMSA believes these resources will supply and equip the DMS Division to effectively manage its increased responsibilities and address deficits in its statewide medical and health response capabilities by replacing old, outdated, and safe equipment, bringing current equipment up to proper safety and operational standards, and enhancing statewide cross-agency interoperability. Specifically, EMSA requests resources for the following purposes:

- *Fleet Asset Replacement.* $1.9 million would support the replacement of fleet assets. According to EMSA, many of its current vehicles and equipment require parts that are difficult to find and require costly repairs, technology upgrades and environmental emissions retrofitting. These resources would replace the following vehicles:

    - One-ton crew cab pickup truck with tow package - $85,000
    - Tandem axle, rear-load cargo trailers – $10,000 (two trailers at $5,000 each)
    - DCA 125 kW Tier 4 clean-energy generators - $711,000 (nine generators at $79,000 each)
    - MQP power Whisper Watt 70 kW generators - $300,000 (five generators at $60,000 each)
    - Box trucks with lift gates - $333,000 (three box trucks at $111,000 each)

- Refrigerator box trucks with lift gate - $441,000 (three box trucks at $147,000 each)

- *Existing Fleet Asset Safety Upgrades.* $64,000 would support full equipment and standardization of eight existing sport utility vehicles with safety emergency light/siren packages, radio packages, and safety emergency striping. Specifically, the upgrades would be as follows:

  - Radio package - $24,000 (eight packages at $3,000 each)
  - Emergency light package - $28,000 (eight packages at $3,500 each)
  - Striping package - $12,000 (eight packages at $1,500 each)

- *Radio Cache Replacement with New CRIS System.* $6.6 million one-time and $50,000 ongoing would support replacement of outdated radio assets and alignment with the California Radio Interoperability System (CRIS), a statewide public safety radio system administered by the California Office of Emergency Services (CalOES) that provides agencies the ability to communicate seamlessly. Specifically, these resources would support the following equipment purchases:

  - APX 800 Quad Band Handheld Radios with Encryption - $4.9 million (350 radios at $14,000 each)
  - APX 8500 Quad Band Mobile Radios with Encryption - $1.1 million (100 radios at $11,000 each)
  - Compact rapid deployable "Pod Runner" unit - $70,000
  - Radio programming - $470,000 (450 programs at $1,044 each)
  - CRIS yearly subscription - $50,000 (450 subscriptions at $111 each) – *ongoing*
  - Training for EMSA DMS staff on radio operations, procedures, and protocols - $30,000 (450 students at $66 each)

- *Mobile Communications Vehicle (C3) Upgrades.* $100,000 would support upgrade of equipment for the EMSA C3 communications vehicle including mobile communications, audio/visual (AV) and IT upgrades. According to EMSA, much of the technology in the C3 is outdated, in disrepair, and unusable. In addition, the technology lacks proper security and encryption features and the vehicle itself requires repairs to siding, roof, and interior, and maintenance of mechanical features. Specifically these resources would support the following:

  - New communications equipment - $5,000
  - New furniture upgrades - $20,000
  - New AV equipment - $15,000
  - Cosmetic and mechanical repairs - $15,000
  - IT equipment upgrades - $25,000
  - Electrical system repairs and upgrades - $20,000

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: California Poison Control System Funding Augmentation

Budget Change Proposal – Governor's Budget. EMSA requests General Fund expenditure authority of $1.1 million in 2022-23, $1.5 million in 2023-24, and expenditure authority of $2.1 million ($1.7 million General Fund and $349,000 reimbursements) annually thereafter. If approved, these resources would support increased salaries and benefit expenses for the California Poison Control System.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$1,056,000	$1,470,000
Total Funding Request:	**$1,056,000**	**$1,470,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested: 2024-25 and ongoing: $2,064,000 (including $349,000 reimbursements)

Background. The California Poison Control System (CPCS) is a statewide network of health care professionals that provide free, immediate, confidential expert information and treatment advice or referrals through a public toll-free hotline accessible 24 hours a day, seven days a week. The system also maintains 24 hour hotline numbers for medical professionals, police, and emergency medical services. The CPCS is comprised of four Poison Control Centers (PCC): 1) Fresno/Madera Division (Valley Children's Hospital), 2) Sacramento Division (UC Davis Medical Center), 3) San Diego Division (UC San Diego Medical Center), and 4) San Francisco Division (Zuckerberg San Francisco General Hospital and Trauma Center).

The CPCS is able to provide help and information related to: 1) the ingestion of toxic household products, plants, medications, and street drugs; 2) snake, insect, and spider bites; 3) allergic reactions to household products and medications; 4) medication/drug identification; 5) exposure to pesticides; and 6) reportable disease monitoring. CPS also provides a poison health education and outreach program to raise awareness of the public hotline and potential exposure risks in target populations across the state. The CPCS health education program educates and trains health professionals, such as physicians, nurses and prehospital EMS personnel.

University of California Collective Bargaining Agreement. According to EMSA, approximately 74 percent of CPCS staff are represented under a collective bargaining agreement with the University of California (UC) Office of the President. 43 licensed pharmacists, one registered clinical nurse, and seven pharmacy technicians across the four CPCS centers are covered by a collective bargaining agreement and receive contracted pay increases twice a year for an annual average increase of 4.1 percent. Four other positions are covered under another collective bargaining agreement that also contains mandatory pay increases. The UC Office of the President also mandates pay increases for staff not represented by a union to alleviate salary compression and to keep up with market rates for comparable jobs. In addition, as salaries increase, benefit expenses increase proportionally.

Local Assistance Resource Request. EMSA requests General Fund expenditure authority of $1.1 million in 2022-23, $1.5 million in 2023-24, and expenditure authority of $2.1 million ($1.7 million General Fund and $349,000 reimbursements) annually thereafter to support increased salaries and benefit expenses for the California Poison Control System. According to EMSA, these resources would also be used to

leverage federal Title XXI funding to support the increased salary and benefit costs resulting from the UC Office of the President collective bargaining agreements.

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 4: Paramedic Disciplinary Review Board (AB 450)

Budget Change Proposal – Governor's Budget. EMSA requests three positions and expenditure authority from the Emergency Medical Services Personnel (EMSP) Fund of $703,000 in 2022-23 and $665,000 annually thereafter. If approved, these positions and resources would allow EMSA to establish the Paramedic Disciplinary Review Board, pursuant to the requirements of AB 450 (Gonzalez), Chapter 463, Statutes. Of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0312 – EMS Personnel Fund	$703,000	$665,000
Total Funding Request:	**$703,000**	**$665,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2023-24.

Background. State law authorizes EMSA to deny, suspend, or revoke the license of a paramedic upon a finding of an action by the paramedic of a threat to the public health and safety, including: fraud, gross negligence, repeated negligent acts, incompetence, addiction to or excessive use of controlled substances, functioning outside the supervision of medical control, conviction of a crime related to licensee qualifications, functions or duties; patient abuse, sex-related offenses, or other unprofessional conduct listed in statute. When EMSA issues a disciplinary action or denial of a license, the licensee or applicant may appeal through a process governed by the Administrative Procedures Act, conducted by an independent and neutral administrative law judge appointed by the Office of Administrative Hearings and Appeals. The judge issues a proposed decision affirming, revising, or dismissing the action, which can ultimately be adopted or modified by the EMSA Director.

AB 450 (Gonzalez), Chapter 463, Statutes of 2021, establishes the Paramedic Disciplinary Review Board within EMSA to manage appeals of licensing actions. The board is composed of seven members, including a physician certified in emergency medicine, four licensed field paramedics, and two members of the public. The board may act on appeals of EMSA licensing actions and is required to develop criteria to aid in appeals determinations, including progressive discipline criteria that includes all of the following: 1) the nature and duties of a paramedic, 2) the time that has elapsed since the licensee's offense, 3) the nature and gravity of the offense, 4) the employer-imposed discipline for the offense, 5) the licensee's prior disciplinary record, 6) mitigating evidence, 7) prior warnings to the licensee on record or prior remediation, 8) the actual harm to the patient or the public, 9) evidence of the licensee's rehabilitation, 10) evidence of an expungement proceeding, 11) the licensee's compliance with the terms of a criminal sentence or court order, 12) aggravating evidence, and 13) the licensee's overall criminal record.

Staffing and Resource Request. EMSA requests three positions and expenditure authority from the Emergency Medical Services Personnel (EMSP) Fund of $703,000 in 2022-23 and $665,000 annually thereafter to establish the Paramedic Disciplinary Review Board, pursuant to the requirements of AB 450. Specifically, EMSA is requesting the following positions and resources:

- *Executive Officer*. **One Career Executive Officer (CEA) Level A** would serve as Executive Officer, performing duties delegated by the board, and overseeing administrative, human resources, contracting, and procurement functions. The Executive Officer would also serve as a representative

of the board, act as liaison between EMSA and the board, provide oversight, operationalize the requirements of AB 450, and promulgate regulations to clarify the requirements of AB 450.

- *AGPA.* **One AGPA** would be responsible for administrative support and coordination of the board's activities, arranging travel, completing expense and reimbursement reports, and formatting and redacting legal documents.
- *Attorney.* **One Attorney I** position would serve as the board's legal representation to advise on its decisions, issue administrative fines, serve as board representative in interactions with EMSA, local EMS agencies, and individuals subject to disciplinary action, as well as attending administrative hearings and representing the board upon appeal of decisions to Superior Court.
- *Board Member Expenses.* In addition to the staff resources, EMSA is requesting $49,000 for regular administrative and operational costs for the board. Board members will be reimbursed for each day spent in discharge of official duties, including travel and other expenses. EMSA estimates expenditures of $1,000 per board member per quarterly meeting for per diem and in-state travel costs, as well as meeting room rental costs of $1,000 per meeting. EMSA also estimates expenditures of $2,425 per board member for one-time equipment, supplies, fingerprinting and background checks to ensure confidentiality of proceedings and prevention of the release of personally identifiable information.

EMS Personnel Fund Condition and Paramedic Licensing Fee Increase. According to EMSA, the EMS Personnel Fund recently phased in an overall fee increase of $50 per license type over the 2020-21 and 2021-22 fiscal years to support EMSA's existing paramedic licensing and enforcement activities. Current fees are $300 for initial issuance or reinstatement and $250 for renewal of a paramedic license. EMSA estimates that expenses related to establishing and maintaining the board required by AB 450 may create insolvency issues in the EMS Personnel Fund. As a result, EMSA will require an increase in paramedic licensing fees of $65 per license by January 1, 2023, to keep the EMS Personnel Fund solvent and support the board's activities and operations.

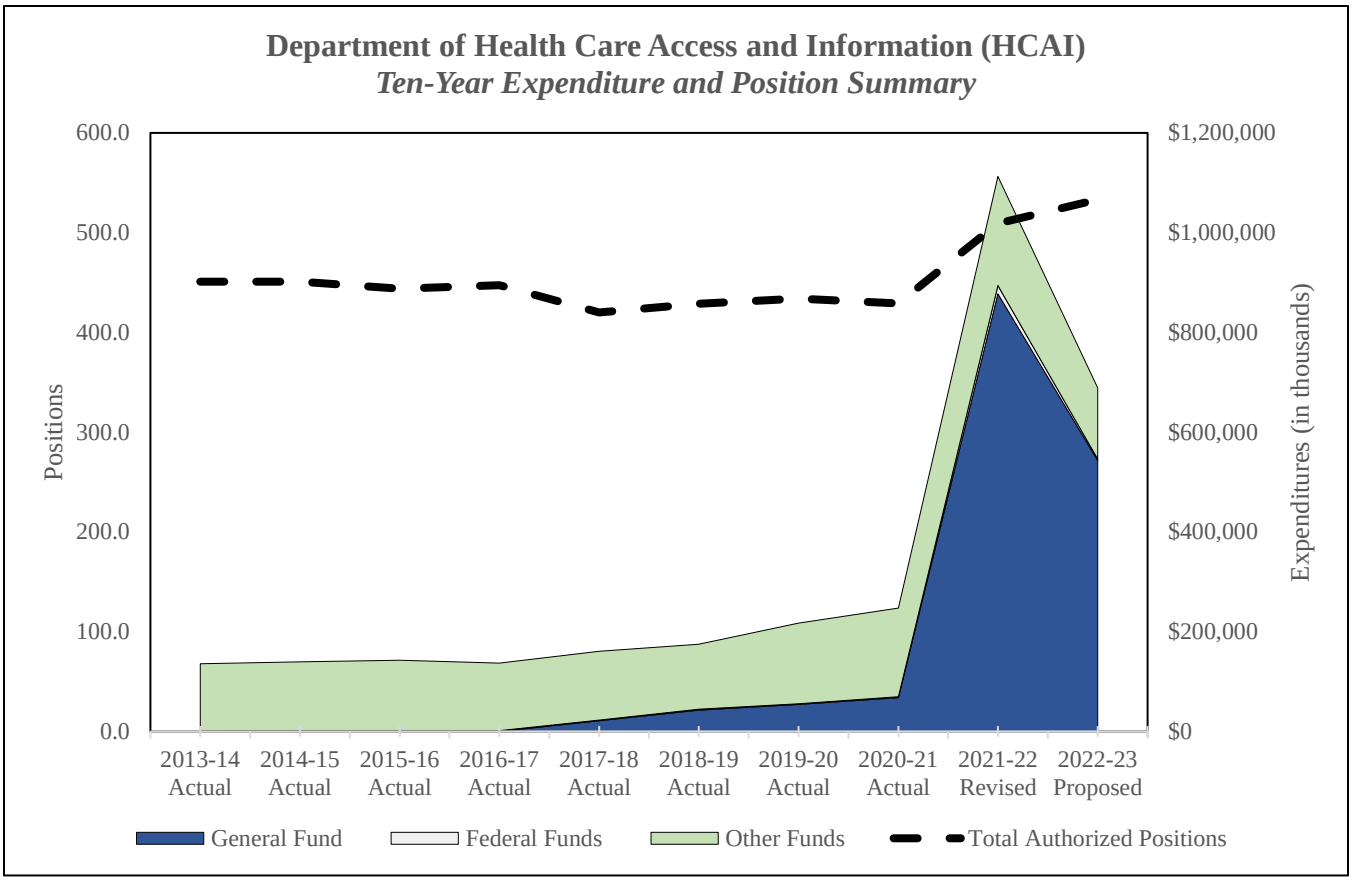
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

Issue 1: Overview



Department of Health Care Access and Information - *Department Funding Summary (dollars in thousands)*				
Fund Source	**2020-21 Actual**	***2021-22 Budget Act***	***2021-22 Revised***	***2022-23 Proposed***
General Fund	$67,676	$36,333	$877,579	$543,304
Federal Funds	$1,694	$1,573	$16,225	$2,850
Other Funds	$177,919	$147,479	$218,844	$142,866
Total Department Funding:	**$247,289**	**$185,385**	**$1,112,648**	**$689,020**
Total Authorized Positions:	**428.9**	**484.9**	**509.1**	**533.2**
Other Funds Detail:				
Hospital Building Fund (0121)	*$64,248*	*$68,587*	*$70,849*	*$70,012*
CA Health Data and Planning Fund (0143)	*$37,860*	*$46,771*	*$37,526*	*$42,022*
Registered Nurse Education Fund (0181)	*$2,194*	*$2,205*	*$2,237*	*$2,158*
Health Facility Const. Loan Ins. Fund (0518)	*$5,040*	*$5,234*	*$5,393*	*$5,350*

Health Professions Education Fund (0829)	*$10,864*	*$10,724*	*$11,500*	*$3,102*
Medically Underserved Account/Phys (8034)	*$4,401*	*$4,404*	*$4,422*	*$4,416*
Reimbursements (0995)	*$4,150*	*$5,903*	*$8,193*	*$8,580*
Mental Health Practitioner Ed. Fund (3064)	*$817*	*$829*	*$841*	*$762*
Vocational Nurse Education Fund (3068)	*$225*	*$228*	*$235*	*$235*
Mental Health Services Fund (3085)	*$48,120*	*$2,594*	*$2,648*	*$2,566*
Small and Rural Hosp Relief Fund (3391)	*$0*	*$0*	*$0*	*$2,442*
CA E-Cig Excise Tax fund (3394)	*$0*	*$0*	*$0*	*$1,221*
HCBS American Rescue Plan Fund (8507)	*$0*	*$0*	*$75,000*	*$0*

Background. The Department of Health Care Access and Information (HCAI) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. HCAI 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.

Reorganization and Recast of Office of Statewide Health Planning and Development. The 2021 Budget Act included revised position and expenditure authority and trailer bill language to reorganize and recast the former Office of Statewide Health Planning and Development (OSHPD) into HCAI.

Health Care Workforce Development Division. HCAI administers programs designed to increase access to healthcare for underserved populations and provide a culturally competent healthcare workforce. Specifically, HCAI 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.

HCAI 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. HCAI 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 Health Workforce Education and Training Council, which consists of 17 members including representatives of the Department of Health Care Services, HCAI, the University of California, the California State University system, and the California Community College system.

The 2017 Budget Act authorized $33.3 million annually over three years for augmentation of health care workforce initiatives at HCAI. In the 2020 Budget Act, this allocation was extended permanently. 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 HCAI 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 2018-19 are available until June 30, 2024. According to HCAI, the Song-Brown program awarded the following in 2021-22:

1) *Existing Primary Care Residency Slots* – $20.8 million to support 166 existing residency slots
2) *New Primary Care Residency Programs* - $3.2 million to support four new programs.
3) *Teaching Health Centers (THC)* - $5.9 million to support 47 residency slots at existing THCs
4) *New Primary Care Residency Slots at Existing Programs* - $5.4 million to support 18 new residency slots in existing programs

Song-Brown: Existing Primary Care Residency Slots Awards – September 2021			
Residency Program Name	**Award**	**Residency Program Name**	**Award**
Adventist Health Hanford Family Medicine	$250,000	Riverside Community Hospital Internal Medicine	$375,000
Adventist Health Tulare Family Medicine	$250,000	RUHS/UC Riverside Family Medicine	$375,000
AltaMed Family Medicine	$375,000	San Joaquin General Hospital Family Medicine	$625,000
Arrowhead Family Medicine	$250,000	San Joaquin General Hospital Internal Medicine	$125,000
Arrowhead Internal Medicine	$125,000	San Ysidro Health Internal Medicine	$375,000
California Hospital Med. Center Family Medicine	$375,000	Santa Rosa Family Medicine	$625,000
Charles R. Drew University Family Medicine	$625,000	Scripps Mercy, Chula Vista Family Medicine	$625,000
Contra Costa County Family Medicine	$375,000	Shasta Community Health Ctr Family Medicine	$125,000
Desert Regional Medical Center Family Medicine	$250,000	St. Joseph's Med Ctr Stockton Family Medicine	$125,000
Dignity/Methodist Hosp. Sacramento Family Medicine	$125,000	Stanford-O'Connor Family Medicine	$370,000
Eisenhower Health Family Medicine	$125,000	UC Davis Family Medicine	$125,000
Eisenhower Health Internal Medicine	$125,000	UC Davis Internal Medicine	$250,000
Emanate Health Family Medicine	$375,000	UC Davis Pediatric	$125,000
Family Health Ctrs of San Diego Family Medicine	$375,000	UC Irvine Family Medicine	$375,000
Glendale Adventist Family Medicine	$125,000	UC Irvine/CHOC Pediatric	$250,000
Harbor-UCLA Family Medicine	$625,000	UCLA Family Medicine	$125,000
Harbor-UCLA Pediatrics	$125,000	UCLA Pediatrics	$125,000
Kaiser Permanente Fontana Family Medicine	$125,000	UCR Saint Bernadine Family Medicine	$375,000
Kaiser Permanente Los Angeles Family Medicine	$250,000	UCSF Benioff Children's Hospital Pediatrics	$125,000
Kaiser Permanente Woodland Hills Family Medicine	$125,000	UCSF OB/GYN	$375,000

Kaweah Delta Health Care Dist. Family Medicine	$625,000	UCSF-Fresno Family Medicine	$375,000
Kern Medical Center OB/GYN	$375,000	UCSF Internal Medicine	$125,000
Kern Medical Internal Medicine	$625,000	UCSF-Fresno OB/GYN	$250,000
KPC Health Family Medicine	$250,000	UCSF-Fresno Pediatrics	$250,000
Lifelong Medical Care Family Medicine	$375,000	UCSF-SFGH Hospital Family Medicine	$625,000
Loma Linda University Pediatrics	$250,000	UC San Diego Family Medicine	$125,000
Loma Linda-Inland Empire Family Medicine	$125,000	UHS Southern California Family Medicine	$250,000
Loma Linda-Inland Empire Pediatrics	$125,000	Valley Family Medicine (Modesto)	$250,000
Loma Linda-Inland Empire OB/GYN	$250,000	Valley Health Team Family Medicine	$500,000
Long Beach Memorial Family Medicine	$125,000	Ventura County Medical Center Family Medicine	$250,000
Marian Regional Medical Ctr Family Medicine	$125,000	White Memorial Medical Center Family Medicine	$625,000
Natividad Medical Center Family Medicine	$375,000	White Memorial Medical Center Internal Medicine	$125,000
Olive View-UCLA Medical Ctr. Internal Medicine	$125,000	White Memorial Medical Center OB/GYN	$250,000
Pomona Valley Hospital Med Ctr Family Medicine	$375,000	**TOTAL - $20,750,000** **Slots Funded - 166**	
Rio Bravo Family Medicine	$625,000		
Riverside Community Hosp./UCR Family Medicine	$625,000		

Song-Brown: New Primary Care Residency Slots Awards – September 2021			
Residency Program Name	**Award**	**Residency Program Name**	**Award**
Keck Medicine – Family Medicine	$800,000	RUHS Internal Medicine	$800,000
MLK Community Hospital Internal Medicine	$800,000	**TOTAL - $3,200,000**	
Mission Community Hospital Family Medicine	$800,000	**Programs Funded – 4**	

Song-Brown: Teaching Health Center Awards – September 2021			
Residency Program Name	**Award**	**Residency Program Name**	**Award**
AltaMed Family Medicine	$625,000	San Ysidro Health Internal Medicine	$625,000
Family Health Ctrs San Diego Family Medicine	$625,000	Shasta Community Health Ctr. Family Medicine	$250,000
LifeLong Medical Care Family Medicine	$625,000	Valley Family Medicine (Modesto)	$625,000
Loma Linda-Inland Empire Family Medicine	$625,000	Valley Health Team Family Medicine	$500,000
Loma Linda-Inland Empire Pediatrics	$625,000	**TOTAL - $5,875,000**	
Rio Bravo Family Medicine	$750,000	**Slots Funded - 47**	

Song-Brown: New Primary Care Slots for Existing Programs – September 2021			
Residency Program Name	**Award**	**Residency Program Name**	**Award**
Arrowhead Internal Medicine	$900,000	Rio Bravo Family Medicine	$600,000
Kern Medical Internal Medicine	$900,000	Scripps Mercy Chula Vista Family Medicine	$300,000
Kern Medical OB/GYN	$300,000	Stanford Pediatrics	$900,000

Loma Linda-Inland Empire Family Medicine	$900,000	**TOTAL - $5,400,000**
Pomona Valley Hospital Family Medicine	$600,000	**Slots Funded - 18**

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 HCAI, 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, HCAI 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 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.

The 2019 Budget Act included a one-time allocation of $60 million ($35 million General Fund and $25 million Mental Health Services Fund) to support implementation of the WET Program Five-Year Plan 2020-2025.

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. HCAI 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) Bachelor of Science in Nursing Loan Repayment (BSNLRP)	Nursing (Bachelor's Degree students)
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)

HCAI plans to dissolve the HPEF and transfer its programs to the Healthcare Workforce Development Division. According to HCAI, the non-profit structure of HPEF is no longer necessary for operation of these programs.

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 HCAI, 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 HCAI to measure a building's ability to withstand a major earthquake. SB 1953 and subsequent HCAI regulations also require hospitals to submit plans to either retrofit or relocate acute care operations according to specific timeframes. According to HCAI, there are approximately 470 general acute care and acute psychiatric hospitals comprised of 2,673 hospital buildings covered by the seismic safety provisions of SB 1953. In addition to oversight of seismic safety compliance for acute care hospitals, HCAI is also responsible for

ensuring seismic and building safety compliance for skilled nursing facilities and intermediate care facilities.

Cal-Mortgage Loan Insurance Division. HCAI'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 November 30, 2021, Cal-Mortgage insures 67 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 HCAI data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments and stakeholders.

2021 BUDGET ACT INVESTMENTS – IMPLEMENTATION UPDATES

The 2021 Budget Act included several important investments in the HCAI budget. The subcommittee is monitoring implementation of the following investments:

Children and Youth Behavioral Health Initiative – Workforce Development Programs. The 2021 Budget Act included expenditure authority of $1.4 billion ($1 billion General Fund, $100 million Coronavirus Fiscal Recovery Fund or CFRF, $222 million federal funds, and $105 million Mental Health Services Fund) in 2021-22, $1.3 billion ($769.2 million General Fund, $429 million CFRF, and $124 million federal funds) in 2022-23, $275.2 million ($175.2 million General Fund and $100 million federal funds) in 2023-24, $262.1 million ($156.1 million General Fund and $106 million federal funds) in 2024-25, and $227.1 million ($121.1 million General Fund and $106 million federal funds) in 2025-26, to support the Children and Youth Behavioral Health Initiative and other interventions to support behavioral health services for students. The total investment over five years is $3.5 billion and includes the following component for implementation by HCAI:

- *Behavioral Health Workforce Development.* $600 million General Fund in 2021-22, $125 million General Fund in 2022-23, and $75 million General Fund in 2023-24 for HCAI to support programs to improve the capacity of the behavioral health workforce, including behavioral health counselors and coaches, substance use disorder counselors, psychiatric nurse practitioners, community health workers, psychosocial rehabilitation specialists, peer support specialists, and social workers.

Implementation Update

- *Behavioral Health Workforce Development.* The workforce development investments in the Children and Youth Behavioral Health Initiative included support for nine individual programs. These programs and the department's progress toward implementation are as follows:

    - School Behavioral Health Coaches and Counselors – The 2021 Budget Act included $267 million in 2021-22 and $71.3 million in 2023-24 to create a school behavioral health coach and counselor workforce. HCAI reports it is in the process of developing a multi-year plan to launch and implement the behavioral health coach and counselor system in partnership with experts in education and behavioral health. The plan will be implemented in 2022-23, including a grant program for certification entities and scholarship or loan repayment programs for individuals to pursue behavioral health coach certification.
    - Substance Use Disorder Workforce – The 2021 Budget Act included $26 million in 2021-22 and $50 million in 2022-23 to develop the provider workforce for substance use disorder services. HCAI reports it plans to leverage existing scholarship, loan repayment, and grant program infrastructure to award SUD funds and increase the number of SUD providers. Program cycles to award SUD funds will open as soon as May 2022.
    - Expand Training for Psychiatry and Social Workers – The 2021 Budget Act included $49.6 million in 2021-22 and $21.5 million in 2022-23 to expand training capacity for psychiatrists and social workers. HCAI reports its existing psychiatry programs will be augmented with these resources. HCAI also reports it is in the process of conducting research into the social work landscape, specialties, and education requirements in partnership with industry experts to inform the design of the new program.
    - Behavioral Health Workforce Pipeline – The 2021 Budget Act included $24 million in 2021-22 to build the pipeline of behavioral health providers. HCAI is planning to jointly administer these

funds through the new Health Career Professions Opportunity Program (HCOP), with a planned funding cycle launch in June 2022.

- "Earn and Learn" Apprenticeship Models – The 2021 Budget Act included $9.5 million to support "earn and learn" apprenticeship models, which provide tuition support and on-the-job training at a behavioral health provider organization while attending school. HCAI reports it will use these funds in two phases: 1) a funding opportunity starting in July 2022 to expand existing "earn and learn" programs and 2) a funding opportunity starting as early as October 2022 to create new programs.
- Training to Serve Justice- and System-Involved Youth – The 2021 Budget Act included $9.5 million in 2021-22 to support training of existing and new staff across a variety of sectors (e.g. child welfare, education, etc.) on effective behavioral health strategies with justice- and system-involved youth. HCAI reports it is meeting with stakeholders to determine programs to build capacity to serve this population.
- Behavioral Health Training for Primary Care Providers – The 2021 Budget Act included $10 million to expand behavioral health training for primary care providers. In particular, HCAI reports it will use these funds to continue support for the Train New Trainers Psychiatry Fellowship Scholarship program. HCAI expects to award approximately $2 million in scholarships this year.
- Peer Personnel Training and Placement – The 2021 Budget Act included $14.2 million in 2021-22 and $14.3 million in 2022-23 to train, recruit, and provide stipends for youth peer support specialists. HCAI reports it will use the existing Peer Personnel Training and Placement program to train and certify new peer personnel serving children and youth, with a new funding cycle opening in spring 2022.
- Augment Existing Behavioral Health Workforce Programs – The 2021 Budget Act included $165.3 million in 2021-22 and $33 million in 2022-23 to expand existing loan repayment, stipend, and scholarship programs for behavioral health disciplines. HCAI reports this augmentation will begin in spring 2022. HCAI also reports it is planning to fund regional partnerships and community based organizations that want to offer scholarships, loan repayment, or stipend opportunities to their staff.

Other Health Workforce Investments. The 2021 Budget Act also included several other health workforce investments, for primary care physicians and nurses, geriatric and Alzheimer's providers, certified nursing assistants, and career pipeline programs.

Implementation Updates

- *Other Health Workforce Investments.* HCAI reports the following progress on 2021 Budget Act investments:

  - Song-Brown Health Care Workforce Training Program – The 2021 Budget Act included General Fund expenditure authority of $50 million in 2021-22 to provide additional awards to support and sustain new primary care residency programs through the Song-Brown Health Care Workforce Training Program. HCAI reports it is developing plans for augmenting the existing Song-Brown program and will open the grant cycle for additional residency slots in spring 2022.
  - Nursing Pre-Licensure Program – The 2021 Budget Act included General Fund expenditure authority of $10 million in 2021-22 to support Board of Registered Nursing-approved pre-licensure programs, with priority to public programs. HCAI reports it is completing the application

cycle for the Song-Brown nursing program and will be using some of these funds to provide awards to public registered nursing programs.

- Alzheimer's Workforce Programs – The 2021 Budget Act included General Fund expenditure authority of $8 million in 2021-22 to support Alzheimer's and geriatric care providers through existing health care workforce development programs. HCAI reports it has awarded $2 million in loan repayments thus far for providers serving older adults.
- Certified Nursing Assistant Workforce Programs – The 2021 Budget Act included General Fund expenditure authority of $45.5 million in 2021-22 to support certified nursing assistant (CNA) training programs. HCAI reports it has awarded a $5 million grant to Empowered Aging to implement a CNA health career pathway program and is engaging with a consultant to build a needs assessment and landscape analysis for the remaining funding to determine how best to support and build the workforce. HCAI expects to open new funding cycles and award additional programs by the middle of 2022.
- Health Professions Career Opportunity Program – The 2021 Budget Act included General Fund expenditure authority of $16 million in 2021-22 to support the Health Professions Career Opportunity Program to implement programs at colleges and universities for pipeline programs and post-baccalaureate opportunities for students from underrepresented regions and background to pursue health careers. HCAI reports it is developing plans for program implementation and will open a new funding cycle in the middle of 2022. HCAI reports it is also augmenting its Health Career Exploration Program with $200,000 to support career exploration grants.

Subcommittee Staff Comment. This is an informational item.

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

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

2. Please provide an update on implementation of the following 2021 Budget Act investments:

    a. Children and Youth Behavioral Health Initiative – Workforce Development Programs
    b. Other Workforce Development Programs:

        i. Song-Brown Healthcare Workforce Training Program
        ii. Nursing Pre-Licensure Program
        iii. Alzheimer's Workforce Programs
        iv. Certified Nursing Assistant Workforce Programs
        v. Health Professions Career Opportunity Program

Issue 2: Workforce Augmentation and Budget Alignment

Budget Change Proposal – Governor's Budget. HCAI requests net expenditure authority from special funds and reimbursements of $2.8 million in 2022-23 and $2.7 million annually thereafter. If approved, these resources would allow HCAI to shift program funding for the Peer Personnel and Mini-Grants Programs from state operations to local assistance consistent with current practice, increase funding for the Mini-Grants Program and the Song-Brown Healthcare Workforce Training Program, and continue its service agreement to administer the County Medical Services Program Loan Repayment Program.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
State Operations:		
0143 – CA Health Data and Planning Fund	($100,000)	($100,000)
0995 – Reimbursements	$290,000	$290,000
3085 – Mental Health Services Fund	($1,810,000)	($1,810,000)
Local Assistance:		
0143 – CA Health Data and Planning Fund	$392,000	$30,000
0995 – Reimbursements	$2,200,000	$2,200,000
3085 – Mental Health Services Fund	$2,000,000	$2,000,000
Total Funding Request:	**$2,782,000**	**$2,690,000**
Total Requested Positions:	**0.0**	**0.0**

* Expenditure authority changes ongoing after 2023-24.

Background. HCAI administers a wide variety of grant programs to support the education and training of primary care and behavioral health professionals. These programs are designed to address California's unmet needs for high quality health care providers with appropriate linguistic and cultural competencies in a diverse state. Workforce development programs may include support for residency programs, scholarships, tuition support, loan repayments, stipends, or other support for students, educational institutions, or health facilities.

Peer Personnel Training and Placement Program. HCAI administers the Peer Personnel Training and Placement Program, which funds organizations that support individuals with lived experience as a behavioral health services consumer, family member, or caregiver. Funded organizations conduct recruitment and outreach, career counseling, training, placement, and six months of support services. The program awarded $6.7 million to 14 eligible organizations in 2021-22:

- Cal Voices - $500,000
- Crestwood Behavioral Health, Inc. - $420,000
- Emotional Health Association - $500,000
- Loma Linda University - $297,000
- Loyola Marymount University - $500,000
- Lutheran Social Services of Southern California - $492,000
- Mental Health Association of San Francisco - $500,000
- NAMI California - $486,000
- NAMI San Diego - $500,000

- PRC - $500,000
- Project Return Peer Support Network - $498,000
- Recovery Innovations International - $500,000
- San Diego State University Research Foundation - $500,000
- Sterling Solutions - $494,000

Health Careers Exploration Program. The Health Careers Exploration Program (HCEP), formerly the Mini-Grants program, awards up to $25,000 to organizations to support conferences, workshops, or career exploration activities, exposing students to health careers. The program is designed to strengthen educational and social foundations by providing direct and indirect program support for underrepresented or disadvantaged individuals interested in pursuing health careers. For the 2020-21 grant cycle, HCEP awarded $108,000 to eight organizations:

- Alliance in Mentorship - $12,000
- Health Care Foundation for Ventura County - $15,000
- Kern Medical Center - $12,000
- Skyrocket, Inc. - $15,000
- The Regents of the University of California - $12,000
- UNITE-LA-INC - $15,000
- University of California, San Francisco - $15,000
- University of Southern California - $12,000

Expenditure Authority Changes for Peer Personnel and HCEP Programs. HCAI requests to shift $2.1 million of expenditure authority from state operations to local assistance for the Peer Personnel Training and Placement Program and HCEP. According to HCAI, this requested net-zero shift would reflect the current operation of the program. In addition, HCAI requests additional expenditure authority of $200,000 to allow HCEP to support more students and expand its geographic reach.

County Medical Services Program Loan Repayment. 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.

HCAI 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 HCAI for the CMSP Loan Repayment Program through a service agreement that funds 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, HCAI and CMSP agreed to extend the termination date until 2022-23 and increase total reimbursement funding to $4.7 million. In August 2019, the Department of Finance approved a request for increased reimbursement authority of $2.2 million under Section 28.00 of the 2019 Budget Act for this purpose. The 2020 Budget Act included 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 agreement with CMSP.

HCAI reports it is in the process of entering into a service agreement with the CMSP Governing Board for additional funding in 2021-22 through 2025-26 totaling $6.9 million. For 2021-22, HCAI indicates it will seek approval for funding through Control Section 28.00 authority in the 2021 Budget Act. For 2022-23 until 2025-26, HCAI is requesting increased reimbursement authority of $2.3 million to continue to administer the program on behalf of CMSP.

Song-Brown Healthcare Workforce Training Program. HCAI administers the Song-Brown Healthcare Workforce Training Program (Song-Brown), which aims to increase the number of students and residents receiving quality primary care education and training in areas of unmet need throughout California. The Song-Brown program supports primary care residency training programs, nurse practitioner and physician assistant training programs, and registered nursing programs. In 2021-22, Song-Brown awarded $20.8 million to support 166 existing residency slots in existing programs, $5.9 million to support 47 residency slots in teaching health centers, $5.4 million to support 18 new residency slots in existing programs, and $3.2 million to support six new residency programs. In 2021-22, Song-Brown awarded $1.9 million to support 162 slots in family nurse practitioner and physician assistant training programs. In 2020-21, Song-Brown awarded $2.7 million to support 122 registered nursing slots.

AB 3426 (Filante), Chapter 1130, Statutes of 1992, authorizes the collection and transfer of voluntary fees by the Medical Board of California for support of the Song-Brown Program. The University of California matches each dollar in collected fees. According to HCAI, yearly contributions from voluntary fees are increasing and will soon meet or surpass the department's reimbursement expenditure authority of $400,000. HCAI requests an increase in reimbursement authority of $200,000 to account for the increased voluntary fee collections to support the Song-Brown program.

HCAI also requests an increase in expenditure authority from the California Health Data and Planning Fund of $92,106 to reflect the return of unspent grant funding awarded to the University of California San Francisco. According to HCAI, the increase in expenditure authority would allow these funds to be awarded to another 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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: SB 650 – Skilled Nursing Facilities

Budget Change Proposal – Governor's Budget. HCAI requests four positions and expenditure authority from the California Health Data and Planning Fund of $1.4 million in 2022-23, two additional positions and expenditure authority of $1.2 million in 2023-24 and $955,000 annually thereafter. If approved, these positions and resources would allow HCAI to receive and audit financial reports from skilled nursing facilities, pursuant to the requirements of SB 650 (Stern), Chapter 493, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0143 – California Health Data and Planning Fund	$1,433,000	$1,209,000
Total Funding Request:	**$1,433,000**	**$1,209,000**
Total Requested Positions:	**4.0**	**6.0**

* Additional fiscal year resources requested: 2024-25 and ongoing: $955,000.

Background. According to HCAI, each skilled nursing facility licensed by the Department of Public Health is required to submit a Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report within four months of the end of the fiscal year. Reports are prepared using HCAI-approved software and uploaded to HCAI's electronic reporting and auditing system. HCAI reviews reports for completeness, accuracy, and compliance with its uniform systems of accounting and reporting.

SB 650 (Stern), Chapter 493, Statutes of 2021, requires skilled nursing facilities to prepare and file an annual consolidated financial report with HCAI. The report must be reviewed by a certified public accountant and must include the following information:

- A balance sheet detailing the assets, liabilities, and net worth at the end of its fiscal year.
- A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.
- A statement detailing patient revenue by revenue center and by payer, such as Medicare, Medi-Cal, and other payers.
- A statement of cash flows, including ongoing and new capital expenditures and depreciation.
- A combined financial statement that includes all entities reported in the consolidated financial report.
- Certain information about related parties or other entities in which the facility's owner has at least a five percent interest.

SB 650 requires HCAI to post the reports and related documents on its website. In addition, HCAI is required to develop policies and procedures related to the format of the information submitted in the report and determine whether the report is complete. According to HCAI, while it is not required by SB 650 to determine if the report is accurate, HCAI is required to audit facility financial statements submitted under current law, including related party profit and loss statements. HCAI would be required to act on any information submitted with the reports required pursuant to SB 650.

Staffing and Resource Request. HCAI requests four positions and expenditure authority from the California Health Data and Planning Fund of $1.4 million in 2022-23, two additional positions and expenditure authority of $1.2 million in 2023-24 and $955,000 annually thereafter to receive and audit

financial reports from skilled nursing facilities, pursuant to the requirements of SB 650. Specifically, HCAI requests the following positions and resources:

- **One Health Program Auditor IV** position would design and maintain the accounting, reporting, and auditing system for related entity and consolidated reporting, including development and maintenance of program regulations.
- **One Health Program Auditor III** position would establish audit procedures and lead the staff level auditors in the review of submitted reports to determine completeness.
- **One Staff Services Analyst** would assist in the creation and maintenance of regulations, identify entities required to report, establish and maintain secure system accounts, and produce compliance records and reports.
- **One IT Specialist** would support the program in data application changes, engineering, maintenance, and continuous operations.
- **Two Health Program Auditor II** positions, beginning in 2023-24, would review submitted reports for completeness and compliance with established reporting requirements.
- **Information Technology Contracting Resources** - $750,000 in 2022-23 and $250,000 in 2023-24 would support contract resources to modify existing data capture, storage and management solutions.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: SB 395 – Excise Tax and Small/Rural Hospital Relief

Budget Change Proposal – Governor's Budget. HCAI requests four positions and expenditure authority from the Small and Rural Hospital Relief Fund of $876,000 in 2022-23, $842,000 in 2023-24, and $684,000 annually thereafter. If approved, these positions and resources would allow HCAI to support administration of the Small and Rural Hospital Relief Program, which supports seismic upgrades for small, rural, and critical access hospitals, pursuant to the requirements of SB 395 (Caballero), Chapter 489, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
3391 – Small and Rural Hospital Relief Fund	$876,000	$842,000
Total Funding Request:	**$876,000**	**$842,000**
Total Requested Positions:	**2.0****	**4.0**

* Additional fiscal year resources requested: 2024-25 and ongoing: $684,000

** Four positions would begin January 1, 2023, resulting in a budget year request of 2.0 positions.

Background. SB 395 (Caballero), Chapter 489, Statutes of 2021, authorizes a tax of 12.5 percent on the sale of electronic cigarettes. SB 395 requires revenues from this tax to be deposited in the California Electronic Cigarette Excise Tax Fund and are continuously appropriated for the following purposes:

- *Health Education Account.* 18 percent of revenue will deposited in the Health Education Account to support tobacco control programs.
- *California Children and Families Trust Fund.* 12 percent of revenue will be deposited in the California Children and Families Trust Fund, which supports First 5 Commissions.
- *Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Program.* 48 percent of revenue will support the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Program at the Department of Health Care Services (DHCS), which provides loan repayment awards of up to $300,000 to physicians and dentists in exchange for a five-year service obligation and a commitment to maintain a patient caseload of 30 percent or more Medi-Cal beneficiaries. Of the revenue transferred to this program, 70 percent will be allocated for physicians and 30 percent for dentists.
- *Medical Education.* Seven percent of the revenue will support the joint program in medical education between the University of California, San Francisco (UCSF) School of Medicine, UCSF Fresno, and the University of California, Merced.
- *Health Professions Career Opportunity Program.* Five percent of the revenue will support the Health Professions Career Opportunity Program at HCAI, which exposes students to health careers by awarding grants to institutions to support conferences, workshops, or career exploration activities.
- *Small and Rural Hospital Relief Program.* Ten percent of the revenue will be transferred to the Small and Rural Hospital Relief Fund to support seismic safety upgrades for small, rural, and critical access hospitals.

Health Professions Career Opportunity Program. The Health Professions Career Opportunity Program (HCOP) at HCAI exposes students to health careers by awarding grants to institutions to support conferences, workshops, or career exploration activities. The 2021 Budget Act included resources and trailer bill language to also allow the program to create health career pipeline programs to support students

from underrepresented regions and backgrounds through internships, post undergraduate fellowships, and post-baccalaureate scholarships. SB 395 requires five percent of revenue from the excise tax on electronic cigarettes to support HCOP. According to HCAI, the administration of this program can be absorbed within existing resources and, after implementation, may make a future staffing and resource request if needed.

Small and Rural Hospital Relief Program. In addition to implementation of the excise tax, SB 395 establishes the Small and Rural Hospital Relief Program. Currently, the Alfred E. Alquist Hospital Facilities Seismic Safety Act (Alquist Act) requires that hospitals be constructed to ensure the safety of patients and staff in the event of an earthquake and to ensure that hospitals are reasonably capable of remaining operational and providing services to the public after a seismic event. Hospitals must comply with the Alquist Act by January 1, 2030. HCAI is responsible for overseeing hospital compliance with the Alquist Act through the Seismic Compliance Unit of its Facilities Development Division. Under the requirements of SB 395, HCAI will provide grants to small, rural, and critical access hospitals to support seismic safety compliance with the Alquist Act if: 1) compliance imposes a financial burden on the hospital that could result in closure, and 2) hospital closure would substantially impact the accessibility of health care in the surrounding communities.

According to HCAI data, 50 out of 62 small and rural hospitals and 31 out of 36 critical care access hospitals have buildings that do not comply with the Alquist Act. Among these hospitals, there are a total of 223 buildings that require seismic upgrades for compliance by the 2030 deadline.

Staffing and Resource Request for Small and Rural Hospital Relief Program. HCAI requests four positions and expenditure authority from the Small and Rural Hospital Relief Fund of $876,000 in 2022-23, $842,000 in 2023-24, and $684,000 annually thereafter to supports administration of the Small and Rural Hospital Relief Program established by SB 395. Specifically, HCAI requests the following positions and resources:

<u>Cal-Mortgage Loan Insurance Division</u> – Two positions

- **One Associate Health Facility Construction Financing Analyst** would develop screening criteria and analyze applications and financial statements for hospital grants.
- **One Associate Governmental Program Analyst (AGPA)** would administer and monitor the contract with the managing entity and serve as point of contact.

<u>Facilities Development Division</u> – Two positions

- **One Senior Structural Engineer** would establish the new program, develop and adopt regulations, create and align the application process and database, and serve as primary point of contact with the Cal-Mortgage Division.
- **One AGPA** would assist with establishment, implementation, and administration of the program and serve as liaison with the Cal-Mortgage Division through 2023-24.

<u>Information Services Division</u> - $500,000 contract resources in 2022-23, $100,000 annually thereafter

- HCAI requests expenditure authority of $500,000 in 2022-23 and $100,000 annually thereafter for a contractor to modify the existing business application report collections; perform project management, business analysis, and system design; and software engineering of existing toolsets.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 5: AB 1204 – Hospital Equity Reporting

Budget Change Proposal – Governor's Budget. HCAI requests two positions and expenditure authority from the California Health Data and Planning Fund of $366,000 in 2022-23, two additional positions and expenditure authority of $1.1 million in 2023-24, one additional position and expenditure authority of $1.2 million in 2024-25, and $861,000 annually thereafter. If approved, these positions and resources would allow HCAI to administer new requirements for hospitals to submit annual equity reports, pursuant to AB 1204 (Wicks), Chapter 751, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0143 – California Health Data and Planning Fund	$366,000	$842,000
Total Funding Request:	**$366,000**	**$842,000**
Total Requested Positions:	**2.0**	**4.0**

* Additional fiscal year resources requested: 2024-25: $1,223,000; 2025-26 and ongoing: $861,000

Background. AB 1204 (Wicks), Chapter 751, Statutes of 2021, requires an acute hospital to prepare an annual equity report that includes an analysis of health status and access to care disparities for patients on the basis of age, sex, race, ethnicity, language, disability status, sexual orientation, gender identity, and payer. The equity report must include a plan to achieve reduction of the disparities identified in the report, with measurable objectives and specific timeframes. Hospitals will submit the report to HCAI, and AB 1204 authorizes HCAI to impose fines not to exceed $5,000 against hospitals that do not comply with these reporting requirements. HCAI will make hospital equity reports available on its website.

In addition to collection, enforcement, and publication of hospital equity reporting, AB 1204 requires HCAI to convene a Health Care Equity Measures Advisory Committee. The committee's membership, appointed by the HCAI Director, will include: 1) associations representing public hospitals and health systems, 2) associations representing private hospitals and health systems, 3) organized labor, 4) organizations representing consumers, 5) organizations representing vulnerable populations, and 6) an HCAI representative. The committee will assist HCAI in reviewing and amending measures to be included in hospital equity reporting, including alignment and integration of measures developed by the federal Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Quality Research (AHRQ).

In addition to hospital equity reporting requirements, AB 1204 expands the definition of vulnerable populations for the purpose of hospital reporting of community benefits. The expanded definition now includes:

- Racial and ethnic groups experiencing disparate health outcomes, including Black/African American, American Indian, Alaska Native, Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Vietnamese, Native Hawaiian, Guamanian or Chamorro, Samoan, as well as individuals of Hispanic/Latino origin, including Mexican, Mexican American, Chicano, Salvadoran, Guatemalan, Cuban, and Puerto Rican.
- Socially disadvantaged groups, including: 1) the unhoused; 2) communities with inadequate access to clean air and water; 3) people with disabilities; 4) people identifying as lesbian, gay, bisexual, transgender, or queer; and 5) individuals with limited English proficiency.

Staffing and Resource Request. HCAI requests two positions and expenditure authority from the California Health Data and Planning Fund of $366,000 in 2022-23, two additional positions and expenditure authority of $1.1 million in 2023-24, one additional position and expenditure authority of $1.2 million in 2024-25, and $861,000 annually thereafter to administer new requirements for hospitals to submit annual equity reports, pursuant to AB 1204. Specifically, HCAI requests the following positions and resources:

2022-23 – Two positions

- **One Health Program Specialist I** position would support analysis of equity reports, support the advisory committee in developing equity measures, and support development and updates to regulations.
- **One Research Scientist II** position would support statistical data de-identification and measure coding, support the advisory committee with subject matter expertise in its development of equity measures, and ensure equity report information posted to the HCAI website is de-identified and protective of personal privacy, pursuant to state and federal privacy laws.

2023-24 – Two additional positions

- **One Associate Governmental Program Analyst (AGPA)** would support analysis of equity reports, issuance of fines, management of appeals, and technical assistance.
- **One Information Technology Specialist I** position would support data application changes, engineering, and maintenance; support system applications, system integration, application maintenance and operations, database administration; and research and evaluation of emerging technologies.

2024-25 – One additional position

- **One AGPA** would support analysis of equity reports, issuance of fines, management of appeals, and technical assistance.

IT Consulting Services - $360,000 in 2023-24 and 2024-25

- HCAI requests expenditure authority of $360,000 in 2023-24 and 2024-25 for IT consulting to modify existing data capture, storage and management solutions, task and schedule planning, data analysis, technical integration of new data fields, testing, and modifications to reports.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: AB 1020 – Health Care Debt and Fair Billing

Budget Change Proposal – Governor's Budget. HCAI requests 16 positions and expenditure authority of $3.9 million ($2 million General Fund and $2 million California Health Data and Planning Fund) in 2022-23, and two additional positions and $3.6 million ($1.8 million General Fund and $1.8 million California Health Data and Planning Fund) annually thereafter. If approved, these positions and resources would allow HCAI to oversee and enforce new hospital requirements for discount payment and charity care policies, pursuant to AB 1020 (Friedman), Chapter 473, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0001 – General Fund	$1,951,000	$1,801,000
0143 – California Health Data and Planning Fund	$1,967,000	$1,817,000
Total Funding Request:	**$3,918,000**	**$3,618,000**
Total Requested Positions:	**16.0**	**18.0**

* Positions and resources ongoing after 2023-24.

Background. AB 774 (Chan), Chapter 755, Statutes of 2006, the Hospital Fair Pricing Act, requires all general acute care hospitals licensed in California to maintain understandable written policies regarding patient discount payment and charity care programs. At a minimum, uninsured patients with income at or below 400 percent of the federal level are eligible to apply for participation in a hospital's discount payment or charity care programs. Hospitals may also grant eligibility for patients with incomes over 400 percent of the federal poverty level for these programs. The hospital's policies must clearly state eligibility criteria, payment terms, and debt collection policies. Expected payments may not exceed the payment the hospital would receive under any government-sponsored health program (e.g. Medi-Cal, Medicare, etc.) in which the hospital participates. The Hospital Fair Pricing Act also requires a hospital to provide patients with a written notice about the hospital's financial assistance or charity care programs. In addition, the Act requires hospitals to provide a copy of its discount payment and charity care policies to HCAI, but authorized the Department of Public Health to enforce the remaining requirements through its oversight of hospital licensing. HCAI publishes links to hospitals' discount payment and charity care policies on its website (https://syfphr.hcai.ca.gov/FacilityList.aspx).

According to a study published in Health Affairs, between 2004 and 2012, the net price actually paid for hospital care by uninsured patients shrank from six percent higher than Medicare prices to 68 percent lower than Medicare prices.[2] In addition, hospitals have reduced the amount collected from uninsured patients and increased the overall percentage of services provided to uninsured patients. Another study found that, by 2011, 81 percent of hospitals charged Medicare rates or less to uninsured patients with incomes under 350 percent of the federal poverty level and 32 percent gave discounts for uninsured patients over 350 percent of the federal poverty level.[3]

[2] Bai G. "California's Hospital Fair Pricing Act Reduced the Prices Actually Paid by Uninsured Patients". *Health Affairs.* January 2015.

[3] Melnick GA, Fonkych K. "Fair pricing law prompts most California hospitals to adopt policies to protect uninsured patients from high charges". *Health Affairs.* June 2013.

AB 1020 Updates Hospital Fair Pricing Act. AB 1020 (Friedman), Chapter 473, Statutes of 2021, was introduced to address concerns that hospitals were withholding charity care from patients and that oversight and enforcement by the Department of Public Health was insufficient to ensure hospitals are complying with the Hospital Fair Pricing Act. AB 1020 restricts debt collection practices, including requirements on hospitals prior to referring debt to a collection agency, as well as requirements on debt collectors to provide information to consumers prior to collections. AB 1020 also increased the eligibility threshold for participation in discount payment or charity care programs from 350 to 400 percent of the federal poverty level and requires hospitals to post their program policies on their own website.

In addition to these reforms, AB 1020 transfers oversight responsibility for the Hospital Fair Pricing Act as amended to HCAI on January 1, 2024, and authorizes the imposition of administrative penalties on hospitals for violations of the Act. HCAI is required to investigate complaints that a hospital has not complied with the Act, including reviewing patient eligibility for discount payment or charity care programs and other hospital compliance requirements. If HCAI determines a violation has occurred, it may impose an administrative penalty of up to $40,000, depending on certain criteria, including: 1) actual financial harm to patients; 2) the nature, scope, and severity of the violation; 3) the facility's history of compliance with related state and federal law and regulations; 4) factors beyond the facility's control; 5) the demonstrated willfulness of the violation; 6) the extent to which the facility detected the violation and took steps to correct it and prevent future violations; and 7) any applicable special circumstances of protecting access to quality care in small or rural hospitals.

Staffing and Resource Request. HCAI requests 16 positions and expenditure authority of $3.9 million ($2 million General Fund and $2 million California Health Data and Planning Fund) in 2022-23, and two additional positions and $3.6 million ($1.8 million General Fund and $1.8 million California Health Data and Planning Fund) annually thereafter to oversee and enforce new hospital requirements for discount payment and charity care policies, pursuant to AB 1020. Specifically, HCAI requests the following positions and resources:

Program Staff – Seven positions

- **One Staff Services Manager II** position would direct the work of the new program, oversee program operations, and would be responsible for developing and implementing efficient and effective program policies and procedures.
- **One Associate Governmental Program Analyst (AGPA)** and **One Staff Services Analyst (SSA)** would process and log patient complaints, make recommendations on administrative and program-related issues, tabulate and analyze data, and prepare reports.
- **Four Associate Health Program Advisors** would support planning, implementation, monitoring, and evaluation of the program, as well as perform financial analysis of patient billing complaints including eligibility determinations and penalty determinations.

Legal Staff – Five positions

- **One Assistant Chief Counsel** would lead a team of attorneys, as well as the program staff unit described above, and would be responsible for assignment of reviews and determinations of patient complaints and assessment of associated penalties.

- **Two Attorney II** positions and **two Attorney** positions would support and advise the program on legal matters, carry out the program's investigation and enforcement responsibilities, and make determinations if a violation has occurred and penalties assessed.

Information Technology Staff – Three positions

- **Two Information Technology (IT) Specialist I** positions and **one IT Associate** position would support business application design, engineering, and maintenance; develop, code, support, and enhance system applications; perform system integration, application maintenance and continuous operations, and database administration; and research and evaluate emerging technologies.

Human Resources Staff – One position

- **One AGPA** would support program needs for human resources, pay and payroll, and benefits.

Accounting Staff – Two positions (Beginning 2023-24)

- **Two Accounting Officer Specialists** would perform fiscal and accounting workload for the program, including accounts payable and receivable functions, and management of records in the Financial Information System for California (FI$Cal) and the State Controller's Office.

IT and Language Contract Resources

- HCAI is requesting expenditure authority of $750,000 in 2022-23 and $250,000 annually thereafter for business analysis, system software engineering, and continuous operation to engineer and maintain technology systems to support the program.
- HCAI is also requesting expenditure authority of $25,000 annually for written translation and verbal interpretation services necessary to prepare forms and materials in multiple languages, support review of patient complaints, and provide meaningful access for limited English proficiency consumers.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 7: Workforce for a Healthy California for All

Budget Change Proposal – Governor's Budget. HCAI requests expenditure authority of $296.5 million ($270.5 million General Fund and $26 million Opioid Settlement Fund) in 2022-23, and General Fund expenditure authority of $370.5 million in 2023-24 and 2024-25. If approved, these resources would allow HCAI to support additional loan repayment, scholarship, stipend, and organizational grant awards for health workforce initiatives in its Workforce for a Healthy California for All Program. Of these requested resources, $14.8 million in 2022-23 and $18.5 million in 2023-24 and 2024-25 would support state operations costs to administer the program.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
State Operations:		
0001 – General Fund	$13,525,000	$18,525,000
3397 – Opioid Settlement Fund	$1,300,000	$-
Local Assistance:		
0001 – General Fund	$256,975,000	$351,975,000
3397 – Opioid Settlement Fund	$24,700,000	$-
Total Funding Request:	**$296,500,000**	**$370,500,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested: 2024-25: $370,500,000.

Background. As California continues to make progress providing affordable health coverage to all its residents, current and projected shortages of providers of health care services make it difficult for many Californians, particularly those enrolled in Medi-Cal or with complex health care needs, to easily access necessary medical care. According to the California Future Health Workforce Commission, a diverse body of public, private, and non-profit stakeholders convened to study the state's health workforce needs, California is facing statewide and regional shortages of many essential providers of primary care, behavioral health, public health interventions, and care for older adults. In addition, California lacks an adequate supply of frontline health care workers, such as community health workers (CHWs), home care workers, medical assistants (MAs), and peer support specialists, as well as an adequate supply of all providers with the necessary cultural and linguistic competency to effectively serve the health care needs of an increasingly diverse state.[4]

Primary Care Workforce Shortages. According to the Healthforce Center at the University of California, San Francisco (UCSF), California will likely face a statewide shortfall of clinicians by 2030, with some regions facing greater shortages than others as providers are not evenly distributed across regions of the state. Based on their forecast of provider supply, the Healthforce Center estimates the supply of primary care physicians (MDs) will decrease between 8 and 25 percent because an insufficient number of new primary care MDs are completing residency programs to replace physicians who are projected to retire. The Healthforce Center also estimates that, by 2030, the supply of primary care nurse

[4] California Future Health Workforce Commission. *Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission.* February 2019.

practitioners (NPs) is projected to increase between 82 and 157 percent and the supply of primary care physician assistants (PAs) is projected to increase between 64 and 127 percent. By 2030, nearly half of California's primary care workforce will consist of NPs and PAs, delivering up to 75 percent of all primary care services.[5]

Behavioral Health Workforce Shortages. Similar to primary care, providers of behavioral health services suffer from geographic maldistribution. For example, the San Joaquin Valley and Inland Empire regions have the lowest provider-to-population ratios in the state for almost every category of behavioral health provider, compared to the Bay Area which has more than three times as many psychiatrists by population as those two regions. In addition, most behavioral health occupations do not reflect the racial, ethnic, or gender diversity of the state. African Americans and Latinos are underrepresented among psychiatrists and psychologists, while Latinos are also underrepresented among counselors and clinical social workers. Men constitute the majority of psychiatrists, while women constitute the majority of psychologists, counselors, and social workers.

Training opportunities are similarly maldistributed. For example, there are no residency programs for psychiatrists and no educational programs for mental health nurse practitioners or psychologists north of Sacramento. There are also no doctoral programs in psychology in the Central Coast or San Joaquin Valley regions. While Latino representation among graduates of social work and psychiatric technician programs has improved, Latinos remain underrepresented among graduates of psychiatric residency programs and clinical or counseling psychology programs.

According to Healthforce researchers, based on current supply of providers and demand for service utilization, by 2028 California will have 50 percent fewer psychiatrists than needed to meet the state's mental health needs, and 28 percent fewer psychologists, licensed marriage and family therapists (LMFTs), licensed professional clinical counselors (LPCCs), and licensed clinical social workers (LCSWs) than needed.[6]

Resource Request. HCAI requests expenditure authority of $296.5 million ($270.5 million General Fund and $26 million Opioid Settlement Fund) in 2022-23, and General Fund expenditure authority of $370.5 million in 2023-24 and 2024-25 to support loan repayment, scholarship, stipend, and organizational grant awards for health workforce initiatives in the Workforce for a Healthy California for All Program. Specifically, these resources would support the following workforce initiatives:

- *Community Health Workers.* HCAI is requesting resources to support a new program to recruit, train, and certify 25,000 new community health workers by 2025, with specialized training to work with certain populations including the justice-involved, the unhoused, older adults, or persons with disabilities. According to HCAI, the training requirements would align with Medi-Cal requirements for reimbursement for providing its new community health worker services benefit.

[5] Joanne Spetz, Janet Coffman, and Igor Geyn (Healthforce Center at UCSF). *California's Primary Care Workforce: Forecasted Supply, Demand, and Pipeline of Trainees, 2016-2030*. August 2017.

[6] Janet Coffman, Timothy Bates, Igor Geyn, and Joanna Spetz (Healthforce Center at UCSF). *California's Current and Future Behavioral Health Workforce.* February 2018. https://healthforce.ucsf.edu/publications/california-s-current-and-future-behavioral-health-workforce

- *Comprehensive Nursing Initiative.* HCAI requests resources to increase the numbers of registered nurses, licensed vocational nurses, certified nursing assistants, certified nurse midwives, certified medical assistants, family nurse practitioners, and other health professions. These resources would expand existing workforce programs at HCAI for these professionals. According to HCAI, these resources would annually support 4,509 loan repayments, 1,666 scholarships, and 20 training program grants for nurses and other professionals covered by this program expansion.
- *Social Workers.* HCAI requests resources to increase the number of social workers trained in California by supporting social work training programs and providing stipends and scholarships for working people to create a new pipeline for diverse social workers. According to HCAI, these resources would annually support 250 loan repayments, 620 stipends, and 5 training program grants for social workers' training.
- *Psychiatric Residents.* HCAI requests resources to increase the number of behavioral health providers such as psychiatrists, psychiatric nurse practitioners, and psychologists. Utilizing its existing workforce programs, HCAI expects these resources to result in eight additional residency slots in 2022-23, 10 in 2023-24, and 12 in 2024-25.
- *Multilingual Health Initiatives.* HCAI requests resources to increase the linguistic and cultural competencies in the health workforce by expanding scholarship and loan repayment opportunities for multilingual applicants. According to HCAI, additional slots will be created and set aside in existing health workforce programs for multilingual applicants, including annual support for 389 loan repayments and 459 scholarships.
- *Opioid Response Initiatives.* HCAI requests expenditure authority from the Opioid Settlement Fund of $26 million for two workforce development, training, and supportive employment efforts focused on opioid abuse:
  - Opioid Provider Training - $22 million in 2022-23 would support a three-year grant program, in partnership with the Department of Health Care Services, for community-based substance use disorder (SUD) providers to increase the number of licensed clinicians and non-licensed providers focused on opioid treatment, particularly fentanyl and fentanyl analogs. These grants would support recruitment, retention, and engagement; apprenticeship programs for high school youth; and recruitment of individuals transitioning from incarceration, transition age youth, low socioeconomic status individuals, or multilingual applicants.
  - Vocational Rehabilitation - $4 million in 2022-23 would support the Department of Rehabilitation, with support from HCAI, to establish a pilot project to provide vocational rehabilitation services for consumers with SUD related to opioid use. The pilot will train the provider workforce on how to include employment services as part of participation in treatment.

In addition to support for workforce programs, HCAI requests resources to support the existing Health Workforce Education and Training Council to research healthcare shortages and best practices and strategies to build a diverse, culturally competent health workforce.

State Operations for Administration of Workforce Programs. In addition to direct support for workforce initiatives, HCAI requests expenditure authority of $14.8 million ($13.5 million General Fund and $1.3 million Opioid Settlement Fund) in 2022-23 and General Fund expenditure authority of $18.5 million in 2023-24 and 2024-25 to support state operations costs to administer the 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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 8: Clinical and Capital Infrastructure for Reproductive Health Care

Budget Change Proposal – Governor's Budget. HCAI requests General Fund expenditure authority of $40 million in 2022-23, available for encumbrance and expenditure through June 30, 2028. If approved, these resources would support workforce development and capital infrastructure for providers of reproductive health services. Of these resources, $2 million would support state operations to administer these programs.

Program Funding Request Summary		
Fund Source	**2022-23***	**2023-24**
State Operations:		
0001 – General Fund	$2,000,000	$-
Local Assistance:		
0001 – General Fund	$38,000,000	$-
Total Funding Request:	**$40,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* Resources available for encumbrance or expenditure through June 30, 2028.

Background. The constitutional guarantee of access to reproductive health care is currently under assault by conservative state governments and the recently installed conservative majority in the United States Supreme Court. Protections provided by previous Supreme Court precedents in *Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992) may be overturned in the Court's review of a challenge to a restrictive abortion law in Mississippi that bans most abortions after 15 weeks in *Dobbs v. Jackson Women's Health Organization.* In addition, the Court allowed a Texas law (SB 8) to be implemented that permits anyone to sue an individual who performs or knowingly aids and abets an abortion after a heartbeat is detected. Judgments against these individuals would include an injunction, a minimum of $10,000 in damages, and attorney's fees. The final disposition of the challenge to the constitutionality of SB 8 is pending before the Court in *United States v. Texas.*

In response to the Court's decision allowing SB 8 to be implemented in Texas, more than 40 organizations established the California Future of Abortion Council, including participation and support from reproductive health care providers, reproductive rights and justice advocacy organizations, legal and policy experts, researchers, advocates, the Governor, the Speaker of the Assembly, and the President Pro tempore of the Senate. The Council was convened to identify barriers to abortion services and recommend policy proposals supporting equitable and affordable access to abortion care for Californians and all others who seek care in California. In December 2021, the Council released a report with the following recommendations:

- *Increased Investment in Abortion Funds, Direct Practical Support and Infrastructure.* These investments ensure sufficient financial support for abortions and practical services, including; 1) funds to support the work of abortion organizations, providers, and other community-based organizations; 2) development of an abortion access landing page to provide information for those seeking abortion care in California; 3) funding for practical support infrastructure, capacity building, coordination, and safety measures for providers, clinics, patients, and funds; and 4) improve access to and capacity of Medi-Cal transportation services and encourage use of this benefit by abortion patients.

- *Adequate and Timely Reimbursement for Abortion and Abortion-Related Services.* These investments would ensure cost is not a barrier to care and reimbursement rates and payment policies for abortion and abortion-related care are adequate and streamlined. Specifically, these investments would: 1) create and fund an uncompensated care program for abortion and abortion-related services provided to individuals without other means of paying for care; 2) establish a gap coverage program to provide coverage for Californians lacking coverage for abortion and abortion-related care; 3) Eliminate cost-sharing for abortion and abortion-related services regardless of a patient's insurance type; 4) improve Medi-Cal reimbursement rates to reflect the cost to provide care; 5) establish a supplemental payment program for providers that serve a high volume of Medi-Cal beneficiaries with abortion and abortion-related care; 6) standardize telehealth policies across Medi-Cal and commercial payers and ensure reimbursement on the same basis and at the same rate as in-person care; and 7) more robust oversight by state health plan and insurance regulators to ensure uniform utilization and reimbursement for abortion, abortion-related care, and comprehensive sexual and reproductive health care.
- *Investments in a Diverse California Abortion Provider Workforce.* These investments would focus on expanding the capacity of California's health care workforce to provide high-quality and client-centered abortion care, including: 1) improve the education pipeline by creating a California Reproductive Scholarship Corps to train physicians, nurse practitioners, certified nurse-midwives, physician assistants, and other health care professions; 2) optimize loan repayment to increase retention and recruitment of clinicians who provide abortion; 3) provide financial support for abortion service providers to access affordable insurance coverage; 4) require primary care and family medicine education programs to provide training in miscarriage management, medication abortion, and aspiration abortion; 5) create and fund a grant program for abortion training and for providers serving medically underserved populations; 6) expand the Song-Brown Healthcare Workforce Training Program to include certified nurse-midwives and additional support for abortion training; 7) support California-based organizations providing and enabling clinical abortion training; 8) review competency requirements for abortion training for nurse practitioners, certified nurse-midwives, and physician assistants; and 9) provide grants to implement or re-introduce medication abortion in clinics.
- *Reduce Administrative and Institutional Barriers to Abortion Care.* These investments would focus on eliminating key barriers to abortion and abortion-related care, including: 1) update Medi-Cal billing policies for medication abortion to facilitate equitable access using telehealth consistent with current clinical guidelines; 2) explore mechanisms for California providers to offer medication abortion services to patients residing in other states using telehealth; 3) update Medi-Cal policies that limit access to abortion care including restrictions on coverage later in a pregnancy and ensure coverage to the extent allowed by state law; 4) address existing barriers to abortion care later in pregnancy in licensing boards, and other health care institutions, to address disparities in the interpretation of state law regarding abortion care; 5) assess and address gaps in abortion access in areas of the state primarily served by religiously-affiliated hospitals and health systems; 6) modernize the presumptive eligibility for pregnant women program in Medi-Cal; and 7) provide funding for security infrastructure, training and enforcement of existing security and privacy laws to protect reproductive health care providers patients, and clinics.
- *Strengthen Legal Protections for Abortion Patients, Providers, Supporting Organizations and Individuals.* These investments seek to ensure the privacy and security of abortion patients, providers, and supporters to protect them from criminal, civil, or administrative liability for providing, obtaining, or assisting in abortion care or in the event of pregnancy loss. These investments include: 1) legal protections from civil and criminal liability and disciplinary actions for clinicians that provide abortions to patients in California or other states; 2) protect people from prosecutions and

criminalization of abortion or pregnancy loss; 3) protect patients that self-manage their abortion; 4) protect Californians from third-party enforcement of abortion restrictions; 5) repeal invalidated law requiring parental consent for abortion services; and 6) enhance implementation and compliance with laws protecting patient confidentiality when they seek sensitive services.

- *Address Misinformation and Disinformation and Provide Access to Medically Accurate, Culturally Relevant and Inclusive Education about Abortion and Access to Care.* These investments would expand, strengthen, and ensure the provision of medically accurate and inclusive comprehensive education around sexual and reproductive health, including: 1) adequately fund implementation and monitoring of California's existing comprehensive sexual health education mandate; 2) fund culturally relevant, community-based organizations that serve and provide medically accurate, comprehensive sexual and reproductive health education, including information about abortion, to communities that experience extreme barriers to care; 3) ensure eligible beneficiaries accessing services through the Medi-Cal Minor Consent program or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit have coverage for and access to medically accurate, age appropriate comprehensive sexual health education inclusive of abortion education; and 4) require school districts to participate in the California Healthy Kids Survey and include a module on sexual and reproductive health care in the survey.
- *Support Data Collection, Research, and Reporting to Assess and Inform Abortion Care and Education Needs.* These investments would support research designed to inform policies and improve access to abortion care and education, including: 1) the California Future of Abortion Council progress and impact report; 2) comprehensive community survey and research to identify unmet educational and health needs; 3) data on the effectiveness of sexual health education in public schools; 4) data on the effectiveness and impact of the provision of medication abortion; and 5) data on the effectiveness of current reproductive and sexual health education interventions.

Resource Request. To support implementation of some of the recommendations of the California Future of Abortion Council, HCAI requests General Fund expenditure authority of $40 million in 2022-23, available for encumbrance and expenditure through June 30, 2028, to support workforce development and capital infrastructure for providers of reproductive health services. Specifically, HCAI requests resources for the following:

- *Reproductive Clinical Health Care Workforce.* HCAI requests General Fund expenditure authority of $19 million to support expansion of slots within existing scholarship and loan repayment programs for reproductive health care providers (e.g. physicians, nurse-midwives, physician assistants, and nurse practitioners) who commit to practice in reproductive health clinics for several years. According to HCAI, slots would be expanded in the National Health Corps State Loan Repayment Program, the Steven M. Thompson Physician Corp Loan Repayment Program, and the Advanced Practice Health Scholarship Program.
- *Capital Infrastructure for Reproductive Healthcare Facilities.* HCAI requests General Fund expenditure authority of $19 million to assist reproductive healthcare facilities with capital costs to improve security and privacy protections for abortion providers, patients, volunteers, and staff. Capital costs could include facility security, cybersecurity, security personnel, and staff training.

Of the requested resources, $2 million would support state operations to administer these programs.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 9: Office of Health Care Affordability

Trailer Bill Language and Reappropriation – Governor's Budget. HCAI proposes trailer bill language and requests reappropriation of General Fund authority of $30 million approved in the 2021 Budget Act. If approved these statutory changes and reappropriation of resources would allow HCAI to establish the Office of Health Care Affordability to increase price and quality transparency, develop specific strategies and cost targets for different sectors of the health care industry, and financial consequences for entities that fail to meet these targets.

Program Funding Request Summary		
Fund Source	**2022-23***	**2023-24**
0001 – General Fund	$30,000,000	$-
Total Funding Request:	**$30,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* Reappropriation of $30 million approved in the 2021 Budget Act.

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 Health Care Foundation found approximately one in five Californians reported problems paying medical bills, nearly half of Californians experienced some type of cost-related health care access problem, and more than two in five reported delaying or forgoing care in the previous 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 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 3.4 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 3.6 percent per year, sets and enforces 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.

Office of Health Care Affordability and Health Care Payments Data Program. The Governor, in his 2020 January budget, proposed the establishment of an Office of Health Care Affordability to increase price and quality transparency, develop specific strategies and cost targets for different sectors of the health care industry, and financial consequences for entities that fail to meet these targets. The proposal included expansion and recasting of existing health care cost data efforts as the Health Care Payments Data Program at HCAI, and expected this program to become an integrated part of the data collection efforts to support the efforts of the new Office of Health Care Affordability. Due to the pandemic, the Administration withdrew its proposal to implement the Office of Health Care Affordability, but continued with its proposal to move forward to the next stage of development of the Health Care Payments Data Program.

The 2021 January budget reintroduced the proposal for the Office of Health Care Affordability, with updated statutory language. According to the Administration, the proposed Office of Health Care Affordability would do the following:

- **Set Health Care Cost Targets by Sector.** The Office would establish a statewide health care cost target with the authority to set specific targets by sector, including by payer, provider, insurance market or line of business.
- **Increase Cost Transparency.** The Office would collect and analyze data from existing and emerging public and private data sources to publicly report total health care spending and factors contributing to health care cost growth. The Office would publish an Annual Report and conduct public hearings about performance against the health care cost targets, trends in health care costs, and recommendations for mitigating cost growth.
- **Enforce Compliance with Cost Targets.** The Office would oversee the state's progress towards meeting health care cost targets by providing technical assistance, requiring public testimony, requiring submission of corrective action plans, monitoring progress of corrective action plans, and assessing escalating civil penalties for noncompliance.
- **Promote and Measure Quality and Health Equity.** The Office would utilize HCAI and other departmental data to standardize quality measures for evaluating spending of health care service plans, insurers, hospitals, and physician organizations, with consideration for minimizing administrative burden and duplication.
- **Advance and Monitor Adoption of Alternative Payment Models.** The Office would promote a shift from payments based on 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.
- **Advance Standards for Health Care Workforce Stability and Training Needs.** The Office would monitor the effects of health care cost targets on workforce stability, high-quality jobs, and training needs of health care workers. The Office would develop standards to assist health care entities in implementing cost-reduction strategies that advance the stability of the health care workforce and avoid exacerbating existing health care workforce shortages.
- **Address Consolidation and Market Power.** The Office would monitor cost trends in the health care market including the impact of consolidation and market power on competition, prices, access, and quality. The Office would partner with the Attorney General, Department of Managed Health Care, and Department of Insurance to examine mergers, acquisitions, or corporate affiliations in the health care sector to promote competitive health care markets.

The Administration also proposed to establish a Health Care Affordability Advisory Board within the Office, composed of 11 members. Seven members would be appointed by the Governor, two would be appointed by the Senate Committee on Rules, and two would be appointed by the Speaker of the Assembly. Each board member would be required to have demonstrated and acknowledged expertise in one of several health care delivery, management, consumer, or workforce areas. The board would advise the Director and the Office on the following:

1) Establishment of health care cost targets
2) Collection, analysis, and public reporting of data
3) Factors that contribute to cost growth in the state's health care system
4) Strategies to improve affordability for individual consumers and purchasers of health care
5) Recommendations for administrative simplification in the health care delivery system
6) Approaches for measuring access, quality, and equity of care
7) Setting statewide goals and measuring progress for adoption of alternative payment models and developing standards for payers and providers to use during contracting

8) Recommendations for updates to statute necessary to promote innovation and enable increased adoption of alternative payment models
9) Healthcare workforce stability and training related to health care costs
10) Addressing market failures, including consolidation and market power

Proposed Funding for the Office of Health Care Affordability. In its 2021 January budget proposal, HCAI proposed to support the Office of Health Care Affordability with expenditure authority from the California Health Data and Planning Fund. This fund is supported by annual assessments on licensed health facilities in the state. Section 127280 of the Health and Safety Code authorizes HCAI to establish a fee structure sufficient to pay for required functions of health-related programs it administers, which would include the Office of Health Care Affordability. The 2021 proposal also assumed the General Fund would support initial implementation of the Office and be reimbursed by revenue received for annual assessments. The 2021 Budget Act included General Fund expenditure authority of $30 million for this purpose.

2021 Budget Act Staffing and Resources. The 2021 Budget Act included 58 positions and expenditure authority from the California Health Data and Planning Fund of $11.2 million in 2021-22, 106 positions and $24.5 million in 2022-23, 123 positions and $27.3 million in 2023-24, and 123 positions and $27.3 million annually thereafter to establish the Office of Health Care Affordability. HCAI expected to phase in staff over three years, as shown in the table below:

Office of Health Care Affordability	**2021-22**	**2022-23**	**2023-24 (Ongoing)**
Health Care Affordability Division			
Deputy Director (CEA B)	1	1	1
Chief Medical Officer	1	1	1
Pharmaceutical Consultant II Specialist	1	1	1
Health Program Specialist II (HPS II)	1	1	1
Staff Services Manager I Specialist	1	1	1
Assoc Governmental Program Analyst (AGPA)	1	1	1
Subtotal	**6**	**6**	**6**
Health Care Cost Trends Branch			
Branch Chief (CEA A)	1	1	1
Senior Health Policy Researcher	0	1	1
Office Technician (Typing)	1	1	1
Subtotal	**2**	**3**	**3**
Data Management Unit			
Data Integrity Manager	1	1	1
Senior Data Integrity Specialist	1	2	3
Data Integrity Specialist	1	2	4
Subtotal	**3**	**5**	**8**
Research and Analytics Unit			
Health Policy Research Manager	1	1	1
Senior Health Policy Specialist	1	2	3
Health Policy Specialist	1	2	4

Subtotal	**3**	**5**	**8**
Quality Performance Branch			
Branch Chief (CEA A)	1	1	1
Healthcare Workforce Specialist	0	1	1
Office Technician (Typing)	1	1	1
Subtotal	**2**	**3**	**3**
Quality Analysis Unit			
Unit Manager (Health Program Manager II)	1	1	1
Senior Quality Specialist (HPS II)	2	4	5
Subtotal	**3**	**5**	**6**
Payment Reform Unit			
Unit Manager (Health Program Manager II)	1	1	1
Senior Quality Specialist (HPS II)	2	3	4
Subtotal	**3**	**4**	**5**
Investigations and Enforcement Branch			
Deputy Director (CEA B)	1	1	1
Assistant Chief Counsel	1	2	3
Attorney IV	6	8	8
Attorney III	5	9	16
Office Technician (Typing)	1	1	1
Supervising Corporation Examiner	0	1	1
Corporation Examiner IV (Supervisor)	0	3	3
Corporation Examiner	0	9	9
Auditor I	0	6	6
Staff Services Manager I	0	1	1
AGPA	0	2	2
Staff Services Analyst	0	1	1
Subtotal	**14**	**44**	**52**
Information Technology Services Division			
Data Architect	1	1	1
Prescription Drug Policy Lead (HPS II)	1	1	1
Sr Enterprise Data Warehouse Database Admin	1	1	1
Assoc Enterprise Data Warehouse Admin	1	1	1
Senior Program and Policy Liaison (HPS II)	1	1	1
Assoc Program and Policy Liaison (HPS I)	1	1	1
Prescription Drug Data Lead	1	1	1
Application Developer	0	1	2
Business Analyst	1	1	1
Project Director	1	1	1
Project Manager	1	1	1
Subtotal	**10**	**11**	**12**
Office of Health Care Affordability Subtotal	**45**	**86**	**103**
Shared Resources			
Office of Legislative and Public Affairs			

AGPA	0	1	1
Subtotal	**0**	**1**	**1**
Administrative Services Division			
Associate Administrative Analyst	1	1	1
Contract Analyst (AGPA)	0	1	1
Associate Budget Analyst	1	1	1
Facility Services Analyst (AGPA)	0	1	1
Classification and Pay Analyst	2	2	2
Exams Analyst (AGPA)	1	1	1
Personnel Specialist	1	1	1
Accounting Officer Specialist	1	2	2
Office Technician (Typing)	1	1	1
Subtotal	**8**	**11**	**11**
Information Services Division			
Security Specialist	0	1	1
Infrastructure Engineer	1	2	2
IT Service Desk Technician	1	1	1
Senior Website Developer	1	1	1
Associate Website Developer	1	1	1
IT Acquisitions Specialist	0	1	1
IT Budget and Training Specialist (AGPA)	1	1	1
Subtotal	**5**	**8**	**8**
Shared Resources Subtotal	**13**	**20**	**20**
GRAND TOTAL	**58**	**106**	**123**

Contract Resources. The 2021 Budget Act also included expenditure authority from the California Health Data and Planning Fund for the following contract resources:

- $1.3 million in 2021-22, $750,000 in 2022-23, and $500,000 annually thereafter for information technology (IT) consulting for systems development and continuous operation.
- $400,000 annually for IT software, services, and infrastructure.
- $1.3 million in 2021-22, $550,000 in 2022-23, and $50,000 annually thereafter for program planning and management consulting.
- $2.8 million annually, beginning in 2022-23, for enforcement consulting contracts.

No Resources Expended or Positions Filled Pending Approval of Trailer Bill Language. According to HCAI, despite the approval of state operations resources in the 2021 Budget Act, it has not moved forward with hiring, contracting or other implementation activities for the Office of Health Care Affordability. HCAI indicates it will wait for approval of the trailer bill language authorizing implementation of the office before moving forward with hiring staff or other implementation activities. As a result, HCAI is requesting reappropriation of General Fund expenditure authority approved in the 2021 Budget Act for initial implementation of the Office.

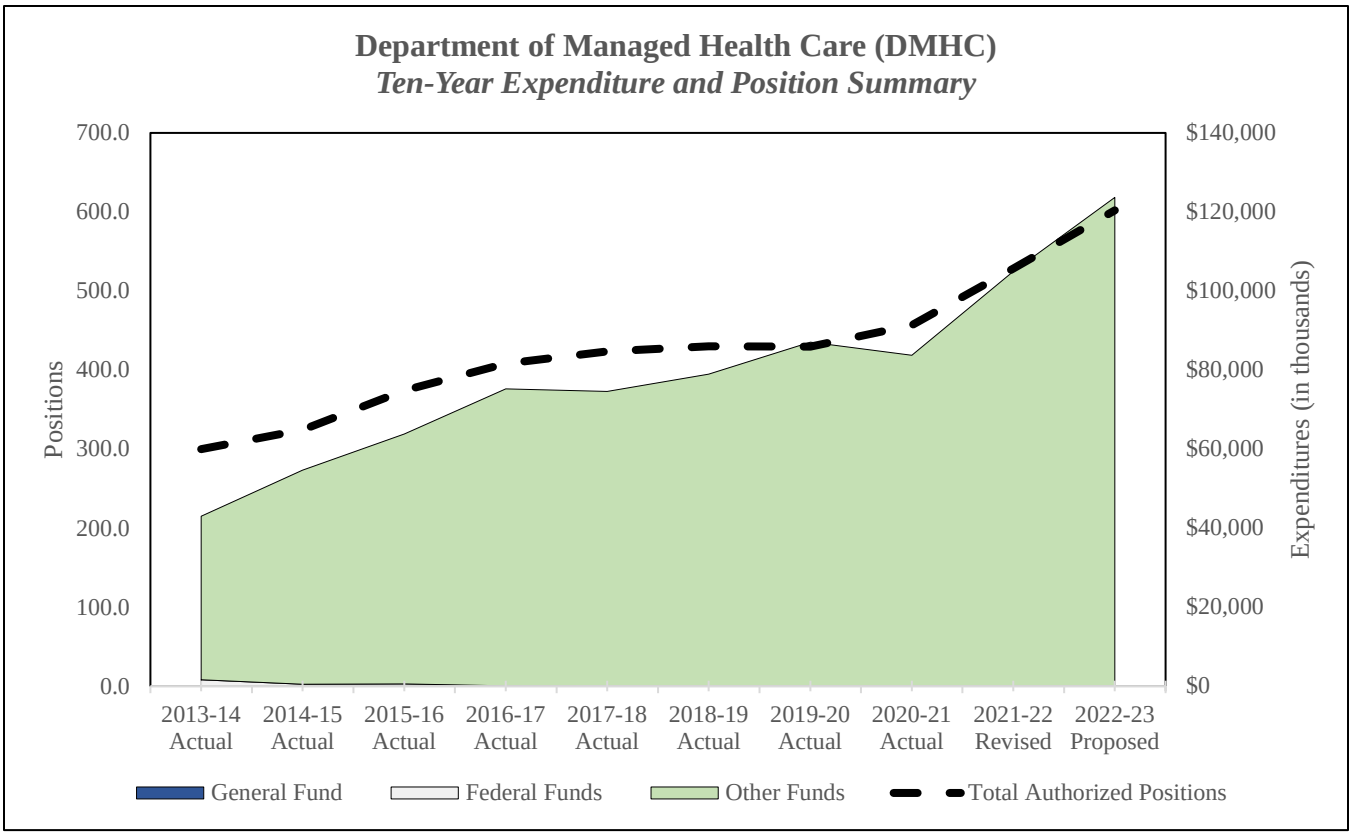
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview



Department of Managed Health Care - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	***2020-21 Actual***	***2021-22 Budget Act***	***2021-22 Revised***	***2022-23 Proposed***
General Fund	$0	$0	$0	$0
Federal Funds	$0	$0	$0	$0
Other Funds	$83,758	$102,444	$104,919	$123,679
Total Department Funding:	**$83,758**	**$102,444**	**$104,919**	**$123,679**
Total Authorized Positions:	**456.6**	**449.3**	**528.5**	**602**
Other Funds Detail:				
Managed Care Fund (0933)	*$83,758*	*$102,444*	*$104,919*	*$123,679*

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 132 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 27.7 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.

DMHC is composed of the following offices and other units:

Help Center. The Help Center educates consumers about their health care rights, resolves consumer complaints against health plans, helps consumers navigate and understand their coverage, and assists consumers in getting timely access to appropriate health care services. The Help Center provides direct assistance in all languages to health care consumers through the department's website (www.HealthHelp.ca.gov) and a toll free number (1-888-466-2219). DMHC collects data on calls received by the Help Center to identify common challenges experienced by consumers to inform potential changes to health plan oversight, regulation, or statutory authority. Common complaints include cancellation of coverage, billing issues, quality of services, coverage disputes, and access complaints. The Help Center often addresses consumer issues through a three-way call between its staff, the consumer, and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Help Center also oversees the independent medical review (IMR) program. IMR is available to consumers if a health plan denies, modifies, or delays a request for a service as not medically necessary or as experimental or investigational. Independent physicians review these issues and make a determination about whether the service should be provided. If an IMR determines the consumer should receive the service, health plans must provide it promptly.

The Help Center also provides assistance to health care providers to ensure they receive timely and accurate payments from health plans. This assistance includes managing individual provider complaints, complaints with multiple claims, emergency service complaints, and non-emergency service complaints.

The Help Center also manages the Independent Dispute Resolution Process (IDRP) for emergency and non-emergency billing disputes, in which an external reviewer adjudicates between payers and providers to determine the appropriate payment rate.

Office of Plan Licensing. The Office of Plan Licensing (OPL) reviews all aspects of a health plan's operations, including benefits and coverage, template contracts with doctors and hospitals, provider networks, mental health parity and complaint and grievance systems. After a health plan is licensed, OPL monitors the plan and any changes made to plan operations, including changes in service areas, contracts, benefits, or systems. OPL also periodically identifies specific licensing issues for non-routine focused examination or investigation.

Office of Plan Monitoring. The Office of Plan Monitoring (OPM) monitors health plan networks and delivery systems. OPM conducts routine surveys every three years, and conducts non-routine surveys when a specific issue or problem requires a focused review of a health plan's operations. OPM also monitors health plan provider networks and the accessibility of services to enrollees by reviewing the geographic standards, provider-to-patient ratios, and timely access to care. Additionally, OPM reviews health plan block transfer filings when a contract terminates between a health plan and a hospital or provider group.

Office of Financial Review. The Office of Financial Review monitors health plan financial statements and filings, and analyzes health plan reserves, financial management systems and administrative arrangements. The Office conducts routine financial examinations of each health plan every three to five years and initiates non-routine financial examinations as needed. The Office also administers the department's premium rate review program, which holds health plans accountable through transparency and ensures consumers get value for their premium dollar. When the Office finds a proposed rate change to be unreasonable, the health plan must notify impacted members of the unreasonable finding.

Office of Enforcement. The Office of Enforcement represents the department in actions to enforce managed health care laws. The primary purpose of an enforcement action is to change plan behavior to comply with the law, and may include issuing cease and desist orders, imposing administrative penalties, freezing enrollment, and requiring corrective actions. When necessary, the Office pursues legal action to ensure health plans follow the law.

Office of Legal Services. The Office of Legal Services provides legal, legislative, and policy analysis and advice to the department, and develops necessary and appropriate regulations to administer the Knox-Keene Health Care Service Plan Act of 1975.

Office of Administrative Services. The Office of Administrative Services provides a variety of administrative support services to the department, including accounting, budgets, business management services, and human resources.

Office of Technology and Innovation. The Office of Technology and Innovation provides technology support to the department including hardware, software, and information security services.

2021 BUDGET ACT INVESTMENTS – IMPLEMENTATION UPDATES

The 2021 Budget Act included important investments and other proposals in the DMHC budget. The subcommittee is monitoring implementation of the following:

Annual Health Care Service Plan Health Equity and Quality Reviews. The 2021 Budget Act included two positions and expenditure authority from the Managed Care Fund of $952,000 in 2021-22, $351,000 in 2022-23, 13 additional positions and $3.6 million in 2023-24, 4.5 additional positions and $4.4 million in 2024-25 and 2025-26, five additional positions and $6.3 million in 2026-27, and $5.4 million annually thereafter for DMHC to establish and enforce health equity and quality standards for all DMHC licensed full-service and behavioral health plans. The Legislature also approved trailer bill language to implement and enforce these new standards.

Implementation Update

- *Annual Health Care Service Plan Health Equity and Quality Reviews.* DMHC reports it is establishing a health equity and quality committee to make recommendations for standard health equity and quality measures to be used to assess health plan performance. The committee will convene on or before March 1, 2022, and will provide initial recommendations by September 30, 2022. The recommendations will consider the following: 1) quality measures including Healthcare Effectiveness Data and Information Set (HEDIS) measures and federal Centers for Medicare and Medicaid Services Child and Adult Core Set measures, 2) surveys or other measures to assess consumer experience and satisfaction, and 3) other child and adult quality or outcome measures including establishing new measures.

  DMHC announced the members of the health equity and quality committee on February 1, 2022. The committee's first meeting will occur on February 24, 2022. The committee includes representatives from the following organizations:

  - Integrated Healthcare Association
  - America's Physician Groups
  - California LGBTQ Health and Human Services Network
  - HealthNet
  - RAND Corporation
  - Health Access California
  - Children Now
  - Justice in Aging
  - Inland Empire Health Plan
  - Latino Coalition for a Healthy California
  - Cedars-Sinai Health System
  - AltaMed
  - California Pan-Ethnic Health Network
  - California Black Health Network
  - National Committee for Quality Assurance
  - Asian Resources, Inc.
  - Disability Rights Education and Defense Fund
  - Department of Health Care Services (ex-officio, non-voting)
  - Covered California (ex-officio, non-voting)
  - California Department of Insurance (ex-officio, non-voting)
  - California Public Employees Retirement System (ex-officio, non-voting)
  - Department of Health Care Access and Information (ex-officio, non-voting)

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 an update on implementation of the following 2021 Budget Act investments:

    a. Annual Health Care Service Plan Health Equity and Quality Reviews

Issue 2: Office of Plan Licensing Workload

Budget Change Proposal – Governor's Budget. DMHC requests three positions and expenditure authority from the Managed Care Fund of $628,000 in 2022-23, $604,000 in 2023-24, one additional position and $842,000 in 2024-25, and $834,000 annually thereafter. If approved, these positions and resources would allow DMHC to address additional workload in its Office of Plan Licensing related to major transaction reviews of health plans.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$628,000	$604,000
Total Funding Request:	**$628,000**	**$604,000**
Total Requested Positions:	**3.0**	**3.0**

* Additional fiscal year resources requested: 2024-25: 842,000; 2025-26 and ongoing: $834,000.

Background. DMHC's Office of Plan Licensing reviews all aspects of a health plan's operations, including benefits and coverage, template contracts with doctors and hospitals, provider networks, mental health parity, and complaint and grievance systems. After a health plan is licensed the Office monitors the plan and any changes made to plan operations, including changes in service areas, contracts, benefits, or systems. The Office also periodically identifies specific licensing issues for non-routine focused examination or investigation.

AB 595 (Wood), Chapter 292, Statutes of 2018, requires a health plan that intends to merge or consolidate with another entity to provide notice and secure prior approval from the DMHC director. DMHC refers to these mergers and consolidations as "change of control transactions". Prior to passage of AB 595, a health plan regulated under the Knox-Keene Act was required to obtain DMHC approval prior to a change of control transaction. However, DMHC's review previously focused on organizational and administrative changes, health delivery system changes, changes to products and subscriber contracts, the effect on the health plan's financial viability, the financing for the transaction, and the merger's impact on consumers. DMHC's approval of a change of control transaction is also frequently contingent on the health plan fulfilling certain commitments, called undertakings, to benefit California enrollees. DMHC's previous merger review did not include review for the impact on competition, as those considerations were outside of DMHC's authority.

AB 595 authorizes DMHC to disapprove a health plan merger or acquisition upon finding the merger either violates the Knox-Keene Act, substantially lessens competition in health care service plan products, or creates a monopoly in the state. AB 595 also clarifies DMHC's existing authority to review mergers and secure health plan undertakings to benefit consumers, and adds requirements to ensure transparency and public participation for major mergers. Specifically, AB 595 requires the following of plans and DMHC:

- Requires a health plan that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition or control by, any entity, including another health plan or health insurer, to give notice to, and secure prior approval from, DMHC.

- Requires the health plan to provide all information necessary for DMHC to approve, conditionally approve, or disapprove the transaction or agreement.
- Allows DMHC to conditionally approve the transaction or agreement, contingent on the health plan's agreement to fulfill required undertakings to benefit enrollees or provide for a stable health care delivery system. DMHC must engage stakeholders in determining the measures for improvement included in the required undertakings.
- Requires DMHC to obtain an independent analysis of the impact of the transaction or agreement on subscribers and enrollees, the stability of the health care delivery system, and other relevant provisions of the Knox-Keene Act, for major transactions or agreements.
- Allows DMHC to disapprove a transaction or agreement if it fails to satisfy the Knox-Keene Act, substantially lessens competition in health care service plan products, or creates a monopoly in the state. DMHC may obtain an opinion from an expert consultant to assess the competitive impact of a transaction.
- Requires DMHC, prior to approving, conditionally approving, or denying a major transaction or agreement, to hold a public meeting on the proposal in accordance with the Bagley-Keene Open Meetings Act. DMHC must consider public comments and testimony from the meeting in making its decision regarding the proposed transaction or agreement.
- Requires DMHC to prepare a statement describing the transaction or agreement if the department determines a material amount of health plan assets is subject to purchase, acquisition, or control, and to make the statement available to the public before any public meeting.
- Requires DMHC to specify fees and obtain reimbursement of reasonable costs payable by the health plans involved in the proposed transaction or agreement.

Staffing and Resource Request. The 2019 Budget Act included expenditure authority from the Managed Care Fund of $1 million annually to allow DMHC to analyze and assess the impact of change of control transactions on subscribers, enrollees, provider networks, the overall stability of the health care delivery system, and anti-competitive impacts, pursuant to the requirements of AB 595. The funding was intended to support a contract with an external consultant to perform independent analyses of these transactions. In its request for these resources, DMHC assumed it would review 10 transactions per year at a cost of $100,000 per analysis.

In the Governor's January budget, DMHC requests three positions and expenditure authority from the Managed Care Fund of $628,000 in 2022-23, $604,000 in 2023-24, one additional position and $842,000 in 2024-25, and $834,000 annually thereafter. According to DMHC, the number of change of control transactions has exceeded the estimate in the 2019 Budget Act request for resources. As a result, DMHC requests positions for the following workload:

- **One Associate Governmental Program Analyst (AGPA)** would track and monitor submissions and responses to health plan undertakings, as well as provide administrative support for public meetings and posting and maintaining the public website.
- **Three Attorney III** positions would review plan documents for legal compliance, including preparing summaries of the filing or briefing memorandum, preparing memos regarding market impact analysis and participating in interdepartmental meetings to gather additional information necessary for AB 595 compliance. Two of the Attorney III positions would begin in 2022-23 and one would begin in 2024-25.

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: Office of Plan Monitoring Workload

Budget Change Proposal – Governor's Budget. DMHC requests 11 positions and expenditure authority from the Managed Care Fund of $3.3 million in 2022-23, and $3.2 million annually thereafter. If approved, these positions and resources would allow DMHC to address routine and follow-up medical surveys on an increasing number of licensed health plans, support increased rates charged by clinical consultants, and manage additional workload from an increase in network review volume, complexity, and technological expertise requirements.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$3,253,000	$3,165,000
Total Funding Request:	**$3,253,000**	**$3,165,000**
Total Requested Positions:	**11.0**	**11.0**

* Positions and resources ongoing after 2023-24.

Background. DMHC's Office of Plan Monitoring monitors health plan networks and delivery systems. The office conducts routine surveys every three years, and conducts non-routine surveys when a specific issue or problem requires a focused review of a health plan's operations. The office also monitors health plan provider networks and the accessibility of services to enrollees by reviewing geographic standards, provider-to-patient ratios, and timely access to care. Additionally, the office reviews health plan block transfer filings when a contract terminates between a health plan and a hospital or provider group.

According to DMHC, the number of licensed health plans and covered lives under the department's jurisdiction has steadily increased from 121 licensed health plans and 25 million covered lives in 2015 to 132 licensed health plans and 27.7 million covered lives in 2020. This increase in plans and covered lives has driven additional survey workload in the Office of Plan Monitoring, including additional triennial routine medical surveys, follow-up surveys, non-routine surveys when necessary, final evaluations of corrective action plans, and review of quality assurance, utilization management, and language assistance policies and procedures. In addition, the increase in plans and covered lives has driven additional provider network oversight workload, including network reviews, oversight of restricted health plans and review of tiered networks.

Staffing and Resource Request. DMHC requests 11 positions and expenditure authority from the Managed Care Fund of $3.3 million in 2022-23, and $3.2 million annually thereafter to address routine and follow-up medical surveys on an increasing number of licensed health plans, support increased rates charged by clinical consultants, and manage additional workload from an increase in network review volume, complexity, and technological expertise requirements. Specifically, DMHC requests positions and resources in the following divisions:

Division of Plan Surveys – Five positions

- **One Assistant Chief Counsel** position would manage one of two attorney units to develop legal memoranda to executive management, develop implementation tools, and provide legal guidance.

- **One Attorney IV** position would coordinate with the Assistant Chief Counsel and other attorneys to complete routine surveys and enforcement referrals, as well as provide legal guidance and consultation to legal and analytical staff in the review of amendments, material modifications, new license applications, and other health plan filings.
- **One Staff Services Manager III** position would provide senior management to one of two analyst units to provide support and management of routine surveys, follow-up surveys, enforcement referrals and management of analytical and contracted clinical staff.
- **One Health Program Specialist (HPS) II** position would manage and oversee routine surveys, follow-up surveys, provide analytical and project management support for enforcement referrals, and review amendments resulting from survey findings and implementation of new legislation.
- **One Associate Governmental Program Analyst (AGPA)** would manage and oversee routine and follow-up surveys, provide technical assistance and guidance to associate analysts for medical surveys, and ensure proper organization and documentation of survey working papers and supporting documents.

Clinical Consultant - $816,000

- DMHC requests expenditure authority from the Managed Care Fund of $816,000 annually to support clinical consultant contracts to assist with conducting routine and follow-up surveys. DMHC contracts with clinical consultants to perform clinical and medical compliance reviews of health plan programs, policies, procedures, reports, and other documents to evaluate the delivery of health care. DMHC has current expenditure authority of $4.4 million to support these consultants, but estimates costs based on expected number of routine, follow-up, and non-routine surveys of $5.2 million.

Division of Provider Networks – Six positions

- **One Assistant Chief Counsel** position would oversee annual network review and timely access reports, handle inter-office coordination, and process changes, including implementation of new laws and regulations.
- **One Attorney IV** position would conduct legal review of the most complex network-related plan filings, review of all submitted health plan documents and reports, identify applicable law, identify areas of potential variations in interpretation, and assist with briefing memos.
- **One Attorney III** position would evaluate plan network reports for legal compliance with network and data submission requirements, develop reports to inform plans of DMHC's determination regarding compliance, and oversee the data collection process including data integrity review, outreach to clarify or validate data errors and ensuring processes are consistent with applicable laws and regulations.
- **One HPS II** position would review health plan filings and reports, prepare comment letters to health plans, and review health plan responses to comment letters.
- **One HPS I** position would perform data integrity reviews, perform outreach to clarify or validate data errors, and collapse network database during network reviews and timely access reports.
- **One Research Data Specialist II** position would serve as the subject matter expert for Tableau data analytics and the geographic information system, assist in development, maintenance, testing, and documenting of stored procedures.

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: Help Center Workload

Budget Change Proposal – Governor's Budget. DMHC requests 21 positions and expenditure authority from the Managed Care Fund of $3.6 million in 2022-23 and $3.4 million annually thereafter. If approved, these positions and resources would allow DMHC to address the increased volume of workload in its Help Center's Consumer and Provider complaint sections including meeting mandated timeframes for complaint review, facilitating a more robust case-auditing process, and aligning supervisory staffing with department growth.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$3,580,000	$3,412,000
Total Funding Request:	**$3,580,000**	**$3,412,000**
Total Requested Positions:	**21.0**	**21.0**

* Positions and resources ongoing after 2023-24.

Background. DMHC's Help Center educates consumers about their health care rights, resolves consumer complaints against health plans, helps consumers navigate and understand their coverage and assists consumers in getting timely access to appropriate health care services. The Help Center provides direct assistance in all languages to health care consumers through the department's website (www.HealthHelp.ca.gov) and a toll free number (1-888-466-2219). DMHC collects data on calls received by the Help Center to identify common challenges experienced by consumers to inform potential changes to health plan oversight, regulation, or statutory authority. Common complaints include cancellation of coverage, billing issues, quality of services, coverage disputes, and access complaints. The Help Center often addresses consumer issues through a three-way call between its staff, the consumer, and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Help Center also oversees the independent medical review (IMR) program. IMR is available to consumers if a health plan denies, modifies, or delays a request for a services as not medically necessary or as experimental or investigational. Independent physicians review these issues and make a determination about whether the service should be provided. If an IMR determines the consumer should receive the service, health plans must provide it promptly.

The Help Center also provides assistance to health care providers to ensure they receive timely and accurate payments from health plans. This assistance includes managing individual provider complaints, complaints with multiple claims, emergency service complaints, and non-emergency service complaints. The Help Center manages the Independent Dispute Resolution Process (IDRP) for emergency and non-emergency billing disputes, in which an external reviewer adjudicates between payers and providers to determine the appropriate payment rate.

According to DMHC, since the implementation of the Affordable Care Act, the Help Center's workload has continued to increase. Help Center staff are experiencing challenges answering incoming phone calls and addressing complaints and IMRs in a timely manner. Despite several initiatives in recent years to

mitigate the workload, maximize efficiency, and leverage technological improvements, DMHC requires additional staff and resources to manage its increasing Help Center workload.

Staffing and Resource Request. DMHC requests 21 positions and expenditure authority from the Managed Care Fund of $3.6 million in 2022-23 and $3.4 million annually thereafter to address the increased volume of workload in its Help Center's Consumer and Provider complaint sections including meeting mandated timeframes for complaint review, facilitating a more robust case-auditing process, and aligning supervisory staffing with department growth. Specifically, DMHC requests the following staff and resources in the following Help Center units:

Contact Center – Two positions

- **One Staff Services Manager (SSM) II** position would oversee organizing, managing and direct processing of Contact Center administrative workload.
- **One Staff Services Analyst (SSA)** would address incoming calls, helpline inquiries, and provide timely customer service to consumers.

Standard Complaint Section – Four positions

- **One SSM II** position would oversee planning, organizing, managing, and direct processing of Standard Complaint Section administrative workload.
- **Three Associate Governmental Program Analysts (AGPA)** would review and resolve consumer standard complaints.

Independent Medical Review Section – Four positions

- **One SSM III** position would oversee the planning, organizing, and direct processing of complaints and IMR requests.
- **One SSM II** position would oversee daily activities of the IMR Section and manage and evaluate workload and staff development.
- **One SSM I** position would monitor daily staff performance, address staff training and development, assist analytical staff with sensitive and complex cases, and review data reports.
- **One AGPA** would review IMR requests and health plan responses.

Provider Complaint Section – Three positions

- **One SSM I** position would provide daily support and oversight to the analytical professional staff in the Provider Complaint Section.
- **Two AGPAs** would review and resolve provider complaints and IDRP submissions.

Legal Affairs Branch – Six positions

- **One SSM II** position would oversee the planning, organizing, managing, and direct processing of the Legal Affairs Branch administrative workload.

- **One SSM I** position would monitor daily staff performance, address staff, training and development, and assist analytical and legal support staff with sensitive and complex cases.
- **Two Attorney IV** positions would address the most complex complaints, and compose medical expert analysis requests and correspondence.
- **Two AGPAs** would provide analytical support to address incoming correspondence and complaint workload.

Data Analytics Unit – One position

- **One Research Data Specialist I** position would address data requests and assist in ensuring data integrity.

Spotlight Support Unit – One position

- **One AGPA** would address additional workload resulting from the increased volume of quality assurance audits for consumer complaints and IMRs and would support the Provider and Consumer Customer Relationship Management (CRM) modules.

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: Administrative Workload

Budget Change Proposal – Governor's Budget. DMHC requests 12 positions and expenditure authority from the Managed Care Fund of $3.5 million in 2022-23, $3.4 million annually between 2023-24 and 2028-29, and $2.2 million annually thereafter. If approved, these positions and resources would allow DMHC to support administrative workload including human resources, business services, legal services, information technology, support for addressing systemic racism in the workplace, and to align supervisory, analytical and professional staffing with department growth.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$3,520,000	$3,424,000
Total Funding Request:	**$3,520,000**	**$3,424,000**
Total Requested Positions:	**12.0**	**12.0**

* Positions and resources ongoing after 2023-24 until 2028-29. 2029-30 and ongoing: $2,224,000.

Background. According to DMHC, the department's expenditure authority has grown more than 30 percent, from $80 million to $104 million, and its position authority more than 14 percent, from 451 employees to 516 employees, between 2017-18 and 2021-22. Much of this growth is due to the implementation of several different program responsibilities, pursuant to various federal and state laws and regulations. DMHC reports that as its staff and programs have grown, its administrative staff performing human resources and other administrative functions, information technology (IT) services, and legal services have not kept pace with this growth.

DMHC's Office of Administrative Services reports significant workload increases from procuring IT goods and services, processing payroll related transactions, implementing new personnel laws and regulations, and implementing policies to address systemic racism. The Office provides administrative support of budgets, business services, procurements and contracting, request for personnel actions (RPAs), recruitment, meeting preparation, legislative analysis, invoice processing, and administrative consultation.

DMHC's Office of Technology and Innovation reports significant increased workload to respond to new legislation and regulations. In particular, DMHC reports compliance with accessibility requirements pursuant to AB 434 (Baker), Chapter 780, Statutes of 2017, has driven increased workload. In addition, modernization projects driven by implementation of AB 315 (Wood), Chapter 905, Statutes of 2018, AB 2674 (Aguiar-Curry), Chapter 303, Statutes of 2018, and AB 290 (Wood), Chapter 862, Statutes of 2019, have resulted in increased workload to modernize the department's Provider Complaint System, implement a new Delegated Entity Registration System and a new Delegated Entity Electronic Filing System for Pharmacy Benefit Management organizations, and modernize the Risk Bearing Organization Electronic Filing System.

DMHC's Office of Legal Services conducts legal research, drafts legal analyses, and makes policy and operational recommendations consistent with those analyses. The Office also leads rulemaking activities including pre-notice stakeholder engagement, drafting regulation language, creating the regulation packages, conducting public hearings, and responding to public comments. The Office also handles requests for information under the Public Records Act (PRA), Information Practices Act (IPA), and court

subpoenas. These requests often cover records related to health plan filings, block transfers, timely access data and statistics, and rulemaking files. Since 2014, DMHC reports the Office has seen a constant increase in PRA and IPA requests, increasing by 52 percent since 2011.

Staffing and Resource Request. DMHC requests 12 positions and expenditure authority from the Managed Care Fund of $3.5 million in 2022-23, $3.4 million annually between 2023-24 and 2028-29, and $2.2 million annually thereafter to support administrative workload including human resources, business services, legal services, information technology, support for addressing systemic racism in the workplace, and to align supervisory, analytical and professional staffing with department growth. Specifically, DMHC requests positions and resources in the following Offices:

Office of Administrative Services – Five positions

- **One Staff Services Manager I** position would serve as a dedicated Equal Employment Opportunity (EEO) officer in the Office, participate in implementing DMHC's diversity, equity, and inclusion goals, assist in implementing processes, policies, and procedures to make DMHC a more transparent and equitable department and seek to reduce disparities and inequities.
- **One Senior Personnel Specialist** would be responsible for processing various, more complex personnel transactions.
- **One Personnel Specialist** would be responsible for processing routine personnel transactions.
- **One Associate Governmental Program Analyst (AGPA)** would prepare and maintain budget, procurement, and contract tracking documents, as well as assist in legislative fiscal analysis and developing and managing contract and RPA documents.
- **One Office Technician** would process confidential human resources mail, confidential document filing, track probationary reports and annual performance appraisals for DMHC staff, manage the human resources email in-box, respond to general human resources inquiries and perform other support duties.

Office of Technology and Innovation – Five positions

- **Two Information Technology (IT) Manager I** positions would provide managerial support and align ratios between employees and manager in the Office. One of the positions would also serve as the Office's Configuration and Quality Manager.
- **One IT Supervisor II** position would consolidate and supervise all server and desktop support activities.
- **One IT Specialist III** position would be responsible for modernizing and maintaining the department's enterprise architecture across the enterprise software, infrastructure, and business intelligence domains.
- **One IT Specialist II** position would serve as the Senior Configuration Specialist and act as lead for all ongoing low-code cloud solutions development.

Office of Legal Services – Two positions

- **One AGPA** and **one Staff Services Analyst** would provide administrative and analytical support, review documents for confidential information, process regulations through the formal rulemaking process, and assist with processing of PRA and IPA requests.

Consultant Funding - $1.2 million (2022-23 through 2028-29)

- DMHC requests expenditure authority from the Managed Care Fund of $1.2 million from 2022-23 until 2028-29 for technical service augmentation for legacy solution maintenance and operations. Contracted staff would include a Senior Software Developer ($246,648), a Senior Project Manager ($325,040), and a Senior Configuration Specialist ($630,960).

Cloud Subscription Costs - $325,000

- DMHC requests expenditure authority from the Managed Care Fund of $325,000 annually for cloud subscription costs to acquire modern, low-code business intelligence technology to support an internally-facing modern data and analytics platform.

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 6: Protection of Patient Choice in Telehealth Provider Act (AB 457)

Budget Change Proposal – Governor's Budget. DMHC requests three positions and expenditure authority from the Managed Care Fund of $1.1 million in 2022-23, $957,000 in 2023-24, and $614,000 annually thereafter. If approved, these positions and resources would allow DMHC to oversee health plan compliance with new telehealth rules, pursuant to the provisions of AB 457 (Santiago), Chapter 439, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$1,130,000	$957,000
Total Funding Request:	**$1,130,000**	**$957,000**
Total Requested Positions:	**3.0**	**3.0**

* Additional fiscal year resources requested – 2024-25 and ongoing: $614,000.

Background. AB 457 (Santiago), Chapter 439, Statutes of 2021, establishes the Protection of Patient Choice in Telehealth Provider Act, which implements consumer protections for services received through third-party corporate telehealth providers. Health plans, prior to offering a service to an enrollee through a third-party corporate telehealth provider, must disclose to the enrollee the availability of receiving the service on an in-person basis or via telehealth from the enrollee's own provider and a reminder of the availability of receiving the service through an out-of-network provider, including all cost-sharing obligations and balance billing protections. If an enrollee chooses and consents to receive the service through a third-party corporate telehealth provider, the plan must: 1) notify the enrollee of their right to access their medical records, 2) notify the enrollee and ensure that records are shared with their primary care provider unless the enrollee objects, 3) notify the enrollee the service is available at in-network cost-sharing and 4) advise the enrollee of any cost-sharing obligations.

In addition to notifications to enrollees, a health plan must include the following information in its annual network filing report to DMHC:

- Total number of services delivered via third-party corporate telehealth providers, by specialty.
- Names of each third-party corporate telehealth provider contracted with the plan and, for each, the number of services provided by specialty.
- The percentage of each third-party corporate telehealth provider's contracted providers available to the plan's enrollees that are also contracting individual health professionals.
- The types of telehealth services utilized by enrollees for each third-party corporate telehealth provider, including frequency of use, gender, age, and any other information determined by DMHC.
- For each enrollee that has accessed services from a third-party corporate telehealth provider, enrollee demographic data, including gender and age, and any other information determined by DMHC.

AB 457 also authorizes DMHC to investigate and take enforcement action against health plans that fail to comply with its requirements and requires DMHC to periodically evaluate health plan contracts to determine if any audit, evaluation, or enforcement actions are necessary. According to DMHC, these requirements will result in the need to develop four new reports as part of health plan annual network data submissions. These reports focus on the services delivered by third-party corporate telehealth providers,

identifying the individual providers, the potential overlap with in-person providers, and information regarding the enrollees who access third-party corporate telehealth providers.

Staffing and Resource Request. DMHC requests three positions and expenditure authority from the Managed Care Fund of $1.1 million in 2022-23, $957,000 in 2023-24, and $614,000 annually thereafter to oversee health plan compliance with new telehealth rules, pursuant to the provisions of AB 457. Specifically, DMHC requests the following positions and resources:

Office of Legal Services –Resources equivalent to 0.5 position

- Resources equivalent to **0.5 Attorney III** position would conduct complex policy research and legal analysis, issue legal memoranda, and promulgate a regulation to clarify the annual report format, conduct stakeholder meetings, and develop the process for collecting overpayments.

Office of Plan Licensing – One position

- **One Attorney III** position would annually review evidence of coverage documents, provider contracts, plan-to-plan contracts, policies and procedures, consent forms, and other health plan documents for compliance with AB 457.

Office of Plan Monitoring – Two positions and resources equivalent to 0.5 position

- **One Attorney III** position would develop and review the four new third-party corporate telehealth provider report forms and promulgate regulations to clarify the requirements of AB 457.
- **One Health Program Specialist (HPS) I** position would assist in the development and annual review of the four new third-party corporate telehealth provider report forms as part of the annual health plan network filings.
- Resources equivalent to **0.5 HPS I** position would assist in revising templates and instructions for health plan reporting and develop tools for conducting annual network reviews.

Consultant Funding - $343,000

- DMHC requests expenditure authority from the Managed Care Fund of $343,000 in 2023-24 to enhance its network adequacy analysis system, ArcGIS, to incorporate the data sets required by AB 457. According to DMHC, these resources would support a developer consultant ($185,000), a project manager ($79,000), and a business analyst consultant ($79,000). These estimates are based on DMHC's previous experience with similar network adequacy analysis.

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 7: Health Care Coverage – Deductibles and Out-of-Pocket Expenses (SB 368)

Budget Change Proposal – Governor's Budget. DMHC requests two positions and expenditure authority from the Managed Care Fund of $591,000, $571,000 in 2023-24, and $456,000 annually thereafter. If approved, these positions and resources would support review of health plan documents to determine compliance with requirements that plans provide enrollees with accrual balances toward their deductible and out-of-pocket maximum, pursuant to SB 368 (Limón), Chapter 602, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$591,000	$571,000
Total Funding Request:	**$591,000**	**$571,000**
Total Requested Positions:	**2.0**	**2.0**

*Additional fiscal year resources requested – 2024-25 and ongoing: $456,000.

Background. SB 368 (Limón), Chapter 602, Statutes of 2021, requires health plans and insurers to monitor and provide to an enrollee the accrual toward their annual deductible or out-of-pocket maximum. Plans and insurers must provide this information to enrollees every month in which benefits are used until the accrual balance equals the full deductible amount or full maximum out-of-pocket amount. Plans and insurers must also establish and maintain a system to allow an enrollee to request their most updated accrual balances.

According to DMHC, the department currently ensures health plans comply with existing provisions of the Knox-Keene Health Care Service Plan Act of 1975 that require plans to inform enrollees of the amount of their cost-sharing, including deductibles and out-of-pocket maximums, in an evidence of coverage or disclosure form. The additional health plan requirements imposed by SB 368 require DMHC to do the following:

- Promulgate a regulation to clarify the scope and parameters of the system health plans must implement to allow an enrollee to request their updated accrual balances, the standards for how a plan informs enrollees of their accruals, and the requirements for how plans must monitor this accrual.
- Establish through regulation what constitutes a violation of SB 368 and potential penalties.
- Annually review health plan documents, including evidence of coverages, disclosure forms, summary of benefits, and subscriber contracts to ensure compliance with SB 368.
- Annually review provider contracts and plan-to-plan contracts to ensure compliance with SB 368.
- Annually review policies and procedures, including the health plan's system that allows an enrollee to request their updated accrual balances.

Staffing and Resource Request. DMHC requests two positions and expenditure authority from the Managed Care Fund of $591,000, $571,000 in 2023-24, and $456,000 annually thereafter to support review of health plan documents to determine compliance with requirements that plans provide enrollees with accrual balances toward their deductible and out-of-pocket maximum, pursuant to SB 368. Specifically, DMHC requests the following positions and resources:

Office of Plan Licensing – Two positions

- **Two Attorney III** positions would annually review evidence of coverages, provider contracts, plan-to-plan contracts, and other health plan documents for compliance with SB 368.

Office of Legal Services – Resources equivalent to 0.5 position (2022-23 and 2023-24)

- Resources equivalent to **0.5 Attorney III** position would conduct legal research, issue legal memoranda, and promulgate a regulation package for SB 368 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 8: Follow-Up Appointments for MH/SUDS Timely Access Standards (SB 221)

Budget Change Proposal – Governor's Budget. DMHC requests 16 positions and expenditure authority from the Managed Care Fund of $3.9 million in 2022-23, an additional three positions and $4.5 million in 2023-24, $4.3 million in 2024-25, $4.4 million in 2025-26, and $4.2 million annually thereafter. If approved, these positions and resources would allow DMHC to address timeliness standards for follow-up appointments for certain mental health and substance use disorders, pursuant to the requirements of SB 221 (Wiener), Chapter 724, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$3,882,000	$4,479,000
Total Funding Request:	**$3,882,000**	**$4,479,000**
Total Requested Positions:	**16.0**	**19.0**

* Additional fiscal year resources requested – 2024-25: $4,267,000; 2025-26: $4,357,000; 2026-27: $4,151,000; 2027-28 and ongoing: $4,241,000.

Background. SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and insurers, applies those requirements to Medi-Cal managed care plans, prohibits contracting providers and employees from being disciplined for informing patients about timely access standards, and adds a new standard for non-urgent follow up appointments for non-physician mental health care or substance use disorder providers that is within 10 business days of the prior appointment.

AB 2179 (Cohn), Chapter 797, Statutes of 2002, required DMHC to adopt regulations by January 1, 2004, to ensure access to needed health care services in a timely manner. DMHC's timely access regulation requires health plan networks be sufficient to meet a set of standards, which include specific timeframes under which enrollees must be able to obtain an initial appointment with a health care provider, as well as wait times to access urgent and non-urgent care appointments, and the availability of telephone triage or screening services during and after regular business hours. The timely access standards for appointment availability are as follows:

- Urgent care without prior authorization: within 48 hours
- Urgent care with prior authorization: within 96 hours
- Non-urgent primary care appointments: within 10 business days
- Non-urgent specialist appointments: within 15 business days
- Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: within 15 business days.

SB 964 (Hernandez), Chapter 573, Statutes of 2014, required DMHC to develop standardized methodologies for measuring compliance with timely access standards, collect data from health plans annually regarding compliance, and publish findings on health plan compliance in an annual timely access report.

According to DMHC, SB 221 makes several changes to the Knox-Keene Act, including:

- Deletes sections directing DMHC to develop timely access regulations and instead codifies many of the standards contained within those regulations.
- Requires a health plan, as of July 1, 2022, to ensure that its contracted provider network can offer non-urgent follow-up appointments with a nonphysician mental health care or substance use disorder provider within 10 days of the prior appointment, or longer if such a wait does not have a detrimental impact on the health of the enrollee.
- Requires interpreter services with scheduled appointments for health care services, without delaying the scheduling of the appointment.
- Requires a health plan that uses a tiered network to demonstrate compliance with timely access standards at the lowest cost-sharing tier.
- Requires a health plan to arrange out-of-network coverage if medically necessary treatment of mental health or substance use disorder is not available in-network.
- Includes mental health and substance use disorder providers in provisions related to advanced scheduling, telephone triage requirements, and requirements for plans to arrange out-of-network coverage if the treatment is not available in-network.
- Requires DMHC's methodology for health plan timely access reporting to include demonstration of the average waiting time for each class of appointment.

DMHC expects implementation of SB 221 to result in the following workload for the department:

- Promulgate timely access regulation to clarify SB 221 requirements and the new standards for follow-up appointments for nonphysician mental health and substance use disorder providers.
- Promulgate regulation to develop standards to make specific network requirements for health plans to comply with timely access standards.
- Establish parameters and standards for adequate capacity, availability and sufficiency of provider types subject to timely access standards.
- Revise the methodology for health plan reporting to include demonstration of the average waiting time for each class of appointment.
- Develop standardized reporting methodologies for health plans to demonstrate compliance with SB 221.
- Issue guidance on follow-up appointments by July 1, 2022, and promulgate regulations by January 1, 2025.
- Annually review health plan documents for compliance with timely access standards.
- Investigate and take enforcement action or assess administrative penalties against health plans for noncompliance with SB 221.

Staffing and Resource Request. DMHC requests 16 positions and expenditure authority from the Managed Care Fund of $3.9 million in 2022-23, an additional three positions and $4.5 million in 2023-24, $4.3 million in 2024-25, $4.4 million in 2025-26, and $4.2 million annually thereafter to address timeliness standards for follow-up appointments for certain mental health and substance use disorders, pursuant to the requirements of SB 221. Specifically, DMHC requests positions and resources as follows:

Office of Legal Services – Resources equivalent to 0.5 position

- Resources equivalent to **0.5 Attorney III** position would conduct complex policy research and legal analysis, issue legal memoranda, and develop standardized methodologies for reporting to promulgate timely access regulations pursuant to SB 221.

Office of Enforcement – Eight positions

- **0.5 Assistant Chief Counsel** position would oversee complex referrals from the Office of Plan Monitoring, including initial review of referral documents and team requirements for staffing, as well as attend trials, oversee complex review of settlement negotiations or judgements, conduct meetings with primary attorneys, review details of referrals, and consult with experts for purposes of evaluating and reviewing trial and hearing preparation.
- **Three Attorney III** positions would coordinate with the Office of Plan Monitoring to evaluate case and document production, perform complex legal review and analysis of the findings reports, conduct legal research of statutes, respond to complex legal questions during investigations, and develop strategies to respond to difficult and sensitive matters.
- **Two Attorneys** would coordinate with the Office of Plan Monitoring to address annual network review referrals, including review of procedural or moderately complex compliance violations to evaluate cases, investigate, negotiate settlements, recommend corrective action, and prepare appropriate course of resolution.
- **1.5 Legal Assistant** positions would finalize any documents prepared by attorneys, manage documents and information in the case management database, review and coordinate discovery specific documents and filings.
- **0.5 Associate Governmental Program Analyst (AGPA)** would prepare and maintain an attorney log and all other supporting administrative functions, manage all enforcement action settlement documents, input settlement related data into the case management database, and prepare a monthly Resolution Summary Report.
- **0.5 Legal Analyst** would assist attorneys with planning investigations and conducting legal research.

Office of Plan Monitoring – Five positions (eight positions beginning 2023-24)

- **Three Attorney III** positions would provide legal guidance and review health plan documents, aid with enforcement actions and referrals, draft and amend regulations to resolve conflicts with SB 221 and add new network adequacy requirements, review filings related to SB 221 implementation, prepare and review new data in health plan submissions, create and implement a filing checklist for the new follow-up appointment standards, and review amended timely access policies and procedures.
- **Three Health Plan Specialist II** positions, two beginning in 2022-23 and one beginning in 2023-24, would assist in the development of the methodology and assessment tools, prepare reports and supporting documents, oversee corrective action plan submittals, manage and coordinate documents and data, assist in reviews related to regulatory amendments, provide technical advice on impact to programs, finalize the implementation checklist, draft report form instructions for regulation and for web portal validations, review implementation policies and procedures, provide web portal updates, analyze plan data, develop network finding and timely access reports, provide support in development of regulations and standards, assist in implementing the developed regulatory standards into existing network reviews, and evaluate data for capacity, availability, and sufficiency standards.

- **Two Health Plan Specialist I** positions, beginning in 2023-24, would assist in review of implementation policies and procedures and annual plan data submissions, implement developed regulatory standards into existing network reviews, evaluate data for capacity availability and sufficiency standards under existing network review, assist in preparation of a provider data repository, review plan submissions, assist in development of network finding timely access reports development, and review and track enforcement referrals.

Office of Administrative Services – One position

- **One AGPA** would provide administrative support for these new positions, including accounting, budgeting, human resources, training, organizational effectiveness, and business management.

Office of Technology and Innovation – Two positions

- **One Information Technology Specialist II** position would support backlog creation for the timely access application enhancements; implement changes to support data collection, data validation, and data processing; collaborate with business stakeholders and the Quality Assurance team to verify SB 221 related functionality; implement changes based on testing feedback; and collaborate with business stakeholders and the Business Intelligence Division to enhance and develop reports to support SB 221 requirements.
- **One Information Technology Specialist I** position would support information technology needs for new staff including new employee setup, service requests, change requests, collection of data analytics, security log analysis, and ongoing maintenance of each new staff members' devices.

Consultant Funding – $611,000 in 2022-23, $855,000 in 2023-24, $667,000 in 2024-25, $757,000 in 2025-26, $667,000 in 2026-27, $757,000 annually thereafter

- DMHC requests expenditure authority from the Managed Care Fund of $611,000 in 2022-23, $855,000 in 2023-24, $667,000 in 2024-25, $757,000 in 2025-26, $667,000 in 2026-27, and $757,000 annually thereafter to support the following consultant contracts: 1) a statistical consultant to assist in developing the regulations; 2) a clinical consultant to assist with ongoing review of health plans policies and procedures, and analyze utilization management processes; and 3) an expert witness consultant to assist with trials .

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 9: Health Care Coverage – Step Therapy (AB 347)

Budget Change Proposal – Governor's Budget. DMHC requests 12 positions and expenditure authority from the Managed Care Fund of $3.1 million in 2022-23, and $3 million annually thereafter. If approved, these positions and resources would allow DMHC to address step therapy requirements implemented pursuant to AB 347 (Arambula), Chapter 742, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$3,116,000	$2,975,000
Total Funding Request:	**$3,116,000**	**$2,975,000**
Total Requested Positions:	**12.0**	**12.0**

* Additional fiscal year resources requested – 2024-25 and ongoing: $3,020,000.

Background. Step therapy is a type of prior authorization for prescription drugs that begins medication for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary. The Knox-Keene Act authorizes a health plan to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition. The Act also requires health plans to issue a decision on a prior authorization request within 72 hours of receipt of the request, or within 24 hours in expedited cases.

AB 347 (Arambula), Chapter 742, Statutes of 2021, establishes a timeline for approval or denial of step therapy exception requests for prescription drugs based on the existing timeline for prior authorization requests for prescription drugs. Beginning January 1, 2022, a health plan or insurer must grant a request for exception from step therapy if a provider determines the use of the drug required under step therapy is inconsistent with good professional practice for the provision of medically necessary covered services, while taking into consideration the enrollee's needs, medical history, and professional judgment. If a health plan requires additional information to make a determination, AB 347 requires notification to the prescribing provider. Once the health plan receives the requested information, the time period to approve or deny a prior authorization or step therapy request would begin. Enrollees may appeal to the health plan under existing grievance processes and providers may appeal under the health plan's utilization management procedures.

According to DMHC, AB 347 would require the department to do the following:

- Promulgate a regulation to clarify the requirements of AB 347.
- Develop new medical survey questions and procedures related to AB 347.
- Review the new internal appeals process and review any related revised grievance policies and procedures.
- Review revised prescription drug policies and procedures.
- Review provider contracts, administrative service agreements, and plan-to-plan agreements with utilization review organizations that perform utilization review or utilization management functions on a health plan's behalf.
- Review product formularies and prescription drug benefits charts for compliance with the step therapy and appeal requirements.

- Review health plan documents, including evidence of coverage and disclosure forms, utilization management data and health plan survey data to ensure compliance with AB 347.
- Investigate and take enforcement action or assess administrative penalties against health plans not in compliance with AB 347.

Staffing and Resource Request. DMHC requests 12 positions and expenditure authority from the Managed Care Fund of $3.1 million in 2022-23, and $3 million annually thereafter to address step therapy requirements implemented pursuant to AB 347. Specifically, DMHC requests positions and resources as follows:

Office of Plan Licensing – Three positions

- **Two Attorney III** positions would design filing review guidelines for internal review, summarize and review plan documents for legal compliance, prepare deficiency comment letters, conduct teleconferences with plans to resolve issues, submit periodic written and oral reports, coordinate weekly review, and provide annual compliance training.
- **One Associate Governmental Program Analyst (AGPA)** would assist with developing the structure of the compliance project, identifying specific compliance requirements within plan disclosure documents, creating and maintaining weekly tracking reports, conducting initial administrative file review of plan submissions, participating in compliance training, and assisting with the annual review of plan documents.

Office of Plan Monitoring – Four positions

- **Two Attorney III** positions would develop regulations, provide ongoing legal review and consultation, revise survey tools, provide legal guidance for medical surveys, and draft enforcement referrals for uncorrected AB 347 deficiencies.
- **One Health Program Specialist II** position would review health plan amendment filings and survey findings, develop survey scope of work, conduct analysis of health plan information related to AB 347 requirements, review and validate deficiency findings in medical surveys, and assist with drafting enforcement referrals for uncorrected AB 347 deficiencies.
- **One AGPA** would develop, implement, and maintain administrative and analytical program activities to monitor compliance with AB 347.

Office of Enforcement – Three positions

- **0.5 Assistant Chief Counsel** position would oversee complex enforcement referrals, attend trials, oversee review of settlement negotiations or judgments, meet with primary attorneys, review details of referrals, consult with experts to evaluate the referral and prepare for trial and hearings, and address staffing and training due to the nature of the investigations and subsequent prosecutions.
- **Two Attorney III** positions would provide legal support to evaluate enforcement referrals, including drafting and sending investigative discovery, recommending course of action, negotiating settlement and corrective action, preparing appropriate course of resolution, and conducting pre-trial preparations, court order status conference briefs, settlement conference statements, attendance and preparation for trial and hearings, post-trial briefings, and enforcement of verdicts.

- **0.5 AGPA** would prepare an attorney log and a monthly report, manage all enforcement action settlement documents, manage the administrative side of the Office's contract and procurement needs, prepare resolution summary reports, and conduct administrative tasks.

Office of Administrative Services – One position

- **One AGPA** would provide administrative support for these new positions, including accounting, budgeting, human resources, training, organizational effectiveness, and business management.

Office of Technology and Innovation – One position

- **One Information Technology (IT) Specialist I** position would provide IT support including application and system development and support, procurement and management of IT assets, and data security and support for staff members' IT needs.

Consultant Funding – $681,000

- DMHC requests expenditure authority from the Managed Care Fund of $583,000 annually for a clinical consultant to assist the Office of Plan Monitoring with review of amendments to health plan utilization management policies and conduct clinical assessments during medical surveys.
- DMHC requests expenditure authority from the Managed Care Fund of $45,000 biannually to support a medical expert consultant for the Office of Enforcement.
- DMHC requests expenditure authority from the Managed Care Fund of $53,000 annually to support trial-related costs for the Office of Enforcement.

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 10: Health Care Coverage – Employer Associations (SB 255)

Budget Change Proposal – Governor's Budget. DMHC requests one position and expenditure authority from the Managed Care Fund of $237,000 in 2022-23 and $229,000 annually thereafter. If approved, this position and resources would allow DMHC to conduct annual reviews of Multiple Employer Welfare Arrangement (MEWA) documents, pursuant to SB 255 (Portantino), Chapter 725, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$237,000	$237,000
Total Funding Request:	**$237,000**	**$237,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and resources ongoing after 2023-24.

Background. SB 255 allows a multiple employer welfare arrangement (MEWA), an association of employers, to offer a large group health plan contract or health insurance policy if the following conditions are met:

- The association was established prior to March 23, 2010.
- The association provides an equivalent to or greater level of coverage than the platinum level offered through the Covered California health benefit exchange.
- The association provides the essential health benefits.
- The association includes coverage for job categories on a project-by-project basis for one or more participating employers, for at least 101 employees.

SB 255 also requires the association to file an application for registration with DMHC or the Department of Insurance on or before June 1, 2022, and annually file evidence of ongoing compliance.

According to DMHC, SB 255 would require the following workload:

- Develop a MEWA registration process by June 1, 2022.
- Create processes for MEWA registration including research, checklist for requirements for documentation, registration application form, annual compliance requirement process or form, and any necessary outreach to stakeholders.
- Issue guidance to MEWAs regarding registration requirements and ongoing compliance with state laws and regulations, as well as advise health plans of MEWA eligibility criteria.
- Review initial applications for the exemption to determine whether required documentation was submitted and if the documentation supports approval of the registration.
- Annually review each MEWA for ongoing compliance with SB 255.

Staffing and Resource Request. DMHC requests one position and expenditure authority from the Managed Care Fund of $237,000 in 2022-23 and $229,000 annually thereafter to conduct annual reviews of Multiple Employer Welfare Arrangement (MEWA) documents, pursuant to SB 255. Specifically, DMHC requests the following position and resources:

Office of Plan Licensing – One position

- **One Attorney III** position would conduct legal research and review annual MEWA and large group health care plan submissions for compliance with SB 255.

Software Licensing Costs - $2,000

- DMHC requests expenditure authority from the Managed Care Fund of $2,000 annually to support software licensing costs for the development and implementation of a new solution in the department's Necessary Infrastructure Modernization for Business Unified Services (NIMBUS) platform for MEWAs to register and submit annual compliance findings.

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 11: Health Care Coverage – Small Employer Groups (SB 718)

Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $313,000 in 2022-23 and $301,000 in 2023-24 through 2026-27. If approved, these resources would allow DMHC to receive and review Multiple Employer Welfare Arrangement (MEWA) documents for compliance with SB 718 (Bates), Chapter 736, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
0933 – Managed Care Fund	$313,000	$301,000
Total Funding Request:	**$313,000**	**$301,000**
Total Requested Positions:	**0.0**	**0.0**

* Positions and resources ongoing after 2023-24 until 2026-27.

Background. SB 718 (Bates), Chapter 736, Statutes of 2021, creates an exception from Knox-Keene Act requirements that a small employer cannot purchase large croup health care coverage through an association health plan (AHP) or multiple employer welfare arrangement (MEWA). SB 718 requires a MEWA that intends to offer large group coverage to its members to meet the following requirements:

- The association is headquartered in California, was established prior to March 23, 2010, has been in continued existence since, and is a bona fide association or group of employers that may act as an employer under ERISA.
- The association is the sponsor of a multiple employer welfare arrangement (MEWA), and the MEWA is fully insured, headquartered in California, and is in full compliance with all applicable state and federal laws.
- The MEWA has offered a large group health plan contract or health insurance policy since January 1, 2012, in connection with an employee welfare benefit plan.
- The large group health plan contract or health insurance policy offers to employees a level of coverage having an actuarial value greater than or equivalent to the platinum level of coverage available through Covered California and covers essential health benefits, as specified.
- The large group health plan contract or health insurance includes coverage of common law employees, and their dependents, who are employed by an association member in the biomedical industry and whose employer has operations in California.
- The large group health plan contract or health insurance policy offers only fully insured benefits through an insurance contract with an insurance carrier licensed by CDI or with a health maintenance organization licensed by DMHC.
- Association members purchasing health coverage have a minimum of four full-time common law employees and are current employer members of the association sponsoring the plan. Employer members subsidize employee premiums by at least 51 percent.
- The association is an organization with business and organizational purposes unrelated to the provision of health care benefits and existed prior to the establishment of the MEWA offering the employee welfare benefit plan.
- The participating employers have a commonality of interests from being in the same industry, unrelated to the provision of health care benefits.

- Membership in the association is open solely to employers, and the participating employers, either directly or indirectly, exercise control over the employee welfare benefit plan, the large group health plan contract or health insurance policy, both in form and substance.
- The large group health plan contract or health insurance policy is treated as a single-risk-rated contract that is guaranteed issued and renewable for member employers, as well as their employees and dependents. An employee or dependent is not charged premium rates based on health status and is not excluded from coverage based upon any preexisting condition. Employee and dependent eligibility are not directly or indirectly based on health status or claims of any person.
- An employer otherwise eligible is not excluded from participating in a MEWA, or offering or renewing the large group health care service plan contract based on health status or claims of any employee or dependent.
- The MEWA at all times covers at least 101 employees.

In addition to meeting these requirements, the MEWA must file an application for registration with DMHC or the Department of Insurance on or before June 1, 022, and submit annual filings of ongoing compliance with SB 718. SB 718 sunsets on January 1, 2026.

According to DMHC, SB 718 would require the department to do the following:

- Develop a MEWA registration process by June 1, 2022.
- Create processes for MEWA registration including research, checklist for requirements for documentation, registration application form, annual compliance requirement process or form, and any necessary outreach to stakeholders.
- Issue guidance to MEWAs regarding registration requirements and ongoing compliance with state laws and regulations, as well as advise health plans of MEWA eligibility criteria.
- Review initial applications for the exemption to determine whether required documentation was submitted and if the documentation supports approval of the registration.
- Annually review each MEWA for ongoing compliance with SB 255.
- Review end of exemption filings to wind down changes adopted under SB 718 prior to the sunset date of January 1, 2026.

Staffing and Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $313,000 in 2022-23 and $301,000 in 2023-24 through 2026-27 to receive and review Multiple Employer Welfare Arrangement (MEWA) documents for compliance with SB 718. Specifically, DMHC requests the following resources:

Office of Plan Licensing

- Resources equivalent to **one Attorney III** position would
- Resources equivalent to **0.5 Associate Governmental Program Analyst** would

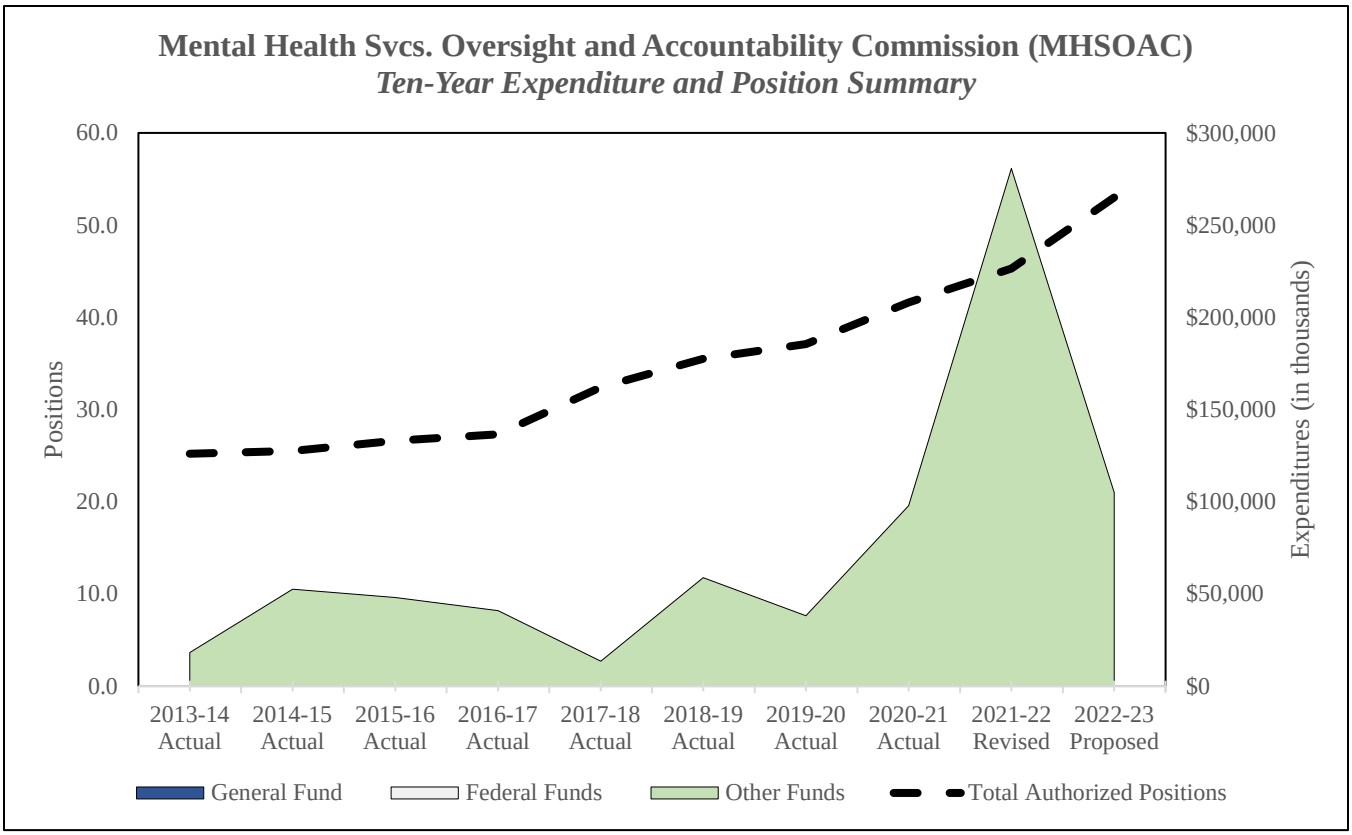
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Overview



Mental Health Svcs. Oversight and Accountability Commission - *Department Funding Summary (dollars in thousands)*				
Fund Source	**2020-21 Actual**	***2021-22 Budget Act***	***2021-22 Revised***	***2022-23 Proposed***
General Fund	$0	$0	$0	$0
Federal Funds	$0	$0	$0	$0
Other Funds	$97,800	$70,097	$280,682	$104,888
Total Department Funding:	**$97,800**	**$70,097**	**$280,682**	**$104,888**
Total Authorized Positions:	**41.6**	**449.3**	**45.3**	**53**
Other Funds Detail:				
Reimbursements (0995)	*$0*	*$69,858*	*$0*	*$42,900*
Mental Health Services Fund (3085)	*$97,800*	*$0*	*$180,682*	*$61,988*
Suicide Prev Vol Contribution Fund (8124)	*$0*	*$239*	*$0*	*$0*
Coronavirus Fiscal Recovery Fund (8506)	*$0*	*$0*	*$100,000*	*$0*

Mental Health Services Act (Proposition 63; 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Mental Health Services Oversight and Accountability Commission. The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in 2005 and is composed of 16 voting members. These members include:

Elected Officials:

- Attorney General
- Superintendent of Public Instruction
- Senator selected by the President pro Tempore of the Senate
- Assemblymember selected by the Speaker of the Assembly

12 members appointed by the Governor:

- Two persons with a severe mental illness
- A family member of an adult or senior with a severe mental illness
- A family member of a child who has or has had a severe mental illness
- A physician specializing in alcohol and drug treatment
- A mental health professional
- A county sheriff
- A superintendent of a school district
- A representative of a labor organization
- A representative of an employer with less than 500 employees
- A representative of an employer with more than 500 employees
- A representative of a health care services plan or insurer

In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

MHSOAC's responsibilities are as follows:

- **Review of MHSA Programs -** The MHSOAC oversees the MHSA funded programs and services through the counties' annual updates. Counties submit updates every year to reflect the status of programs and services in their counties.

- **Evaluations -** The MHSOAC has a statutory mandate to evaluate how MHSA funding has been used, what outcomes have resulted, and how to improve services and programs.

- **Research -** The MHSOAC supports collaborative research efforts to develop and implement improved tools and methods for program improvement and evaluation statewide.

- **Triage -** County triage personnel provide linkages and services to what may be the first mental health contact for someone in crisis. Crisis services are provided at shelters, jails, clinics and hospital emergency rooms to help link a person to appropriate services.

- **Stakeholder Contracts -** Statewide stakeholder advocacy contracts are focused on supporting the mental health needs of consumers, children and transition aged youth, veterans, racial and ethnic minority communities and their families through education, advocacy, and outreach efforts.

- **Commission Projects -** The MHSOAC selects special project topics and under the direction of a subcommittee of commissioners, conducts research through discussion, review of academic literature, and interviews with those closely affected by the topic to formulate recommendations for administrative or legislative changes.

- **Technical Assistance & Training -** The MHSOAC offers technical assistance and training to counties, providers, clients and family members, and other stakeholders to support the goals of the MHSA and specific responsibilities of the commission, such as review of counties' MHSA-funded Innovative Program plans.

2021 BUDGET ACT INVESTMENTS – IMPLEMENTATION UPDATES

The 2021 Budget Act included several important investments in the MHSOAC budget. The subcommittee is monitoring implementation of the following:

Mental Health Student Services Act Augmentation. The 2021 Budget Act included $205 million ($100 million CFRF and $105 million Mental Health Services Fund) in 2021-22 for MHSOAC for the Mental Health Student Services Act program, which provides grants to school and county mental health partnerships that support the mental health and emotional needs of children and youth as they return to schools and everyday life.

Implementation Update

- *Mental Health Student Services Act Augmentation.* The 2019 Budget Act included expenditure authority from the Mental Health Services Fund of $50 million in 2019-20 and $10 million annually thereafter for the Mental Health Student Services Act (MHSSA), a competitive grant program to establish mental health partnerships between county mental health or behavioral health departments and school districts, charter schools, and county offices of education. These partnerships support: (1) services provided on school campuses; (2) suicide prevention; (3) drop-out prevention; (4) outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), and youth who have been expelled or suspended from school; (5) placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services; and (6) other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth. The initial allocation of funding allowed MHSOAC to support 18 grant awards totaling $75 million in

2020, 10 counties with existing partnerships and eight establishing new partnerships. However, 20 counties that submitted applications did not receive funding.

The 2021 Budget Act augmentation of the MHSSA was intended to rapidly provide funding to the 20 counties that applied, but did not receive partnership grant awards. The potential impacts of the COVID-19 pandemic on the behavioral health needs of students made rapid deployment of resources to school campuses a high priority for the Legislature. According to MHSOAC, the initial 2019 Budget Act funding, as well as the 2021 Budget Act augmentation of MHSSA funding supported the following phases of grant awards:

- Phase I (2020) – 18 grants awarded totaling $75 million
- Phase II (Early 2021) – 6 grants awarded totaling $25 million
- Phase III (Mid 2021) – 6 grants awarded totaling $25 million
- Phase IV (Late 2021) – 8 grants to be awarded totaling $30 million
- Phase V (2022) – 20 grants to be awarded totaling $95 million

Subcommittee Staff Comment. This is an informational item.

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

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

2. Please provide an update on implementation of the following 2021 Budget Act investment:

    a. Mental Health Student Services Act Augmentation

Issue 2: Children and Youth Behavioral Health Initiative – Evidence Based BH Programs

Budget Change Proposal – Governor's Budget. MHSOAC requests reimbursement authority of $42.9 million in 2022-23 to reflect an interagency agreement with the Department of Health Care Services (DHCS) to support statewide expansion of evidence-based behavioral health programs as part of the Children and Youth Behavioral Health Initiative.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24**
0995 - Reimbursements	$42,900,000	$-
Total Funding Request:	**$42,900,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The 2021 Budget Act included expenditure authority of $1.4 billion ($1 billion General Fund, $100 million Coronavirus Fiscal Recovery Fund or CFRF, $222 million federal funds, and $105 million Mental Health Services Fund) in 2021-22, $1.3 billion ($769.2 million General Fund, $429 million CFRF, and $124 million federal funds) in 2022-23, $275.2 million ($175.2 million General Fund and $100 million federal funds) in 2023-24, $262.1 million ($156.1 million General Fund and $106 million federal funds) in 2024-25, and $227.1 million ($121.1 million General Fund and $106 million federal funds) in 2025-26, to support the Children and Youth Behavioral Health Initiative and other interventions to support behavioral health services for students. The total investment over five years is $3.5 billion.

Of the resources approved in the 2021 Budget Act, $429 million CFRF in 2022-23 was allocated for DHCS to develop and expand evidence-based behavioral health programs addressing early psychosis, disproportionately impacted communities and communities of color, youth drop-in wellness centers, intensive outpatient programs for youth, and prevention and early intervention services for youth. DHCS will coordinate with MHSOAC to implement these programs and allocate 10 percent of the funding for administration by the commission.

Early Psychosis Intervention Plus Program. According to the National Institute of Mental Health, psychosis describes a condition that affects the mind, where there has been some loss of contact with reality, or a psychotic episode. During a period of psychosis, a person's thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not. Symptoms of psychosis may include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear). Other symptoms include incoherent or nonsense speech, and behavior that is inappropriate for the situation. A person in a psychotic episode may also experience depression, anxiety, sleep problems, social withdrawal, lack of motivation, and difficulty functioning overall. Psychosis often begins when a person is in their late teens to mid-twenties. Three out of 100 people will experience psychosis at some time in their lives and about 100,000 adolescents and young adults nationwide experience their first episode of psychosis each year. According to the National Association of Mental Illness, several factors may contribute to psychosis, including genetics, trauma, substance use, physical illness or injury, or mental health conditions such as schizophrenia, schizoaffective disorder, bipolar disorder, or depression.

The average delay between the onset of symptoms and diagnosis and treatment of psychosis is 18.5 months. Clinical research suggests that early intervention at the first signs of psychosis results in better treatment outcomes. There are emerging evidence-based strategies to identify, diagnose, and treat individuals with early signs of serious mental illness, including psychotic symptoms and behaviors. Some of these interventions include cognitive and behavioral psychotherapy, low doses of antipsychotic medications, family education and support, educational and vocational rehabilitation and coordinated case management.

AB 1315 (Mullin), Chapter 414, Statutes of 2017, established the Early Psychosis Intervention Plus (EPI Plus) Program at MHSOAC. The bill established an advisory committee to the commission to: 1) provide advice and guidance on approaches to early psychosis and mood disorder detection and intervention programs from an evidence-based perspective, 2) review and make recommendations on funding awards for early psychosis and mood disorder detection and intervention programs, 3) assist and advise on evaluation of the programs, 4) recommend a core set of standardized clinical and outcome measures programs would be required to collect, and 5) inform funded programs about opportunities to participate in clinical research studies. The bill established the Early Psychosis and Mood Disorder Detection and Intervention Fund to collect private or federal funding, but prohibited allocation of General Fund for this purpose. Once $500,000 is deposited in the fund, MHSOAC is authorized to develop a competitive grant program for counties to accomplish the following goals:

- Expanding the provision of high-quality, evidence based early psychosis and mood disorder detection and intervention services in the state.
- Improving access to effective services for transition-aged youth and young adults at high risk for, or experiencing, psychotic symptoms.
- Measuring more comprehensively and effectively, programmatic effectiveness and enrolled client outcomes of programs receiving awards.
- Improving client experience in accessing services and in working toward recovery and wellness.
- Increasing participation in school attendance, social interactions, personal bonding relationships, and active rehabilitation.
- Reducing unnecessary hospitalizations and inpatient days by using community-based services and improving access to timely assistance to early psychosis and mood disorder detection and intervention services.
- Expanding the use of innovative technologies for mental health information feedback, including technologies for treatment and symptom monitoring.
- Providing local communities with increased financial resources to leverage additional public and private funding sources.

The 2019 Budget Act included expenditure authority from the Mental Health Services Fund of $20 million in 2019-20 to support the Early Psychosis Intervention Plus program established by AB 1315. The first funding round was awarded in August 2020 to the behavioral health departments of Kern, Lake, San Francisco, Santa Barbara, and Sonoma counties. The second round of funding was awarded in April 2021 to Santa Clara and Nevada counties.

Youth Drop-In Centers. The 2019 Budget Act included expenditure authority from the Mental Health Services Fund of $15 million in 2019-20 for a grant program to establish youth drop-in centers that provide integrated mental health services for individuals between 12 and 25 years of age and their families, with

a focus on vulnerable and marginalized youth and disparity populations including, but not limited to, LGBTQ, homeless, and indigenous youth. In May 2020, the commission awarded contracts to Wellnest (Los Angeles), Peninsula Health Care District (Burlingame), University of California Irvine (Orange County; hub and spoke model), Sacramento County Behavioral Health Services (Sacramento), and Beach Cities Health District (Los Angeles).

Resource Request. MHSOAC requests reimbursement authority of $42.9 million in 2022-23 to reflect an interagency agreement with the Department of Health Care Services (DHCS) to support statewide expansion of evidence-based behavioral health programs as part of the Children and Youth Behavioral Health Initiative. The commission's previous experience with early psychosis interventions, youth drop-in centers, and other evidence-based behavioral health interventions would support expansion of its existing efforts and inform the efforts of DHCS for the balance of the funding provided through the Children and Youth Behavioral Health Initiative. Specifically, the funds transferred to MHSOAC through the interagency agreement could support the following:

- Participation in a workgroup that will recommend evidence-based programs for DHCS to support for statewide expansion.
- Expansion of existing grant programs at MHSOAC.
- Support of reporting requirements to DHCS for grant awardees.

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 MHSOAC to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Mental Health Student Services Act Partnership Grant Program Augmentation

Budget Change Proposal – Governor's Budget. MHSOAC requests two positions and expenditure authority from the Mental Health Services Fund of $16.6 million in 2022-23, available over five years. Included in this request is a net-zero shift of expenditure authority of $1.2 million from local assistance to state operations in 2023-24 and annually thereafter. If approved, these positions and resources would allow MHSOAC to support the administration and evaluation of the Mental Health Student Services Act Partnership Grant Program.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
3085 – Mental Health Services Fund – State Operations	$16,646,000	$1,224,000
3085 – Mental Health Services Fund – Local Assistance	$-	($1,224,000)
Total Funding Request:	**$16,646,000**	**$-**
Total Requested Positions:	**2.0**	**2.0**

* Positions ongoing after 2023-24.

Background. The 2019 Budget Act included expenditure authority from the Mental Health Services Fund of $50 million in 2019-20 and $10 million annually thereafter for the Mental Health Student Services Act (MHSSA), a competitive grant program to establish mental health partnerships between county mental health or behavioral health departments and school districts, charter schools, and county offices of education. These partnerships support: (1) services provided on school campuses; (2) suicide prevention; (3) drop-out prevention; (4) outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), and youth who have been expelled or suspended from school; (5) placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services; and (6) other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth.

Prior to the MHSSA, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, known as the Investment in Mental Health Wellness Act, included expenditure authority from the Mental Health Services Fund of $32 million annually for MHSOAC to support counties to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. In 2018-19 the expenditure authority was reduced to $20 million annually. According to MHSOAC, since 2017-18, 50 percent of the funding has been allocated to programs dedicated to children and youth aged 21 and under, and approximately $20 million was allocated for four School-County Collaboration Triage grants to: 1) provide school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families or caregivers; and 2) supporting the development of partnerships between behavioral health departments and educational entities. Humboldt County, Placer County, Tulare County Office of Education, and a joint powers authority in San Bernardino County were awarded $5.3 million annually over four years in this program. MHSOAC also awarded grants for school-based triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo.

Building on the partnership model in the triage grant program, MHSSA supports partnerships between county behavioral health programs and educational entities. Combining the $50 million allocation in 2019-20 with the annual $10 million allocations for the subsequent three fiscal years, MHSOAC allocated a total of $75 million over four years for funding of the MHSSA Partnership Grant Program. The funding was made available in two categories: 1) $45 million for counties with existing school mental health partnerships, and 2) $30 million for counties developing new or emerging partnerships. Within each category, funding was made available based on the population size of a county with a total of six grants at $2.5 million each made available to small counties (less than or equal to 200,000 population), six grants at $4 million each made available to medium counties (between 200,000 and 750,000 population), and six grants at $6 million each made available to large counties (greater than 750,000 population).

According to MHSOAC, 38 counties submitted applications for funding. 20 counties with existing partnerships submitted applications and 10 received awards. 18 counties developing new or emerging partnerships submitted applications and eight received awards. However, 20 counties that submitted applications did not receive funding.

The 2021 Budget Act included $205 million ($100 million CFRF and $105 million Mental Health Services Fund) in 2021-22 for MHSOAC for the Mental Health Student Services Act program, which provides grants to school and county mental health partnerships that support the mental health and emotional needs of children and youth as they return to schools and everyday life. The 2021 Budget Act augmentation of the MHSSA was intended to rapidly provide funding to the 20 counties that applied, but did not receive partnership grant awards. The potential impacts of the COVID-19 pandemic on the behavioral health needs of students made rapid deployment of resources to school campuses a high priority for the Legislature. According to MHSOAC, the initial 2019 Budget Act funding, as well as the 2021 Budget Act augmentation of MHSSA funding supported the following phases of grant awards:

- Phase I (2020) – 18 grants awarded totaling $75 million
- Phase II (Early 2021) – 6 grants awarded totaling $25 million
- Phase III (Mid 2021) – 6 grants awarded totaling $25 million
- Phase IV (Late 2021) – 8 grants to be awarded totaling $30 million
- Phase V (2022) – 20 grants to be awarded totaling $95 million

Resource Request. MHSOAC requests two positions and expenditure authority from the Mental Health Services Fund of $16.6 million in 2022-23, available over five years. Included in this request is a net-zero shift of expenditure authority of $1.2 million from local assistance to state operations in 2023-24 and annually thereafter. If approved, these positions and resources would allow MHSOAC to support the administration and evaluation of the Mental Health Student Services Act Partnership Grant Program.

According to MHSOAC, the MHSSA statute requires the commission to develop metrics and a system to measure and publicly report on the performance outcomes of services provided under the partnership grant program. In addition, the commission will need to conduct engagement with the public to ensure perspectives and participation of diverse community members reflective of California populations suffering from severe mental illness and their family members. Specifically, MHSOAC is requesting the following positions and resources:

- **One Research Scientist Supervisor I** position would support program research and data analytics; supervise staff in the collection, analysis, monitoring, evaluation, reporting, and dissemination of data and research findings; provide direction in program evaluation designs, statistical procedures, and policy research and analysis; support staff in management of external research and evaluation contracts; utilize subject matter expertise and research knowledge to critically review deliverables submitted by contractors; evaluate effectiveness of MHSSA funded services and potential for best practices and innovative approaches to improve outcomes; facilitate and respond to internal and external data requests; collect and analyze data and identify new strategies and sources for collecting data; and coordinate data migration efforts.
- **One Research Scientist III** position would perform higher level research and evaluation tasks; support design, development, and maintenance of an ongoing statewide school mental health performance outcome monitoring system; maintain and use large-scale processes for utilizing large statewide and local databases; perform, interpret, and present highly complex statistical analyses; become familiar with other data and monitoring systems to strengthen the commission's school mental health performance outcome system; coordinate with subject matter experts and integrate subject matter expertise into evaluations; identify limitations with current data collection and reporting systems; and act as policy and data subject matter expert for the commission's data collaboration work across other state entities.

In addition to these positions, MHSOAC requests expenditure authority from the Mental Health Services Fund of $15.7 million in 2022-23 and $758,000 annually thereafter for contract resources that would: 1) develop a performance outcome monitoring system; 2) provide consultation to grantees, commission staff, and others; and 3) conduct an evaluation of the MHSSA.

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 MHSOAC to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: Evaluation of Full-Service Partnership Model Outcomes (SB 465)

Budget Change Proposal – Governor's Budget. MHSOAC requests one position and expenditure authority from the Mental Health Services Fund of $400,000 annually. If approved, this position and resources would allow MHSOAC to annually evaluate outcomes for those receiving community mental health services under a full service partnership, pursuant to the requirements of SB 465 (Eggman), Chapter 544, Statutes of 2021.

Program Funding Request Summary		
Fund Source	**2022-23**	**2023-24***
3085 – Mental Health Services Fund	$400,000	$400,000
Total Funding Request:	**$400,000**	**$400,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2023-24.

Background. The Mental Health Services Act (MHSA) requires counties to direct at least half of Community Services and Supports (CSS) funds to support full service partnerships. In the full service partnership model, a required service category under the MHSA, counties and clients or their representatives negotiate an individual services and supports plan (ISSP) to provide clients with a full spectrum of community services necessary to achieve the clients goals, which may include a broad array of mental health services and supports, as well as non-mental health services and supports such as food, clothing, housing, employment support, respite care, medical care, or wrap-around services. The full service partnership model is often described as a "whatever it takes" delivery model, ensuring clients are provided with all the services and supports needed to successfully meet treatment goals.

AB 465 (Eggman), Chapter 544, Statutes of 2021, directs MHSOAC to report on the number of persons eligible for full service partnerships by whether they are enrolled or not, and the community mental health services received and outcomes obtained for each group. According to MHSOAC, these reporting requirements build on several prior initiatives pursued by the commission, including: 1) data use agreements with multiple state departments and agencies to build a data warehouse of client-level, linked "whole person" information about persons with serious mental illness served in the community mental health system; 2) a pilot project with three counties to demonstrate the feasibility of linking client data to program data and analyzing the effect of program characteristics and services on client outcomes; and 3) a multi-county collaborative project and learning community funded by the commission's Innovation Incubator to identify and share effective practices in full service partnerships.

Staffing and Resource Request. MHSOAC requests one position and expenditure authority from the Mental Health Services Fund of $400,000 annually to annually evaluate outcomes for those receiving community mental health services under a full service partnership, pursuant to the requirements of SB 465. Specifically, MHSOAC requests the following position and resources:

- **One Research Scientist Supervisor I** position would direct research and data analytic work mandated by SB 465; supervise contracted and supervised staff in collection, analysis, monitoring, evaluation, reporting, and dissemination of full service partnership data and research findings; provide direction and staff development in program evaluation designs, statistical procedures, and policy research and analysis; manage external research and evaluation contracts; utilize subject matter expertise and

research knowledge to critically review contractor deliverables; evaluate the effectiveness of full service partnership services and the potential for best practices and innovative approaches to improve outcomes; facilitate and respond to internal and external data requests; collect and analyze full service partnership data and identify new strategies and sources for collecting data and coordinating data migration; organize, manage, and lead public engagement activities related to full service partnership program evaluation and reporting.

MHSOAC also requests expenditure authority from the Mental Health Services Fund of $161,000 annually to support a contract with a University of California campus to provide additional professional staffing resources.

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 MHSOAC to respond to the following:

1. Please provide a brief overview of this proposal.

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

Issue 1: Overview and Open Enrollment Update

Background. The federal Patient Protection and Affordable Care Act (ACA) implemented significant improvements to health care coverage offered in the individual health insurance market. Beginning in September 2010, ACA individual market reforms:

1. Eliminated lifetime limits on coverage.
2. Prohibited post-claims underwriting and rescission of policies.
3. Required health plans to offer coverage to dependent children up to age 26.
4. Eliminated pre-existing condition exclusions for children.
5. Eliminated copays and other cost sharing provisions for 45 preventive services.
6. Required health plans to spend at least 85 percent of premium dollars on health expenditures or provide rebates to customers (effective January 2012).

According to federal data, by 2013, more than eight million Californians received access to no-cost preventive services and 1.4 million residents with private insurance coverage received $65.7 million in insurance company rebates.

Beginning in January 2014, the ACA implemented additional market reforms and required establishment of health benefit exchanges, which provide federally subsidized health care coverage to individuals with incomes between 138 and 400 percent of the federal poverty level (FPL). California established its own health benefit exchange, Covered California, funded by assessments on health plan premiums. Covered California offers several options for individual health care coverage negotiated for cost and quality with health plans. Enrollment occurs during an annual open enrollment period that begins November 1 and ends January 31. The ACA requires all health insurance products, with some exceptions, to cover certain essential health benefits to be considered minimum essential coverage. These benefits include:

- Ambulatory patient services
- Prescription drugs
- Emergency services
- Rehabilitative and habilitative services and devices
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Preventive and wellness services and chronic disease management
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services, including oral and vision care

Metal Tiers for Health Insurance Products in Covered California. Consumers purchasing coverage in the Covered California health benefit exchange may choose from different "metal tiers" that determine the level of coverage and cost-sharing amounts provided by the product. According to Covered California, the metal tiers provide coverage as follows:

- **Bronze:** On average, Bronze health plans pay 60 percent of medical expenses, and consumers pay 40 percent.

- **Silver:** On average, Silver health plans pay 70 percent of medical expenses, and consumers pay 30 percent. Certain income-eligible individuals may qualify for an Enhanced Silver plan, which provides coverage with lower cost-sharing. Individuals in these savings categories get the benefits of a Gold or Platinum plan for the price of a Silver plan. The three categories of Enhanced Silver plans pay 94, 87 or 73 percent of medical expenses.

- **Gold:** On average, Gold health plans pay 80 percent of medical expenses, and consumers pay 20 percent.

- **Platinum:** On average, Platinum health plans pay 90 percent of medical expenses, and consumers pay 10 percent.

Figure 1. Metal Tiers of Coverage in Covered California Health Benefit Exchange
Source: *Covered California website: "Coverage Levels/Metal Tiers"*
https://www.coveredca.com/individuals-and-families/getting-covered/coverage-basics/coverage-levels/

Advance Premium Tax Credit Subsidies. The ACA subsidizes health care coverage purchased in health benefit exchanges, such as Covered California, for individuals between 138 and 400 percent of the FPL. The subsidies are provided in the form of advance premium tax credits (APTC), which reduce the amount of premium paid by income-eligible consumers purchasing coverage on the exchange. The amount of the APTC is linked to the cost of the second-lowest cost Silver plan in a consumer's coverage region. The APTC is meant to ensure that consumers are required to spend no more than two percent to 9.6 percent of their income for Silver plan premiums. Consumers may use the APTC subsidy amount to purchase other metal tiers of coverage that may be less expensive (e.g. Bronze) or more expensive (e.g. Gold or Platinum).

Individual Mandate Penalty and Cost-Sharing Reductions. In addition to individual market reforms and new coverage options, the ACA eliminated pre-existing condition exclusions for adults beginning in 2014, and imposed a requirement that individuals enroll in health plans that offer minimum essential coverage or pay a penalty, known as the individual mandate penalty. The individual mandate penalty was designed to stabilize premiums by encouraging healthy individuals to enroll in health coverage and reduce the overall acuity of health insurance risk pools. Because health plans cannot deny coverage based on a pre-existing condition, in the absence of a mandate penalty, individuals may delay enrolling in coverage until they are diagnosed with a high-cost health condition, resulting in higher overall plan expenditures, which lead to higher premiums. The ACA also limited the amount of cost-sharing that could be required of plan beneficiaries with incomes under 250 percent of the FPL. These cost-sharing reductions result in

savings to beneficiaries on deductibles, copayments, coinsurance, and maximum out-of-pocket costs. Until 2017, the federal government provided cost-sharing reduction subsidies to health plans to help mitigate the costs of limiting cost-sharing amounts for these beneficiaries. These subsidies were designed to maintain those cost-sharing limits while reducing higher premium costs that would otherwise be required.

Elimination of Cost Sharing Reduction Subsidies and Repeal of Individual Mandate. In October 2017, the federal Administration eliminated cost-sharing reduction subsidies that prevented premium growth due to ACA requirements that limited cost-sharing for health plan beneficiaries with incomes under 250 percent of the FPL. According to Covered California, the loss of these subsidies resulted in an annual reduction of approximately $750 million of federal funds available to reduce premiums. According to the Kaiser Family Foundation, health plans imposed resulting cost-sharing reduction surcharges ranging from seven to 38 percent on premiums beginning in 2018. In addition, recently enacted federal tax legislation included a reduction to zero of the individual mandate penalty for failing to purchase health care coverage. The reduction took effect for coverage in the 2019 calendar year.

State Subsidy Program and State Individual Mandate Penalty. The 2019 Budget Act included General Fund expenditure authority of $428.6 million in 2019-20, $479.8 million in 2020-21, and $547.2 million in 2021-22 to provide state premium subsidies for individuals up to 600 percent of the FPL purchasing health care coverage in Covered California. Approximately 17 percent of the funds supplement federal APTC subsidies for individuals with incomes between 200 and 400 percent of the FPL (between $51,500 and $103,000 for a family of four) and approximately 83 percent for individuals with incomes between 400 and 600 percent of the FPL (between $103,000 and $154,500 for a family of four). The funding also covers full premium costs for individuals below 138 percent of the FPL ($35,500 for a family of four). In addition, the 2019 Budget Act included trailer bill language to implement a penalty on individuals that fail to maintain minimum essential coverage during a coverage year, to encourage enrollment in the absence of the federal individual mandate penalty. The minimum penalty is $695 for adults in a household and $347.50 for each child. The revenue from the penalty offsets General Fund expenditures for the state subsidy program. According to Covered California, as of June 2020, approximately 598,000 individuals received state subsidies, with 546,000 under 400 percent of the FPL receiving an average of $14 per month and 42,000 between 400 and 500 percent of the FPL receiving an average of $301 per month.

The state subsidy program design is based on the funding available through the budget appropriation and the provisional language governing the division of the funds: 17 percent for individuals 200 to 400 percent of the FPL and 83 percent for individuals 400 to 600 percent of the FPL. The current subsidy design for the 2021 Plan Year requires the following post-subsidy contributions to health plan premiums as a percentage of household income:

2021 Required Contribution Table Household income (percent of FPL)	Initial Premium Percentage	Final Premium Percentage
At or below 138 percent	0	0
Greater than 200 percent up to and including 250 percent	6.24	7.80
Greater than 250 percent up to and including 300 percent	7.80	8.90

Greater than 300 percent up to and including 400 percent	8.90	9.68
Greater than 400 percent up to and including 450 percent	9.68	14.00
Greater than 450 percent up to and including 500 percent	14.00	16.00
Greater than 500 percent up to and including 600 percent	16.00	18.00

The Federal American Rescue Plan Offers More Generous Subsidies. In March 2021, President Biden signed the American Rescue Plan (ARP), which makes a significant investment in advance premium tax credits (APTC) to improve affordability for consumers seeking health care coverage in health benefit exchanges, including Covered California. For the 2021 and 2022 plan years, the ARP removes the income eligibility cap on APTC premium subsidies, which previously limited subsidies to individuals at or below 400 percent of the FPL. The ARP provides subsidies so that no individual at any income level will have to pay more than 8.5 percent of their income for a silver plan in an ACA marketplace, such as Covered California. In addition, no individual with income below 150 percent of the FPL, or any individual that receives unemployment insurance payments at any point in 2021, will pay any premiums at all for silver level coverage.

As a result of the more generous subsidies provided by the ARP, the three-year state premium subsidy program implemented by the 2019 Budget Act was subsumed by the new federal subsidies. The state subsidy program was designed to limit individuals between 400 and 600 percent of the FPL to spending between 9.68 percent and 18 percent of income on premiums. Because the ARP caps premiums at 8.5 percent for all income levels, no state premium subsidy is necessary to reach the required contribution levels included in the state premium subsidy design. As a result, the 2021 Budget Act reverted General Fund expenditure authority of $405.6 million in 2021-22 to reflect savings in the state subsidy program resulting from the more generous federal premium subsidies.

Health Care Affordability Reserve Fund and Marketplace Affordability Report. The 2021 Budget Act also included trailer bill language to establish the Health Care Affordability Reserve Fund, as well as a transfer of General Fund resources of $333.4 million, which is the revenue the Administration estimates the state will receive from the individual mandate penalty. The reserve fund was meant to provide available resources to support state subsidies if the more generous federal subsidies are not extended beyond the 2022 coverage year, or if the state implements future health care affordability measures.

In addition to establishing the fund, the trailer bill language required Covered California to prepare a report by January 1, 2022, with options for utilizing the Health Care Affordability Reserve Fund to further improve affordability or cost-sharing requirements, including timelines and system requirements for implementation. (*see also "Issue 2: Bringing Coverage Within Reach – Marketplace Affordability and Access Report"*)

2022 Open Enrollment Update. The 2022 Open Enrollment period began on November 1st, 2021, and closed on Monday, January 31st, 2022, for the 2022 coverage year. The 2022 Open Enrollment benefitted from full-year implementation of more generous federal subsidies from the American Rescue Plan, as well as implementation of a one-dollar state subsidy program to allow for zero-dollar premiums for income-eligible individuals.

According to Covered California, as of January 25, 2022, with six days remaining of the open enrollment period, a record 1.8 million Californians enrolled in coverage through the Covered California health

benefits exchange. The record enrollment was driven by the American Rescue Plan subsidies, which has allowed two-thirds of Covered California enrollees to be eligible for coverage that costs $10 or less per month.

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 Covered California to respond to the following:

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

2. Please provide an update on enrollment in Covered California during the most recent open enrollment period.

Issue 2: Bringing Coverage Within Reach – Marketplace Affordability and Access Report

Background. In March 2021, President Biden signed the American Rescue Plan (ARP), which makes a significant investment in advance premium tax credits (APTC) to improve affordability for consumers seeking health care coverage in health benefit exchanges, including Covered California. For the 2021 and 2022 plan years, the ARP removes the income eligibility cap on APTC premium subsidies, which previously limited subsidies to individuals at or below 400 percent of the FPL. The ARP provides subsidies so that no individual at any income level will have to pay more than 8.5 percent of their income for a silver plan in an ACA marketplace, such as Covered California. In addition, no individual with income below 150 percent of the FPL, or any individual that receives unemployment insurance payments at any point in 2021, will pay any premiums at all for silver level coverage.

As a result of the more generous subsidies provided by the ARP, the three-year state premium subsidy program implemented by the 2019 Budget Act was subsumed by the new federal subsidies. The state subsidy program was designed to limit individuals between 400 and 600 percent of the FPL to spending between 9.68 percent and 18 percent of income on premiums. Because the ARP caps premiums at 8.5 percent for all income levels, no state premium subsidy is necessary to reach the required contribution levels included in the state premium subsidy design. As a result, the 2021 Budget Act reverted General Fund expenditure authority of $405.6 million in 2021-22 to reflect savings in the state subsidy program resulting from the more generous federal premium subsidies.

Build Back Better Act Continues ARP Subsidies and Implements Other Programs. Pending federal legislation, the Build Back Better Act, would permanently extend the generous federal premium subsidies implemented by the ARP and set to expire in the 2023 coverage year. Permanent extension of the federal ARP subsidies would continue to subsume the state's previously enacted state subsidy program, allowing those resources to be devoted to additional support to make coverage more affordable such as yet more generous premium subsidies, or subsidies to reduce or eliminate deductibles, co-pays, or other cost-sharing. If the ARP subsidies are not extended, the state would likely need to consider implementation of a replacement subsidy program to prevent a drastic increase in premiums year-over-year and a concomitant reduction in take-up of coverage in the exchange. Covered California estimates failure to extend the ARP subsidies would result in a loss of $1.6 billion annually in premium support to California consumers.

In addition to the extension of premium subsidies, the Build Back Better Act also includes $10 billion annually for three years for states to implement programs to reduce consumer cost-sharing. While these funds would only be available for three years, passage of Build Back Better would represent a substantial investment in reducing deductibles, co-pays, and other cost-sharing.

Health Care Affordability Reserve Fund and Marketplace Affordability Report. The 2021 Budget Act also included trailer bill language to establish the Health Care Affordability Reserve Fund, as well as a transfer of General Fund resources of $333.4 million, which is the revenue the Administration estimates the state will receive from the individual mandate penalty. The reserve fund was meant to provide available resources to support state subsidies if the more generous federal subsidies are not extended beyond the 2022 coverage year, or if the state implements future health care affordability measures.

In addition to establishing the fund, the trailer bill language required Covered California to prepare a report by January 1, 2022, with options for utilizing the Health Care Affordability Reserve Fund to further improve affordability or cost-sharing requirements, including timelines and system requirements for implementation.

Bringing Care Within Reach. In January 2022, Covered California released its report, titled "Bringing Care Within Reach – Promoting California Marketplace Affordability and Improving Access to Care in 2023 and Beyond". The report included options for use by policy makers under three potential scenarios:

1) **American Rescue Plan premium subsidies expire after 2022** – In this scenario, the state would need to evaluate options to backfill the loss in federal premium support to avoid drastic increases in consumer premium costs.
2) **American Rescue Plan premium subsidies are extended with federal cost-sharing support** – In this scenario, the state would continue to benefit from generous ARP subsidies and significant additional federal resources would be available to support cost-sharing reduction subsidies for three years.
3) **American Rescue Plan premium subsidies are extended without federal cost-sharing support** – In this scenario, the state would need to consider utilizing its own funds to implement a cost-sharing reduction subsidy program.

In addition to its evaluation of options for subsidies, the report also evaluates operational or other technical challenges to implementing any of the subsidy options. This evaluation includes information about the work that Covered California staff would have to perform to design and implement a new subsidy program.

Focus on Cost-Sharing Reduction Subsidy Options. In general, the report focuses on scenarios 2) and 3) in which the ARP premium subsidies are extended with or without federal cost-sharing support, respectively. The report acknowledges that, if ARP subsidies are not extended, the loss of $1.6 billion in federal premium support would require the state to consider revisiting its investment in state premium subsidies to mitigate a drastic increase in consumer costs and a significant drop in affordability and uptake of coverage in the exchanges.

The report provides various options for cost-sharing reduction subsidies and estimates three levels of cost estimates for each option based on the level of plan switching that occurs due to changes in cost-sharing provisions. The report provides an illustration of seven options, four of which could be supported by the $333.4 million in the Health Care Affordability Reserve Fund, and three of which could be supported with additional federally-funded cost-sharing reduction subsidies, such as those contained in the Build Back Better Act. However, despite the presentation of the options in the report in this format, it is important to note there is no legal or other barrier that would prevent the state from making a larger General Fund investment than the $333.4 million in the fund, particularly considering that California was committed to investing $547.2 million in 2021-22 for its state premium subsidy program prior to approval of the American Rescue Plan. The options presented in the report are as follows:

- **Option 1: Actuarial Value (AV) 95/90/85/80 with no deductibles ($475 million to $626 million).** In this option, cost-sharing reduction support would be expanded to all enrollees up to 600 percent of the federal poverty level (FPL). Coverage generosity would be increased with new cost-sharing

reduction (CSR) plan actuarial values set to 95, 90, 85 and 80. All individuals above 150 percent of FPL would be upgraded from their existing plans. As modeled, all deductibles would be eliminated under this option. This is the only modeled option that incorporates CSR enhancements above 400 percent of FPL.

- **Option 2: AV 95/90/85 with no deductibles ($463 million to $604 million).** In this option, CSR support would be expanded to all enrollees up to 400 percent of the FPL. Coverage generosity would be increased with new CSR plan actuarial values set to 95, 90 and 85. All individuals above 150 percent of FPL would be upgraded from their existing plans. As modeled, all deductibles would be eliminated under this option.

- **Option 3: Affordable Care Act cost-sharing reduction plan upgrade with no deductibles and Gold AV for individuals between 300 and 400 percent of the FPL ($386 million to $489 million).** In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to a Silver 94 plan with no deductibles, and individuals between 200 and 300 percent of the FPL would be upgraded from a Silver 73 to a Silver 87 plan with no deductibles. Individuals between 300 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

- **Option 4: Affordable Care Act cost-sharing reduction plan upgrade with no deductibles and Gold AV for individuals between 250 and 400 percent of the FPL ($362 million to $452 million).** In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan, and individuals between 200 and 250 percent of the FPL would be upgraded from a Silver 73 to an existing Silver 87 plan. Individuals between 250 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

- **Option 5: Affordable Care Act cost-sharing reduction plan upgrade for individuals between 150 and 250 percent of the FPL ($278 million to $322 million).** In this option, eligibility for CSR plans would remain at 250 percent of the FPL, but individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan, and individuals between 200 and 250 percent of the FPL would be upgraded from a Silver 73 to an existing Silver 87 plan. Deductibles would not be eliminated in this option, which would potentially prevent the need for benefit-design changes in 2023.

- **Option 6: Affordable Care Act cost-sharing reduction plans with no deductibles and Gold AV for individuals between 200 and 400 percent of the FPL ($128 million to $189 million).** In this option, CSR support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 200 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

- **Option 7: Affordable Care Act cost-sharing reduction plans with no deductibles ($37 million to–$55 million).** In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. State funding would be used to eliminate all deductibles in existing CSR plans

and upgrade the Silver base plan to a Silver 73 for individuals between 250 and 400 percent of the FPL.

Operational Assessment. In addition to presenting options for cost-sharing reduction subsidies, the report also provides an operational assessment for implementing a state-administered cost-sharing reduction program for benefit year 2023. According to Covered California, the major operational work streams for implementing a cost-sharing reduction program include: 1) development of the benefit design; 2) development of a payment methodology; 3) enrollment forecasting and budgeting; 4) system changes for the eligibility determination process; 5) development and implementation of enrollment processes; 6) planning for education and outreach to consumers and stakeholders; 7) process for cost-sharing reduction payments to carriers; 8) consideration of state risk-adjustment provisions; and 9) renaming of plans to match the new value with cost-sharing reduction subsidies. The report indicates the following planning milestones that would need to occur to prepare for implementation in the 2023 coverage year:

Milestone	Estimated Timeframe
Plan Management Advisory: Benefit Design and Certification Policy Recommendation	January 2022
January Board Meeting: Discussion of Benefit Design and Certification Policy Recommendation	January 2022
Final Federal Actuarial Value Calculator Released	February 2022
Qualified Health Plan and Qualified Dental Plan Issuer Applications Open	March 1, 2022
March Board Meeting: Anticipated Approval of 2022 Patient-Centered Benefit Designs and Certification Policy	March 2022
Final CalHEERS Design Needed for State-Administered CSR Program	May 2022
May Board Meeting: Discussion of 2022-23 Covered California Budget	May 2022
June Board Meeting: Anticipated Approval of 2022-23 Covered California Budget	June 2022
Qualified Health Plan Negotiations	June 2022
Public Posting of Proposed Rates	July 2022
Carrier Integration Testing for 2023 Plan Year	July-August 2022
CalHEERS Release for the 2023 Plan Year	September 2022
Public Posting of Final Rates	September-October 2022

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 Covered California to respond to the following:

1. Please provide an overview of the cost-sharing reduction options and other findings of the "Bringing Care Within Reach" Affordability Report.