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.

Friday, February 5, 2021
1:00 p.m.
State Capitol - Room 3191

Consultant: Scott Ogus

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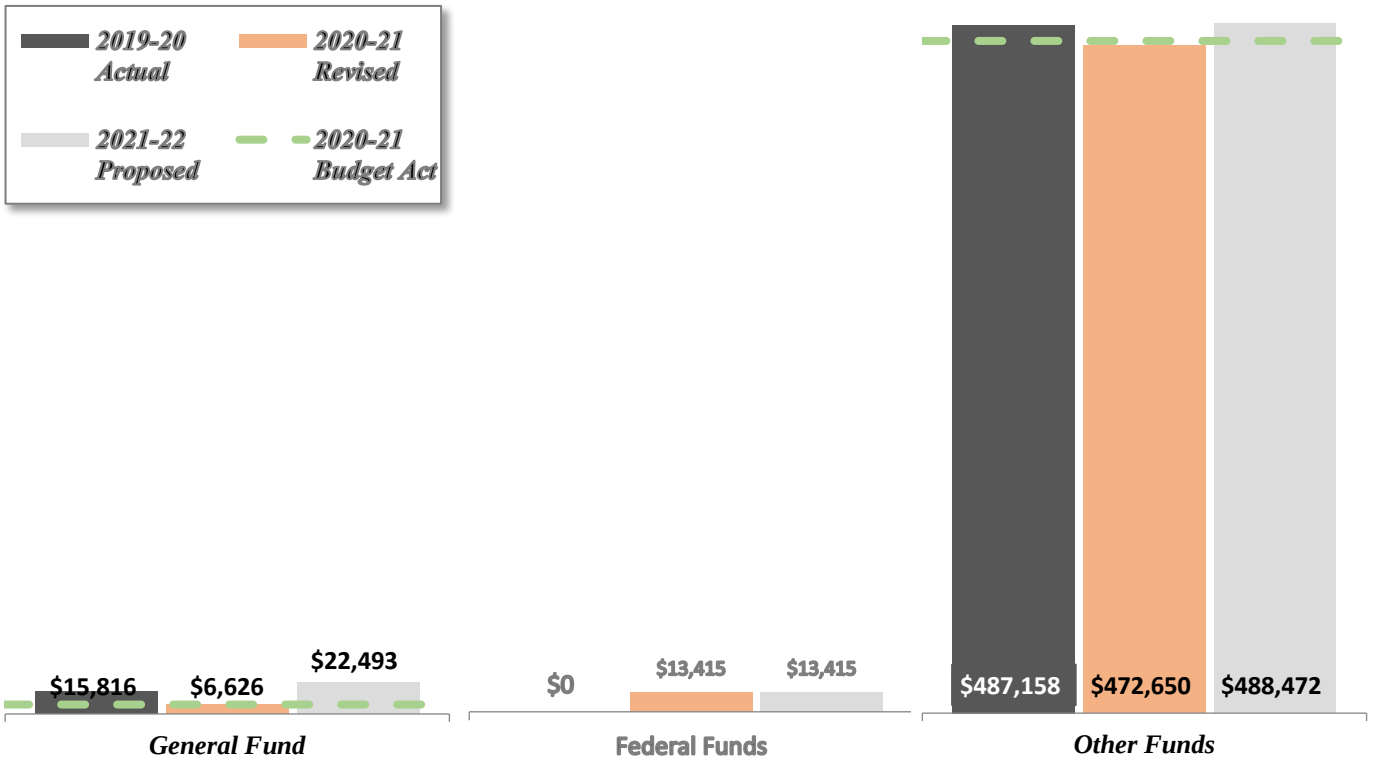
0530 California Health and Human Services Agency

Issue 1: Overview

California Health and Human Services Agency – *Three-Year Funding Summary*

(dollars in thousands)



California Health and Human Services Agency- *Department Funding Summary*			
Fund Source	**2019-20 *Actual***	***2020-21 Revised***	***2021-22 Proposed***
General Fund	$15,816,000	$6,626,000	$22,493,000
Federal Funds	$0	$13,415,000	$13,415,000
Other Funds	$487,158,000	$472,650,000	$488,472,000
Total Department Funding:	**$502,974,000**	**$492,691,000**	**$524,380,000**
Total Authorized Positions:	**376.3**	**351.7**	**376.7**
Other Funds Detail:			
Reimbursements (0995)	*($1,122,000)*	*$3,810,000*	*$4,131,000*
Office of Patient Advocate Trust Fund (3209)	*$1,838,000*	*$2,037,000*	*$2,205,000*
Data Insights and Innovation Fund (3377)	*$0*	*$0*	*$443,000*
Central Service Cost Recovery Fund (9740)	*$2,658,000*	*$4,633,000*	*$5,105,000*
California HHS Automation Fund (9745)	*$483,784,000*	*$462,170,000*	*$476,588,000*

Background. The California Health and Human Services Agency (CHHSA) 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. CHHSA 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 CHHSA, 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 the CHHSA include:

- Department of Aging (CDA)
- Department of Public Health (CDPH)
- 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)
- Office of Statewide Health Planning and Development (OSHPD)

Within CHHSA 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

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

Within the organizational structure of CHHSA are five offices.

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

- Provide statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA implementation by impacted state departments.
- Establish policy, provide direction to state entities, monitor progress, and report on HIPAA implementation efforts.

- Determine which provisions of state law concerning personal health information are preempted by HIPAA for state agencies.

Office of the Patient Advocate (OPA). The Office of the Patient Advocate (OPA) provides public data for informed decision making by policy makers and consumers to improve California health care quality. OPA produces annual report cards on clinical performance, patient experience, and cost of care for the largest health plans in California. In addition, OPA provides an annual analysis of consumer health care complaints about their health plans received by the Department of Managed Health Care, the Department of Health Care Services, the Department of Insurance, and Covered California. This complaint reporting enables the identification of systemic problems or disparities and the promotion of effective complaint resolution efforts.

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, as well as investigating incidents involving law enforcement personnel at state hospitals or developmental centers.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of the CHHSA's mission and oversight of key departments and other entities.

Issue 2: Electronic Visit Verification Phase II

Budget Change Proposal – Governor's Budget. The Office of Systems Integration (OSI), the Department of Health Care Services (DHCS), the Department of Public Health (DPH), and the Department of Developmental Services (DDS) request total expenditure authority of $24.1 million ($5.8 million General Fund and $18.3 million federal funds) in 2021-22. If approved, these resources would continue the multi-departmental planning effort for the second phase (Phase II) of implementation of Electronic Visit Verification for personal care services and home health care services, including completion of activities required by the Department of Technology's Project Approval Lifecycle (PAL) Stage Gate requirements and the federal Advanced Planning Document (APD) process.

Program Funding Request Summary (CHHSA-OSI)		
Fund Source	**2021-22***	**2022-23**
9745 – CHHS Automation Fund	$21,234,000	$-
Total Funding Request:	**$21,234,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

***** Transfers from other Departments (included below): DHCS: $10,617,000; DDS: $10,617,000

Program Funding Request Summary (DHCS)		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$1,832,000	$-
0890 – Federal Trust Fund	$18,312,000	$-
Total Funding Request:	**$20,144,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Program Funding Request Summary (DDS)		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$3,922,000	$-
0995 – Reimbursements*	$7,512,000	$-
Total Funding Request:	**$11,434,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

***** Reimbursements are the result of federal matching funds transferred from DHCS and are included in the total $18,312,000 attributed to the DHCS request.

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 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

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

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. According to DSS, as of October 2020, 95 percent of IHSS and Waiver Personal Care Services providers and recipients are enrolled in the EVV system.

Phase II will include non-IHSS and non-Waiver Personal Care Services self-directed model components, as well as the agency model components of the IHSS and Waiver Personal Care Services programs.

Electronic Visit Verification Phase II Programs

Department	Program	Self-Directed	Agency Model	PCS	HHCS
DDS	1915 (c) DD Waiver	X	X	X	X
DDS	1915 (i) State Plan Services	X	X	X	X
DDS	1915 (c) Waiver Self-Determination Program	X	X	X	X
DHCS	1915 (c) Home- and Community-Based Alternatives Waiver	X	X	X	X
DHCS	Home Health Care Services		X		X
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 calendar year 2020, 0.5 percent in 2021, 0.75 percent in 2022, and one percent annually thereafter. States that do not adopt EVV for HHCS by January 1, 2023, would be subject to an additional decrease in federal match of 0.25 percent in 2023 and 2024, 0.5 percent in 2025, 0.75 percent in 2026, and 1 percent annually thereafter. The CURES Act allows a state to apply for a one-year exemption from the federal match reduction if the state made a good faith effort to comply and has encountered unavoidable delays. DHCS requested and the federal government approved a one-year exemption under this provision, delaying any reduction in federal matching funds until 2021. A state may only apply for a single, one-year exemption. According to DHCS, 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 in the 2020-21 and 2021-22 fiscal years:

Electronic Visit Verification Delay – Federal Matching Fund Penalties by Department		
Department	**2020-21**	**2021-22**
Department of Social Services	($14,831,000)	($16,100,000)
Department of Developmental Services	($5,376,000)	($5,376,000)
Department of Health Care Services	($417,000)	($417,000)
Department of Aging	($31,000)	($31,000)
Department of Public Health	($11,000)	($11,000)
TOTAL	**($20,665,000)**	**($21,934,000)**

Resources for 2021-22 to Complete Project Lifecycle Approval and Begin EVV Implementation. OSI, DHCS, and DDS request expenditure authority of $24.1 million ($5.8 million General Fund and $18.3 million federal funds) in 2021-22. If approved, these resources would allow OSI, DHCS, and DDS to complete the California Department of Technology's Project Lifecycle Approval (PAL) process and begin implementation of EVV. According to DHCS, Stage 3 (Solution Development) of the PAL process was scheduled to be completed in October 2020, and Stage 4 (Project Readiness and Approval) and execution of the prime vendor contract would be completed in the last quarter of the 2020-21 fiscal year (April-June 2021). DHCS expects implementation of EVV for Personal Care Services by January 1, 2022, and for Home Health Care Services by January 1, 2023.

The resources included in this request are comprised of a continuation of existing position equivalents, as well as new contract and solution vendor resources for completion of the project. The allocation of funds and position equivalents in this request for each of these departments are as follows:

Department/Office	Federal Funds (90 percent)	General Fund (10 percent)	TOTAL FUNDS	Position Equivalents
OSI*	[$-]	[$-]	[$21,234,000]	6.0
DHCS	$10,800,000	$1,832,000	$12,632,000	9.0
DDS	$7,512,000	$3,922,000	$11,434,000	5.0
Total	**$18,312,000**	**$5,754,000**	**$24,066,000**	**20.0**

* OSI Allocation is non-add, as this allocation is the result of a transfer from DHCS and DDS of $10,617,000 each for a total of $21,234,000 of the approved funding to OSI to fund contract costs and the equivalent of six positions. The remaining funds in these departments ($2 million at DHCS and $817,000 at DDS) support the requested position equivalents for 2021-22 (nine position equivalents at DHCS, five position equivalents at DDS).

Project Team Staff Resources – $2.8 million. The Project Team is composed of a mix of state and consultant staff, including six position equivalents at OSI, nine at DHCS, and five at DDS. The state position equivalents are extensions of resources received in the 2018-19 and 2020-21 fiscal years. The six position equivalents at OSI include a Project Director, a procurement and contract management analyst, a technical manager, a librarian, and one Associate Governmental Program Analyst.

The nine position equivalents at DHCS include one Staff Services Manager II position (serving as Program Manager), four Information Technology Specialist II positions (one serving as Project Manager, three as Technical Leads), one Health Program Specialist I position, and three Associate Governmental Program Analysts.

The five position equivalents at DDS include one Staff Services Manager I position, two Information Technology Specialist II positions, and two Associate Governmental Program Analysts.

Consultant Contracts - $4 million. In addition to the position equivalents, OSI is requesting $4 million for a consultant contract for project management and business analyst support throughout implementation, as well as business, testing, and technical support to complete design, development, and implementation (DD&I) activities and for department implementation. These requested resources would also support interdepartmental consulting costs for the California Department of Technology project oversight.

EVV Solution Vendor Services - $16.3 million. If these resources are approved, OSI expects the EVV Phase II Solution Vendor to start implementation in the last quarter of 2020-21 (April-June 2021). OSI estimates costs for the EVV Solution Vendor would be $16.3 million in the 2021-22 fiscal year, although the actual costs would not be known until receipt of Requests for Proposal and award of the contract.

Operating Expenses and Equipment (OE&E). OSI is also requesting $948,000 for other operating expenses and equipment, including general expenses, printing, communications, travel, training, facilities, and administrative support costs.

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

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

1. Please provide a brief overview of this proposal.

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

3. What is the expected total of the federal funding penalties due to the delays in implementation of EVV?

Issue 3: California Affordable Drug Manufacturing Act Implementation (SB 852)

Budget Change Proposal – Governor's Budget. CHHSA requests one position and General Fund expenditure authority of $2.2 million in 2021-22, and $184,000 annually thereafter. If approved, these resources would allow CHHSA to conduct research and analysis to support implementation of SB 852 (Pan), Chapter 207, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$2,197,000	$184,000
Total Funding Request:	**$2,197,000**	**$184,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2022-23.

Background. SB 852 (Pan), Chapter 207, Statutes of 2020, the California Affordable Drug Manufacturing Act of 2020, requires CHHSA to enter into partnerships or contracts resulting in the production or distribution of generic prescription drugs, with the intent that these drugs be made widely available to public and private purchasers, providers, suppliers, and pharmacies. SB 852 targets failures in the market for generic drugs resulting from supplier concentration and other anti-competitive practices that lead to higher prices for consumers and health care service providers. CHHSA is required to prioritize production and distribution of drugs that would have the greatest impact on lowering patient drug costs, increasing competition, addressing shortages, and improving public health. In making these determinations, CHHSA must consider the drug expenditure reporting from the Department of Managed Health Care and the Department of Insurance pursuant to SB 17 (Hernandez), Chapter 603, Statutes of 2017, as well as prioritize the production of at least one form of insulin, drugs for chronic and high-cost conditions, and those that can be delivered through mail order. SB 852 also requires CHHSA to report its progress on implementation to the Legislature by July 1, 2022, and report to the Legislature by July 1, 2023, on the feasibility of the state directly manufacturing and selling prescription drugs at a fair price. The requirement to conduct the feasibility report is subject to appropriation of funding in the budget for that purpose.

Staffing and Resource Request. CHHSA requests one position and General Fund expenditure authority of $2.2 million in 2021-22, and $184,000 annually thereafter to support implementation of SB 852. Of these requested resources, $197,000 in 2021-22 and $184,000 annually thereafter would support **one Health Program Manager III** position to serve as Project Manager. The Project Manager, under the direction of the Deputy Secretary for Policy and Strategic Planning, would coordinate, brief, and advise senior leadership at CHHSA on emerging issues and decision points, research state and federal policies related to generic drugs and biosimilars, perform data analysis on utilization costs for various policy options, and review and provide feedback on various project deliverables from the expert consultants.

Of the requested resources, $2 million would support expert consulting services in 2021-22 to assist CHHSA to: 1) identify top drugs for generic manufacturing; 2) assess legal, market, policy, and regulatory factors; and 3) assist with strategic and operational issues. The request includes provisional budget bill language to allow expenditure and encumbrance of these consulting resources until June 30, 2023.

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

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

1. Please provide a brief overview of this proposal.

2. What is the expected timeline for entering into the first contracts for manufacture of generic drugs?

3. Does the Administration intend to fund the feasibility study for direct state generic drug manufacturing contained in SB 852?

Issue 4: Center for Data Insights and Innovation

Budget Change Proposal and Trailer Bill Language – Governor's Budget. CHHSA requests four positions and expenditure authority from the Data Insights and Innovation Fund of $443,000 annually. If approved, these positions and resources would allow CHHSA to establish the Center for Data Insights and Innovation, which will consolidate several CHHSA offices to improve the transparency, efficiency, availability, and utilization of data, while also managing the data's integrity, quality, and strategic use to promote person-centered, data-driven decision making and integrated care and services. CHHSA also proposes trailer bill language to reorganize the existing entities and establish the new center.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3377 – Data Insights and Innovation Fund	$443,000	$443,000
Total Funding Request:	**$443,000**	**$443,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and resources ongoing after 2022-23.

Background. According to the Administration, CHHSA is California's largest agency and includes many key departments and entities that deliver an array of health and social programs and services to California's vulnerable and at-risk residents. CHHSA manages a vast amount of health, business, welfare, and public health data, which could be utilized to improve public programs and policies, help target resources to vulnerable and underserved populations, and address disparities in health and socioeconomic status. The Administration's proposed Center for Data Insights and Innovation (CDII) would consolidate several existing entities within CHHSA and transfer entities within the Office of Statewide Health Planning and Development (OSHPD) to accomplish the following objectives:

1) Institutionalize analytics as a service,
2) Internalize data intelligence,
3) Operational focus and rapid prototyping, and
4) Analytical excellence

The existing entities that would be consolidated into CDII are:

1) Office of the Patient Advocate (OPA)
2) Office of Health Information Integrity (CalOHII)
3) Committee on the Protection of Human Subjects (CPHS)
4) Open Data Portal

Office of Patient Advocate. The Office of Patient Advocate (OPA) rates health plans and medical groups using health performance measures based on quality of medical care and patient experience. OPA also provides information to help consumers compare health plans and medical groups, track consumer complaints, and identify patient rights and health care resources. Specifically, OPA produces the following reports annually: 1) Health Care Quality Report Cards with clinical performance and patient experience data for the state's largest health plans and over 200 medical groups; 2) Complaint Data Reports and Baseline Review of State Consumer Assistance Call Centers with data findings based on health care consumer complaint data and call center information submitted to OPA from the Department of Managed Health Care, Department of Insurance, Department of Health Care Services, and Covered California; and

3) Model Protocols for State Consumer Assistance Call Centers with recommendations for responding to and referring calls outside of a call center's jurisdiction.

The proposed CDII would assume the responsibilities of OPA, including production of the Health Care Quality Report Cards and Complaint Data Reports. In addition, upon appropriation of funding for these purposes CDII would: 1) coordinate with state entities that regulate or administer public and commercial health coverage programs to help address issues of quality of care and patient experience that have been found to be deficient in the Health Care Quality Report Cards; 2) create and provide tools and education to consumers of health insurance and public health coverage programs to better enable them to access and utilize the Health Care Quality Report Cards; 3) develop tools and education related to improvement of consumer access to care, quality of care, and addressing disparities in quality of care related to socioeconomic status; 4) develop and implement consumer surveys of patient experience, quality of care, or other relevant topics; 5) develop standards for departments related to public reports to ensure consumer readability and understanding.

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

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

The proposed CDII would assume the responsibilities of CalOHII to enforce state law mandating the confidentiality of medical information, including, but not limited to, the Confidentiality of Medical Information Act, the Information Practices Act of 1977, HIPAA, and the federal Health Information Technology for Economic and Clinical Health (HITECH) Act. CDII would also complete an independent security assessment once every three years, consistent with the requirements of AB 670 (Irwin), Chapter 518, Statutes of 2015.

Committee on the Protection of Human Subjects (CPHS). The Committee on the Protection of Human Subjects (CPHS), currently administered by the Office of Statewide Health Planning and Development, (OSHPD) serves as the institutional review board (IRB) for departments administered by the California Health and Human Services Agency to ensure that research involving human subjects is conducted ethically and with minimum risk to participants. CPHS also reviews all research-related requests for state personal information from the University of California and non-profit educational institutions, as well as approving research requests for certain vital records from the Department of Public Health. CPHS is composed of 13 volunteer members appointed by the Secretary of CHHSA, chosen for their expertise in differing fields of research and abilities to represent and understand the needs of diverse research

subjects, particularly those who may be vulnerable due to factors such as age, socio-economic status, ethnicity, or medical conditions.

The proposed CDII would assume oversight of CPHS from OSHPD.

Open Data Portal. The Open Data Portal initiative offers access to standardized data that may be used by individuals, business, researchers, journalists, developers, and government entities. According to CHHSA, the initiative was launched to increase public access to non-confidential health and human services data to spark innovation, promote research and economic opportunities, engage public participation in government, increase transparency, and inform decision-making. The data is freely available, machine-readable, and formatted according to national technical standards to facilitate visibility and reuse of published data. Data sets are available from 14 entities within CHHSA, including the Department of Public Health, the Department of Social Services, the Department of Health Care Services, and the Office of Statewide Health Planning and Development.

The proposed CDII would administer the Open Data Portal on behalf of CHHSA, as well as develop and administer the Research Data Hub and any other significant data initiatives for the agency or its departments.

New Responsibilities of CDII. In addition to the assumption of responsibilities of OPA, CalOHII, CPHS, and the Open Data Portal, the proposed CDII would also be tasked with using data to improve processes and provide strategic planning and services to CHHSA and its departments, including the following responsibilities:

1. Establishing health information sharing guidance that balances the need for patient privacy with the benefits of data sharing to support and encourage integrated care and services to assist health and social services organizations.
2. Enabling the transmission of protected health information while increasing privacy protections by ensuring only required health data is transmitted for purposes and uses consistent with state and federal law.
3. Improving and strengthening the security of data processes within CHHSA and its departments.

Staffing and Resource Request. CDII requests redirection of a total of 18 positions from the entities that would be absorbed by the center. These positions are as follows:

- **One Career Executive Assignment (CEA)** position from OPA would be redirected to serve as Director and Chief Data Officer of CDII
- **One CEA** position from CalOHII would be redirected to serve as Chief Deputy Director of CDII
- **One Attorney IV, one Staff Services Manager II,** and **one Staff Services Manager I** would be redirected from CalOHII to focus on internal and external data sharing to improve program and service delivery.
- **One CEA, one Office Technician, one Research Program Specialist II, one Staff Services Manager I Specialist, one Associate Governmental Program Analyst,** and **one Staff Services Analyst** would also be redirected from OPA to focus on internal and external data sharing to improve program and service delivery.

- **One Associate Governmental Program Analyst** and **one Staff Services Manager I** would be redirected from the CHHSA Information Office to support the Research Data hub and other similar efforts at CDII.
- **One Research Scientist II** would be redirected from CHHSA to develop research and data protocols and guidelines that can be adopted by all agency departments.
- **Two Staff Services Manager II positions** and **two Office Technicians** would be redirected from OSHPD to administer the Committee for the Protection of Human Subjects.

In addition, the following resources would be redirected to the new center:

- $634,000 annually in contract funding would be redirected from CalOHII
- $1.2 million annually in contract funding would be redirected from OPA
- Reimbursements that support the Committee for the Protection of Human Subjects would be redirected from OSHPD to CDII to reflect its oversight of the committee.

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

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

1. Please provide a brief overview of this proposal.

2. Please describe how the new Center would continue the work of OPA to improve the consumer's experience with health plans. Does CHHSA believe the practice of monitoring the most frequent topics of health care complaints or other barriers faced by consumers would help the Center identify ways to improve the delivery of health care?

3. What changes does the Center envision to current departments' treatment of protected health information or other information protected by state and federal privacy laws?

Issue 5: Equity-Centered Programs

Budget Change Proposal – Governor's Budget. CHHSA requests six positions and General Fund expenditure authority of $7.6 million in 2021-22, $4.1 million in 2022-23, and four positions and $1.3 million annually thereafter. If approved, these positions and resources would allow CHHSA to implement several equity-related proposals including a post-pandemic equity analysis, language access resources, an equity dashboard, and workforce training.

In addition, DHCS requests 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. If approved, these positions would allow DHCS to partner with CHHSA on implementation of the equity dashboard.

Program Funding Request Summary - CHHSA		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$7,633,000	$4,099,000
Total Funding Request:	**$7,633,000**	**$4,099,000**
Total Requested Positions:	**6.0**	**6.0**

* Additional fiscal year resources requested: 2023-24 and ongoing: 4.0 positions and $1,292,000

Program Funding Request Summary - DHCS		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$484,000	$461,000
0890 – Federal Trust Fund	$483,000	$461,000
Total Funding Request:	**$967,000**	**$922,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and resources ongoing after 2022-23.

Background. The COVID-19 pandemic has devastated California communities, resulting in more than 3.3 million confirmed cases, more than 40000 fatalities, and unprecedented stress on California's hospitals and other health care delivery systems. These statewide statistics obscure the well-documented disproportionate impact of the pandemic on Black, Latino, Asian and Native American communities, with case and fatality rates that greatly exceed these communities' share of the state's population. Nationwide, a July 2020 analysis from the Kaiser Family Foundation and the Epic Health Research Network found the hospitalization rates and death rates per 10,000 population, respectively, were 24.6 and 5.6 for Black patients, 30.4 and 5.6 for Latino patients, 15.9 and 4.3 for Asian patients, and 7.4 and 2.3 for White patients. Among some of the factors driving higher rates of infection, these populations are more likely to live in crowded conditions, in multigenerational households, have jobs that cannot be performed remotely, and utilize public transportation. Once infected, persons who have high levels of social vulnerability are at greater risk for hospitalization due to the presence of chronic medical comorbidities, such as hypertension, diabetes, and obesity, which are associated with worse outcomes of COVID-19 [2].

[2] Lopez, Leo, Hart, Louis H., Katz, Mitchell H., "Racial and Ethnic Health Disparities Related to COVID-19". JAMA., January 22, 2021.

According to CHHSA, California was the first state in the nation to implement a health equity metric as part of the Blueprint for a Safer Economy framework, a tier-based system that governs the level of pandemic-related restrictions in effect in a given county. The equity metric requires a county, prior to relaxation of pandemic restrictions, to submit a plan to target investments to protect disproportionately impacted populations and to demonstrate that test positivity rates in disadvantaged neighborhoods do not significantly lag the county's overall test positivity rate.

Staffing and Resource Request. CHHSA requests six positions and General Fund expenditure authority of $7.6 million in 2021-22, $4.1 million in 2022-23, and four positions and $1.3 million annually thereafter to implement several equity-related proposals. In addition, DHCS requests 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 as part of the equity dashboard proposal.

The four equity-related proposals are as follows:

1. Post-COVID Equity Analysis – CHHSA requests 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. According to CHHSA, the analysis would help the state better understand how health disparities fueled the pandemic and how to prepare for future crises.
2. Language Access Policy Framework – CHHSA requests two limited-term positions and 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.
3. Equity Dashboard – CHHSA requests three positions and General Fund expenditure authority of $3.2 million in 2021-22 and $1.1 million annually thereafter. DHCS requests five positions and $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. If approved, these positions and resources would allow CHHSA and 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 would be part of the agency's Open Data Portal and would identify data gaps by race, ethnicity, sexual orientation, and gender identity.
4. Workforce Training – CHHSA requests General Fund expenditure authority of $2.5 million in 2021-22 and 2022-23 to expand training opportunities in agency departments and other entities to identify and eliminate barriers to an inclusive, just, and sustainable society. Staff would receive racial equity training to ensure the programs and services are respectful and mindful of the communities being served.

Previous Legislation and Budget Augmentations to Address Equity. Over the past several years, the Legislature has enacted legislation and approved budget augmentations to address some of the same equity concerns identified by this request.

The California Reducing Disparities Project, a collaboration between the Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, the California Behavioral Health Directors Association and the California Behavioral Health Planning Council, was founded in 2009 with the goal of achieving mental health equity for African American, Latino, Native American, Asian and Pacific Islander, and LGBTQ+ communities. The 2012 Budget Act included expenditure authority from the Mental Health Services Fund of $60 million for the Office of Health Equity at the Department of Public Health to administer the program. Phase I of the program resulted in development of a Strategic Plan to Reduce Mental Health Disparities, which provides a roadmap for reducing mental health disparities in unserved, underserved, and inappropriately served communities. The plan identifies strategies to improve access, services, and outcomes for these populations. According to DPH, Phase II of the program is currently underway and is focused on funding and evaluating the practices identified in the strategic plan.

AB 470 (Arambula), Chapter 550, Statutes of 2017, requires DHCS to utilize existing data sources for specialty mental health services to help identify mental health disparities. AB 470 requires the department's performance outcome reports to provide data at the statewide and county level regarding access to care, waiting times for assessment and for a first appointment, language capacity and language access, quality, utilization and penetration. AB 470 requires all of these data to be stratified by age, sex gender identity, race, ethnicity, primary language, sexual orientation, or any other data elements for which there is peer-reviewed evidence to assess performance outcomes related to mental health disparities. The AB 470 implementation process identified several areas in which DHCS does not currently collect the necessary information to detect disparities.

AB 635 (Atkins), Chapter 600, Statutes of 2016, authorized a pilot project for medical interpreters, along with a study to identify current requirements for medical interpretation services and strategies to be employed regarding the provision of interpretation services for Medi-Cal beneficiaries. The 2016 Budget Act included $6 million ($3 million General Fund) for the study and the project. However, DHCS only conducted the study and did not implement any pilot projects. As a result, the 2019 Budget Act included General Fund expenditure authority of $5 million specifically to conduct the pilot projects and SB 165 (Atkins), Chapter 365, Statutes of 2019, requires the establishment of up to four separate sites to evaluate the provision of medical interpretation services for Medi-Cal beneficiaries.

New Federal Task Force to Advance Health Equity. On January 21, 2021, the Biden Administration issued an executive order establishing a COVID-19 Health Equity Task Force at the federal Department of Health and Human Services. The task force is composed of agency and department leaders, as well as up to 20 members with expertise and lived experience relevant to groups suffering disproportionate rates of illness and death in the United States or relevant to equity in public health, health care, education, housing, and community-based services. The task force will provide recommendations to the President for mitigating health inequities caused or exacerbated by the COVID-19 pandemic and for preventing such inequities in the future. The recommendations will include: 1) how best to allocate COVID-19 resources to address disproportionately negative impacts of COVID-19 outcomes by race, ethnicity, and other factors; 2) how to disburse COVID-19 relief funding in a manner that advances equity; and 3) effective, culturally aligned communication, messaging, and outreach to communities of color and other underserved populations. The task force will also collaborate with relevant agencies to develop a data strategy, including: 1) recommendations for expediting data collection for communities of color and other underserved populations; 2) identifying data sources, proxies, or indices that would enable development

of short-term targets for pandemic related actions for such communities and populations; and 3) developing longer-term recommendations to address data shortfalls and other foundational data challenges, including those related to data intersectionality.

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

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

1. Please provide a brief overview of this proposal.

2. Would the post-COVID equity analysis also include recommendations or a plan of action for how to address the inequities identified in the analysis?

3. How would the language access policy framework address gaps in the availability of linguistically appropriate health care providers or health information? Does the Administration have any next steps in mind beyond developing a policy framework?

4. How would the proposed equity dashboard address the current gaps in the collection of certain demographic or other key information in health care programs that prevent identification of inequities? Does the Administration plan to include the collection of additional information in its Medi-Cal Enterprise System and other health-related IT projects to improve the quality of the equity dashboard and related analyses of inequities?

5. Please describe the curriculum of the workforce training opportunities in racial equity.

6. How does the Administration plan to integrate its efforts with the health equity initiatives recently announced by the new federal Administration?

Issue 6: Office of Youth and Community Restoration

Budget Change Proposal – Governor's Budget. CHHSA requests 19 positions and General Fund expenditure authority of $3.4 million in 2021-22 and $3.1 million annually thereafter. If approved, these positions and resources would allow CHHSA to establish and operate the Office of Youth and Community Restoration (OYCR), authorized by SB 823 (Committee on Budget and Fiscal Review), Chapter 337, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$3,433,000	$3,087,000
Total Funding Request:	**$3,433,000**	**$3,087,000**
Total Requested Positions:	**19.0**	**19.0**

* Positions and resources ongoing after 2022-23.

Background. Senate Bill 94 (Committee on Budget and Fiscal Review), Chapter 25, Statutes of 2019, moved the Division of Juvenile Justice (DJJ) from the California Department of Corrections and Rehabilitation (CDCR) to CHHSA as a new Department of Youth and Community Restoration. However, this proposal was subsequently withdrawn, and the Legislature approved Senate Bill 823. SB 823 (Committee on Budget and Fiscal Review), Chapter 337, Statutes of 2020, repealed previous provisions that would have created the Department of Youth and Community Restoration and the provisions that would have transferred the responsibilities of the Division of Juvenile Justice (DJJ) to CHHSA. This statute established the OYCR within CHHSA, effective July 1, 2021. SB 823 directed the juvenile justice subcommittee of the Children Welfare Council to advise and provide recommendations to the OYCR related to the policies, programs, and approaches that improve youth outcomes, reduce youth detention, and reduce recidivism. The OYCR will provide staffing support to elicit, examine, and operationalize the expertise of subcommittee members.

The DJJ houses California's youthful offenders up to the age of 25 who have the most serious criminal offenses and most intense treatment needs. Moving the DJJ under CHHSA was intended to align the rehabilitative mission of the state's juvenile justice system with trauma-informed and developmentally appropriate services supported by programs overseen by CHHSA. The transition of justice-involved youth being served in local communities will promote trauma-responsive, culturally informed services for youth involved in the juvenile justice system that supports the youths' successful transition into adulthood and help them become responsible, thriving, and engaged members of their communities.

Responsibilities of the OYCR include:

- Identifying and disseminating best practices and assessing the efficacy of local programs.

- Reviewing local Juvenile Justice Realignment Grants. The Juvenile Justice Realignment Block Grant program provides state General Fund for county-based custody, care, and supervision of youth realigned from DJJ. Funding will be allocated to counties based on a formula developed by the Department of Finance. The formula will remain in place until 2023-24 when it will then be reassessed by the Legislature. Counties must file a plan with OYCR by January 1, 2022, to receive

funding. Note that the OYCR will take over the administration of the grant program from the Board of State and Community Corrections no later than January 1, 2025.

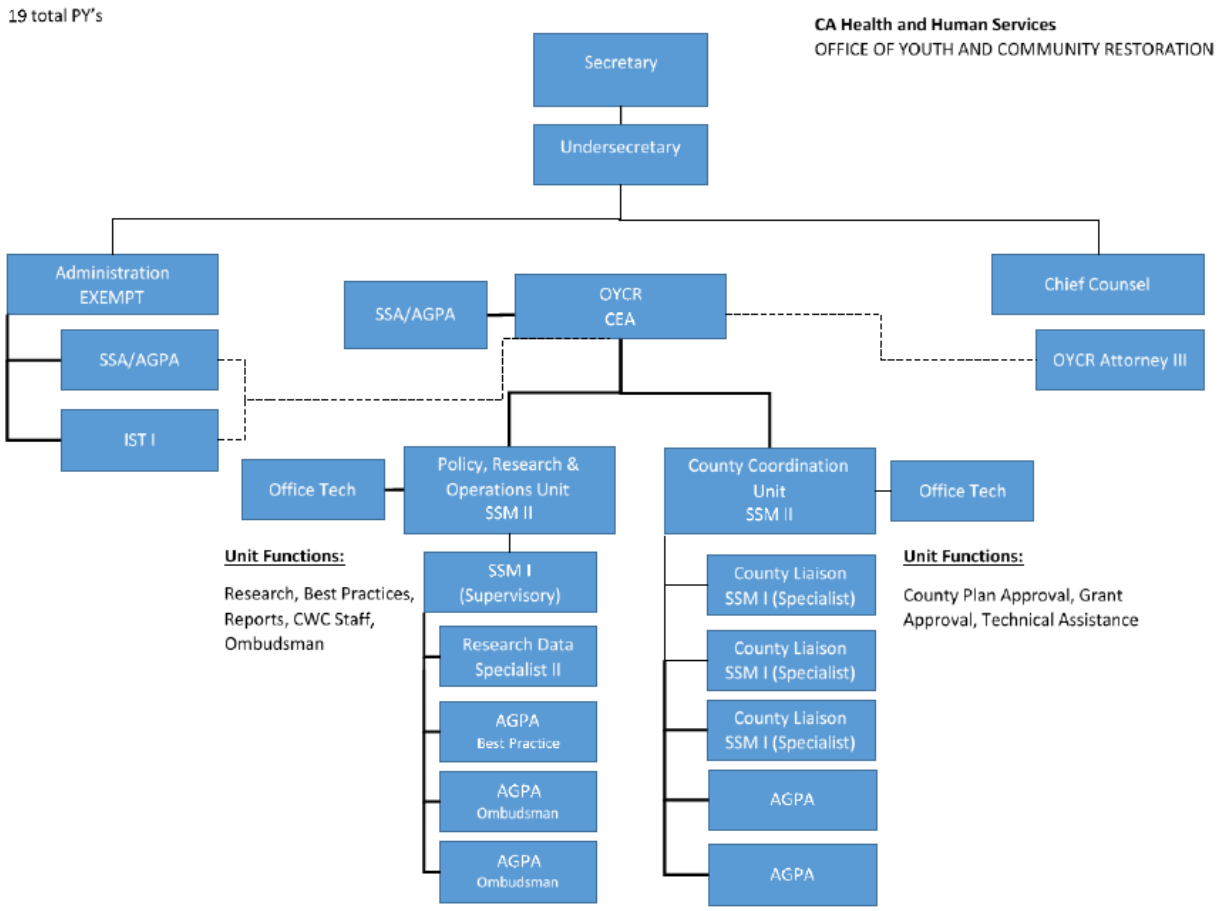
- Developing policy recommendations to improve outcomes and integrate programs and services to support delinquent youth.

- Receive and assess complaints and provide reports to the Legislature via an Ombudsperson. The Ombudsperson will have the ability to review and investigate complaints or refer complaints to another entity for investigation.

- Develop a report on youth outcomes in the juvenile justice system and an annual report on the work of the office.

- Evaluate the efficacy of local programs utilized for realigned youth and report its findings to the Governor and the Legislature no later than July 1, 2025.

Staffing and Resource Request. The proposal includes resources for 19 full-time employees. A proposed organizational chart for the office is below.



Subcommittee Staff Comment and Recommendation—Hold Open. Reviewing county plans is a significant responsibility of the OYCR. Currently, the budget proposes six full-time positions in the unit that will review all 58 county plans. The Subcommittee may wish to inquire as to how the proposed staffing level was determined to ensure that proposed staffing is adequate for the complete review of county plans.

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

1. Please provide a brief overview of this proposal.

2. As it may be some time before OYCR takes over the administration of the Juvenile Justice grant program, what other duties will staff in the county coordination unit have before that switch? How did CHHSA determine the level of staffing needed for the office?

3. Does CHHSA expect to come back to the Legislature in future budget years to request additional resources once the OYCR takes over the administration of those grants?

4. Please provide more detail on the oversight responsibilities of the OYCR in regards to the Juvenile Justice Realignment Block Grant program. Is the acceptance of county plans tied to funding?

5. To what entity will the Ombudsperson refer complaints?

Issue 7: Healthy California for All Commission Reappropriation

Reappropriation Budget Bill Language – Governor's Budget. CHHSA requests reappropriation of General Fund expenditure authority of up to $2.5 million, previously authorized in the 2019 Budget Act, to support the Healthy California for All Commission.

Program Funding Request Summary		
Fund Source	**2021-22***	**2022-23**
0001 – General Fund	$2,500,000	$-
Total Funding Request:	**$2,500,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* Reappropriation of expenditure authority from 2019 Budget Act, available for encumbrance and expenditure until June 30, 2022.

Background. SB 104 (Committee on Budget and Fiscal Review), Chapter 67, Statutes of 2019, authorized the establishment of the Healthy California for All Commission. The commission is an independent body comprised of 13 members tasked with the development of a plan that includes options for advancing progress toward achieving a health care delivery system in California that provides coverage and access through a unified financing system, including, but not limited to, a single-payer financing system, for all Californians. The commission members are as follows:

- Secretary of the California Health and Human Services Agency, who serves as Chair
- Eight members appointed by the Governor
- Two members appointed by the Senate Committee on Rules
- Two members appointed by the Speaker of the Assembly
- Five ex officio, non-voting members including:
    - Executive Director of the California Health Benefit Exchange
    - Director of the Department of Health Care Services
    - Chief Executive Officer of the Public Employees' Retirement System
    - Chair of the Senate Health Committee
    - Chair of the Assembly Health Committee

SB 104 required the Commission to submit a report by July 1, 2020, analyzing California's existing health care delivery system, including cost, quality, workforce, and provider consolidation trends, as well as options for additional steps California can take to prepare for transition to a unified financing system. These steps could include administrative changes, reorganization of state programs, federal waivers, and statutory and constitutional changes. The commission published its report, "An Environmental Analysis of Health Care Delivery, Coverage, and Financing in California" in August 2020.

SB 104 also required the commission to submit a report by February 1, 2021, that includes options for key design considerations for a unified financing system, including: 1) eligibility and enrollment, 2) covered benefits and services, 3) provider participation, 4) purchasing arrangements, 5) provider payments, 6) cost containment, 7) quality improvement, 8) participant cost sharing, 9) quality monitoring and disparities reduction, 10) information technology and financial management systems, 11) data sharing and transparency, and 12) governance and administration. Due to the COVID-19 pandemic, the commission

has suspended all of its activities until February 2021, which will likely result in delay of the delivery of the commission's second report on options and design considerations for the unified financing system.

Reappropriation Request. The 2019 Budget Act included General Fund expenditure authority of $5 million to fund the activities of the commission, including contract resources to develop the required reports. This expenditure authority was made available for encumbrance or expenditure until June 30, 2021. Due to the pandemic-related delays of the commission's responsibilities, CHHSA requests reappropriation of up to $2.5 million of General Fund expenditure authority approved in the 2019 Budget Act to continue the commission's activities. The reappropriated expenditure authority would extend the availability of this funding for one year, until June 30, 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 CHHSA to respond to the following:

1. Please provide a brief overview of this proposal.

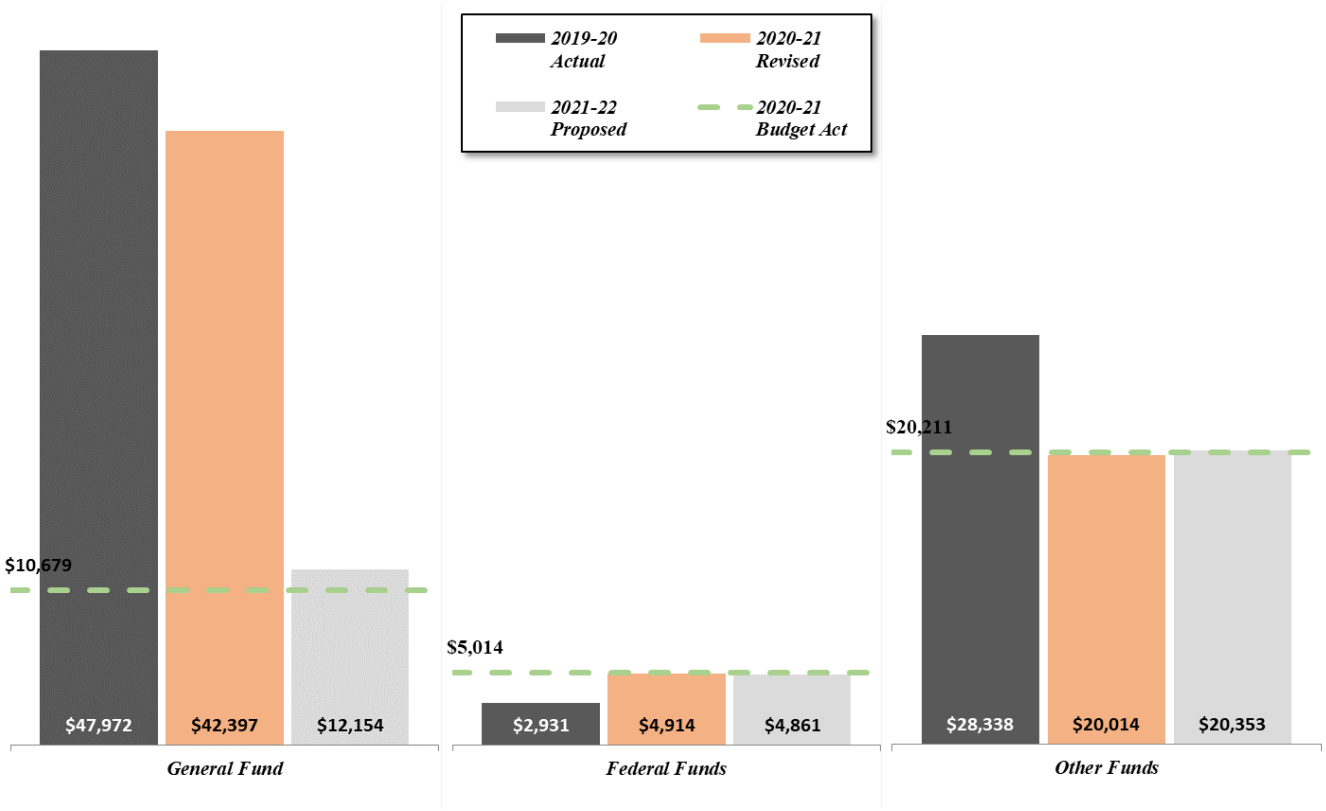
2. When does the Commission expect to release its report on key design considerations for a unified financing system?

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Overview

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

(dollars in thousands)



Emergency Medical Services Authority - *Department Funding Summary*			
Fund Source	**2019-20 *Actual***	***2020-21 Revised***	***2021-22 Proposed***
General Fund	$47,972,000	$42,397,000	$12,154,000
Federal Funds	$2,931,000	$4,914,000	$4,861,000
Other Funds	$28,338,000	$20,014,000	$20,353,000
Total Department Funding:	**$79,241,000**	**$67,325,000**	**$37,368,000**
Total Authorized Positions:	**118.6**	**70.8**	**74.8**
Other Funds Detail:			
EMS Training Prog. Approval Fund (0194)	*$211,000*	*$135,000*	*$150,000*
EMS Personnel Fund (0312)	*$2,813,000*	*$2,704,000*	*$2,796,000*
Reimbursements (0995)	*$23,822,000*	*$15,568,000*	*$15,738,000*
EMT Certification Fund (3137)	*$1,492,000*	*$1,607,000*	*$1,669,000*

Background. The Emergency Medical Services Authority (EMSA), authorized by the Emergency Medical Services System and Prehospital Emergency Care Act, administers a statewide system of coordinated emergency medical care, injury 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.

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.

Issue 2: Office of Legislative, Regulatory and External Affairs and Legal Unit

Budget Change Proposal – Governor's Budget. EMSA requests two positions and General Fund expenditure authority of $286,000 annually. If approved, these resources would allow EMSA to address increased workload within the Office of Legislative, Regulatory, and External Affairs (LEA) and the Legal Unit.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$286,000	$286,000
Total Funding Request:	**$286,000**	**$286,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2022-23.

Background. According to EMSA, the Office of Legislative, Regulatory, and External Affairs (LEA) serves as the central point of contact for EMSA. LEA is responsible for all state and federal legislation, all EMSA regulatory matters and actions, policy matters, and public-facing programming. LEA publicizes EMS-related events, educates the public on injury and illness preparation, supports the state in disasters, and communicates program progress, legislative issues, and rulemaking activity through various platforms including print media, social media, photography, and video. LEA is composed of four staff members including a Deputy Director, two full-time Staff Services Managers, and one part-time student assistant.

The EMSA Legal Unit provides legal services to the EMS Personnel Division's licensure and enforcement sections, which oversee paramedic licensure and discipline. The Legal Unit prosecutes paramedic licensees that violate state law or regulations, which may result in disciplinary action that ranges from an administrative fine for minor offenses to license revocation for serious matters that put the public's health and safety at risk. The Legal Unit is composed of five staff members including an Administrative Advisor, an attorney, a retired annuitant attorney, a staff services analyst, and one student assistant.

Increased Disaster-Related Workload. EMSA reports it has experienced an increase in demand for information from the public, media, and various public and private stakeholders, particularly related to the increased number of disaster events such as wildfires and the COVID-19 pandemic. The COVID-19 pandemic has required coordinated intergovernmental communication and information sharing with the Governor's Office of Emergency Services (Cal OES), the Department of Public Health (DPH), and other entities. EMSA has not been able to fully participate in the intergovernmental coordination of information due to its lack of a dedicated information officer.

Increased Paramedic Discipline Workload. EMSA also reports an increase in legal support workload related to compliance with new state laws and regulations including compliance with accessibility standards pursuant to AB 434 (Baker), Chapter 780, Statutes of 2017, as well as various internal, state, and federal database reporting and tracking of licensure activities.

Staffing and Resource Request. EMSA requests **one Information Officer II** position in the LEA to plan, organize, and perform the analytical, technical, and professional work required in the production of printed materials, audio, and digital marketing materials. The Information Officer would also provide

analytical support to public record act requests, agency reporting, media inquiries, and publication development.

EMSA also requests **one Staff Services Analyst** in the Legal Unit to perform the mandated AB 434 compliance activities, as well as the various required database tracking and entries. This analyst would also assume the current workload of the Legal Unit's part-time assistant, including processing of paramedic discipline cases.

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: Regional Disaster Medical Health Response (RDMHS) Local Assistance

Budget Change Proposal – Governor's Budget. EMSA requests General Fund expenditure authority of $365,000 annually. If approved, these resources would allow EMSA to improve regional disaster medical and health mitigation, preparedness, response and recovery by funding three additional local Regional Disaster Medical Health Specialists (RDMHS) in three California Office of Emergency Services (CalOES) Mutual Aid Regions.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$365,000	$365,000
Total Funding Request:	**$365,000**	**$365,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2022-23.

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

Because the RDMHC position is voluntary and filled by individuals with other full-time local government positions, EMSA provides local assistance funding for regional disaster medical health specialists (RDMHS) that support the RDMHC by addressing routine and emergent needs within the mutual aid region and outside the region, if necessary. Until the 2020-21 fiscal year, EMSA contracted with local EMS agencies to provide one RDMHS to support the RDMHC program in each of the six mutual aid regions, as well as to support the Medical Health Operational Area Coordinator (MHOAC), who is responsible for the coordination of medical and health resources within a county. When an RDMHS is not engaged in immediate disaster response activities, this individual is engaged in planning, training, and preparing for disasters.

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

The 2020 Budget Act included General Fund expenditure authority of $365,000 annually to fund three additional RDMHS in three of the six mutual aid regions. The three regions chosen were the administrative regions designated by the California Office of Emergency Services. In addition, the 2020 Budget Act included provisional language authorizing EMSA to augment its General Fund expenditure

authority by up to $365,000 to support three additional RDMHS personnel in the remaining three mutual aid regions if the federal Emergency Management Agency (FEMA) does not provide sufficient funding to support those positions.

Local Assistance Resource Request. EMSA requests ongoing General Fund expenditure authority of $365,000 to support three additional RDMHS personnel in the remaining three mutual aid regions permanently. If approved, these resources would allow all six mutual aid regions to support two RDMHS personnel to provide 24-hour emergency and disaster support, enhanced backup during, before, and after disaster responses, and improved development of the regional and county medical and health disaster response system.

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: Community Paramedicine or Triage to Alternative Destination Act of 2020 (AB 1544)

Budget Change Proposal – Governor's Budget. EMSA requests two positions and General Fund expenditure authority of $768,000 in 2021-22 and three positions and General Fund expenditure authority of $789,000 in 2022-23 and 2023-24. If approved, these positions and resources would allow EMSA to implement community paramedicine projects for local EMS agencies, pursuant to the requirements of AB 1544 (Gipson), Chapter 138, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$768,000	$789,000
Total Funding Request:	**$768,000**	**$789,000**
Total Requested Positions:	**2.0**	**3.0**

* Additional fiscal year resources requested – 2023-24: $789,000

Background. Community paramedicine is an innovative model of care that uses specially trained paramedics in partnership with other health care providers to address identified patient needs in local health care systems. Community paramedics utilize their specialized training to provide care outside of their traditional role, which is restricted to responding to 911 calls, treating patients at the scene of an emergency, transporting patients to emergency departments, and inter-facility transfers.

The Office of Statewide Health Planning and Development (OSHPD) operates the Health Workforce Pilot Project (HWPP) program to enable health care organizations to test and evaluate innovative models of care that utilize health professionals in new roles. In 2014, OSHPD approved an application by EMSA to evaluate community paramedicine. Over the course of the pilot, EMSA has established and evaluated 20 different projects in 14 California communities. 14 projects are still enrolling patients, while five have closed and one has suspended operations. The projects are testing seven different concepts for the practice of community paramedicine and were evaluated by the University of California San Francisco's (UCSF) Healthforce Center:

1. Post-Discharge – Short-term follow-up – This model provides short-term, home-based follow-up care to people recently discharged from a hospital due to a chronic condition to reduce the risk of readmission and improve management of the condition. According to UCSF, through March 2020 the five pilot projects with this model avoided potential costs of approximately $1.4 million, 61 percent of which would accrue to Medicare. Participating hospitals also reduced their risk of Medicare readmissions penalties.

2. Frequent EMS User – This model provides case management services to individuals with high utilization of emergency services or visits to emergency departments to identify needs that could be met more effectively outside of an emergency department, and assist patients in accessing primary care, behavioral health services, or other services. According to UCSF, the three pilots with this model have achieved reductions in 911 calls, ambulance transports, and emergency department visits and avoided potential costs of approximately $966,140. Two of the projects, in San Diego and San Francisco, also potentially reduced uncompensated care costs, as many of the enrolled patients were uninsured.

3. Directly Observed Therapy for Tuberculosis – This model provides directly observed therapy to individuals with tuberculosis to ensure effective treatment and prevent transmission. According to UCSF, people with tuberculosis who received directly observed therapy from community paramedics were more likely to receive all doses of medication prescribed by the physician than people who received directly observed therapy from the clinic's staff.

4. Hospice – This model collaborates with hospice agency nurses, patients, and family members to treat patients in their homes according to their wishes instead of transporting them to an emergency department when a 911 call is made. According to UCSF, the hospice project reduced 911 calls, transports to an emergency department, and avoided potential costs of $318,097.

5. Alternate Destination – Mental Health – This model offers individuals who have mental health needs but no acute medical needs transport directly to a mental health crisis center instead of an emergency department with subsequent transfer to a mental health facility. According to UCSF, the four pilots with this model avoided potential costs of $4.3 million by reducing the number of 911 calls that resulted in an emergency department visit and subsequent transport of a patient from an emergency department to an inpatient psychiatric facility.

6. Alternate Destination – Urgent Care – This model offers individuals with low-acuity medical conditions transport to an urgent care center for evaluation by a physician instead of an emergency department. According to UCSF, enrollment in these pilot projects was lower than expected due to strict inclusion criteria, calls occurring when urgent care centers were closed, and clinicians reluctant to treat some conditions.

7. Alternate Destination – Sobering Center – This model offers individuals who are acutely intoxicated but do not have acute medical or mental health needs transport directly to a sobering center for monitoring instead of an emergency department. According to UCSF, of the two pilots with this model that enrolled patients, 98.2 percent of patients in San Francisco and 100 percent of patients in Los Angeles were treated safely and effectively at the sobering center, without the need to transfer to an emergency department within six hours of admission to the sobering center.

AB 1544 (Gipson), Chapter 138, Statutes of 2020, establishes the Community Paramedicine or Triage to Alternate Destination Act of 2020. AB 1544 requires EMSA to do the following:

- Establish a Community Paramedicine oversight advisory committee, consisting of at least 15 members serving in various emergency medical services positions and health care delivery fields to advise EMSA on the development and oversight of the program.
- Consult on medical protocols with a separate advisory committee comprised of individuals in public health, social work, hospice, substance use, or mental health expertise.
- Approve local EMS agencies' Community Paramedicine programs.
- Amend regulations to create standards for development of Community Paramedicine programs and EMS Plan updates that include:
    - Community Paramedicine training and curriculum development
    - Certification or accreditation of community paramedics by the local EMS agencies
    - Standards for approval, withdrawal, or revocation of a Community Paramedicine program
    - Data collection and submission

  - Process to assess the Community Paramedicine program's impact on the local EMS system
  - Alternate destination triage protocols
  - Documentation requirements for secondary transfers from a sobering center or behavioral health facility
  - Minimum medical staffing, procedures, and equipment requirements for sobering centers and behavioral health facilities
  - Periodic updates to EMSA from the local EMS agencies certifying alternate destination facilities meet staffing, procedure, and equipment standards
- Creating and submitting reports to the Legislature
- Creating a mechanism to receive and store data from local EMS agencies on their Community Paramedicine programs.

Staffing and Resource Request. EMSA requests two positions and General Fund expenditure authority of $768,000 in 2021-22 and three positions and General Fund expenditure authority of $789,000 in 2022-23 and 2023-24 to implement community paramedicine projects for local EMS agencies, pursuant to the requirements of AB 1544. Specifically, EMSA requests the following positions:

- **One Health Program Specialist I** position, which would be responsible for creating the advisory committee, hosting meetings, convening stakeholders to assist with drafting of regulations, draft protocols, assist with EMS plan reviews, monitor programs, receive and analyze program data, and draft and post reports on EMSA's website.
- **One Information Technology Specialist I** position would support database infrastructure.
- **One Associate Governmental Program Analyst**, which would begin January 1, 2022, would be responsible for review and processing of local EMS agency Community Paramedicine programs, assist with promulgation of regulations, create standardized requirements for reporting in annual plan submissions, and establish program requirements for approval and monitoring.

EMSA is also requesting a Project Manager during 2021-22 to assist current Community Paramedicine pilot projects to transition to permanent programs, and an Independent Evaluator beginning January 1, 2022 to collect data and prepare reports to be delivered to the Legislature, pursuant to the requirements of AB 1544.

Included in the resource request is $150,000 in 2021-22 and $27,000 annually thereafter for maintenance to implement system modifications to the California EMS Information System to receive the new data elements required to be collected by AB 1544. In addition, EMSA expects one additional EMS plan appeal per year, at a cost of $20,000. EMSA also expects additional costs associated with the addition of a member to the Commission, pursuant to AB 1544.

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 5: COVID-19 Pandemic Response

Oversight Issue – 2019-20 and 2020-21 Pandemic-Related Emergency Budget Augmentations. During the COVID-19 pandemic, the Administration augmented expenditure authority for EMSA through a variety of Executive Orders, provisional language, budget control sections, and transfers from the Disaster Response-Emergency Operations Account (DREOA). In addition, a variety of federal funding streams have supported the pandemic response including reimbursements from the Federal Emergency Management Agency (FEMA) and direct categorical funding from Congressional relief packages.

SB 89 General Fund Allocation for 2019-20. SB 89 (Committee on Budget and Fiscal Review), Chapter 2, Statutes of 2020, appropriated up to $1 billion of General Fund expenditure authority to any item for any purpose related to the Governor's declaration of a state of emergency related to the coronavirus pandemic. SB 89 required the Department of Finance to notify the Joint Legislative Budget Committee (JLBC) 72 hours prior to any expenditures made pursuant to this authority. EMSA received the following augmentations under SB 89:

- Ventilator Supply - $8.6 million (Item 4120-001-0001) to support the purchase of new ventilators, the refurbishment of ventilators already possessed by the state, and the purchase of intravenous fusion pumps. JLBC was notified of this expenditure on March 20, 2020.
- Medical Transportation - $2 million (Item 4120-001-0001) for a contract with American Medical Response to provide patient transportation and stand-by services. JLBC was notified of this expenditure on March 20, 2020.

Disaster Response-Emergency Operations Account (DREOA). Government Code Section 8690.6 established the Disaster Response-Emergency Operations Account (DREOA) within the Special Fund for Economic Uncertainties (SFEU). DREOA begins with an unencumbered balance of $1 million at the beginning of each fiscal year, but allows the Director of Finance to transfer sufficient funds from the SFEU to support DREOA expenditures. Section 8690.6 also authorizes DREOA funds, upon allocation by the Director of Finance, to be transferred to state agencies for disaster response operation costs incurred as a result of a proclamation by the Governor of a state of emergency. On March 4th, 2020, the Governor declared a state of emergency related to the COVID-19 pandemic, which allows transfers for this purpose to state departments, with notification to JLBC and the chairpersons of the fiscal committees in the Senate and Assembly.

On March 25, 2020, the Department of Finance notified JLBC of the transfer of $1.3 billion from the SFEU to DREOA to secure personal protective equipment and critical medical supplies, enhance the surge capacity of hospitals and medical facilities, and procure other items necessary to support the state's efforts to protect public health and safety and reduce the spread of the COVID-19 outbreak.

On May 21, 2020, the Department of Finance notified JLBC of the transfer of an additional $1.8 billion to continue emergency response actions, including procurements of personal protective equipment and critical medical supplies, support for over 3,000 hospital and medical surge beds, hotels for healthcare workers and support staff, state response operations, testing, contact tracing and tracking, and other support services.

EMSA received a total augmentation of General Fund expenditure authority of $30.9 million from two allocations of funds from DREOA in 2019-20, and $53.3 million from five allocations of funds from DREOA in 2020-21.

The EMSA response activities supported by SB 89 and DREOA funding in 2019-20 and 2020-21 are as follows:

- **Ambulance Transport** – Provision of patient transportation, medical staffing, and stand by services at various medical sites.
    - *2019-20 SB 89 Funding* - $2 million
    - *2019-20 DREOA Funding* - $11.6 million
    - *2020-21 DREOA Funding* - $12.1 million
    - **TOTAL (2019-20 and 2020-21) - $25.7 million**

- **Ventilators** – Purchase of new ventilators, refurbishment of existing ventilators already possessed by the state, and ventilator certification.
    - *2019-20 SB 89 Funding* - $8.6 million
    - *2019-20 DREOA Funding* - $6.8 million
    - *2020-21 DREOA Funding* - $8.5 million
    - **TOTAL (2019-20 and 2020-21) - $23.9 million**

- **Bio-Medical Equipment** – Purchase of medical equipment needed to assess patients with acute respiratory distress, cardiac monitors, and defibrillators.
    - *2019-20 DREOA Funding* - $3.4 million
    - **TOTAL (2019-20 and 2020-21) - $3.4 million**

- **California Medical Assistance Teams (CalMAT) Personnel** – Staff costs for CalMAT personnel deployments at various locations and alternate care sites.
    - *2019-20 DREOA Funding* - $5.2 million
    - *2020-21 DREOA Funding* - $19 million
    - **TOTAL (2019-20 and 2020-21) - $24.2 million**

- **CalMAT Support** – Purchase of CalMAT equipment and supplies to support field medical and alternate care sites.
    - *2019-20 DREOA Funding* - $646,000
    - *2020-21 DREOA Funding* - $430,000
    - **TOTAL (2019-20 and 2020-21) - $1.1 million**

- **EMSA Infrastructure** – Staffing, equipment, supplies, and services to support the infrastructure needs of EMSA during the pandemic.
    - *2019-20 DREOA Funding* - $1.2 million
    - *2020-21 DREOA Funding* - $8 million
    - **TOTAL (2019-20 and 2020-21) - $9.1 million**

- **EMSA Overtime** – EMSA staff overtime expenses incurred while deploying to field medical sites and staffing various operational centers, including the State Operations Center (SOC), the Departmental Operations Center (DOC), and the Medical and Health Coordination Center (MHCC)
    - *2019-20 DREOA Funding* - $415,000
    - *2020-21 DREOA Funding* - $521,000
    - **TOTAL (2019-20 and 2020-21) - $936,000**

- **Health Corps Personnel** – Staff costs for Health Corps personnel deployments at various locations and alternate care sites.
    - *2019-20 DREOA Funding* - $835,000
    - *2020-21 DREOA Funding* - $2.5 million
    - **TOTAL (2019-20 and 2020-21) - $3.4 million**

- **Health Corps Support** – Purchase of equipment, supplies, and services to support the infrastructure needs of the Health Corps.
    - *2019-20 DREOA Funding* - $29,000
    - *2020-21 DREOA Funding* - $21,000
    - **TOTAL (2019-20 and 2020-21) - $50,000**

- **Medical Supplies** – Purchase and replenishment of medical supplies required at alternate care sites.
    - *2019-20 DREOA Funding* - $152,000
    - *2020-21 DREOA Funding* - $925,000
    - **TOTAL (2019-20 and 2020-21) - $1.1 million**

- **Personal Protective Equipment** – Purchase of equipment to minimize exposure to COVID-19.
    - *2019-20 DREOA Funding* - $108,000
    - **TOTAL (2019-20 and 2020-21) - $108,000**

- **Travel Expenses (EMSA and CalMAT Staff)** – Travel, airfare, per diem, hotel, and care rental expenses for deployed staff in the field and to meet DOC operational needs
    - *2019-20 DREOA Funding* - $559,000
    - *2020-21 DREOA Funding* - $1.4 million
    - **TOTAL (2019-20 and 2020-21) - $2 million**

Federal Funding for Pandemic Emergency Response. The Federal Emergency Management Agency (FEMA) provides reimbursements for state, local, tribal, and territorial government entities for emergency protective measures taken during the COVID-19 pandemic. FEMA reimburses for eligible expenditures related to the emergency at no less than 75 percent of the cost. During California's pandemic response, the Administration has reported it believes FEMA will reimburse the state for much of its response expenditures at 75 percent. It is unclear how much, if any, of EMSA's pandemic-related costs have been reimbursed by FEMA. In addition, the Biden Administration issued an Executive Order on January 21, 2021, authorizing 100 percent FEMA reimbursement for certain pandemic-related response expenditures. It is also unclear how the change in reimbursement would affect funding for EMSA's pandemic-related expenditures to date, or in the future.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief accounting of allocations of state funding to EMSA for pandemic-related expenditures in 2019-20 and 2020-21 under SB 89.

2. Please provide a brief accounting of allocations of state funding to EMSA for pandemic-related expenditures in 2019-20 and 2020-21 under DREOA.

3. Please provide a brief accounting of allocations of federal funding to EMSA for pandemic-related expenditures in 2019-20 and 2020-21 from FEMA.

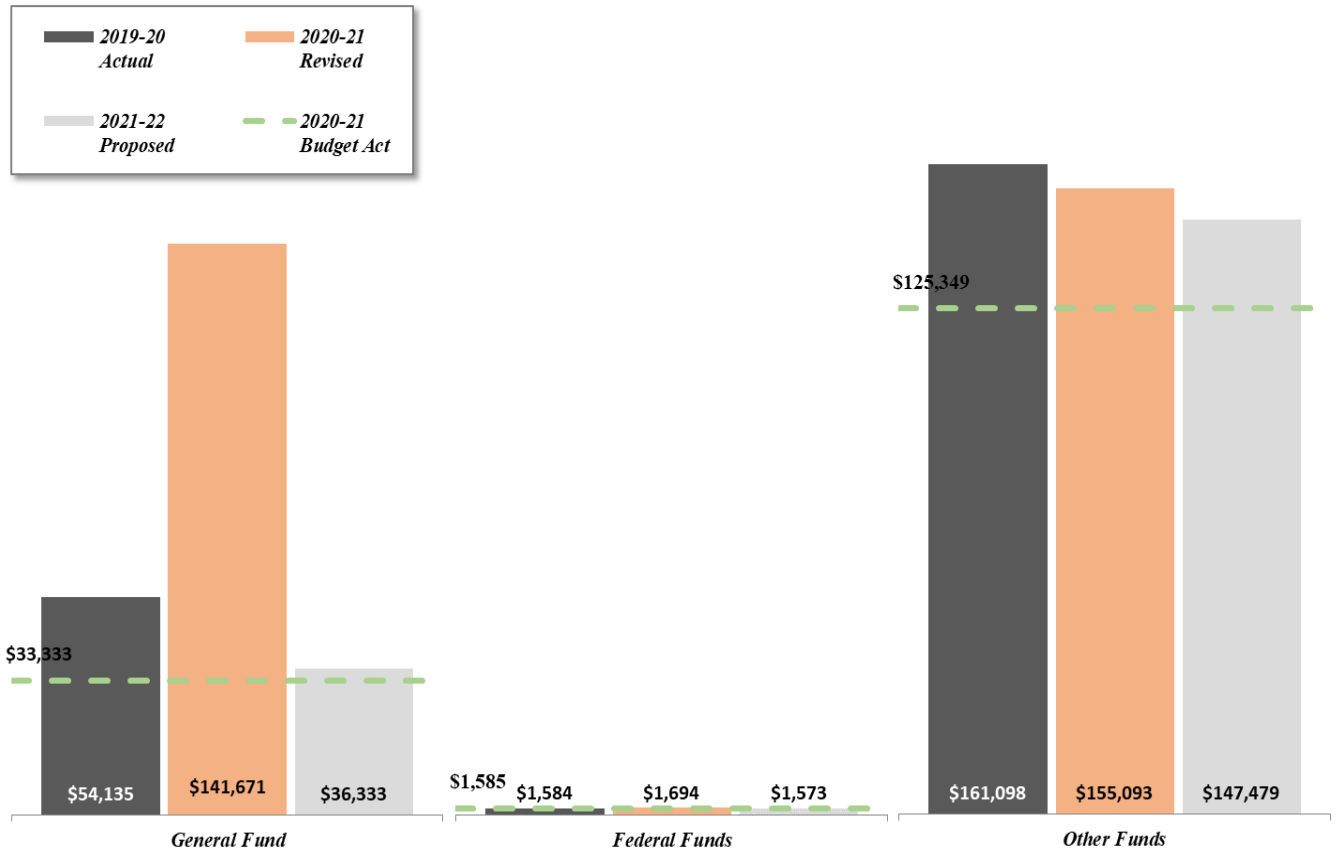
4. Please provide a brief accounting of allocations of federal funding to EMSA for pandemic-related expenditures in 2019-20 and 2020-21 from the Coronavirus Relief Fund or other direct federal funding.

5. What additional federal funding does EMSA expect for pandemic-related expenditures in 2021-22 from the federal government pursuant to existing federal law, regulation, or executive actions?

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Overview

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



Office of Statewide Health Planning and Development - *Department Funding Summary*			
Fund Source	**2019-20 *Actual***	***2020-21 Revised***	***2021-22 Proposed***
General Fund	$54,135,000	$141,671,000	$36,333,000
Federal Funds	$1,584,000	$1,694,000	$1,573,000
Other Funds	$161,098,000	$155,093,000	$147,479,000
Total Department Funding:	**$216,817,000**	**$298,458,000**	**$185,385,000**
Total Authorized Positions:	**433.9**	**428.9**	**484.9**
Other Funds Detail:			
Hospital Building Fund (0121)	*$68,269,000*	*$64,248,000*	*$68,587,000*
CA Health Data and Planning Fund (0143)	*$37,309,000*	*$34,513,000*	*$46,771,000*

Registered Nurse Education Fund (0181)	*$2,200,000*	*$2,194,000*	*$2,205,000*
Health Facility Const. Loan Ins. Fund (0518)	*$5,212,000*	*$5,040,000*	*$5,234,000*
Health Professions Education Fund (0829)	*$10,983,000*	*$10,864,000*	*$10,724,000*
Medically Underserved Account/Phys (8034)	*$4,403,000*	*$4,401,000*	*$4,404,000*
Reimbursements (0995)	*$3,316,000*	*$3,099,000*	*$5,903,000*
Mental Health Practitioner Ed. Fund (3064)	*$827,000*	*$817,000*	*$829,000*
Vocational Nurse Education Fund (3068)	*$226,000*	*$225,000*	*$228,000*
Mental Health Services Fund (3085)	*$28,353,000*	*$29,692,000*	*$2,594,000*

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

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

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

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

The 2017 Budget Act authorized $33.3 million annually over three years for augmentation of health care workforce initiatives at OSHPD. 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

OSHPD state operations costs. Unspent funds in each of these categories from prior years are available for expenditure for the subsequent five fiscal years. For example unspent funds from 2017-18 are available until June 30, 2023, and unspent funds from 2018-19 are available until June 30, 2024. According to OSHPD, the Song-Brown program awarded the following in 2020-21:

1) *Existing Primary Care Residency Slots* – $19.4 million to support 155 existing residency slots
2) *New Primary Care Residency Programs* - $4 million to support six new programs.
3) *Teaching Health Centers (THC)* - $8.5 million to support 50 residency slots at existing THCs
4) *New Primary Care Residency Slots at Existing Programs* - $3.9 million to support 13 new residency slots in existing programs

Song-Brown: Existing Primary Care Residency Slots Awards – September 2020			
Residency Program Name	**Award**	**Residency Program Name**	**Award**
Adventist Health Hanford Family Medicine	$375,000	Riverside Community Hospital Internal Medicine	$125,000
Adventist Health Ukiah Valley Family Medicine	$125,000	RUHS/UC Riverside Family Medicine	$625,000
AltaMed Family Medicine	$375,000	Saint Agnes Med. Ctr. Family Medicine	$125,000
Arrowhead Family Medicine	$375,000	San Joaquin General Hospital Family Medicine	$625,000
California Hospital Med. Center Family Medicine	$625,000	San Joaquin General Hospital Internal Medicine	$125,000
Charles R. Drew University Family Medicine	$625,000	San Ysidro Health Internal Medicine	$250,000
Contra Costa County Family medicine	$125,000	Santa Rosa Family Medicine	$250,000
Dignity/Methodist Hosp. Sacramento Family Medicine	$125,000	Scripps Mercy, Chula Vista Family Medicine	$625,000
Eisenhower Health Family Medicine	$125,000	Shasta Community Health Ctr Family Medicine	$125,000
Emanate Health Family Medicine	$250,000	St. Joseph Hospital Eureka Family Medicine	$125,000
Family Health Ctrs of San Diego Family Medicine	$375,000	St. Joseph's Med Ctr Stockton Family Medicine	$250,000
Glendale Adventist Family Medicine	$125,000	Stanford-O'Connor Family Medicine	$250,000
Harbor-UCLA Family Medicine	$625,000	UC Davis Family Medicine	$250,000
Harbor-UCLA Pediatrics	$125,000	UC Davis Internal Medicine	$375,000
John Muir Family Medicine	$125,000	UC Irvine Family Medicine	$375,000
Kaiser Permanente Fontana Family Medicine	$125,000	UCLA Family Medicine	$625,000
Kaiser Permanente Los Angeles Family Medicine	$250,000	UCLA Pediatrics	$125,000
Kaiser Permanente Los Angeles Internal Medicine	$125,000	UCR Saint Bernadine Family Medicine	$125,000
Kaiser Permanente Los Angeles Pediatrics	$125,000	UCSF Benioff Children's Hospital Pediatrics	$250,000
Kaiser Permanente Woodland Hills Family Medicine	$125,000	UCSF OB/GYN	$250,000
Kaweah Delta Health Care Dist. Family Medicine	$375,000	UCSF-Fresno Family Medicine	$625,000
Kern Medical Center OB/GYN	$125,000	UCSF-Fresno Internal Medicine	$250,000
Kern Medical Internal Medicine	$375,000	UCSF-Fresno OB/GYN	$375,000
Lifelong Medical Care Family Medicine	$375,000	UCSF-Fresno Pediatrics	$125,000
Loma Linda University Internal Medicine	$375,000	UCSF-SFGH Hospital Family Medicine	$625,000
Loma Linda University Pediatrics	$125,000	Valley Children's Pediatrics	$125,000

Loma Linda-Inland Empire Family Medicine	$125,000	Valley Family Medicine (Modesto)	$250,000
Loma Linda-Inland Empire Pediatrics	$375,000	Valley Health Team Family Medicine	$500,000
Mercy Medical Center Merced Family Medicine	$375,000	Ventura County Medical Center Family Medicine	$250,000
Natividad Medical Center Family Medicine	$625,000	White Memorial Medical Center Family Medicine	$625,000
Olive View-UCLA Medical Ctr. Internal Medicine	$125,000	White Memorial Medical Center Internal Medicine	$125,000
Pomona Valley Hospital Med Ctr Family Medicine	$125,000	**TOTAL - $19,375,000** **Slots Funded - 155**	
Rio Bravo Family Medicine	$625,000		
Riverside Community Hosp./UCR Family Medicine	$250,000		

Song-Brown: New Primary Care Residency Slots Awards – September 2020			
Residency Program Name	**Award**	**Residency Program Name**	**Award**
Adventist Health Tulare Family Medicine	$800,000	Los Robles Regional Med Ctr Internal Medicine	$800,000
Charles R. Drew University Internal Medicine	$788,596		
Kaiser Permanente Sacramento Family Medicine	$800,000	**TOTAL - $3,988,596**	
Loma Linda University - Murrieta Family Medicine	$800,000	**Programs Funded - 6**	

Song-Brown: Teaching Health Center Awards – September 2020			
Residency Program Name	**Award**	**Residency Program Name**	**Award**
AltaMed Family Medicine	$850,000	San Ysidro Health Internal Medicine	$850,000
Family Health Ctrs San Diego Family Medicine	$850,000	Shasta Community Health Ctr. Family Medicine	$510,000
LifeLong Medical Care Family Medicine	$850,000	Valley Family Medicine (Modesto)	$850,000
Loma Linda-Inland Empire Family Medicine	$850,000	Valley Health Team Family Medicine	$680,000
Loma Linda-Inland Empire Pediatrics	$850,000	**TOTAL - $8,500,000**	
Rio Bravo Family Medicine	$1,360,000	**Slots Funded - 50**	

Song-Brown: New Primary Care Slots for Existing Programs – September 2020			
Residency Program Name	**Award**	**Residency Program Name**	**Award**
Adventist Health Hanford Family Medicine	$600,000	Loma Linda-Inland Empire Family Medicine	$900,000
Dignity/Methodist Sacramento Family Medicine	$900,000	Rio Bravo Family Medicine	$600,000
Kern Medical Internal Medicine	$600,000	**TOTAL - $3,900,000**	
Kern Medical OB/GYN	$300,000	**Slots Funded - 13**	

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

WET Program Five-Year Plan 2020-2025. In February 2019, OSHPD released the third five year WET plan covering the period from 2020-2025. After engaging with stakeholders, the report is meant to guide efforts to improve and expand the public mental health system (PMHS) workforce throughout California. The 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. OSHPD administers the Health Professions Education Foundation (HPEF), a 501(c)(3) non-profit public benefit corporation established in 1987 through legislation. The HPEF offers scholarships and loan repayments for students and graduates willing to practice in underserved areas. The HPEF manages the following six scholarship and seven loan repayment programs:

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

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

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

In 1994, the Northridge earthquake struck the San Fernando Valley again, resulting in major structural damage to many hospitals constructed prior to the Alquist Act, many of which were evacuated. In contrast, hospitals constructed in compliance with Alquist Act standards resisted the Northridge earthquake, suffering very little structural damage. In response, the Legislature approved SB 1953 (Alquist), Chapter 740, Statutes of 1994, which amended the Alquist Act to require hospitals to evaluate and rate all general acute care hospital buildings for seismic resistance according to standards developed by OSHPD to measure a building's ability to withstand a major earthquake. SB 1953 and subsequent OSHPD regulations also require hospitals to submit plans to either retrofit or relocate acute care operations according to specific timeframes. According to OSHPD, there are 476 general acute care and acute psychiatric hospitals comprised of 3,066 hospital buildings and 88,126 licensed beds covered by the seismic safety provisions of SB 1953. In addition to oversight of seismic safety compliance for acute care hospitals, OSHPD is responsible for ensuring seismic and building safety compliance for skilled nursing facilities and intermediate care facilities. According to OSHPD, SB 1953 covers 1,162 skilled nursing facilities with 1,200 buildings and 114,333 licensed beds. The Facilities Development Division receives funding from fees paid by hospitals and skilled nursing facilities for plan review and building permits of construction projects, as follows:

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

Cal-Mortgage Loan Insurance Division. OSHPD's Cal-Mortgage Loan Insurance Division administers the California Health Facility Construction Loan Insurance Program. Cal-Mortgage provides credit enhancement for eligible health care facilities when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of California, which permits borrowers to obtain lower interest rates. Eligible health facilities must be owned and operated by private, nonprofit public benefit corporations or political subdivisions such as cities, counties, healthcare districts or joint powers authorities. Health facilities eligible for Cal-Mortgage include hospitals, skilled nursing facilities, intermediate care facilities, public health centers, clinics, outpatient facilities, multi-level facilities, laboratories, community mental health centers, facilities for the treatment of chemical dependency, child day care facilities (in conjunction with a health facility), adult day health centers, group homes, facilities for individuals with developmental disabilities, and office or central service facilities (in conjunction with a health facility). As of October 31, 2020, Cal-Mortgage insures 75 loans with a total value of approximately $1.7 billion.

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

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

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

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

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

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: Administrative Support Services

Budget Change Proposal – Governor's Budget. OSHPD requests a net-zero adjustment of expenditure authority between four special funds. If approved, this adjustment would allow OSHPD to better support administrative services related to accounting and human resources.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0121 – Hospital Building Fund	$6,000	$6,000
0143 – CA Health Data and Planning Fund	$31,000	$31,000
0518 – Health Facility Construction Loan Ins. Fund	($41,000)	($41,000)
3085 – Mental Health Services Fund	$4,000	$4,000
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* Expenditure authority changes ongoing after 2022-23.

Background. OSHPD's Administrative Services Division (ASD) provides administrative support to the office's programs including business services, accounting services, and human resources. Accounting services include management of accounts payable, cash receipts, accounts receivable, payroll distribution, travel claims, revolving fund, general ledger, labor cost adjustments, table maintenance, distribution of management reports, preparation of Plans of Financial Adjustment, preparation and submission of reports and claims to the federal government, and preparation and submission of year-end financial statements and reports. The section also provides budget services including developing and presenting OSHPD's budget and federal grant applications, monitors performance, appropriateness, and necessity of program expenditures, ensures fiscal integrity, and prepares legislative fiscal analyses and budget change proposals.

OSHPD reports the implementation of the Financial Information System for California (FI$Cal) as OHSPD's financial system led to in an increase in the length of time for several processes undertaken by ASD, resulting in delays to payment processing, unreconciled documents, encumbrances, and prompt payment penalties. In addition, the Department of Finance conducted an audit of OSHPD in 2019-20 that identified delays in processing Plans of Financial Adjustment were due to significant staff resources that were needed to close the 2017-18 fiscal year.

As a result of these delays and the audit findings, OSHPD redirected resources in 2020-21 to carry out its fiduciary responsibilities and meet mandated timeframes. Eight positions were redirected and reclassified to manage the increased workload in ASD. These positions were redirected from CalMortgage, the Healthcare Workforce Development Department and the Facilities Development Division.

Reallocation of Funding Request. OSHPD requests a net-zero adjustment of expenditure authority between four special funds to better support administrative services related to accounting and human resources. This adjustment of expenditure authority represents a permanent allocation of the previously redirected resources to ASD.

While the overall impact on OSHPD's budget is net-zero, support would increase from three of the special funds, which would be offset by a decrease in support from one special fund. The detail of these net adjustments by fund and program are as follows:

Hospital Building Fund (Fund 0121)

- *Facilities Development Division* – reduction of $632,000 of expenditure authority
- *Administrative Services Division* – increase of $638,000 of expenditure authority
- ***NET IMPACT ON FUND*** – $6,000

CA Health Data and Planning Fund (Fund 0143)

- *Healthcare Workforce Development Division* – reduction of $254,000 of expenditure authority
- *Administrative Services Division* – increase of $285,000 of expenditure authority
- ***NET IMPACT ON FUND*** – $31,000

Health Facility Construction Loan Insurance Fund (Fund 0518)

- *Cal-Mortgage* – reduction of $92,000 of expenditure authority
- *Administrative Services Division* – increase of $51,000 of expenditure authority
- ***NET IMPACT ON FUND*** – ($41,000)

Mental Health Services Fund (Fund 3085)

- *Administrative Services Division* – increase of $4,000 of expenditure authority
- ***NET IMPACT ON FUND*** –$4,000

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 OSHPD to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Reimbursements for Health Care Payments Data Program

Budget Change Proposal – Governor's Budget. OSHPD requests expenditure authority from reimbursements of $5 million in 2021-22, $5.3 million in 2022-23, $4.7 million in 2023-24, and $4.7 million in 2024-25. If approved, these resources would allow OSHPD to use federal funds to support the Health Care Payments Data System through the end of the California Department of Technology's Project Approval Lifecycle process.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0995 – Reimbursements	$5,009,000	$5,316,000
Total Funding Request:	**$5,009,000**	**$5,316,000**
Total Requested Positions:	**0.0**	**1.0**

* Additional fiscal year resources requested: 2023-24: $4,736,000, 2024-25: $4,743,000.

Background. AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018 authorized OSHPD to establish and administer a health care cost transparency database to collect data from health care service plans, health insurers and other payers regarding payments and pricing for health care services. The 2018 Budget Act included General Fund expenditure authority of $60 million for OSHPD to begin work on the database, including convening a review committee composed of health care stakeholders and experts to advise the office on the establishment, implementation, and ongoing administration of the database. AB 1810 also required OSHPD to submit a report to the Legislature by July 1, 2020, regarding key elements of data and implementation details for the database, as well as recommendations for additional legislation needed for the database to operate successfully. The report was submitted on March 9, 2020.

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. As part of the proposal, the health care cost transparency database effort was expanded and renamed the Health Care Payments Data Program at OSHPD, and would 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 Office of Health Care Affordability has been reintroduced in the Governor's 2021 January budget proposal *(see Issue 5: Office of Health Care Affordability)*.

AB 80 (Committee on Budget), Chapter 12, Statutes of 2020, authorizes the Health Care Payments Data Program and requires OSHPD to do the following:

- Establish a system to collect and aggregate information from many disparate systems regarding health care costs, utilization, quality, and equity, with the goal of providing greater transparency and public benefit.
- Improve data transparency to achieve a sustainable healthcare system with more equitable access to affordable and high-quality health care for all.

- Encourage use of such data to deliver health care that is cost effective and responsive to the needs of enrollees, including recognizing the diversity of California and the impact of social determinants of health.

AB 80 also requires OHSPD to develop the Health Care Payments Data System no later than July 1, 2023.

Federal Funding Available Through Medicaid. AB 80 establishes requirements for how the data system will be funded, including directing OSHPD to work with the Department of Health Care Services (DHCS) to seek federal financial participation through the Medicaid program. Federal Medicaid law provides federal financial participation for certain information technology (IT) system costs related to Medicaid and Children's Health Insurance Program (CHIP) populations. For the design, development, and implementation of an IT system, the portion related to Medicaid (Medi-Cal in California) is matched at 90 percent and the portion related to CHIP (also part of Medi-Cal in California) is matched at 65 percent. For ongoing system maintenance and operations activities, the Medi-Cal portion is matched at 75 percent.

To qualify for enhanced federal financial participation, states must apply to the federal Centers for Medicare and Medicaid Services (CMS) through the Advanced Planning Document (APD) process, which includes planning for implementation and regular status updates on the project. According to OSHPD, DHCS submitted an APD to CMS in October 2019 to seek federal financial participation in 2020-21 and 2021-22 for the Health Care Payments Data System. CMS approved the APD on November 3, 2020, with an effective date of October 5, 2020. The APD, which utilizes Medi-Cal caseload as of February 2020, matches 90 percent of the portion of the system attributed to Medi-Cal, which is assumed to be 37.06 percent of the total cost. The APD matches 65 percent of the portion of the system attributed to CHIP, which is assumed to be 3.62 percent of the total cost. The APD will be updated annually to reflect the most recent caseload figures for the two programs to determine the relevant levels of federal financial participation. According to OSHPD, the first update will be submitted by July 29, 2021.

Reimbursement Authority Request. As a result of the approval of federal financial participation, OSHPD requests expenditure authority from reimbursements of $5 million in 2021-22, $5.3 million in 2022-23, $4.7 million in 2023-24, and $4.7 million in 2024-25 to authorize the use of federal funds to support the Health Care Payments Data System through the end of the California Department of Technology's Project Approval Lifecycle process. Because DHCS is the single state Medicaid agency, it would receive the federal financial participation on behalf of the state, which it would then transfer to OSHPD in the form of reimbursements. This increase in expenditure authority would be required to utilize the funding for the data system.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: SB 17 Attorney Fees

Budget Change Proposal and Budget Bill Language – Governor's Budget. OSHPD requests expenditure authority from the California Health Data and Planning Fund of $457,000 in 2021-22 and $567,000 in 2022-23. If approved, these resources would allow OSHPD to support attorney fees from the state Office of the Attorney General for legal services associated with challenges to California's drug price transparency law, SB 17 (Hernandez), Chapter 603, Statutes of 2017. OSHPD also proposes provisional budget bill language to provide increased expenditure authority in the event the attorney fees exceed the amount in this budget request.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0143 – CA Health Data and Planning Fund	$457,000	$567,000
Total Funding Request:	**$457,000**	**$567,000**
Total Requested Positions:	**0.0**	**0.0**

Background. SB 17 (Hernandez), Chapter 603, Statutes of 2017, requires drug manufacturers to provide notice to health care purchasers and publicly report to OSHPD certain information regarding price increases for existing drugs exceeding 16 percent and for new drugs priced above certain federally established thresholds. SB 17 was enacted in response to the significant growth in expenditures for prescription drugs by public health care programs, commercial health plans, and the general public. These increased expenditures have been attributable to both blockbuster drugs newly brought to market, such as new treatments for hepatitis C, and existing drugs, often no longer under patent protection, for which a single manufacturer controls the drug's supply and substantially increases its price. SB 17 imposes the following requirements on drug manufacturers:

- *Significant Price Increases for Existing Drugs – Notice to Purchasers of Health Care Services.* SB 17 requires a drug manufacturer to report to certain public and private sector purchasers of health care services if the price of one of its manufactured drugs increases by more than 16 percent. The required notice must be provided at least 60 days prior to the price increase and must include cumulative price increases over the prior two years, the date of the expected increase, the current price, the dollar amount of the expected increase, and information about whether a change or improvement in the drug necessitates the price increase.
- *Significant Price Increases for Existing Drugs – Quarterly Reporting.* SB 17 also requires drug manufacturers subject to notice requirements due to price increases over the 16 percent threshold to report quarterly to OSHPD the following information: 1) a description of the factors used to make the decision to increase the price of the drug, the amount of the increase, and an explanation of how these factors explain the price increase; 2) a schedule of price increases for the drug for the previous five years if the drug was manufactured by the company; 3) if the drug was acquired by the manufacturer within the previous five years, current and historical pricing information and other details regarding the drug. OSHPD is required to post this information publicly within 60 days of receipt.
- *New High-Cost Drugs.* For newly introduced drugs, SB 17 requires manufacturers to notify OSHPD within three days after release if the price exceeds the threshold set for a specialty drug for the Medicare Part D program. No later than 30 days after submitting the notification,

manufacturers must provide the following information to OSHPD: 1) a description of the marketing and pricing plans used in the launch of the new drug in the United States and internationally; 2) the estimated volume of patients that may be prescribed the drug; 3) if the drug was granted breakthrough therapy designation or priority review by the federal Food and Drug Administration prior to final approval; and 4) the date and price of acquisition if the drug was not developed by the manufacturer. OSHPD is also required to post this information publicly.

PhRMA vs. David. In 2017, the Pharmaceutical Research and Manufacturers of America (PhRMA) brought an action against the state seeking to enjoin implementation and enforcement of the notification and reporting requirements of SB 17. PhRMA contends these provisions are an unconstitutional violation of the dormant commerce clause, a violation of First Amendment freedom of speech rights of PhRMA members, and in violation of the due process clause of the 14th Amendment. As of December 2020, the case remains before the U.S. District Court, Eastern District of California, with the court hearing preliminary motions and discovery yet to begin.

The state is represented in the PhRMA vs. David suit by the state Attorney General, which began providing legal services beginning in 2017-18. Costs for these legal services are billable between the two named defendants, the Governor's Office and OSHPD. In 2017-18 and 2018-19, legal services costs were billed solely to the Governor's Office. In 2019-20, the Governor's Office and OSHPD shared responsibility for billing for legal services related to the litigation. The Administration reports that, beginning in 2020-21, OSHPD will be solely responsible for these costs, which will be covered by expenditure authority from the California Health Data and Planning Fund. For 2020-21 costs, OSHPD requested an augmentation of $357,000 pursuant to Item 9840-001-0494 of the 2020 Budget Act, which provides for support for unanticipated costs from special funds, subject to approval by the Department of Finance and notice to the Joint Legislative Budget Committee.

Ongoing Support for Legal Services Costs. OSHPD reports it does not have sufficient expenditure authority in the California Health Data and Planning Fund to absorb the costs of legal services related to the PhRMA vs. David litigation. OSHPD expects the litigation will not be dismissed and proceedings will continue through at least 2022-23. OSHPD requests expenditure authority from the California Health Data and Planning Fund of $457,000 in 2021-22 and $567,000 in 2022-23 to support these legal services costs. OSHPD also proposes provisional budget bill language to provide increased expenditure authority in the event the attorney fees exceed the amount in this budget request. According to OSHPD, the request is limited to the next two fiscal years because it is unclear if the litigation will continue beyond 2022-23.

Managed Care Fund and Insurance Fund Support SB 17 Activities. OSHPD's responsibilities under SB 17 are supported by the California Health Data and Planning Fund, which receives transfers for this purpose from the Managed Care Fund and the Insurance Fund. These special funds are supported by fees paid by health care service plans and insurers, respectively. The amount of the transfer from each fund is based on the number of covered individuals in health care service plans, regulated by the Department of Managed Health Care, and insurers, regulated by the Department of Insurance.

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Office of Health Care Affordability

Budget Change Proposal and Trailer Bill Language – Governor's Budget. OSHPD requests 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. If approved, these positions and resources would allow OSHPD to establish an Office of Health Care Affordability to increase health care price and quality transparency, develop strategies and cost targets for different sectors of the health care industry, impose financial consequences for entities that fail to meet these targets, and promote health care workforce stability and training needs. OSHPD is also proposing trailer bill language to establish the Office.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0143 – CA Health Data and Planning Fund	$11,194,000	$24,528,000
Total Funding Request:	**$11,194,000**	**$24,528,000**
Total Requested Positions:	**58.0**	**106.0**

* Additional fiscal year resources requested: 2023-24: 123 pos and $27,296,000, 2024-25 & ongoing: 123 pos and $27,262,000.

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 3.44 percent, which was lower than the target rate of 3.6 percent.

2) Maryland Health Services Cost Review Commission – In 1972, Maryland established the Health Services Cost Review Commission (HSCRC), focused on setting payment rates for hospital services. In 2019, Maryland expanded the model of the HSCRC to include all care for Maryland's Medicare enrollees, adopting a total cost of care model that encourages value-based health care redesign and provides tools and resources for primary care providers to better meet the needs of patients with complex health care needs and achieve better health for all Maryland residents. The HSCRC sets a hospital per capita cost growth limit of 3.58 percent per year, sets and enforces the quality of care and population health goals, and provides incentive programs to reward population health and encourage value-based care.

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

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

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 OSHPD, 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 reintroduces the proposal for the Office of Health Care Affordability. 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 OSHPD 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 proposes 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

Funding for the Office of Health Care Affordability. OSHPD proposes 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 OSHPD to establish a fee structure sufficient to pay for required functions or health-related programs it administers, which would include the Office of Health Care Affordability. Included in its budget request, OSHPD proposes provisional budget bill language to provide for a General Fund cash flow loan to support the Office due to expected delays in collecting assessments for health facilities for this purpose. The General Fund cash flow loan would be repaid when these assessments are received, according to the requirements of Section 16351 of the Government Code.

Staffing and Resource Request. OSHPD requests 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. OSHPD is also proposing trailer bill language to establish the Office. OSHPD is modeling its staffing for this effort on the Massachusetts Health Policy Commission, and expects to phase in staff over three years. In 2020-21, the 58 staff needed to establish the program include the following:

- **One Deputy Director (CEA B)**
- **One Chief Medical Officer**
- **One Pharmaceutical Consultant II (Specialist)**
- **Two Branch Chiefs (CEA A)**
- **One Deputy Chief Counsel (CEA B)**
- **One Assistant Chief Counsel**
- **Four Managers**
- **47 Staff-Level Positions**

Within the Office would be the following divisions, branches, and units:

- Health Care Affordability Division – This division would support setting and enforcing cost targets, measuring quality performance through a set of standard measures, promoting health care workforce stability and training needs, setting a statewide goal for the adoption and monitoring of progress towards alternative payment models, developing standards for alternative payment models, and promoting competitive health care markets. The Health Care Affordability Division would oversee the Health Care Cost Trends Branch and the Quality Performance Branch.
    - Health Care Cost Trends Branch – This branch would oversee all data management, research, and analytic activities for the health care cost target program. The branch would manage the production of high quality, objective research and analysis to support the goal of reducing per capita health costs in California. The Health Care Cost Trends Branch would oversee a Data Management Unit and a Research and Analytics Unit.

        - Data Management Unit – This unit would support data collection efforts to enable measurement of total health care expenditures including use of databases and systems to collect expenditure data, implementing reporting schedules for expenditure data, technical specifications and other resources for data submission, and implementation of quality assurance processes for data completeness, timeliness, and accuracy.
        - Research and Analytics Unit – This unit would lead all research and analytic activities for the health care cost target program including analysis of data on health care expenditures, assembling findings and policy recommendations for the annual report and other cost research and study, and provide advice on research or technical projects related to health care costs.
    - Quality Performance Branch – This branch would support identification and adoption of standard measures to assess quality performance of health care service plans, insurers, hospitals, and physician organizations, while reducing administrative burdens and duplication. This branch would also oversee data collection and reporting of quality performance in the annual report and develop recommendations for improving the quality of care. In addition, this branch would oversee monitoring of workforce impacts and manage the setting of statewide goals and standards for adoption of alternative payment models. The Quality Performance Branch would oversee a Quality Analysis Unit and a Payment Reform Unit.
        - Quality Analysis Unit – This unit would oversee research and analysis to evaluate quality performance of health care service plans, insurers, hospitals and physician organizations. This unit would also oversee the development and monitoring of quality performance measures, creation of dashboards, production of data visualizations for the annual report, review of literature on quality improvement efforts, and recommendations for policy actions to improve quality of care.
        - Payment Reform Unit – This unit would lead the setting of statewide goals and standards for the adoption of alternative payment models, creation of dashboards, and production of data visualizations for the annual report.
- Investigations and Enforcement Branch – This branch would manage legal staff to advise the Office on legal matters, and carry out the Office's investigation and enforcement responsibilities including interpreting laws, rules and regulations, representing the Office in administrative proceedings and litigation, and managing outside counsel. This branch would also establish the regulatory program for enforcement of cost targets and cost and market impact reviews including development of regulations, guidance, and bulletins, as well as the assignment of cost target violations, notices of proposed material changes, and corrective action plans. These responsibilities would also include financial and market impact reviews. The Investigations and Enforcement Branch would be led by a Deputy Chief Counsel that would report directly to OSHPD's Chief Counsel in its Legal Office.
- Information Technology Services Division – This division would provide support for the information technology infrastructure used to collect data from health care entities and other sources for the Office.

In addition to these units, OSHPD reports establishment of the Office would result in staffing and resource needs in the following existing offices and divisions:

- Office of Legislative and Public Affairs – One new staff position would be required to advise OSHPD management regarding impacts of legislation, provide recommendations in the development of analyses, formulate position statements for CHHSA and other state departments, attend and monitor hearings and other legislative business, facilitate and review policy and correspondence, and prepare responses to constituent inquiries.
- Administrative Services Division – New staff would be required to support the additional administrative workload resulting from the addition of a significant number of new staff for the Office.
- Information Services Division – New staff would be required to support additional information technology workload on existing enterprise services and systems resulting from the addition of a significant number of new staff for the Office.

The proposed phase-in of staffing for the various divisions of the Office are 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. OSHPD also requests 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.

Provisional Budget Bill Language. OSHPD also proposes provisional budget bill language to: 1) authorize General Fund cash flow loans due to delays in collecting health care facility assessments, and 2) specify that $1 million of the request for information technology resources would be contingent upon approval of California Department of Technology Project Approval Lifecycle documents.

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

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

1. Please provide a brief overview of this proposal.

2. Please provide more detail about how the Office would set cost targets.

3. How would the compliance and penalty process be enforced at the provider level?

4. What data would be used to determine compliance? Would there be an appeals process?

Issue 6: Alzheimer's Health Care Workforce Development

Budget Change Proposal and Budget Bill Language– Governor's Budget. OSHPD requests General Fund expenditure authority of $3 million in 2021-22, with $2.9 million allocated to local assistance and $150,000 allocated to state operations. If approved, these resources would allow OSHPD to support geriatric care providers through its existing health care workforce development programs. OSHPD also proposes provisional budget bill language to authorize availability of state operations funding for encumbrance and expenditure through June 30, 2023.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$3,000,000	$-
Total Funding Request:	**$3,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. In January 2021, the Administration released its Master Plan for Aging (MPA), a comprehensive framework for supporting aging Californians. According to the MPA, the increasing number of older adults living longer requires California to develop a larger and more diverse pool of health care workers with expertise and experience in geriatric medicine, including dementia care, behavioral health, palliative care, and the ability to work in interdisciplinary teams. Among the recommendations contained within the MPA is an expansion of training opportunities for geriatricians, gerontologists, as well as nurses and social workers with geriatric training.

OSHPD administers programs designed to increase access to healthcare to underserved populations and provide a culturally competent healthcare workforce. These programs award 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. According to OSHPD, its existing workforce programs administered by the Healthcare Workforce Development Division (HWDD), and Health Professions Education Foundation (HPEF) train health care professionals that include geriatric providers. In particular, OSHPD reports geriatric providers participate in the Health Careers Training Program Mini Grants, the State Loan Repayment Program, and the six scholarship and six loan repayment programs in the HPEF.

Funding for Existing Programs to Expand Geriatric Workforce. OSHPD requests General Fund expenditure authority of $3 million in 2021-22, with $2.9 million allocated to local assistance and $150,000 allocated to state operations. The local assistance resources would support scholarships and loan repayments for geriatric care providers through existing health care workforce development programs in HWDD and HPEF. According to OSHPD, expanding funding for existing programs would enable the state to leverage these programs' infrastructure to quickly increase awards to geriatric providers. If this funding is approved, OSHPD expects to be able to support 17 additional workforce awards annually, including ten loan repayment awards, two scholarships, and five career pipeline grants.

OSHPD also proposes provisional budget bill language to authorize availability of state operations funding for encumbrance and expenditure through June 30, 2023. OSHPD's existing authority would authorize availability of the local assistance funds for encumbrance and expenditure until June 30, 2027.

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

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

1. Please provide a brief overview of this proposal.

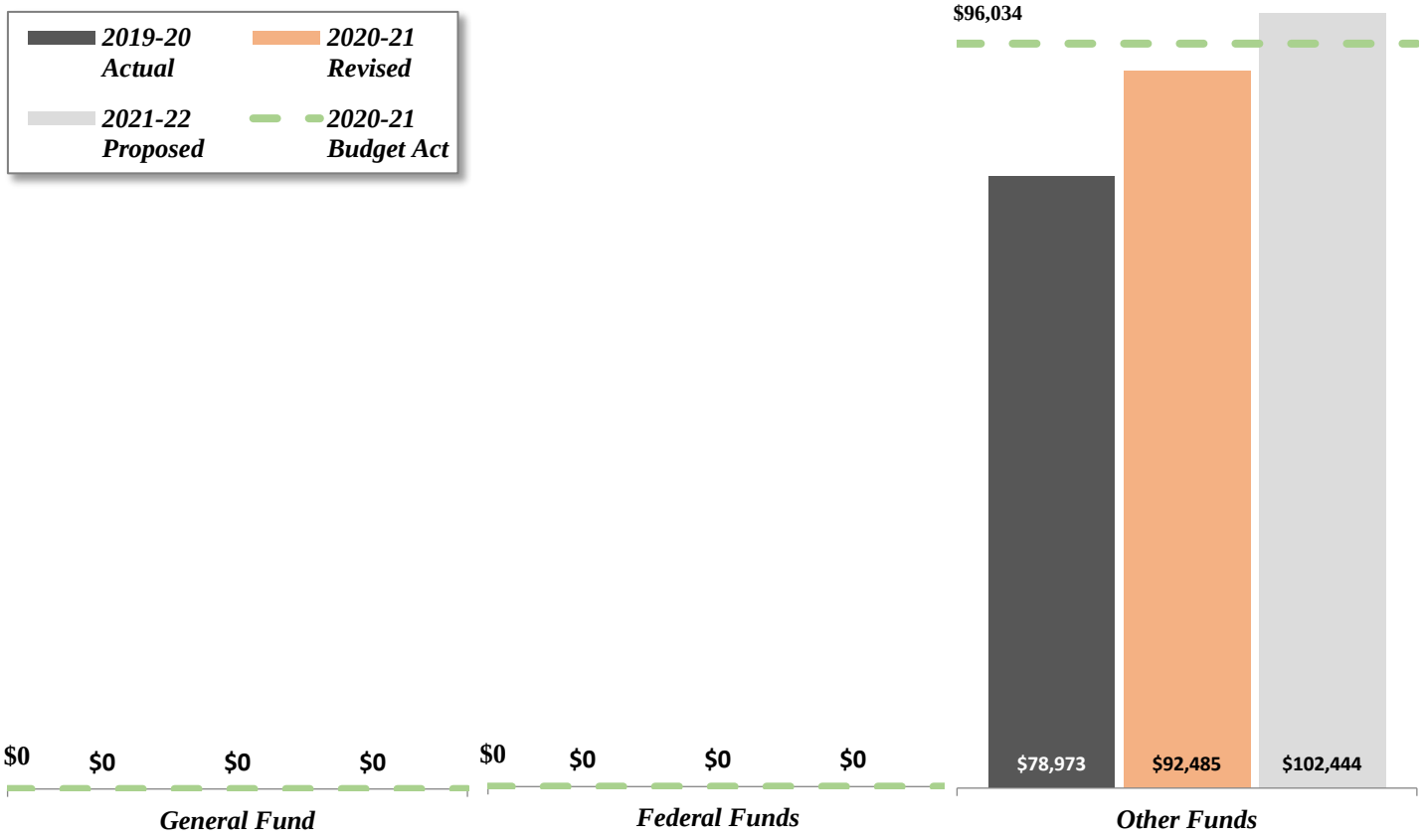
2. How would OSHPD ensure these funds specifically support geriatric providers? Would there be slots in the existing workforce programs dedicated to geriatric providers?

3. Does OSHPD intend to add any geriatric-specific requirements or conditions to scholarship or loan repayment awards supported by this requested funding?

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview

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



Department of Managed Health Care - *Department Funding Summary*			
Fund Source	**2019-20 *Actual***	***2020-21 Revised***	***2021-22 Proposed***
General Fund	$0	$0	$0
Federal Funds	$0	$0	$0
Other Funds	$78,973,000	$92,485,000	$102,444,000
Total Department Funding:	**$87,058,000**	**$92,485,000**	**$102,444,000**
Total Authorized Positions:	**429.5**	**440.3**	**449.3**
Other Funds Detail:			
Managed Care Fund (0933)	*$78,973,000*	*$92,485,000*	*$102,444,000*

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 125 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 26.4 million Californians. Established in 2000, DMHC enforces the Knox-Keene Health Care Service Plan Act of 1975, which implemented California's robust oversight regime of the managed care system. In fulfilling its regulatory responsibilities under the Act, DMHC conducts medical surveys and financial examinations to ensure health plan compliance and financial stability, provides a 24-hour call center to help consumers resolve health plan complaints, and administers Independent Medical Reviews of services denied by health plans.

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

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

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

In February 2017, DMHC published its timely access report for calendar year 2015. According to DMHC, 90 percent of the timely access compliance reports submitted by plans contained one or more significant inaccuracies including: 1) submission of data for providers not in the plan's network, 2) errors in calculating compliance rates, and 3) omission of compliance data for one or more required provider types. The use of an external vendor by 24 health plans to gather data and prepare compliance reports contributed to the submission of erroneous reports. The widespread inaccuracy of the data submissions made it

impossible for DMHC to analyze whether plans were in compliance with timely access standards for 2015. In response, DMHC required the use of a department-approved vendor to monitor data accuracy for the 2016 calendar year submissions.

The timely access reports have steadily improved the overall quality of the data, although some errors remain. According to DMHC, these errors, while common, do not undermine the integrity of the findings. The key findings for the calendar year 2019 report, published in December 2020 were as follows:

Full-Service Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 94 percent to a low of 52 percent.
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 96 percent to a low of 60 percent.
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 92 percent to a low of 45 percent

Behavioral Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 79 percent to a low of 66 percent.
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 87 percent to a low of 73 percent.
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 72 percent to a low of 59 percent.

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

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

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

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

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

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

SB 17 also requires DMHC by January 1 of each year to compile and publish this information by plan in a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. In its most recent report for the 2019 calendar year, DMHC reported the following key findings:

- Health plans paid nearly $9.6 billion for prescription drugs in 2019, an increase of almost $600 million or 6.3 percent from 2018.
- Since 2017, prescription drug costs paid by health plans increased by $1 billion
- Prescription drugs accounted for 12.8 percent of total health plan premiums in 2019, a slight increase from 12.7 percent in 2018, but lower than the 12.9 percent reported in 2017.
- Health plans' prescription drug costs increased by 6.3 percent in 2019, whereas medical expenses increased by 5.2 percent. During the same period, health plan premiums increased 5.3 percent.
- Health plans received manufacturer drug rebates of approximately $1.2 billion or about 12.5 percent of the $9.6 billion spent on prescription drugs in 2019.
- While specialty drugs accounted for only 1.5 percent of all prescription drugs, they accounted for 56.1 percent of total annual spending on prescription drugs.
- Generic drugs accounted for 88.5 percent of all prescribed drugs but only 20.9 percent of the total annual spending on prescription drugs.
- Brand name drugs accounted for 10 percent of prescriptions and constituted 23 percent of the total annual spending on prescription drugs.
- The 25 most frequently prescribed drugs represented 47.4 percent of all drugs prescribed and approximately 44.9 percent of the total annual spending on prescription drugs.
- For the 25 most frequently prescribed drugs enrollees paid 2.9 percent of the cost of specialty drugs, 11.5 percent of the cost of brand name drugs, and 53 percent of the cost of generics.
- Overall, plans paid 92.4 percent of the cost of the 25 most costly drugs across all three categories (generic, brand name and specialty).

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: Health Coverage: Mental Health or Substance Use Disorders (SB 855)

Budget Change Proposal – Governor's Budget. DMHC requests five positions and expenditure authority from the Managed Care Fund of $1.5 million in 2021-22, and 5.5 positions and $1.3 million annually thereafter. If approved, these positions and resources would allow DMHC to enforce mental health and substance use disorder treatment coverage mandates on health plans pursuant to SB 855 (Wiener), Chapter 151, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0933 – Managed Care Fund	$1,500,000	$1,345,000
Total Funding Request:	**$1,500,000**	**$1,345,000**
Total Requested Positions:	**5.0**	**5.5**

* Positions and resources ongoing after 2022-23.

Background. Disparities in health plan coverage for behavioral health conditions have led to decades of efforts to achieve parity for coverage of these services compared with coverage of services for physical health conditions. Historically, health plans have covered treatments for behavioral health conditions differently than for physical health conditions, imposing higher barriers for treatment authorization, more expensive cost-sharing, or less generous annual or lifetime caps on coverage. While several federal and state efforts have made progress towards the goal of achieving parity in California, SB 855 achieves significant progress by expanding the types of health coverage and behavioral health conditions that are subject to parity requirements.

Mental Health Parity Act. In 1996, the U.S. Congress passed the Mental Health Parity Act (MHPA) authored by Senators Paul Wellstone and Pete Domenici. MHPA prohibited large employer-sponsored group health plans from imposing higher annual or lifetime limits on mental health benefits than for medical or surgical benefits. However, there were numerous waiver provisions and MHPA only applied to group health plans that offered mental health benefits.

California Mental Health Parity Act. In 1999, California passed the California Mental Health Parity Act, which required all health plans and insurers to cover the diagnosis and medically necessary treatment of nine severe mental illnesses and, in children, serious emotional disturbances, under the same terms and conditions applied to physical health conditions. The nine mental health conditions included schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa. Serious emotional disturbance includes one or more mental disorders identified in the most recent Diagnostic and Statistical Manual of Mental Disorders (currently, DSM-5), other than a primary substance use disorder or developmental disorder.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), builds on the MHPA by preventing group health plans and health insurance issuers that provide coverage for behavioral health conditions from imposing less favorable benefit limitations on those benefits than on coverage for physical

health conditions. However, MHPAEA does not require any health plan to offer any of these benefits, but imposes parity requirements on plans that include them.

The federal Affordable Care Act (ACA) and the state's legislation governing ACA implementation extended the parity requirements of MHPAEA to individual and small group products, as well. In November 2013, the federal Department of Health and Human Services released its final rule on MHPAEA compliance, including specific requirements on health plans to conduct parity analyses. DMHC is responsible for ensuring health plan compliance with MHPAEA. In addition, the ACA requires health plans in the small group and individual markets to cover Essential Health Benefits, which include behavioral health services.

As a result of the combination of ACA requirements and state law, in California health plans in the small group and individual markets were required to cover behavioral health services, including substance use disorder services, while large group plans were only required to cover treatment for the nine severe mental illnesses or serious emotional disturbances for children, but were not required to cover substance use disorder treatment.

SB 855 Significantly Expands Behavioral Health Parity Requirements. SB 855 makes the following changes to California behavioral health parity:

- Expands behavioral health parity requirements to commercial health plans in all markets, including large group.
- Requires coverage of all medically necessary behavioral health services, including for substance use disorders.
- Expands parity requirements beyond the treatment of the nine severe mental illnesses or serious emotional disturbances for children, instead requiring parity for all recognized mental health disorders.
- Revises utilization management requirements and expands plan responsibilities to help plan members obtain out-of-network care when required.

According to DMHC, SB 855 will require the department to:

- Annually review health care service plan documents for compliance with the behavioral health requirements of SB 855.
- Review health plan documents related to utilization management.
- Review health plan documents related to network access for services.

Staffing and Resource Request. DMHC requests five positions and expenditure authority from the Managed Care Fund of $1.5 million in 2021-22, and 5.5 positions and $1.3 million annually thereafter to monitor and enforce the behavioral health treatment coverage mandates on health plans included in SB 855, as well as respond to complaints from consumers and providers regarding compliance. These positions and resources include the following:

Office of Plan Licensing - The Office of Plan Licensing would need to promulgate regulations to implement SB 855 provisions and review 53 full service commercial plans' documents for compliance. DMHC is requesting **temporary resources equivalent to one Attorney III**, effective between July 1,

2021 and June 30, 2022, to conduct legal research and promulgate the regulations package. Effective July 1, 2022, DMHC is requesting **0.5 Attorney III** position ongoing to review evidence of coverage documents, provider contracts, plan-to-pan contracts, and other health plan documents for annual compliance with SB 855.

Help Center – According to DMHC, the Help Center received an average of 180 complaints about coverage of substance use disorder treatment annually over the past three years. DMHC expects the volume of these complaints to double due to the expansion of covered mental health disorders and the new out-of-network treatment requirements. DMHC is requesting **0.5 Attorney III** position for enforcement referrals and independent medical reviews due to the increased volume of complaints.

Office of Plan Monitoring – According to DMHC, the expansion of coverage requirements for behavioral health services will require additional review of 14 health plans annually for compliance. DMHC is requesting two **0.5 Attorney III** positions to provide legal guidance, review health plan documents, review annual network filings, participate in the evaluation of network availability issues, and provide assistance with enforcement actions and referrals. DMHC is also requesting expenditure authority of $284,000 from the Managed Care Fund annually to support clinical expert consultants to assist with the clinical review and analysis of health plan documents.

Office of Enforcement – DMHC expects its Office of Enforcement to experience an additional 39 referrals for investigation or litigation related to health plan compliance with SB 855. DMHC is requesting **two Attorney III** positions and **1.5 Legal Assistant** positions. The attorneys would provide legal support to investigations or litigation of compliance issues, perform complex legal review and analysis, conduct legal research, respond to legal questions, develop strategies to respond to difficult and sensitive matters, and serve as lead counsel during litigation. The legal assistant positions would assist the attorneys with these responsibilities.

Office of Technology and Innovation – DMHC requests expenditure authority of $6,000 from the Managed Care Fund annually to support additional user licenses and managed services costs for the information technology applications that facilitate the processing of consumer complaints.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Risk-Based or Global Risk Provider Arrangement Pilots (AB 1124)

Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $413,000 in 2021-22, $401,000 in 2022-23 through 2024-25, $322,000 in 2025-26, and $342,000 in 2026-27. If approved, these resources would allow DMHC to create two pilot programs to permit a qualifying voluntary employees' beneficiary association (VEBA) or trust fund to enter into capitation payment agreements with qualified providers while being exempt from licensure under the Knox-Keene Health Care Service Plan Act of 1975 for no more than four years, pursuant to AB 1124 (Maienschein), Chapter 266, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0933 – Managed Care Fund	$413,000	$401,000
Total Funding Request:	**$413,000**	**$401,000**
Total Requested Positions:	**0.0**	**0.5**

* Additional fiscal year resources requested – 2023-24 to 2024-25: $401,000, 2025-26: $322,000, 2026-27: $342,000.

Background. In addition to its role regulating health plans under the Knox-Keene Health Care Service Plan Act of 1975, DMHC is responsible for monitoring the financial solvency of risk-bearing organizations (RBOs). An RBO is a provider group that, in its contracts with a health plan, pays claims and assumes financial risk for the cost of professional health care services by accepting a fixed monthly payment for each plan member it is assigned. DMHC monitors financial solvency through analysis of financial filings, financial examinations, review of claims payment practices, and development and monitoring of corrective action plans.

AB 1124 (Maienschein), Chapter 266, Statutes of 2020, requires DMHC to authorize two pilot programs, one in Northern California and one in Southern California, no later than May 1, 2021, allowing a voluntary employees' beneficiary association (VEBA) or trust fund to undertake a risk-bearing arrangement with approved providers without being subject to licensure under the Knox-Keene Act. To be eligible, VEBAs must cover more than 100,000 lives, while trust funds must cover more than 25,000 lives, and both would be required to comply with federal requirements and contract with a health care provider who is a RBO, limited licensee, or restricted licensee regulated by DMHC. The health care provider is required to comply with financial solvency standards and audit requirements, including financial reporting on a quarterly basis during the pilot. The VEBA or trust fund must also appoint an ombudsperson to monitor and respond to complaints, including referral to DMHC's grievance and appeals process if the enrollee is unsatisfied with the result, and report on complaints to DMHC on a quarterly basis.

According to DMHC, AB 1124 requires the department to do the following:

- Create two pilot programs for VEBAs or trust funds, one in Northern California and one n Southern California
- Review annual cost savings, clinical patient outcomes, enrollee satisfaction reports, and quarterly reporting of any complaints lodged by an enrollee during the pilot
- Review quarterly financial reports submitted by the participating health care providers
- Report pilot program findings to the Legislature by January 1, 2027.

AB 1124 also requires pilot participants to reimburse DMHC up to $500,000 for commissioning the legislative report, developing the application process for the pilot programs, and monitoring compliance with AB 1124.

Staffing and Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $413,000 in 2021-22, $401,000 in 2022-23 through 2024-25, $322,000 in 2025-26, and $342,000 in 2026-27 to create the two pilot programs. DMHC expects the pilots will begin no earlier than January 1, 2022, and end no later than December 31, 2025. These resources include the following:

Office of Financial Review – DMHC expects the Northern California pilot participant would contract with five health care providers and the Southern California participant with 10 health care providers. Including the two pilot participants, DMHC expects its Office of Financial Review would be required to review report submissions and statements for 17 additional entities. DMHC is requesting limited-term resources **equivalent to 0.5 Corporation Examiner IV** to review the submissions, review financial solvency standards for RBOs, review financial statements of new licensees, and assist in preparing the report to the Legislature. In addition, DMHC requests expenditure authority from the Managed Care Fund of $163,000 until 2026-27 for clinical consultant services to review patient outcomes in the pilots, and an additional $80,000 in 2026-27 for preparation of the report to the Legislature.

Help Center – DMHC assumes there would be a total of 300,000 lives covered under the two pilot programs, which would lead to an estimated increase of 120 complaints per year to its Help Center. DMHC requests limited-term resources **equivalent to one Associate Governmental Program Analyst (AGPA)** until 2024-25 and **equivalent to 0.5 AGPA** in 2025-26 to review and process the increased volume of consumer complaints, review and analyze Independent Medical Review requests and health plan responses.

Office of Technology and Innovation – DMHC requests expenditure authority of $4,000 from the Managed Care Fund until 2025-26 to support additional user licenses and managed services costs for the information technology applications that facilitate the processing of consumer complaints.

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

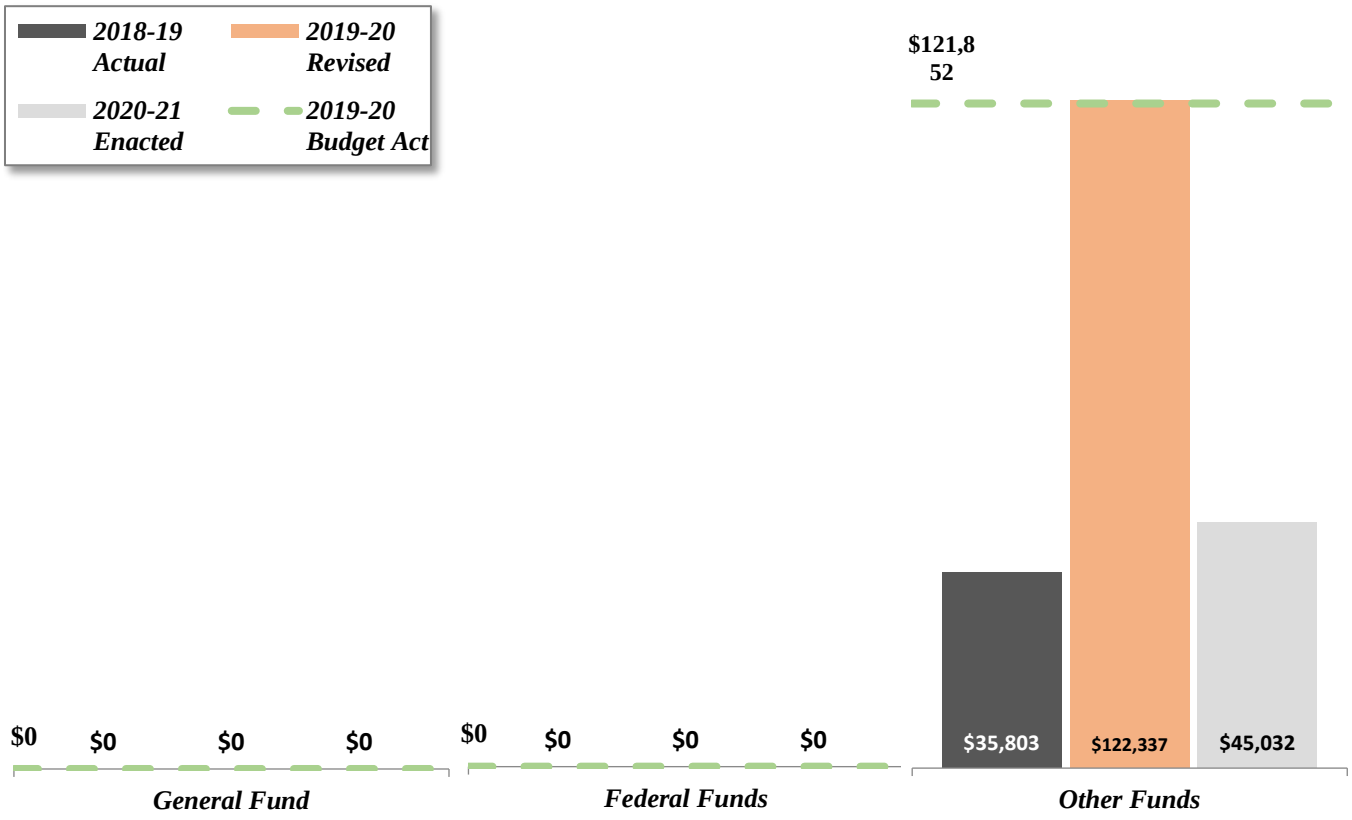
Questions. The subcommittee has requested DMHC to respond to the following:

1. Please provide a brief overview of this proposal.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Overview

Mental Health Services Oversight & Accountability Commission – *Three-Year Funding Summary*
(dollars in thousands)



Mental Health Svcs Oversight & Accountability Commission - *Department Funding Summary*			
Fund Source	**2019-20 *Actual***	***2020-21 Revised***	***2021-22 Proposed***
General Fund	$0	$0	$0
Federal Funds	$0	$0	$0
Other Funds	$38,206,000	$128,868,000	$70,097,000
Total Department Funding:	**$38,206,000**	**$128,868,000**	**$70,097,000**
Total Authorized Positions:	**37.1**	**36.4**	**36.4**
Other Funds Detail:			
Mental Health Services Fund (3085)	*$38,206,000*	*$128,459,000*	*$69,858,000*
Suicide Prev. Vol. Contribution Fund (8124)	*$-*	*$409,000*	*$239,000*

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.

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.

Issue 2: Mental Health Student Services Act Partnership Grant Program Augmentation

Budget Change Proposal – Governor's Budget. MHSOAC requests expenditure authority from the Mental Health Services Fund of $25 million in 2021-22. If approved, these resources would allow MHSOAC to expand the Mental Health Student Services Act Partnership Grant Program, which facilitates partnerships between county mental health plans and schools to provide mental health services to students.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
3085 – Mental Health Services Fund	$25,000,000	$-
Total Funding Request:	**$25,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

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. The counties that submitted applications in each category and their award status are as follows:

County	Size	Existing or New	Awarded
Amador	Small	New	NO
Calaveras	Small	New	YES
Contra Costa	Large	New	NO
Fresno	Large	Existing	YES
Glenn	Small	Existing	NO
Humboldt	Small	Existing	YES
Imperial	Small	New	NO
Kern	Large	Existing	YES
Lake	Small	Existing	NO
Los Angeles	Large	Existing	NO
Madera	Small	New	YES
Marin	Medium	Existing	NO
Mariposa	Small	Existing	NO
Mendocino	Small	Existing	YES
Monterey	Medium	Existing	NO
Nevada	Small	New	NO
Orange	Large	Existing	YES
Placer	Medium	Existing	YES
Riverside	Large	New	NO
Sacramento	Large	Existing	NO
San Bernardino	Large	Existing	NO
San Diego	Large	Existing	NO
San Francisco	Large	Existing	NO
San Luis Obispo	Medium	Existing	YES
San Mateo	Large	New	YES
Santa Barbara	Medium	New	YES
Santa Clara	Large	New	YES
Santa Cruz	Medium	New	NO
Shasta	Small	New	NO
Solano	Medium	Existing	YES
Sonoma	Medium	New	NO
Sutter-Yuba	Small	New	NO

Tehama	Small	New	YES
Trinity-Modoc	Small	New	YES
Tulare	Medium	Existing	YES
Tuolomne	Small	New	NO
Ventura	Large	Existing	YES
Yolo	Medium	New	YES

According to MHSOAC, only 18 awards were made due to funding constraints. MHSOAC estimates approximately $80.5 million would be required to fund all 38 grant applications for school-mental health partnerships, $45.5 million with existing partnerships and $35 million for new and emerging partnerships.

Resource Request. MHSOAC requests expenditure authority from the Mental Health Services Fund of $25 million in 2021-22 to expand the MHSSA Partnership Grant Program to additional counties. In an October 2020 report, MHSOAC documented the expanding need for school mental health services, highlighting the following research findings:

- One in three high school students report feeling chronically sad and hopeless – including more than half of LGBTQ students.
- One in six high school students report having considered suicide in the past year – including one in three LGBTQ students.
- 50 to 75 percent of students with mental health needs do not receive needed care.
- Racial, ethnic, and cultural disparities concentrate the risk factors, prevalence rates and service gaps in low-income communities of color.

In addition, public health interventions related to the COVID-19 pandemic including stay-at-home orders and school closures have led to social isolation and economic disruption that cause additional stress and anxiety, particularly for school-aged children. As the state considers relaxing public health interventions in the coming months, in particular the reopening of schools, there is likely to be a significant unmet need for behavioral health services on school campuses as the accumulated trauma of the pandemic among school-aged children interfaces with the reintegration of these children into routine social interactions with peers and educators.

Package of School-Based Behavioral Health Proposals in January Budget. In addition to this request, the budget includes two additional proposals in other departments that address school-based behavioral health:

1) Department of Health Care Services – The budget includes expenditure authority of $400 million ($200 million General Fund and $200 million federal funds) to support an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services.
2) K-12 Schools Proposition 98 Funding – The budget includes General Fund expenditure authority from Proposition 98 education funds to support innovative partnerships with county behavioral health to support student mental health services. The funding would be provided to local education agencies to match funding in county Mental Health Services Act spending plans dedicated to the mental health needs of students.

It is unclear how these two proposals and the MHSOAC request to expand grants in the MHSSA Partnership Grant Program would be coordinated to maximize the impact on delivery of services to students.

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.

2. How is the Administration coordinating between MHSOAC, DHCS, the Department of Education, and local partners to integrate the three proposals for school-mental health partnerships?

3. Why is the commitment of funds $25 million when the unfulfilled applications require $80.5 million? Given the alarming rise in behavioral health issues among school-aged children during the pandemic, why would the state not seek to maximize participation in this existing program?

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). According to Covered California, as of June 2020, approximately 1.5 million individuals had enrolled in coverage in the exchange. Approximately 1.4 million individuals covered by exchange products received an average of $454 per month in federal APTC subsidies. Approximately 103,000 individuals received exchange-based coverage, but were not eligible for APTC subsidies.

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 will result 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

Covered California Response to the COVID-19 Pandemic – Special Enrollment Period. On March 4th, 2020, the Governor declared a state of emergency related to the COVID-19 pandemic. As transmission of the virus began to increase across the state, the nation, and the world, providing opportunities for uninsured Californians to obtain affordable health care coverage became increasingly important. Fortuitously, Covered California had already implemented a Special Enrollment Period (SEP) beginning on February 18th, designed to allow consumers whose annual tax filings made them aware of the state mandate penalty to enroll in coverage. The SEP was originally scheduled to end on April 30th, but due to the COVID-19 emergency Covered California extended the enrollment period until June 30th. In June, the deadline was extended again until July 31st, and extended again in July until August 31st.

According to Covered California, 289,000 individuals signed up for coverage during the COVID-19 SEP, including 21 percent who were previously uninsured and likely ineligible to enroll under federal rules. More than half previously had job-based coverage, while one in four left the marketplace to become uninsured, raising concerns about the affordability of coverage.

Open Enrollment for 2021 Plan Year. Covered California began Open Enrollment for the 2021 Plan Year on November 1st, 2020, reporting a record-low weighted average premium rate increase of 0.5 percent. Covered California also reported all 11 carriers would continue offering products in 2021, with two expanding their coverage areas. Nearly all Californians (99.8 percent) have two or more choices for coverage and 77 percent have four or more choices.

On January 12th, 2021, Covered California reported a record 1.6 million Californians had either renewed coverage or selected a plan during open enrollment, an increase of nearly 200,000 or 14 percent over the same time period in 2020. Over 640,000 are eligible for the state subsidy program, including 44,500 middle-income consumers between 400 and 600 percent of the FPL.

Impacts of Federal Executive Actions and Legislative Proposals. On January 28th, 2021, President Biden signed an Executive Order directing HealthCare.gov, the federally facilitated health insurance exchange serving 36 states without their own state-based exchange, to provide a special enrollment period between February 15th and May 15th, 2021, to allow individuals in need of health care coverage during the pandemic the opportunity to sign up. On the same day, Covered California announced that it would also extend its Open Enrollment period, previously scheduled to end on January 31st, 2021, until May 15th, 2021, to match the federal extension.

In addition to the executive actions, the Biden Administration has proposed to substantially increase federal support for APTC subsidies for individuals purchasing health care coverage in a state or federal

exchange. The proposal would limit the required contribution towards health care premiums to 8.5 percent of household income and base the subsidy amount on the cost of a gold plan rather than a silver plan. If this proposal were to be adopted, the federal APTC subsidies would be significantly more generous than Covered California's current combined federal and state program design, which requires contributions up to 18 percent of household income for those near 600 percent of the FPL, based on the cost of the second lowest cost silver plan. The state subsidy program devotes the vast majority of resources to subsidize individuals between 400 and 600 percent of the FPL, due to their current ineligibility for any federal subsidy. However, if one or both of the subsidy-related components of the Biden Administration proposal is adopted, the state would likely need to reevaluate the program design of the state subsidy 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 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, as well as expected impacts of the recently announced special enrollment period.

3. How do the recent executive actions of the new federal administration affect coverage for Californians enrolled through Covered California?

4. How would the proposed federal changes to advance premium tax credits, as well as the rebasing of credits to gold plans rather than silver plans, affect affordability for Covered California enrollees. How would these changes affect the design of the state subsidy program?