*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 12, 2021**
**Upon Adjournment of Session**
**State Capitol - Room 3191**

Consultant: Scott Ogus



**PUBLIC COMMENT**

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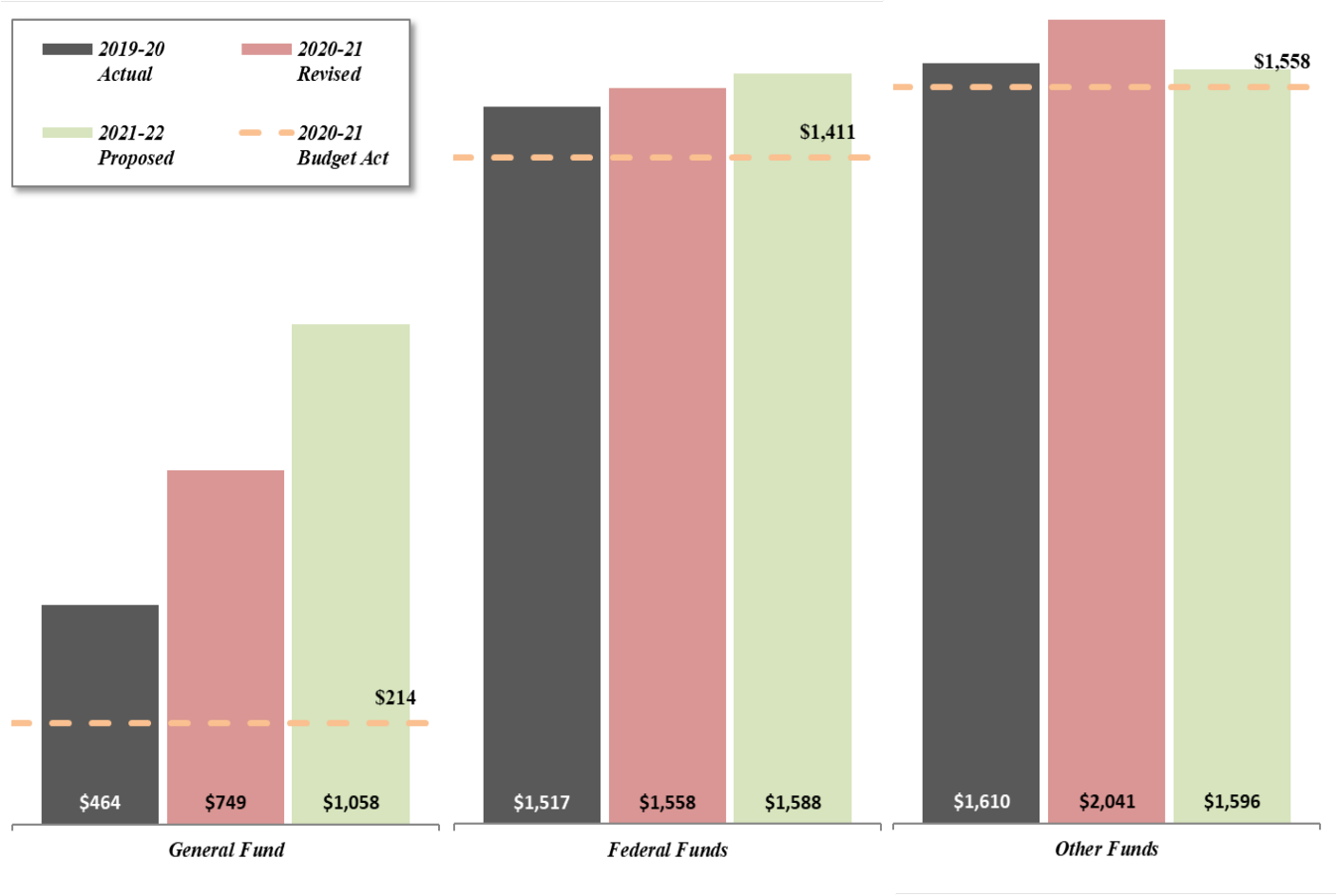
# 4265 DEPARTMENT OF PUBLIC HEALTH

## Issue 1: Overview

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




| Department of Public Health - *Department Funding Summary* | | | |
|---|---|---|---|
| **Fund Source** | **2019-20 *Actual*** | ***2020-21 Revised*** | ***2021-22 Proposed*** |
| **General Fund** | $463,622,000 | $748,987,000 | $1,058,070,000 |
| **Federal Funds** | $1,517,420,000 | $1,557,612,000 | $1,587,791,000 |
| **Other Funds** | $1,609,513,000 | $2,040,607,000 | $1,595,717,000 |
| **Total Department Funding:** | **$3,590,555,000** | **$4,347,206,000** | **$4,241,578,000** |
| **Total Authorized Positions:** | **3611.9** | **3741.4** | **3699.4** |
| **Other Funds Detail:** | | | |
| ***Breast Cancer Research Account (0007)*** | *$1,244,000* | *$791,000* | *$965,000* |

| | | | |
|---|---|---|---|
| ***Nuclear Planning Assessment Acct (0029)*** | *$1,003,000* | *$971,000* | *$1,020,000* |
| ***Motor Vehicle Acct, Trans. Fund (0044)*** | *$1,595,000* | *$1,551,000* | *$1,621,000* |
| ***Sale of Tobacco to Minors Ctrl Acct (0066)*** | *$1,180,000* | *$14,000* | *$811,000* |
| ***Occup. Lead Poisoning Prev Acct (0070)*** | *$3,787,000* | *$2,120,000* | *$3,847,000* |
| ***Medical Waste Management Fund (0074)*** | *$2,884,000* | *$2,755,000* | *$2,948,000* |
| ***Radiation Control Fund (0075)*** | *$28,623,000* | *$27,564,000* | *$29,176,000* |
| ***Tissue Bank License Fund (0076)*** | *$665,000* | *$636,000* | *$679,000* |
| ***Childhood Lead Poisoning Prev Fund (0080)*** | *$42,045,000* | *$44,729,000* | *$42,480,000* |
| ***Export Document Program Fund (0082)*** | *$859,000* | *$823,000* | *$590,000* |
| ***Clinical Lab. Improvement Fund (0098)*** | *$13,458,000* | *$12,956,000* | *$13,790,000* |
| ***Health Statistics Special Fund (0099)*** | *$30,246,000* | *$30,374,000* | *$31,587,000* |
| ***Dept. of Pesticide Regulation Fund (0106)*** | *$330,000* | *$314,000* | *$336,000* |
| ***Air Pollution Control Fund (0115)*** | *$305,000* | *$298,000* | *$305,000* |
| ***CA Health Data and Planning Fund (0143)*** | *$240,000* | *$240,000* | *$240,000* |
| ***Food Safety Fund (0177)*** | *$12,237,000* | *$9,650,000* | *$11,348,000* |
| ***Genetic Disease Testing Fund (0203)*** | *$143,229,000* | *$139,453,000* | *$145,885,000* |
| ***Health Education Account, Prop 99 (0231)*** | *$52,576,000* | *$42,015,000* | *$35,852,000* |
| ***Research Account, Prop 99 (0234)*** | *$7,507,000* | *$6,151,000* | *$3,481,000* |
| ***Unallocated Account, Prop 99 (0236)*** | *$4,506,000* | *$3,735,000* | *$1,861,000* |
| ***Infant Botulism Treatment/Prev Fund (0272)*** | *$14,300,000* | *$10,309,000* | *$9,068,000* |
| ***Child Health and Safety Fund (0279)*** | *$551,000* | *$551,000* | *$551,000* |
| ***Registered Enviro. Health Spec Fund (0335)*** | *$467,000* | *$407,000* | *$477,000* |
| ***Indian Gaming Spec Dist Fund (0367)*** | *$8,369,000* | *$8,320,000* | *$8,391,000* |
| ***Vectorborne Disease Account (0478)*** | *$216,000* | *$160,000* | *$195,000* |
| ***Toxic Substances Control Acct (0557)*** | *$543,000* | *$529,000* | *$559,000* |
| ***Domestic Violence Training/Ed Fund (0642)*** | *$636,000* | *$610,000* | *$647,000* |
| ***CA Alzheimers Research Fund (0823)*** | *$657,000* | *$645,000* | *$663,000* |
| ***Special Deposit Fund (0942)*** | *$11,059,000* | *$15,564,000* | *$13,163,000* |
| ***Reimbursements (0995)*** | *$255,602,000* | *$714,233,000* | *$255,156,000* |
| ***Drug and Device Safety Fund (3018)*** | *$6,552,000* | *$4,609,000* | *$7,685,000* |
| ***WIC Manufacturer Rebate Fund (3023)*** | *$210,098,000* | *$196,784,000* | *$174,414,000* |
| ***Medical Marijuana Program Fund (3074)*** | *$163,000* | *$3,000* | *$17,000* |
| ***AIDS Drug Assistance Program Fund (3080)*** | *$307,061,000* | *$373,037,000* | *$409,717,000* |
| ***Cannery Inspection Fund (3081)*** | *$3,145,000* | *$3,040,000* | *$3,227,000* |
| ***Mental Health Services Fund (3085)*** | *$42,483,000* | *$2,393,000* | *$2,468,000* |
| ***Licensing and Certification Fund (3098)*** | *$193,927,000* | *$212,458,000* | *$257,179,000* |
| ***Gambling Addiction Program Fund (3110)*** | *$150,000* | *$150,000* | *$150,000* |
| ***Birth Defects Monitoring Prog Fund (3114)*** | *$2,410,000* | *$2,347,000* | *$2,434,000* |
| ***Lead-Related Construction Fund (3155)*** | *$861,000* | *$1,244,000* | *$1,298,000* |
| ***Cost/Impl Acct, Air Poll. Ctrl Fund (3237)*** | *$379,000* | *$373,000* | *$386,000* |

| | | | |
|---|---|---|---|
| ***Cannabis Control Fund (3288)*** | *$13,973,000* | *$28,216,000* | *$908,000* |
| ***State Dental Program Acct., Prop 56 (3307)*** | *$31,339,000* | *$25,541,000* | *$25,054,000* |
| ***DPH Tobacco Law Enforc, Prop 56 (3318)*** | *$12,982,000* | *$4,583,000* | *$4,463,000* |
| ***DPH, Tobacco Prev/Ctrl, Prop 56 (3322)*** | *$143,071,000* | *$106,761,000* | *$88,625,000* |
| ***Coronavirus Relief Fund (8505)*** | *$0* | *$600,000* | *$0* |

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

According to DPH, the goals of these programs include the following:

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

The department is composed of seven major program areas:

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

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

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

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

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

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

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

**Subcommittee Staff Comment.** This is an informational item.

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

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

## Issue 2: COVID-19 Pandemic - Public Health Response

**Oversight – COVID-19 Pandemic Public Health Response.** The state of California, like much of the rest of the nation and the world, has been responding for more than a year to a pandemic outbreak of novel coronavirus (COVID-19), which causes respiratory illness with symptoms similar to the flu, including fever, cough, and shortness of breath. COVID-19 can also cause more severe respiratory illness, which may result in hospitalization and the need for mechanical ventilation or other critical medical interventions. The California Office of Emergency Services (CalOES), DPH, and local health departments have been leading the public response to the pandemic, including mitigation strategies to slow the spread of COVID-19 such as stay-at-home orders and other restrictions, managing hospital and health system surge capacity, COVID-19 testing capacity and logistics, contact tracing of confirmed cases and contacts, and the distribution and administration of two recently approved COVID-19 vaccines.

**Outbreak Origin and Transmission.** According to the federal Centers for Disease Control and Prevention (CDC), coronaviruses are a large family of viruses that are common in people and many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with MERS-CoV and SARS-CoV. COVID-19 is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats and sequencing in the early stages of the pandemic suggests a likely single, recent emergence of this virus from an animal reservoir.

COVID-19 was first identified in Wuhan, Hubei Province, China. Early on, many of the patients at the epicenter of the outbreak in Wuhan had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside Hubei and in countries outside China, including in the United States, with nearly every nation reporting cases of COVID-19. Epidemiological studies of COVID-19 estimate infected individuals transmit COVID-19 to an average of 2.5 additional people. For reference, the equivalent transmission rate of influenza A is 1.1 to 1.5.

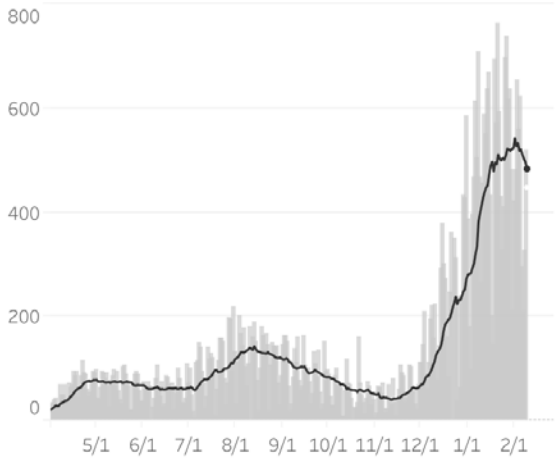
**Current Status of Individuals Affected in California.** Nearly one year ago, on March 12th, 2020, this subcommittee held one of the first hearings on the COVID-19 outbreak. At that time, DPH reported there were a total of 157 positive cases of COVID-19 in California and 2 deaths. As of February 10th, 2021, there have been 3,362,981 positive cases and 44,995 deaths. 11,516 Californians are hospitalized for COVID-19, with 3,127 in the ICU and only 1,394 ICU beds available statewide. The state is currently in the midst of an alarming surge of COVID-19 cases and deaths that began in mid-November and tested the capacity limits of the state's hospitals and health care systems. During this surge, in multiple regions of the state, particularly in Southern California and the San Joaquin Valley, intensive care needs for COVID-19 patients exceeded the limits of licensed ICU bed capacity and these regions had to resort to surge planning and other modifications to accommodate the increased need for ICU beds. Recent data suggest the rate of new cases may be slowing, and although COVID-19 deaths remain near their pandemic peaks, the expected lag between cases and deaths suggests the rate of deaths may slow in the coming weeks, as well.

Total cases in California

**3,362,981** positive cases
8,390 new cases
0.3% increase from prior day total


Total deaths in California

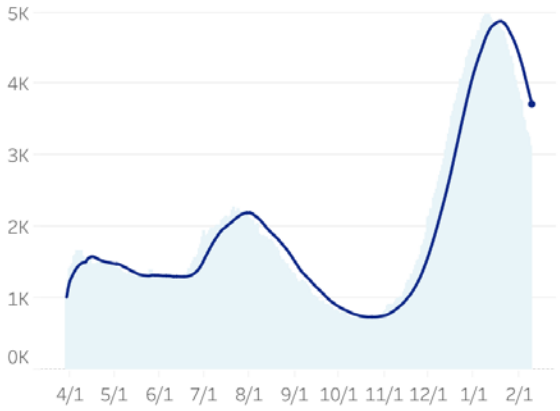
**44,995** total deaths
518 new deaths
1.2% increase from prior day total




COVID-19 ICU hospitalized patients in California

Hospitalized | ICU

**3,127** COVID-19 ICU hospitalized patients
-137 patients
4.4% decrease from prior day

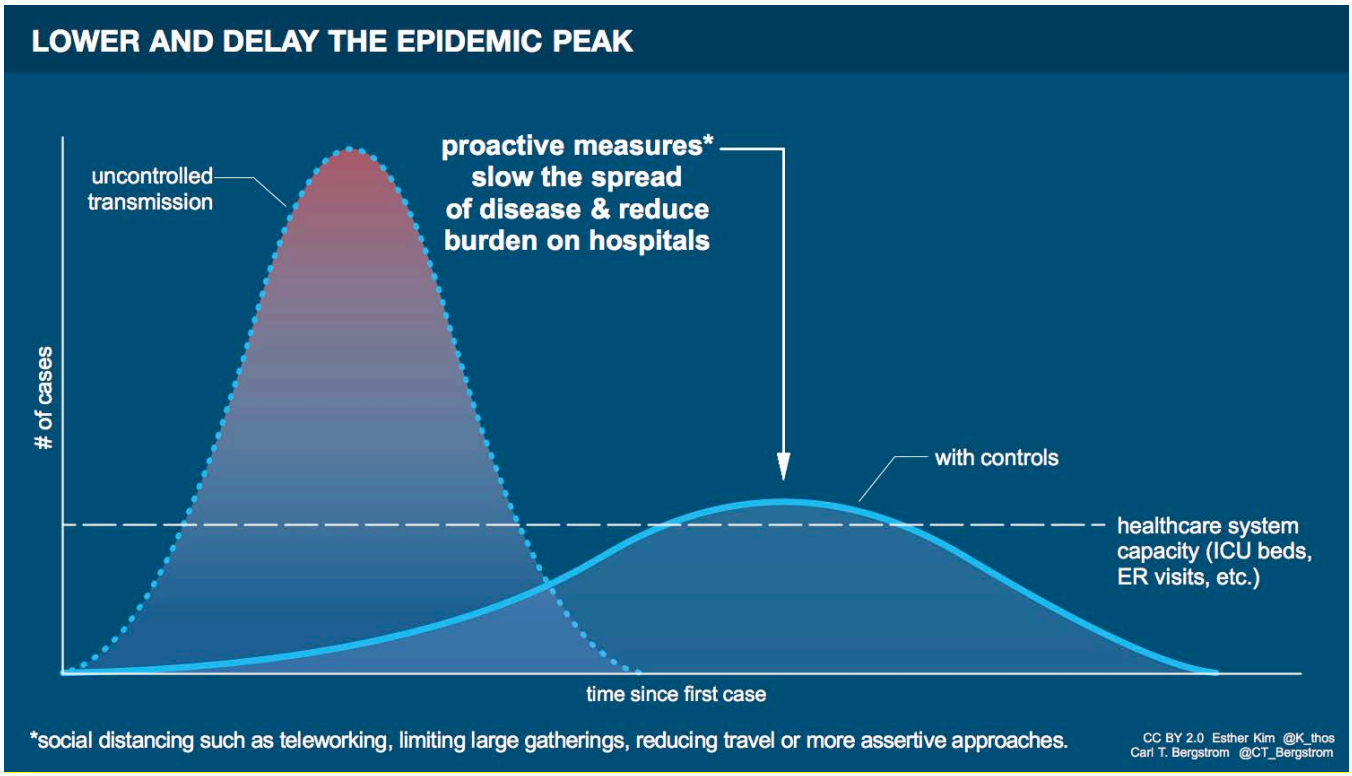



ICU beds in California

**1,394** ICU beds available
10 increase from prior day


***Cumulative, Daily, and 14-Day Average of COVID-19 Case Counts, Deaths, Hospitalized Patients, and ICU Capacity***
***Source:*** *California COVID-19 State Dashboard: https://covid19.ca.gov/state-dashboard/. Retrieved February 10th, 2021.*

**Non-Pharmaceutical Interventions to Mitigate COVID-19 Transmission.** During the initial phases of the pandemic, much of the response was focused around efforts to "flatten the curve", which refers to mitigation efforts to slow down the spread of COVID-19 and reduce the burden on the health care system. The chart below, many versions of which were circulating during the early stages of the pandemic, demonstrates the relative levels of epidemic peaks with uncontrolled COVID-19 transmission compared with the implementation of mitigation strategies including social distancing, telework, limitations on gatherings, and reducing travel.




The first recommendations for non-pharmaceutical interventions included guidance to Californians to:

- Wash hands with soap and water
- Avoid touching eyes, nose or mouth with unwashed hands
- Avoid close contact with people who are sick
- Stay away from work, school, or other people if you become sick

Initially, the use of masks and face coverings was only recommended for health care settings, but the most updated guidance emphasizes the importance of wearing masks and the overwhelming scientific evidence that masks minimize the spread of respiratory droplets and aerosols that may transmit COVID-19.

**Stay-at-Home Orders and Other Public Health Interventions.** On March 19th, 2020, DPH issued a statewide stay-at-home order, requiring all individuals in California to stay home or at their place of residence except for workers in 16 federally-identified critical sectors, or to shop for essential needs. Telework was encouraged to the extent feasible for business that could be conducted remotely, but K-12 schools and universities began to close their doors, as well. These interventions were implemented to

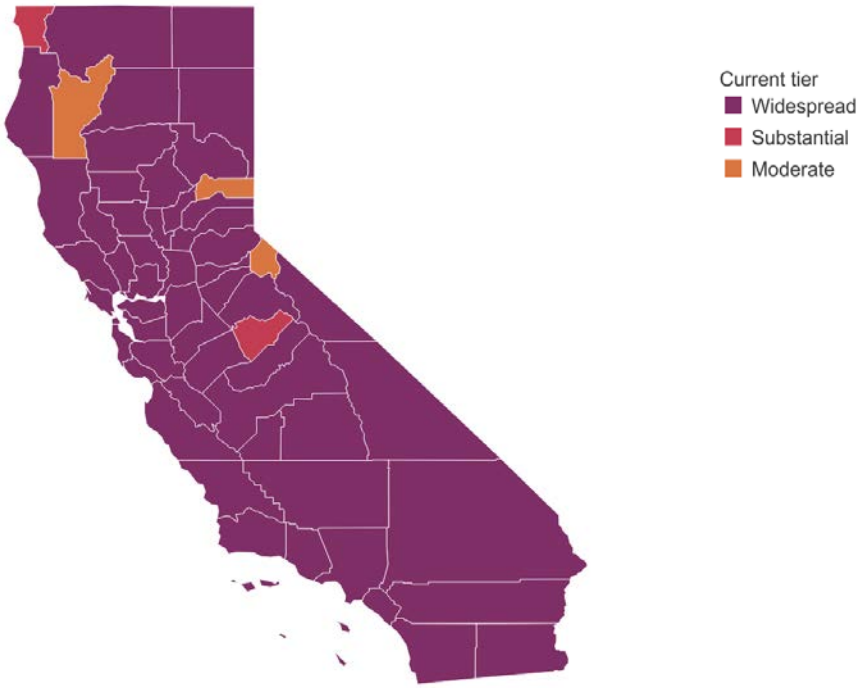
mitigate the rapid transmission of COVID-19 occurring in California to allow time for the health system to prepare for a potential surge of patients. These preparations included efforts to procure sufficient supplies of personal protective equipment (PPE), implementation of health facility surge planning to expand the availability of treatment space and staff, and expand the state's COVID-19 testing and contact tracing infrastructure.

On May 4th, 2020, DPH issued the California Pandemic Roadmap, which identified four stages of reopening safely: 1) safety and preparation, 2) reopening of lower-risk workplaces and other spaces, 3) reopening of higher-risk workplaces and other spaces, and 4) an easing of final restrictions leading to the end of the stay-at-home order. At the same time, DPH allowed all areas of the state to move into stage 2 and reopen lower-risk workplaces, but to practice social distancing, minimize time outside the home, and wash hands frequently. However, by summer of 2020, transmission of COVID-19 and hospitalizations began to rise significantly, and much of the reopening progress was stalled or reversed.

**Blueprint for a Safer Economy.** On August 28, 2020, DPH unveiled the Blueprint for a Safer Economy, which currently governs public health interventions and allowable activities by county. The Blueprint assigns each county to one of four tiers based on the transmission of COVID-19 in the county:

| TIER LEVEL | New Cases per 100,000 | Test Positivity Rate |
|---|---|---|
| **Widespread - Tier 1** | More than seven | More than eight percent |
| **Substantial - Tier 2** | Four to seven | Five to eight percent |
| **Moderate - Tier 3** | One to 3.9 | Two to 4.9 percent |
| **Minimal - Tier 4** | Less than one | Less than 2 percent |

**County Tier Status as of February 10th, 2021**



A county must remain in its current tier for a minimum of three weeks before it may advance to a less restrictive tier. To advance, a county must meet the less restrictive tier's criteria for two consecutive weeks. Counties must also meet the California Health Equity Metric, which ensures the test positivity rate in the most disadvantaged neighborhoods does not significantly lag behind the overall county test positivity rate, and requires counties to have submitted a plan to DPH to make targeted investments to address disproportionately impacted populations. Changes in tier levels are announced every Tuesday. As of February 10th, 2021, 53 counties are in Tier 1 (Widespread), two counties are in Tier 2 (Substantial), and three counties are in Tier 3 (Moderate). No counties are in Tier 4 (Minimal).

The restrictions imposed by Tier are as follows:

| **Blueprint for a Safer Economy Guidelines** | | | | |
|---|---|---|---|---|
| **SECTORS** | **Widespread Tier 1** | **Substantial Tier 2** | **Moderate Tier 3** | **Minimal Tier 4** |
| Critical Infrastructure | Open with modifications | Open with modifications | Open with modifications | Open with modifications |
| Gatherings | Outdoor only with modifications (3 households) | Indoor allowed (but, discouraged) with modifications (3 households) | Indoor allowed (but, discouraged) with modifications (3 households) | Indoor allowed (but, discouraged) with modifications (3 households) |
| Limited Services | Open with modifications | Open with modifications | Open with modifications | Open with modifications |
| Outdoor Playgrounds/Rec. Facilities | Open with modifications | Open with modifications | Open with modifications | Open with modifications |
| Hair Salons and Barbershops | Open indoors with modifications | Open indoors with modifications | Open indoors with modifications | Open indoors with modifications |
| All Retail | Open indoors with modifications Max 25% capacity | Open indoors with modifications Max 50% capacity | Open indoors with modifications | Open indoors with modifications |
| Shopping Centers | Open indoors with modifications Max 25% capacity Closed common areas and food courts | Open indoors with modifications Max 50% capacity Closed common areas and reduced capacity at food courts | Open indoors with modifications Closed common areas and reduced capacity at food courts | Open indoors with modifications Reduced capacity at food courts |
| Personal Care Services | Open indoors with modifications | Open indoors with modifications | Open indoors with modifications | Open indoors with modifications |
| Museums, Zoos, and Aquariums | Outdoor only with modifications | Open indoors with modifications Max 25% capacity | Open indoors with modifications Max 50% capacity | Open indoors with modifications |
| Places of Worship | Open indoors with modifications Max 25% capacity | Open indoors with modifications Max 25% capacity | Open indoors with modifications Max 50% capacity | Open indoors with modifications Max 50% capacity |

| | | | | |
|---|---|---|---|---|
| Movie Theaters | Outdoor only<br>with modifications | Open indoors<br>with modifications<br>Max 25% capacity<br>or 100 people | Open indoors<br>with modifications<br>Max 50% capacity<br>or 200 people | Open indoors<br>with modifications<br>Max 50% capacity |
| Hotels/Lodging | Open<br>with modifications | Open<br>with modifications<br>Fitness Ctrs (10%) | Open<br>with modifications<br>Fitness Ctrs (25%)<br>Indoor pools | Open<br>with modifications<br>Fitness Ctrs (50%)<br>Spa facilities |
| Gyms and Fitness Centers | Outdoor only<br>with modifications | Open indoors<br>with modifications<br>Max 10% capacity<br>Climbing walls | Open indoors<br>with modifications<br>Max 25% capacity<br>Indoor pools | Open indoors<br>with modifications<br>Max 50% capacity<br>Saunas<br>Steam rooms |
| Restaurants | Outdoor only<br>with modifications | Open indoors<br>with modifications<br>Max 25% capacity<br>or 100 people | Open indoors<br>with modifications<br>Max 50% capacity<br>or 200 people | Open indoors<br>with modifications<br>Max 50% capacity |
| Wineries | Outdoor only<br>with modifications | Outdoor only<br>with modifications | Open indoors<br>with modifications<br>Max 25% capacity<br>or 100 people | Open indoors<br>with modifications<br>Max 50% capacity<br>or 200 people |
| Bars, Breweries, and Distilleries | CLOSED | CLOSED | Open outdoors<br>with modifications | Open indoors<br>with modifications<br>Max 50% capacity |
| Family Entertainment Centers<br>(e.g. Kart Racing, Mini Golf, Batting Cages) | Outdoor only<br>with modifications | Outdoor only<br>with modifications | Open indoors for naturally distanced activities with modifications<br>Max 25% capacity<br>Bowling Alleys | Open indoors for activities with increased risk of proximity and mixing with modifications<br>Max 50% capacity<br>Arcade Games<br>Skating<br>Indoor playground |
| Cardrooms, Satellite Wagering | Outdoor only<br>with modifications | Outdoor only<br>with modifications | Open indoors<br>with modifications<br>Max 25% capacity | Open indoors<br>with modifications<br>Max 50% capacity |
| Offices | Remote | Remote | Open indoors<br>with modifications<br>Encourage telework | Open indoors<br>with modifications<br>Encourage telework |
| Professional Sports | Open without live audiences with modifications | Open without live audiences with modifications | Open without live audiences with modifications | Open without live audiences with modifications |
| Live Audience Sports | CLOSED | CLOSED | Outdoors only<br>Max 20% capacity | Outdoors only<br>Max 25% capacity |

| | | | | |
|---|---|---|---|---|
| | | | Regional visitors (120 miles)<br>Adv reservations<br>Assigned seating<br>In-seat concessions only | Regional visitors (120 miles)<br>Adv reservations<br>Assigned seating<br>In-seat concessions only |
| Amusement Parks | CLOSED | CLOSED | Small Parks Open<br>Max 25% capacity or 500 people<br>Outdoor attractions only<br>In-county visitors<br>Adv reservations | Large Parks Open<br>Max 25% capacity<br>Adv reservations |

**Regional Stay-at-Home Order During Fall and Winter Surge.** Beginning in November 2020, the state experienced an alarming rise in transmission of COVID-19, followed by a rise in hospitalizations and deaths. On November 19th, 2020, DPH issued a limited stay-at-home order to slow transmission of COVID-19. Over the subsequent two weeks, the daily number of new cases increased by over 112 percent (from 8,743 to 18,588) and the number of new hospital admissions rose from 777 on November 15th, 2020, to 1,651 on December 2nd, 2020.

On December 3rd, 2020, DPH issued a Regional Stay-at-Home Order, subdividing the state into five regions (Northern California, Bay Area, Sacramento, San Joaquin Valley, and Southern California), utilizing the availability of ICU beds as a metric for assessing the level of restrictions in a region. Under the order, if a region's ICU capacity fell below 15 percent, the following restrictions applied:

1) All gatherings with members of other households were prohibited
2) All individuals in the region were required to stay home or at their place of residence except for critical workers or infrastructure sectors, or to shop for essential needs
3) Worship and political expression were permitted outdoors, consistent with DPH guidance
4) Indoor retail was required to operate at no more than 20 percent capacity, and the sale of food, beverages, and alcohol for in-store consumption was prohibited

During the fall and winter surge, the ICU capacity of both the San Joaquin Valley and Southern California regions fell to zero. Four of the five regions fell below the 15 percent ICU capacity threshold and were subject to the stay-at-home order restrictions. During this period, the Administration began forecasting projections for a region's four-week ICU capacity, which allowed certain regions to reopen before ICU capacity returned to the 15 percent threshold.

On January 25th, 2021, the Administration relied on four-week ICU capacity forecasts to rescind the Regional Stay-at-Home Order, returning counties to the Blueprint for a Safer Economy tiered framework for reopening and public health restrictions.

**Diagnostic Testing for COVID-19.** Shortly after identification of the novel coronavirus as the cause of the respiratory illness spreading throughout the world, scientists had sequenced and published its genome, and developed the nucleotide primers necessary to perform diagnostic polymerase chain reaction (PCR)

testing to identify individuals with COVID-19. PCR testing relies on transcription enzymes to amplify portions of the viral genome specific to COVID-19 to determine the presence of viral RNA and an estimate of the number of copies in a sample. PCR testing has been used for diagnostics for nearly 40 years.

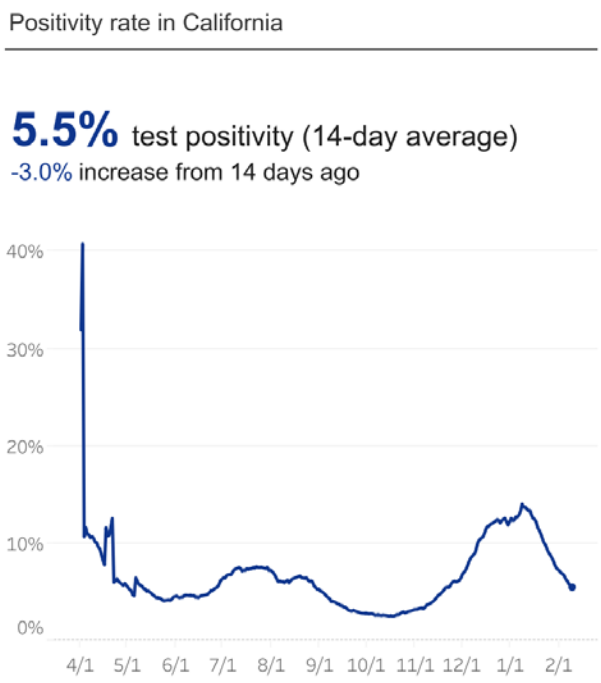
Due to the widespread transmission of COVID-19 during the pandemic, there was limited availability of supplies to conduct the necessary testing to diagnose the significant number of individuals presenting with COVID-19 symptoms. The world experienced shortages of sample collection supplies, transport and other media, and PCR reagents at the same time the need for diagnostic testing for COVID-19 became critical to containment and mitigation strategies. California implemented several initiatives to address the need for COVID-19 testing.

According to DPH, 22 public health laboratories in California began testing for COVID-19 in March 2020, including the DPH State Laboratory in Richmond, and county public health laboratories in Alameda, Contra Costa, Humboldt, Los Angeles, Monterey, Napa-Solano-Yolo-Marin (located in Solano), Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, Santa Clara, Shasta, Sonoma, Tulare and Ventura. California also worked with academic labs at the University of California and Stanford, as well as commercial labs at Quest Diagnostics, LabCorp, and Kaiser to increase testing capacity.

The state also established mass testing sites throughout the state. These included large venues, such as CalExpo in Sacramento, and Dodger Stadium in Los Angeles. The state also partnered with Verily and OptumServe to open additional testing sites, and implemented a web page to allow individuals to find testing resources in their area.

**Valencia Laboratory.** In August 2020, the Administration announced a partnership with PerkinElmer to open a new, dedicated testing laboratory in Valencia. PerkinElmer would begin processing up to an additional 150,000 PCR tests per day, with a contractual turnaround time of 24 to 48 hours. Beginning operations in October 2020, the Administration indicated it expected the lab to reach the goal of 150,000 tests per day no later than March 1, 2021. According to the Administration, the opening of the Valencia Laboratory required approximately $20 to $25 million to build out, with approximately $100 million per month of contract costs for Perkin Elmer. The total cost of the contract is $1.4 billion and covers multiple fiscal years. DPH is requesting General Fund expenditure authority of $483.2 million in 2021-22 for continued operation of the Valencia Laboratory. (*see Issue 3: COVID-19 Direct Response Expenditures).*

**Current Testing Status.** As of February 10th, 2021, the state is averaging 251,294 tests over a 14-day period. Testing capacity in the state rose steadily through the spring and early summer of 2020, stabilized at more than 100,000 tests per day through the summer and early fall of 2020, then began to ramp up to reach more than 300,000 tests per day during the fall and winter surge, and currently down to just over 250,000 per day. The 14-day average test positivity rate, one measure of the levels of community transmission, peaked in early 2021 at 14 percent, but has decreased to 5.5 percent.


**Contact Tracing, Isolation and Quarantine of Identified COVID-19 Cases.** One of the oldest public health tools for managing outbreaks of infectious diseases is contact tracing, isolation, and quarantine. Once a positive case is identified, public health staff interview the individual to determine other individuals who may have been exposed during periods of close contact with the reference case. Public health staff then contact those individuals to notify them of their potential exposure, and to recommend isolation, quarantine, and diagnostic testing to break the onward chain of viral transmission.

Contact tracing activities are typically the responsibility of local health departments. However, during the pandemic, widespread transmission in many local communities overwhelmed the ability of local health departments to keep up with the workload of contact tracing. Decades of state and federal underinvestment in the public health infrastructure that supports contact tracing efforts resulted in a system unprepared for a global pandemic. In addition, there was significant wariness by individuals unaccustomed to being contacted by public health officials to cooperate with contact tracing efforts for COVID-19.

**Virtual Training Academy and Contact Tracing Platform.** In May 2020, DPH received an augmentation of General Fund expenditure authority of $27.4 million to help expand contact tracing efforts. This funding was used to support development of a virtual training academy, in partnership with the University of California (UC) campuses in San Francisco and Los Angeles, for contact tracing staff. According to DPH, these newly trained contact tracers would be available to augment local public health department staff to aid in the contact tracing workload. The academy is primarily conducted online, including live sessions with instructors, and can be completed in approximately 20 hours over five days. Contact tracers receive training in epidemiology, principles of contact tracing, and infectious disease containment strategies. The training is provided to local public health departments at no cost.

In addition to the academy, the augmentation was used to support development of a data management platform, which can interface with the state's disease surveillance system, to support the contact tracing workforce. DPH contracted with Accenture to launch a contact tracing technology platform, developed by Salesforce, and to operate a contact tracing call center in collaboration with Amazon. This system was modeled on a similar system implemented for the contact tracing program in the state of Massachusetts.

**COVID-19 Vaccine Distribution and Administration.** Almost as soon as the novel coronavirus was identified as the cause of the respiratory illness spreading throughout the world, dozens of research laboratories and pharmaceutical companies began work developing a vaccine for the new virus. In May 2020, the federal government launched Operation Warp Speed to accelerate development, production and distribution of COVID-19 vaccines, therapeutics, and diagnostics. The current pipeline of COVID-19 vaccines that have been approved by the Food and Drug Administration (FDA) or are currently in clinical development includes the following:

**FDA Approval - Emergency Use Authorization (EUA)**

mRNA Vaccines

- *Pfizer-BioNTech* – The first COVID-19 vaccine to receive FDA approval, Pfizer-BioNTech's BNT162b2 is an mRNA vaccine that packages the sequence for the COVID-19 spike protein inside lipid nanoparticles. Once injected, the lipid nanoparticles deliver the mRNA sequence into the patient's cells, which produce copies of the spike protein, activating the patient's immune system to produce neutralizing antibodies and confer immunity. Pfizer-BioNTech's vaccine requires two doses, 21 days apart, and requires storage at -60 to -80 degrees Celsius (-76 to -112 degrees Fahrenheit). According to clinical trial data, the Pfizer-BioNTech vaccine is approximately 95 percent effective.
- *Moderna* – Moderna's vaccine, mRNA-1273, the second to receive FDA approval, is also an mRNA vaccine that delivers the sequence for the COVID-19 spike protein with lipid nanoparticles. Moderna's vaccine also requires two doses, 28 days apart, and requires storage at -15 to -25 degrees Celsius (-13 to 5 degrees Fahrenheit). According to clinical trial data, the Moderna vaccine is approximately 95 percent effective.

**Other Vaccines in Clinical Development**

Adenovirus Vectors

- *Johnson and Johnson* – Currently in Phase 3 trials, Johnson and Johnson's Ad26.COV2.S vaccine utilizes an adenovirus, with its viral replication machinery inactivated, to deliver the COVID-19 spike protein into a patient's cells, which then produce the spike protein and activate the patient's immune system. The Johnson and Johnson vaccine requires only a single dose and can be stored at refrigeration temperatures of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data suggests the Johnson and Johnson vaccine may be up to 72 percent effective.
- *CanSino Biologics* – Currently in Phase 3 trials, CanSino's Ad5-nCoV vaccine also utilizes an adenovirus vector to deliver the COVID-19 spike protein. The CanSino vaccine also requires only a single dose and can be stored at refrigeration temperatures of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data suggests the CanSino vaccine may be up to 66 percent effective.
- *Oxford-AstraZeneca* – Currently in Phase 2/3 trials, Oxford-AstraZeneca's AZD1222 vaccine also utilizes an adenovirus vector to deliver the COVID-19 spike protein. The Oxford-AstraZeneca vaccine requires two doses given 12 weeks apart and can be stored at refrigeration temperatures

of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data suggests the Johnson and Johnson vaccine may be up to 82.4 percent effective.

Recombinant Spike Protein

- *Novavax* – Currently in Phase 2b trials, Novavax's NVX-CoV2373 vaccine utilizes a recombinant version of the COVID-19 spike protein itself to mediate an immune response. The Novavax vaccine requires two doses, 21 days apart, and can be stored at refrigeration temperatures of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data conducted in the United Kingdom suggests the Novavax vaccine may be up to 89.3 percent effective.

In addition to these approved vaccines and vaccine candidates, several others are in development that use adenovirus vectors and inactivated COVID-19 viruses.

**Distribution and Administration of Approved COVID-19 Vaccines in California.** Shortly after approval of the Pfizer and Moderna COVID-19 vaccines, doses began to be delivered to California. Because supplies of these vaccines were expected to be in short supply as the companies ramp up production of vaccine doses after FDA approval, California developed a phased prioritization schedule to ensure front-line health care workers and the most vulnerable receive vaccines first. In addition, the CDC developed a partnership with CVS and Walgreens to administer vaccine doses in skilled nursing facilities, assisted living facilities, and other congregate care facilities.

**California's COVID-19 Vaccination Plan.** Prior to the approval of COVID-19 vaccines, the state developed a planning template submitted to the CDC outlining how vaccines would be distributed and administered in California. The plan largely relies on its existing vaccine distribution network, including over 4,000 medical providers enrolled in California's Vaccines for Children program and 500 Federally Qualified Health Centers enrolled in California's Vaccines for Adults program. These programs are supported by funding from the CDC.

The state also adopted CDC-recommended guidelines for a three-phase distribution of the vaccines. Through its Drafting Guidelines Workgroup and Community Vaccine Advisory Committee, the state has identified priority groups in the following phases and tiers:

- **Phase 1a –** Health care workforce, and staff and residents of long-term care facilities
- **Phase 1b, Tier 1 –** Persons 65 years of age and older, and workers in the education, childcare, emergency services, and food and agriculture sectors.

The Drafting Guidelines Workgroup and Community Vaccine Advisory Committee have not released final guidelines on the subsequent tiers and affected individuals or sectors likely to be next to receive the vaccines.

According to CDC data, as of February 10th, 2021, the state has administered 4,957,297 doses of the vaccine, including 3,994,969 first doses and 928,615 second doses. More than 10 percent of California's population has received a first dose of vaccine. The federal partnership with CVS and Walgreens has administered 477,862 doses to residents and staff of long-term care facilities in California, with 369,687 receiving a first dose and 106,842 receiving a second dose.

**Third-Party Administrator and Other Vaccination Efforts – Blue Shield of California and Kaiser.** On January 26, 2021, the Administration announced a new partnership with Blue Shield of California to serve as a third-party administrator for vaccine distribution in California. According to the state's letter of intent, Blue Shield would develop and manage a statewide vaccine administration network by executing contracts with providers that meet state criteria for distribution and administration of vaccines at mobile clinics, vaccine hubs, mega vaccination sites, and to at-risk patients at home. Blue Shield would also assist providers with start-up cost payments and implement incentive payments to encourage vaccine providers to administer vaccines quickly, efficiently, at high volume, and with a focus on communities that have been disproportionately impacted by COVID-19. The Administration also plans to enter into a partnership with Kaiser Foundation Health Plan to assist with the vaccine distribution effort. According to the state's letter of intent, Kaiser would secure, plan, organize, stand up and oversee two or more mass vaccination sites and other efforts to vaccinate hard to reach and disproportionately impacted populations.

**2019-20 and 2020-21 Pandemic-Related Emergency Budget Augmentations.** During the COVID-19 pandemic, the Administration augmented expenditure authority for DPH 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. DPH received the following augmentations under SB 89:

- Hospital Capacity Expansion - $30 million (Item 4265-001-0001) to support lease costs for two hospitals, Seton Medical Center in Daly City and St. Vincent Medical Center in Los Angeles, until June 30, 2020, to expand the state's hospital capacity.
- Testing Capacity at Richmond Laboratory - $1.4 million (Item 4265-001-0001) to expand capacity for diagnostic testing for COVID-19 at DPH's Richmond Laboratory.
- Virtual Training Academy for Contact Tracing - $8.7 million (Item 4265-001-0001) to support development of a virtual training academy to train new staff to augment existing local public health staff to conduct contact tracing of confirmed COVID-19 cases.
- Contact Tracing Technology Platform - $18.7 million (Item 4265-001-0001) to support development of a data management platform to support the contact tracing workforce, developed by Salesforce, and a call center in collaboration with Amazon.

**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.

DPH received a total augmentation of General Fund expenditure authority of $87.7 million from two allocations of funds from DREOA in 2019-20, and $540.3 million from two allocations of funds from DREOA in 2020-21.

**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 DPH'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. Recent federal guidance also suggests the availability of 100 percent FEMA reimbursement would be retroactive to the beginning of the pandemic. It is also unclear how the change in reimbursement would affect funding for DPH's pandemic-related expenditures to date, or in the future.

**Section 11.95 – 2020 Budget Act.** The 2020 Budget Act included budget control section language in Section 11.95 that authorizes the Department of Finance to adjust any item to account for additional federal funding or additional reimbursements to support testing and contact tracing. The federal Paycheck Protection Program and Health Care Enhancement Act provided $499 million to California through the CDC's Epidemiology and Laboratory Capacity (ELC) grant program to assist local public health departments to reduce transmission of COVID-19. The ELC allocations to DPH in 2020-21 were as follows:

- $286 million (Item 4265-101-0001) was provided to local governments to further six strategies, including: 1) enhance laboratory, surveillance, informatics, and other workforce capacity; 2) strengthen laboratory testing; 3) advance electronic data exchange at public health laboratories; 4) improve public health surveillance and reporting of electronic health data; 5) use laboratory data to enhance investigation, response, and prevention; and 6) coordinate and engage with partners.
- $176.1 million (Item 4265-001-0001) was provided to DPH to, in coordination with local governments, further the same six strategies referenced above.

**Other Federal Funding to Support COVID-19 Response.** The annual Budget Act includes provisional language in federal fund appropriations for DPH to allow the augmentation of federal fund expenditure authority if funds are made available by the CDC. Using this provisional authority, the Department of Finance approved augmentation of federal fund expenditure authority for DPH to reflect two awards from the CDC: an Immunization Supplemental Grant and an Immunization and Vaccines for Children award. These augmentations will allow DPH to support state and local COVID-19 response efforts. The augmentations were as follows:

Immunization Supplemental Grant

- $11.8 million in Item 4265-001-0890 (DPH State Operations)
- $8.3 million in Item 4265-111-0890 (Local Assistance)

Immunization and Vaccines for Children

- $18.7 million in Item 4265-001-0890 (DPH State Operations)
- $10.6 million in Item 4265-111-0890 (Local Assistance)

**Local Health Officers, Health Facilities, Health Care Workers, and Consumers - COVID-19 Response Panel.** The subcommittee has requested the following panelists to discuss the state and local public health response to the COVID-19 pandemic:

- Michelle Gibbons, County Health Executives Association of California
- Kat DeBurgh, Executive Director, Health Officers Association of California
- Andie Martinez Patterson, Vice President of Government Affairs, California Primary Care Association
- BJ Bartleson, Vice President – Nursing and Clinical Services, California Hospital Association
- Kiran Savage-Sangwan, California Pan-Ethnic Health Network (CPEHN)
- Julio Ramirez, SEIU Local 721, Microbiology Supervisor, Los Angeles County Dept. of Public Health
- DeAnn Walters, Director of Clinical Affairs, California Association of Health Facilities

**Subcommittee Staff Comment—**This is an informational item.

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

1. Please provide a brief overview of the current case rates, hospitalizations, and mortality statistics for COVID-19 infection in California.

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

3. Please provide a brief overview of the state's COVID-19 testing capacity, including the prevalence of different testing methodologies and their distribution and deployment throughout the state.

4. Please provide a brief overview of the components of California's systems for vaccine distribution, including the role of local health departments, the federal CVS and Walgreens partnership, and the new third-party administrator.

5. Does the department have any data on the effectiveness of case identification and contact tracing efforts in reducing transmission of COVID-19? What lessons, if any, has the department learned about contact tracing during a pandemic that may inform more effective contact tracing efforts in the future?

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

7. Please provide a brief accounting of allocations of state or federal funding to DPH for pandemic related expenditures in 2019-20 and 2020-21 from the following sources: SB 89, DREOA, FEMA, the Coronavirus Relief Fund, CDC grant funding, or other federal funding sources.

The subcommittee has also requested local health officers, health facility, clinic, health care worker, and consumer panelists to respond to the following:

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

2. Hospitals - How have your facilities been impacted by the COVID-19 pandemic? What surge procedures do you employ during periods of high hospital utilization? How have you managed staffing needs, particularly for ICU care, during the most recent surge periods?

3. Clinics – How have your clinics been impacted by the COVID-19 pandemic? What role have your clinics played in testing and treatment of COVID-19 patients, as well as the administration of vaccines? How has the delivery of primary care been affected by the pandemic in your clinics?

4. Skilled Nursing Facilities – How have skilled nursing facilities operations been affected by the COVID-19 pandemic? What protective measures have been implemented to protect residents and staff? Please report on the progress of vaccinations in skilled nursing facilities for residents and staff under the federal long-term care partnership? Can you share an estimate of the percentage of skilled nursing facility residents that have received at least one dose of vaccine?

5. CPEHN – Please describe the impact of the COVID-19 pandemic on the health status and needs of the state's diverse communities of health care consumers? In your view, how have pre-existing health inequities been exacerbated by the pandemic? What is the state doing well to address these inequities and where is it falling short? What should the Legislature and the Administration be thinking about as we consider how to address these inequities?

6. SEIU – Please describe the impact of the COVID-19 pandemic on public health workers. How could federal, state, or local resources be better directed to support your work? What are the most critical investments necessary to address the pandemic and prepare for future public health emergencies?

## Issue 3: COVID-19 Direct Response Expenditures

**Budget Change Proposal – Governor's Budget.** DPH requests General Fund expenditure authority of $820.5 million in 2021-22. If approved, these resources would support response activities to the COVID-19 pandemic, primarily for testing facilities, supplies, and logistics.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23** |
| 0001 – General Fund | $820,549,000 | $- |
| **Total Funding Request:** | **$820,549,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** The state's response to the COVID-19 pandemic has required rapid deployment of state and federal resources to support a wide variety of activities designed to mitigate the spread of the virus, while maintaining vital services and protecting the most vulnerable Californians.

The Administration is requesting total General Fund expenditure authority of $1.8 billion to continue its response and mitigation of the impacts of the COVID-19 pandemic. $1.4 billion of this request is allocated specifically to several departments. The remaining $400 million would be allocated through the Disaster Response-Emergency Operations Account (DREOA), pursuant to proposed budget control section language included in this request. The specified allocations for each department or entity are as follows:

- **Department of Public Health (DPH)** – DPH requests General Fund expenditure authority of $820.5 million in 2021-22 for statewide testing efforts at the Valencia Branch testing laboratory, testing specimen collection through OptumServe, and other miscellaneous services and procurements related to testing.
- **Department of General Services (DGS)** – DGS requests General Fund expenditure authority of $84.4 million in 2021-22 for three key pandemic-related programs: 1) Hotels for Healthcare Workers, which provides hotel rooms to healthcare workers providing critical care to COVID-19 patients to help them avoid bringing the virus home; 2) Housing for the Harvest, which provides hotel rooms for agricultural workers to isolate safely if they are exposed to, or test positive for COVID-19; and 3) Project Hope, which provides hotel rooms to individuals released from prison that need to quarantine safely. This request also includes DGS' contract with FedEx for testing specimen transportation costs, which would be shifted to the DPH budget.
- **Department of Corrections and Rehabilitation (CDCR)** – CDCR requests General Fund expenditure authority of $281.3 million in 2021-22 to support the California Correctional Health Care Services' (CCHCS) efforts to treat COVID-19 and minimize exposure to inmates and staff through testing, vaccinations, medical surge capacity, and personal protective equipment (PPE).
- **Department of Veterans Affairs** – The Department of Veterans Affairs requests General Fund expenditure authority of $5.3 million in 2021-22 to continue efforts to mitigate impacts of the pandemic in veterans' homes. These resources would support enhanced cleaning protocols, testing of staff and residents, procurement of PPE and cleaning products, and procurement of thermometers and medical devices.

- **Department of Social Services (DSS)** – DSS requests General Fund expenditure authority of $5 million in 2021-22 for its Rapid Response Program to support entities that provide assistance and services to immigrants during emergent situations when federal funding is not available.
- **Department of State Hospitals (DSH)** – DSH requests General Fund expenditure authority of $52 million in 2021-22 to support staff costs for cleaning, staffing coverage, environmental projects, custody tasks, screening and isolation. The request also covers commodity purchases, such as PPE, sanitation supplies, changes in food service, as well as equipment for heating and air, filtration, and information technology solutions. In addition, though most testing costs would be shifting to DPH, DSH expects some costs from a contractor hired to work onsite to collect, process, and report staff testing results.
- **Board of State and Community Corrections (BSCC)** – BSCC requests General Fund expenditure authority of $12.1 million in 2021-22 to support county probation departments with increased number of individuals released from state prison on Post-Release Community Supervision to reduce institutional populations in response to the pandemic.
- **Department of Developmental Services (DDS)** – DDS requests General Fund expenditure authority of $36.7 million in 2021-22 for development of surge sites to serve consumers diagnosed with, exposed to, or at high risk of COVID-19. The funding would support an average of 25 beds each at Fairview and Porterville Developmental Centers for six months.
- **Governor's Office of Emergency Services (CalOES)** – CalOES requests General Fund expenditure authority of $119.7 million in 2021-22 to reimburse local governments for eligible costs associated with emergency activities undertaken in response to the COVID-19 pandemic.

According to the Administration, the remaining $400 million would be allocated through the DREOA process for statewide hospital and medical surge preparation, contact tracing, and emergency operations costs. The Administration indicates it would release the departmental allocations for these funds once additional information is available.

**Department of Public Health – Resource Request.** DPH requests total General Fund expenditure authority of $820.5 million in 2021-22 to support response activities to the COVID-19 pandemic, primarily for testing facilities, supplies, and logistics. In particular, this funding would support the following:

- Valencia Laboratory – DPH requests General Fund expenditure authority of $483.2 million in 2021-22 to support testing efforts at its Valencia Laboratory. Beginning operation in October 2020, the Valencia Laboratory will expand the state's COVID-19 testing capacity by an expected 150,000 tests per day by March 2021. DPH contracts with PerkinElmer to operate the lab. Because DPH expects the need for COVID-19 testing capacity will begin to decline in August 2021, this request assumes a small residual cost to maintain the facility in a "warm" shutdown after the end of 2021.
- Logistics Health, Inc. (OptumServe) – DPH requests General Fund expenditure authority of $316.7 million in 2021-22 to support a new specimen collection contract with OptumServe. DPH also expects costs to decline beginning in August 2021 until the end of the calendar year.
- Miscellaneous COVID-19 Testing and Other Costs – DPH requests General Fund expenditure authority of $20.7 million in 2021-22 for service contracts, other operating costs, commodity purchases and other procurements, and a contract to provide revenue collection and banking services for the Valencia Laboratory.

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

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

1. Please provide a brief overview of the DPH-related components of this proposal, as well as a brief description of the components for other state departments.

2. After the pandemic is over, what are the department's long-term plans for the Valencia Laboratory testing facility? Could this capacity be repurposed for other public health priorities?

## Issue 4: Adjustment to Support Infectious Disease Modeling

**Budget Change Proposal – Governor's Budget.** DPH requests General Fund expenditure authority of $450,000 in 2021-22, available for encumbrance or expenditure until June 30, 2023. If approved, these resources would support infectious disease modeling activities to inform public health emergency decision-making.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23** |
| 0001 – General Fund | $450,000 | $- |
| **Total Funding Request:** | **$450,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** During the COVID-19 pandemic, determination of the suitability of various public health interventions required modeling of the transmission and public health impacts of the virus within California communities. In February 2020, DPH established the Coronavirus Modeling Team to provide epidemiologic estimates of the potential consequences of COVID-19 and to provide the evidentiary basis of the state's pandemic response. In July 2020, the University of California (UC) Office of the President, with input from DPH, established the California COVID-19 Modeling and Analytics Consortium to consolidate modeling and analytic activities across the UC system to inform state policy. The Consortium includes over 150 investigators from nine UC campuses. According to DPH, as COVID-19 transmission has continued to increase, disproportionately impacting socially vulnerable communities, infectious disease modeling has been highlighted as a central theme in providing transparent data, primarily through the establishment of an open-source, publicly available modeling platform, CalCAT, which disseminates modeling based results produced through collaborations and partnerships with academic and citizen science modeling groups. DPH also reports its infectious disease modeling may be helpful in the state's understanding of the role of new COVID-19 variants in transmission and disease in the state.

**Resource Request.** DPH requests General Fund expenditure authority of $450,000 in 2021-22, available for encumbrance or expenditure until June 30, 2023, to support its infectious disease modeling activities to inform public health emergency decision-making. DPH reports it has redirected six positions to support its current modeling efforts, including CalCAT, and intends to fund a dedicated staff member to support CalCAT and other infectious disease modeling activities. According to DPH, $300,000 would support the staff salary, benefits, and other operating expenses, and $150,000 would support the modeling and analytics efforts, as well as in-house training for DPH staff.

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

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

1. Please provide a brief overview of this proposal.

2. Once the COVID-19 pandemic is under control, how could these modeling resources and efforts be helpful in addressing other infectious diseases?

## Issue 5: AIDS Drug Assistance Program (ADAP) Estimate

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

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

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

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

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

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

**ADAP Estimate – Governor's Budget.** The November 2020 ADAP Local Assistance Estimate reflects revised 2020-21 expenditures of $467.3 million, an increase of $29 million or 6.6 percent compared to the 2020 Budget Act. According to DPH, this increase is primarily due to higher projected medication expenditures for medication-only clients. For 2021-22, DPH estimates ADAP expenditures of $503.5 million, an increase of $36.1 million or 7.7 percent compared to revised expenditures for 2020-21. According to DPH, this increase is similarly attributable to higher projected medication expenditures for medication-only clients.

| **ADAP Local Assistance Funding Summary** | | |
|---|---|---|
| **Fund Source** | **2020-21** | **2021-22** |
| 0890 – Federal Trust Fund | $109,140,000 | $105,350,000 |
| 3080 – AIDS Drug Assistance Program Rebate Fund | $358,194,000 | $398,116,000 |
| **Total ADAP Local Assistance Funding** | **$467,334,000** | **$503,466,000** |

ADAP tracks caseload and expenditures by client group. DPH estimates ADAP caseload and expenditures for 2020-21 and 2021-22 will be as follows:

| **Caseload by Client Group** | **2019-20** | **2020-21** |
|---|---|---|
| **Medication-Only** | 13,105 | 13,142 |
| **Medi-Cal Share of Cost** | 104 | 108 |
| **Private Insurance** | 10,479 | 10,717 |
| **Medicare Part D** | 7,720 | 7,767 |
| **PrEP Assistance Program** | 3,325 | 3,430 |
| **TOTAL** | **34,733** | **35,164** |

| **Expenditures by Client Group** | **2019-20** | **2020-21** |
|---|---|---|
| **Medication-Only** | $342,103,793 | $356,480,156 |
| **Medi-Cal Share of Cost** | $1,116,065 | $1,158,425 |
| **Private Insurance** | $88,775,907 | $107,608,168 |
| **Medicare Part D** | $24,421,933 | $26,652,684 |
| **PrEP Assistance Program** | $4,136,501 | $4,151,355 |
| **TOTAL** | **$460,554,199** | **$496,050,788** |

In addition, enrollment costs are estimated to be $6.8 million in 2020-21 and $7.4 million in 2021-22. Beginning in 2017-18, ADAP introduced a new reimbursement methodology for enrollment sites which includes a payment floor and variable payments dependent on new client medication enrollment, client

bi-annual self-verification, client annual re-enrollment, client insurance assistance enrollment and re-enrollment, and PrEP client enrollment and re-enrollment.

**General Fund Loan – ADAP Rebate Fund.** The 2020 Budget Act included provisional language to provide for a loan of up to $100 million from the ADAP Rebate Fund to the General Fund. The provisional language requires the repayment of all or a portion of the loan if the Director of Finance determines that any of the following circumstances exist: (a) the fund or account from which the loan was made has a need for the moneys to maintain a prudent reserve of not less than 40 percent of operating expenses in the previous year for the ADAP Program, (b) the fund or account from which the loan was made has a need for the moneys to maintain a prudent reserve due to a decrease in federal funding, (c) the fund or account from which the loan was made has a need for the moneys to provide drugs and services through the ADAP Program or the HIV prevention program, (d) the fund or account from which the loan was made has a need for the moneys to increase eligibility criteria or add new drugs and services to the ADAP Program or the HIV prevention program, or (e) there is no longer a need for the moneys in the fund or account that received the loan.

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

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

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

## Issue 6: Center for Health Care Quality Estimate

**Center for Health Care Quality Program Estimate – Governor's Budget.** The budget includes expenditure authority for the Center for Health Care Quality of $341.1 million ($4.3 million General Fund, $96.6 million federal funds, and $240.2 million special funds and reimbursements) in 2020-21, a decrease of $9.9 million or 2.8 percent compared to the 2020 Budget Act, and $391.5 million ($4.3 million General Fund, $101.5 million federal funds, and $285.7 million special funds and reimbursements) in 2021-22, an increase of $50.4 million or 14.8 percent compared to the revised 2020-21 budget. According to DPH, the increase in 2021-22 is attributed to increased costs for the third year of the department's contract with Los Angeles County, implementation of a centralized application unit, and legislatively mandated requirements related to personal protective equipment stockpiles for healthcare employers, staffing compliance oversight for skilled nursing facilities, and investigation of complaints against caregivers.

| CHCQ Funding Summary, November 2020 Estimate | | |
|---|---|---|
| **Fund Source** | **2020-21** | **2021-22** |
| 0001 – General Fund | $4,296,000 | $4,296,000 |
| 0890 – Federal Trust Fund | $96,643,000 | $101,522,000 |
| 0942 – Special Deposit Fund | | |
| Internal Departmental Quality Improvement Account | $3,600,000 | $3,600,000 |
| State Health Facilities Citation Penalty Account | $2,144,000 | $2,144,000 |
| Federal Health Facilities Citation Penalty Account | $9,873,000 | $9,873,000 |
| 0995 – Reimbursements | $12,134,000 | $12,914,000 |
| 3098 – Licensing and Certification Program Fund | $212,458,000 | $257,178,000 |
| **Total CHCQ Funding** | **$291,351,000** | **$311,429,000** |
| **Total CHCQ Positions** | **1425.3** | **1456.3** |

**Background.** DPH's Center for Health Care Quality, Licensing and Certification Program (L&C) is responsible for administering the licensure, regulation, inspection, and certification of health care facilities and certain health care professionals in California. The program is organized into 14 district offices and Los Angeles County, which operates under a contract with the L&C program. L&C staff conduct periodic inspections and investigation of complaints and entity-reported incidents to ensure health care facilities comply with state and federal laws and regulations, conducting more than 30,000 complaint and entity-reported incident investigations of long-term care facilities annually. L&C also contracts with the federal Centers for Medicare and Medicaid Services (CMS), which provides federal funding to ensure that facilities accepting Medicare and Medi-Cal payments comply with federal laws and regulatory requirements. In addition to facility oversight, L&C oversees the certification of certified nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

**History of Problems with Health Facility Oversight.** L&C's regulatory oversight of health care facilities has raised concerns from the federal government, the Legislature, the California State Auditor, stakeholders, and the media for more than fifteen years. In particular, L&C has demonstrated a consistently poor record of completing investigations of health care facility complaints of abuse and neglect of residents in a timely manner. The Legislature has sought to address the ongoing issues with L&C through a variety of budget actions and reporting requirements.

*2014 Budget Act* – The 2014 Budget Act included trailer bill language requiring L&C to:

- Report metrics quarterly on: (1) investigations of paraprofessional complaints; (2) long-term care health facility complaints, investigations, state relicensing, and federal recertification surveys; and (3) vacancy rates and hiring within L&C.
- Report by October 2016 the above information for all facility types.
- Assess the possibilities of using professional position classifications other than health facility evaluator nurses to perform licensing and certification survey or complaint workload.
- Hold semiannual meetings for all interested stakeholders to provide feedback on improving the L&C program.

*2015 Budget Act* – The 2015 Budget Act included*:*

- Approval of 237 positions over two years to address the licensing and certification workload.
- $2 million from the Internal Departmental Quality Improvement Account to implement quality improvement projects.
- $14.8 million from the L&C Program Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County.
- $378,000 from the L&C Program Fund and 3 positions to provide on-site oversight and perform workload management, training, and quality improvement activities to improve the efficiency and effectiveness of the Los Angeles County contract licensing and certification activities.
- Trailer bill language to establish timeframes to complete complaint investigations at long-term care facilities, as follows:
    - For immediate jeopardy complaints the department must complete the investigation within 90 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
    - For all other categories of complaints received on or after July 1, 2017, the department must complete the investigation within 90 days of receipt, with an additional extension of 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
    - For all complaints received on or after July 1, 2018, the department must complete the investigation within 60 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
    - Report on an annual basis (in the Licensing and Certification Fee report) data on the department's compliance with these new timelines.

- Beginning with the 2018-19 Licensing and Certification November Program budget estimate, the department must evaluate the feasibility of reducing investigation timelines based on experience implementing the timeframes described above.
- States the intent of the Legislature that the department continues to seek to reduce long-term care complaint investigation timelines to less than 60 days with a goal of meeting a 45-day timeline.

*2016 Budget Act* – The 2016 Budget Act included*:*

- $2 million from the Internal Departmental Quality Improvement Account to execute two contracts to redesign the Centralized Applications Unit (CAU) information technology systems, and the Health Facilities Consumer Information System (HFCIS).
- $2.5 million in expenditure authority from the L&C Program Fund to convert 18 existing two-year limited-term positions to permanent positions, and fund two additional positions for the Office of Legal Services, for a total of 20 positions to improve the timeliness of investigations of complaints against caregivers.
- One-time $1 million augmentation to the Long-Term Care Ombudsman Program using funds from the State Health Facilities Citation Account.
- $2.1 million from the L&C Program Fund to augment the Los Angeles County contract to account for two, three percent salary increases effective October 2015 and October 2016, an increase to the employee benefit rate from 55.1 to 57.8 percent, and a decrease in the indirect cost rate from 33.2 to 31.4 percent.

*2017 Budget Act* – The 2017 Budget Act included*:*

- $2 million from the Internal Departmental Quality Improvement Account for IT assessment, performance dashboards, implementation of tablet use, automation of caregiver applications, outcomes and effectiveness evaluation, quality improvement facilitation, onboarding and retention contract for Health Facilities Evaluator Nurses (HFEN), and contracts to continue the redesign of the CAU and HFCIS.
- $1.1 million to augment the Los Angeles County contract to account for salary increases approved by the Los Angeles County Board of Supervisors.
- Implementation of requirements that free-standing skilled nursing facilities have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for certified nurse assistants, beginning July 1, 2018.

*2018 Budget Act* – The 2018 Budget Act included*:*

- $2.6 million from the Licensing and Certification Program Fund to fund a one-year extension of the Los Angeles County contract for licensing and certification activities and to account for adjustments to the indirect cost rate, employee benefits rate, personnel costs, and lease costs.
- Budget bill language to authorize DPH to increase funding for the Los Angeles County contract as needed based on actual cost information that becomes available during 2018-19.
- Trailer bill language to authorize a supplemental license fee on facilities located in Los Angeles County to offset additional costs necessary to regulate facilities in the county.
- 22 positions and expenditure authority of $2.7 million ($2.4 million Licensing and Certification Program Fund and $294,000 Internal Departmental Quality Improvement Account) annually to allow DPH to improve core operations and effectiveness, foster quality improvement projects, and address workforce needs, particularly in the licensing of certified nurse assistants.

**Vacancy Rates: Center for Health Care Quality and HFEN Classification.** According to DPH's Vacancy Reports Metrics Dashboard, the Center for Health Care Quality, which oversees the L&C Division, had a 7.1 percent vacancy rate for all positions reported as of June 30, 2020, compared to 6.5 percent as of June 30, 2019. The vacancy rate for the HFEN classification, the primary classification conducting health facility oversight and investigation, was 5.3 percent as of June 30, 2020, compared to 3.9 percent as of June 30, 2019. L&C vacancies, particularly in the HFEN classification, have been a persistent concern for the program, the Legislature, and stakeholders, about the program's ability to manage its licensing and certification and complaint and entity-reported incident investigation workload. However, DPH has been relatively successful in reducing its HFEN vacancy rate, which was 19.5 percent as of June 30, 2016.

DPH indicates its successful reduction in its vacancy rate is due to recent implementation of recruitment and retention strategies. The program hired two contractors to help remedy the high vacancy rates for HFENs in the L&C program: 1) an onboarding and retention contractor assists hiring candidates to navigate the state civil service process and helps improve retention of hired staff, and 2) a recruitment contractor seeks candidates for HFEN positions at job fairs, conducts outreach to registered nurses in California, develops marketing materials and attempts to meet recruitment targets. Funding for these contracts was approved in the 2015 Budget Act from the Internal Departmental Quality Improvement Account.

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

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

1. Please provide a brief overview of the L&C Program, including regulatory responsibilities, organizational structure, funding, and performance.

2. Please provide an update on the L&C Program's vacancy rate, particularly for the HFEN classification.

3. Please provide an update on the most current timeliness metrics for investigation of complaints and entity-reported incidents.

## Issue 7: Health Care and Essential Workers: Personal Protective Equipment (SB 275)

**Budget Change Proposal – Governor's Budget.** DPH requests one position and expenditure authority from the Licensing and Certification Fund of $164,000 annually. If approved, this position and resources would allow DPH to establish regulations for a personal protective equipment (PPE) stockpile by health care employers, pursuant to the requirements of SB 275 (Pan), Chapter 301, Statutes of 2020.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23*** |
| 3098 – Licensing and Certification Fund | $164,000 | $164,000 |
| **Total Funding Request:** | **$164,000** | **$164,000** |
| **Total Requested Positions:** | **1.0** | **1.0** |

* Position and resources ongoing after 2022-23.

**Background.** During the first months of the pandemic emergency, planning for a potential surge in hospital and intensive care unit (ICU) utilization uncovered serious challenges for the state's health systems and health care providers to obtain the personal protective equipment (PPE) necessary to safely treat an influx of COVID-19 patients. In particular, hospital staff across the nation reported shortages of masks, respirators, gowns, gloves, and other equipment, with hospitals often resorting to one or more rationing procedures to ensure availability for hospital staff.

**Statewide PPE Stockpile.** SB 275 (Pan), Chapter 301, Statutes of 2020, requires DPH and the Governor's Office of Emergency Services (CalOES) to establish a statewide stockpile of PPE by January 1, 2022, upon appropriation and as necessary. The bill requires DPH to establish a PPE Advisory Committee comprised of representatives of various provider associations, labor organizations representing health care and other essential workers, the PPE manufacturing industry, consumers, counties, DPH, CalOES, the Emergency Medical Services Authority, and the Department of Social Services. The Committee will make recommendations to DPH and CalOES to develop guidelines for the procurement, management, and distribution of PPE.

Despite the PPE procurement challenges experienced by health care providers throughout the state during the pandemic, the budget does not include staffing or other resources to establish the statewide stockpile or to support the PPE Advisory Committee. Because the language in SB 275 conditions the establishment of a statewide stockpile on an appropriation in the budget, this omission is allowable. However, it is unclear why the Administration has neglected to include such a vital tool for the stable management of the state's supplies of PPE in its January budget.

**Provider-Specific PPE Stockpiles.** SB 275 also requires health care employers, including general acute care hospitals, health facilities, certain medical practices, and dialysis clinics, to maintain an inventory of unexpired PPE for use in the event of a pandemic or other emergency. Beginning January 1, 2023, health care employers would be required to maintain an inventory at least sufficient for 45 days of surge consumption, as determined by regulations promulgated by the Department of Industrial Relations (DIR) in coordination with DPH. These regulations would include, but not be limited to, the types and amount of PPE to be maintained based on the type and size of each health care employer and the composition of its workforce. Health care employers that fail to maintain the required stockpile would be subject to civil

penalties. This budget request includes staffing and resources for DPH to assist DIR in promulgating regulations. The budget includes a separate request for DIR to promulgate these regulations and enforce the requirements of SB 275.

**Staffing and Resource Request.** DPH requests one position and expenditure authority from the Licensing and Certification Fund of $164,000 annually to assist DIR in the establishment of regulations for health care employers' PPE stockpiles. Specifically, DPH requests the following partial positions:

- **0.5 Research Scientist Supervisor I (Epidemiology/Biostatistics)** would conduct research, analysis, and compilation of PPE types, amount of PPE needed, and workforce composition of health care employers, as well as provide expertise in health care associated infections.
- **0.5 Associate Governmental Program Analyst** would assist DIR in writing regulations for health care employers that would be required to maintain stockpiles of PPE.

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

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

1. Please provide a brief overview of this proposal.

2. Please explain why this request does not include resources to establish a statewide stockpile of PPE. Has the Administration determined such a stockpile is not necessary?

## Issue 8: Skilled Nursing Facility Staffing Requirements Compliance (AB 81)

**Budget Change Proposal – Governor's Budget.** DPH requests six positions and expenditure authority from the Licensing and Certification Fund of $939,000 annually. If approved, these positions and resources would allow DPH to enforce skilled nursing facility compliance with staffing requirements, impose penalties, and manage disputes and appeals, pursuant to the requirements of AB 81 (Committee on Budget), Chapter 13, Statutes of 2020.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23*** |
| 3098 – Licensing and Certification Fund | $939,000 | $939,000 |
| **Total Funding Request:** | **$939,000** | **$939,000** |
| **Total Requested Positions:** | **6.0** | **6.0** |

* Positions and resources ongoing after 2022-23.

**Background.** AB 1629 (Frommer), Chapter 875, Statutes of 2004, authorized the development of a cost-based, facility-specific reimbursement rate methodology for freestanding skilled nursing facilities serving Medi-Cal beneficiaries and imposed a Quality Assurance Fee (QAF), which supports the nonfederal share of reimbursement rate increases to these facilities. The reimbursement rate methodology and QAF have been reauthorized three times since 2004. Though the basic structure of the reimbursement rate methodology and QAF have remained the same, each reauthorization has provided for the rate of reimbursement rate increases each year and imposes certain other requirements on skilled nursing facilities.

**Quality and Accountability Supplemental Payment Program.** SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, the first reauthorization of the AB 1629 QAF, also required the Department of Health Care Services to implement a Quality and Accountability Supplemental Payment (QASP) program to enable the reimbursement of skilled nursing facilities to be partially dependent on demonstrated quality of care improvements and adherence to quality standards. Until 2015, the QASP program withheld a portion of the annual rate increase specified in the AB 1629 QAF reauthorization until the required quality of care improvements or adherence to quality standards were demonstrated by a health facility. AB 119 (Committee on Budget), Chapter 17, Statutes of 2015, amended the structure of the QASP withhold, freezing the total reimbursement withheld at 2014-15 levels, or $81 million ($40.5 million QASP funds and $40.5 million federal funds).

**Skilled Nursing Facility Minimum Staffing Requirements.** SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, requires skilled nursing facilities to have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for certified nursing assistants (CNAs). Previously, the minimum staffing requirement had been 3.2 hours per patient day, with no minimum requirements for CNAs. DPH is responsible for auditing skilled nursing facilities for compliance with these minimum staffing requirements. Failure to comply may result in administrative penalties assessed by DPH, or ineligibility for payments in the QASP program.

**Most Recent AB 1629 QAF Reauthorization Includes Enhanced Appeal Rights.** AB 81 (Committee on Budget), Chapter 13, Statutes of 2020, the most recent reauthorization of the AB 1629 QAF, extends

the current structure until December 31, 2022, with some changes to the schedule of reimbursement rate increases, changes to the treatment of labor costs and other components of the facility-specific reimbursement rate methodology, exemption of freestanding pediatric subacute facilities from the QAF, and an enhanced right for skilled nursing facilities to appeal determinations or assessments of compliance by DPH. According to DPH, skilled nursing facilities are audited for 24 days of staffing annually to ensure compliance with the minimum requirements for direct care services hours per patient day. If a facility is non-compliant for 2 days or more, it is assessed a penalty and is determined ineligible for QASP payments. Prior to AB 81, only facilities in this category could appeal this determination, because they were assessed a penalty. However, a facility determined non-compliant for only one day is not assessed a penalty and, although it would also be ineligible for QASP payments, it previously could not appeal the determination. AB 81 expanded these appeal rights to allow skilled nursing facilities determined non-compliant for one day to appeal the determination, as well. Based on data trends, DPH expects 106 one-day non-compliant findings to be issued annually and, because this finding results in loss of QASP eligibility, expects all skilled nursing facilities with such findings would appeal. As a result, DPH expects an increase in its auditing and appeals workload.

**Staffing and Resource Request.** DPH requests six positions and expenditure authority from the Licensing and Certification Fund of $939,000 annually to enforce skilled nursing facility compliance with staffing requirements, impose penalties, and manage disputes and appeals. Specifically, DPH requests the following positions:

Office of Legal Services (OLS) – **Two Attorney III** positions and **one Senior Legal Analyst** would manage the additional 106 appeals of one-day non-compliant findings for skilled nursing facilities, including reviewing arguments, witnesses, and preparing or responding to any supporting documentation.

Staffing Audits Section (SAS) – **Two Associate Governmental Program Analysts** and **one Office Technician** would work as quality assurance auditors conducting on-site staffing audits, quality assurance reviews, reviewing files, and verifying all documentation is included, complete, and correct.

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

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

1. Please provide a brief overview of this proposal.

## Issue 9: Timely Investigation of Caregivers

**Budget Change Proposal – Governor's Budget.** DPH requests seven positions and expenditure authority from the Licensing and Certification Fund of $1 million annually. If approved, these positions and resources would allow DPH to improve the timeliness of investigations of complaints against caregivers.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23*** |
| 3098 – Licensing and Certification Fund | $1,000,000 | $1,000,000 |
| **Total Funding Request:** | **$1,000,000** | **$1,000,000** |
| **Total Requested Positions:** | **7.0** | **7.0** |

* Positions and resources ongoing after 2022-23.

**Background.** DPH's Professional Certification Branch (PCB) is responsible for the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensure of nursing home administrators. It is also responsible for the investigation of allegations involving health care professionals and the enforcement of disciplinary actions. These caregivers provide approximately 80 percent of direct patient care activities for daily living in skilled nursing facilities licensed by DPH, and may also provide direct care in residences through licensed home health agencies.

Federal and state laws require investigation of complaints against caregivers. DPH received 1,310 complaints in 2017-18, 1,372 in 2018-19, and 1,116 in 2019-20. DPH indicates the decrease in complaints received in 2019-20 is due to the significant impact of the COVID-19 pandemic and expects a return to previous levels once pandemic-related restrictions are lifted. Complaints typically involve physical sexual, mental, or verbal abuse or misconduct; misappropriation of property; or other forms of unprofessional conduct. According to DPH, the backlog of pending caregiver investigations has increased from 246 in 2017-18 to 696 in 2019-20, an increase of 183 percent.

**Staffing and Resource Request.** DPH requests seven positions and expenditure authority from the Licensing and Certification Fund of $1 million annually to improve the timeliness of investigations of complaints against caregivers and mitigate the ongoing investigation backlog. Specifically, DPH requests **one Supervising Special Investigator I** position, who would supervise a team of **six Special Investigators** to manage the increased investigation workload.

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

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

1. Please provide a brief overview of this proposal.

## Issue 10: Medical Breach Enforcement Section Expansion

**Budget Change Proposal – Governor's Budget.** DPH requests 17 positions and expenditure authority from the Licensing and Certification Fund of $2.6 million annually. If approved, these positions and resources would allow DPH to expand its Medical Breach Enforcement Section, which investigates complaints and administers penalties against individuals and health care providers for breaches of medical privacy.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23*** |
| 3098 – Licensing and Certification Fund | $2,616,000 | $2,616,000 |
| **Total Funding Request:** | **$2,616,000** | **$2,616,000** |
| **Total Requested Positions:** | **17.0** | **17.0** |

* Positions and resources ongoing after 2022-23.

**Background.** SB 541 (Alquist), Chapter 605, Statutes of 2008, requires investigation of and assessment of penalties on licensed medical facilities for breaches of patients' confidential medical information. SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014, transferred responsibility for the investigation of medical breaches from the California Health and Human Services Agency to DPH, along with three investigative staff. Since 2009, over 1,600 licensed health facilities have reported nearly 42,000 medical breach incidents.

**Pilot Project to Test Use of Non-Clinical Staff for Medical Breach Investigations.** In 2016-17, DPH expanded its medical breach investigative staff from three to 17, and included non-clinical classifications such as Special Investigators (SIs) and Associate Governmental Program Analysts (AGPAs) in a Medical Breach Enforcement Section (MBES). Previously, most medical breach investigations were conducted by Health Facility Evaluator Nurses (HFENs), the same classification that conducts investigations of abuse and neglect in skilled nursing facilities. The Center for Health Care Quality's Licensing and Certification Division, which is responsible for complaint investigations in skilled nursing facilities, had a long history of challenges completing investigations of abuse and neglect in a timely manner. In 2016-17, one of the contributing factors to these challenges was a high vacancy rate in the division for the HFEN classification. The transition from HFENs to SIs and AGPAs was intended to free up HFENs to focus on improving the timeliness of abuse and neglect complaint investigations. Since this transition began in 2016-17, DPH reports non-clinical staff from MBES have assumed all medical breach investigation workload in 12 of 19 DPH field offices.

**Staffing and Resource Request.** DPH requests 17 positions and expenditure authority from the Licensing and Certification Fund of $2.6 million annually to expand MBES staff to the remaining 7 DPH field offices. This expansion would allow HFENs currently performing this workload in these field offices to focus on complaint investigation workload and other duties. Specifically, DPH is requesting **four AGPAs, one Supervising Special Investigator II, one Supervising Special Investigator I, seven Special Investigators,** and **one Program Technician** for the MBES. In addition, DPH is requesting **one Attorney III** in its Legal Office to support medical breach investigations.

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

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

1. Please provide a brief overview of this proposal.

## Issue 11: COVID-19 Workplace Outbreak Reporting (AB 685)

**Budget Change Proposal – Governor's Budget.** DPH requests three positions and General Fund expenditure authority of $677,225 annually. If approved, these positions and resources would allow DPH to create a new program to manage COVID-19 workplace outbreak reporting, pursuant to the requirements of AB 685 (Reyes), Chapter 84, Statutes of 2020.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23*** |
| 0001 – General Fund | $677,225 | $677,225 |
| **Total Funding Request:** | **$677,225** | **$677,225** |
| **Total Requested Positions:** | **3.0** | **3.0** |

* Positions and resources ongoing after 2022-23.

**Background.** Due to public health interventions implemented during the COVID-19 pandemic, including stay-at-home orders and prohibitions on the operation of certain types of business and other establishments, many workplaces have transitioned employees to remote work or shut down altogether. However, certain classes of employees are considered "essential workers" and are exempt from stay-at-home orders and other restrictions. As a result, many of these workplaces have experienced outbreaks of COVID-19, as workers continue to occupy indoor spaces with other workers and customers, increasing the risk of transmission. In addition, the pandemic has disproportionately affected certain racial and ethnic groups, particularly Latinos who represent 39 percent of California's population, but 60 percent of its COVID-19 cases. According to DPH, these disparities are likely exacerbated by occupational factors such as the large number of workers from racial and ethnic minorities employed as essential workers. Preliminary data indicates that Latino workers make up 81 percent of COVID-19 fatalities in the construction industry, 79 percent in the restaurant and food service industry, and 93 percent in the crop production industry.

The Occupational Health Branch (OHB) at DPH works to prevent injury and illness on the job by: 1) identifying and evaluating workplace hazards, 2) tracking patterns of work-related injury and illness, 3) developing training and informational materials, 4) providing technical assistance, 5) working with partners to develop safer ways to work, and 6) recommending protective occupational health standards. OHB works closely with the Division of Occupational Safety and Health (Cal/OSHA) at the Department of Industrial Relations (DIR), which enforces workplace safety and health regulations.

AB 685 (Reyes) Chapter 84, Statutes of 2020, mandates employer reporting of COVID-19 outbreaks, which is defined as three or more cases at a worksite within a 14 day period. AB 685 also requires DPH to post information about COVID-19 outbreaks by industry on its website to increase public awareness. According to DPH, this reporting will allow the state to more effectively track and analyze data on workplace outbreaks, identify work-related risk factors for COVID-19 transmission, and inform preventive efforts. DPH reports it has received information about approximately 1,700 workplace outbreaks in January 2020, and plans to implement a dashboard for outbreak information on its website in February 2020. The dashboard would include information by industry, outbreak totals, and workplace settings.

**Staffing and Resource Request.** DPH requests three positions and General Fund expenditure authority of $677,225 annually to create the new program to manage COVID-19 workplace outbreak reporting. Specifically, DPH requests the following positions:

- **Two Research Scientist II (Epidemiology/Biostatistics)** positions would manage and analyze data on workplace outbreaks reported to the California Reportable Disease Information Exchange (CalREDIE) by local health departments. These positions would ensure data quality and integrity, analyze data to identify industries and occupations with high numbers of cases and rates of COVID-19 transmission, develop user-friendly visual representations of workplace outbreak data, and developing and delivering online training to local health departments on the accurate collection and reporting of data.
- **One Health Program Specialist II** position would conduct outreach to employers and local health departments to disseminate reporting requirements and data findings, develop partnerships and educational materials for local health departments, as well as workers and employers, receive and respond to inquiries regarding reporting requirements, assist the research scientist positions in developing visual representations of data, and update the website weekly.

Included in this request is General Fund expenditure authority of $200,000 annually to support maintenance and operations of system changes and database modifications to facilitate collection and reporting of workplace outbreak data.

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

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

1. Please provide a brief overview of this proposal.

## Issue 12: Support for Alzheimer's Disease Awareness, Research, and Training

**Budget Change Proposal – Governor's Budget.** DPH requests General Fund expenditure authority of $17 million ($6.8 million in state operations and $10.2 million in local assistance) in 2021-22, available for encumbrance or expenditure until June 30, 2024. If approved, these resources would be available to DPH over three years to support an equitable and coordinated approach to Alzheimer's disease and related dementias, including research grants, a public awareness campaign, caregiver training and certification, community challenge grants, and statewide standards for dementia care.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23** |
| 0001 – General Fund | $17,000,000 | $- |
| **Total Funding Request:** | **$17,000,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** According to DPH, Alzheimer's is the seventh most common cause of death for Americans, including COVID-19. Federal Centers for Disease Control and Prevention data indicates California had 15,570 deaths attributable to Alzheimer's disease in 2016, which made it the 4th leading cause of death in the state. Alzheimer's disease disproportionately impacts women, as nearly two-thirds of Americans with Alzheimer's disease or other dementias are women. While the prevailing view has been that the difference is due to the fact that women, on average, live longer than men and older age is the greatest risk factor for Alzheimer's, many researchers question whether the risk of the disease is higher for women at any given age due to biological or genetic variations, or due to differences in life experiences. Alzheimer's disease also disproportionately impacts some communities of color. African-Americans are about two times more likely than older whites to have Alzheimer's and Hispanics are about one and one-half times more likely. Among people ages 65 and older, African Americans have the highest prevalence of Alzheimer's disease and related dementias (13.8 percent), followed by Hispanics (12.2 percent).

AB 2225 (Felando), Chapter 1601, Statutes of 1984, established the Alzheimer's Disease Program (ADP) at DPH, which seeks to reduce the human burden and economic costs associated with Alzheimer's Disease and related dementias. The program, currently funded by individual voluntary contributions by taxpayers on state tax returns, performs two primary functions:

1. *California Alzheimer's Disease Centers.* ADP established and administers a statewide network of ten California Alzheimer's Disease Centers (CADCs) at university medical centers. These Centers provide diagnostic and treatment services; professional training for medical residents, postdoctoral fellows, nurses, interns, and medical students; and community education such as caregiver training and support.
2. *Alzheimer's Disease and Related Disorders Research Fund Grants.* ADP established and administers the Alzheimer's Disease and Related Disorders Research Fund (ADRDF), which awards grants through a competitive process to scientists in California engaged in the study of Alzheimer's disease and related disorders.

**Alzheimer's Disease and Related Disorders Research Grants.** Since its creation, ADP has provided more than $30 million of funding for more than 130 research projects to contribute to the better

understanding, care, and support of patients and families affected by Alzheimer's Disease and related disorders. Past research grants have contributed to significant breakthroughs including: identifying a novel specific plasma biomarker for Alzheimer's Disease, improving differential diagnosis and training, and providing definitive evidence of how amyloids contribute to the basic pathophysiological abnormalities typical of Alzheimer's and other neurodegenerative diseases.

Before 2018, ADP funded between five and seven research grants with its ADRDF allocations. The 2018 Budget Act included annual General Fund expenditure authority of $3.1 million for Alzheimer's research projects in the following categories:

- *Caregiving*: strengthening caregivers' health and effectiveness
- *Prevention*: reducing risk for cognitive decline and dementia
- *Early Diagnosis and Detection*: expanding early detection and diagnosis
- *Long-Term Services and Support Systems/Health Services:* improving safety and quality of care for people living with dementia
- *Health Disparities:* understanding the prevalence, policies, environmental, and social determinants of health affecting California's diverse population.

The 2019 Budget Act included additional General Fund expenditure authority of $2.7 million annually to support research to understand the greater prevalence of Alzheimer's among women and communities of color.

**Task Force on Alzheimer's Disease Prevention and Preparedness.** The 2019 Budget Act also included General Fund expenditure authority of $300,000 annually to support the Task Force on Alzheimer's Disease Prevention and Preparedness. The task force, led by former California First Lady Maria Shriver, is composed of consumers, caregivers, neuroscientists, researchers, health care providers, family members, education systems, private-sector leaders, and media professionals. The goal of the task force is to provide recommendations on how California can prevent and prepare for the growing number of Alzheimer's cases and forge a path forward. In November 2020, the task force released its report of ten recommendations, which include the following:

1) A senior advisor on Alzheimer's, appointed by the Governor, to lead on implementing recommendations of the task force.
2) Support Alzheimer's research with increased funding, including a focus on historically underrepresented communities, such as women, communities of color and the LGBTQ+ community.
3) Create a multilingual, multicultural, and intergenerational Alzheimer's Disease Public Awareness campaign to shift public perceptions and reduce social stigma.
4) Build a "California Cares" digital portal to serve as a one-stop shop for information and services related to screening and diagnosis of Alzheimer's.
5) Establish voluntary savings accounts for long-term care to address affordability and access.
6) Invest in career incentives for an Alzheimer's health care workforce.
7) Establish a caregiver training and certification program.
8) Establish a California Blue Zone City Challenge to support cities in certifying certain locations and establishments as "Blue Zones" once they adopt a minimum threshold of best practices that

address the needs and challenges of people with dementia, Alzheimer's or other age related diseases.

9) Establish a Californians for All Care Corps, to provide opportunities for people of all ages and life stages to contribute meaningful public service.
10) Establish an evidence-based, statewide standard of care for Alzheimer's detection diagnosis, treatment, and care planning.

**Resource Request.** DPH requests General Fund expenditure authority of $17 million ($6.8 million in state operations and $10.2 million in local assistance) in 2021-22, available for encumbrance or expenditure until June 30, 2024. These resources would support an equitable and coordinated approach to Alzheimer's disease and related dementias, and reflect five of the task force recommendations described above, including:

1) Alzheimer's Research Grant Funding (Recommendation 2) – DPH requests General Fund expenditure authority of $4 million to support research grants that would continue to focus on the greater prevalence of dementia in women and communities of color, but also focus on historically underrepresented populations, such as the LGBTQ+ community. Of this request, $3.4 million would be allocated for research grants and $600,000 would support the state operations costs of administering the grant program.
2) Public Awareness Campaign (Recommendation 3) – DPH requests General Fund expenditure authority of $5 million to create a public awareness campaign focused on educating the public on the signs and symptoms of Alzheimer's Disease and related dementias. The campaign would target at-risk and disproportionately impacted populations, incorporate a culturally competent and equity-targeted messaging strategy, provide critical information about Alzheimer's and other aging-related conditions, and drive the public to linguistically and culturally competent dementia care resources delivered through multiple modalities.
3) Caregiver Training and Certification Program (Recommendation 7) – DPH requests General Fund expenditure authority of $4 million to design and, if funding is available, develop a caregiver training and certification program, The program would provide access to evidence-based dementia related education and training for both paid and unpaid caregivers, as well as those providing In-Home Supportive Services. Of this request, $3.4 million would support the training and certification programs, while $600,000 would support the state operations costs of administering the program.
4) California Blue Zone Challenge (Recommendation 8) – DPH requests General Fund expenditure authority of $2 million to allocate grants to California cities or local health jurisdictions to establish a California Blue Zone program which would, in collaboration with local public and private sector stakeholders, certify certain establishments (e.g. schools, restaurants, grocery stores, workplaces, religious institutions, etc.) as "Blue Zones" if they adopt a minimum threshold of best practices. These best practices would address the unique needs and challenges of people with Alzheimer's disease and related dementias, and other age-related diseases.
5) Statewide Standard of Dementia Care (Recommendation 10) – DPH requests General Fund expenditure authority of $2 million to design a statewide standard of care for dementia. This effort would include ensuring primary care physicians have access to a set of evidence-derived cognitive screening questions for identification of Alzheimer's disease and related dementias, developing a hub and spoke model to leverage resources of the ten California Alzheimer's Disease Centers, and incorporating family caregivers into the diagnostic and care planning process.

DPH also requests provisional budget bill language to authorize availability for encumbrance and expenditure of the requested resources until June 30, 2024.

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

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

1. Please provide a brief overview of this proposal.

2. What is the Administration's plan to address the other five recommendations of the Task Force on Alzheimer's Disease Prevention and Preparedness?

## Issue 13: California Parkinson's Disease Registry Program Extension (AB 2821)

**Budget Change Proposal and Budget Bill Language – Governor's Budget.** DPH requests General Fund expenditure authority of $408,591 in 2021-22. If approved, these resources would allow DPH to continue outreach and surveillance efforts as part of the California Parkinson's Disease Registry, which was extended by AB 2821 (Nazarian), Chapter 103, Statutes of 2020.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23** |
| 0001 – General Fund | $408,591 | $- |
| **Total Funding Request:** | **$408,591** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** The 2017 Budget Act included General Fund expenditure authority of $1.7 million to establish a three-year pilot program to collect data from health providers on the incidence of Parkinson's disease in California. SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, requires healthcare providers diagnosing or providing treatment to Parkinson's disease patients to report each case to DPH. The data is included in the Richard Paul Hemann California Parkinson's Disease Registry (CPDR), a statewide population-based registry utilized to measure the incidence and prevalence of Parkinson's disease.

According to DPH, as of May 31, 2020, CPDR received 272,243 records from over 500 reporting entities for 71,671 total Parkinson's patients in California. The data demonstrate the age-related increase in Parkinson's risk, with only 2,456 patients under the age of 55, just 3.4 percent of all patients. 16,450 patients, or 23 percent, were over age 85.

SB 97 required the registry to begin collecting patient records on July 1, 2018, and included a sunset date for the program of January 1, 2021. AB 2821 (Nazarian), Chapter 103, Statutes of 2020, extended the sunset date until January 1, 2022. However, no additional funding was provided for the additional year.

**Resource Request.** DPH requests General Fund expenditure authority of $408,591 in 2021-22 to continue outreach and surveillance efforts as part of the CPDR. DPH indicates these resources would support redirection of the following existing positions for one year:

- **One Research Scientist I** position would solicit input from stakeholders on data collection and processing to improve the data warehouse, develop an evaluation plan for CPDR data, and respond to and manage external data requests.
- **One Research Scientist II** position would oversee data collection for CPDR, ensure data quality, develop and implement the CPDR surveillance framework, and conduct analyses using epidemiologic and biostatistical techniques.

In addition to this resource request, DPH is requesting budget bill language that would authorize the Director of the department to enter into contracts, grants or other agreements to conduct the registry, as well as accept grants of public or private non-state funds to support operation of the registry. DPH reports it has received foundation funding in the past for this purpose.

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

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

1. Please provide a brief overview of this proposal.

## Issue 14: Women, Infants, and Children (WIC) Program Estimate

**WIC Program Estimate – Governor's Budget.** The November 2020 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($940.5 million federal funds and $196.8 million WIC manufacturer rebate funds) in 2020-21 and $1.2 billion ($1 billion federal funds and $174.4 million WIC manufacturer rebate funds) in 2021-22. The federal fund amounts include state operations costs of $59.2 million in 2020-21 and 2021-22.

| **Women, Infants, and Children (WIC) Funding Summary** | | | |
|---|---|---|---|
| | **2020-21** | **2021-22** | **BY to CY** |
| **Fund Source** | ***Revised*** | ***Proposed*** | ***Change*** |
| 0890 – Federal Trust Fund | | | |
| State Operations: | $59,210,000 | $59,210,000 | $- |
| Local Assistance: | $881,274,000 | $950,951,000 | $69,677,000 |
| 3023 – WIC Manufacturer Rebate Fund | | | |
| Local Assistance: | $196,784,000 | $174,414,000 | ($22,370,000) |
| **Total WIC Expenditures** | **$1,137,268,000** | **$1,184,575,000** | **$47,307,000** |

**Background.** The WIC program provides nutrition services and food assistance for pregnant, breastfeeding, and non-breastfeeding women, infants, and children up to their fifth birthday at or below 185 percent of the federal poverty level. WIC program services include nutrition education, breastfeeding support, assistance with finding health care and other community services, and vouchers for specific nutritious foods that are redeemable at WIC-authorized retail food outlets throughout the state. The WIC program receives federal funds from the United States Department of Agriculture (USDA) under the federal Child Nutrition Act of 1966. Specific uses of WIC Program funds are governed by federal laws and regulations, and DPH must report funds and expenditures monthly.

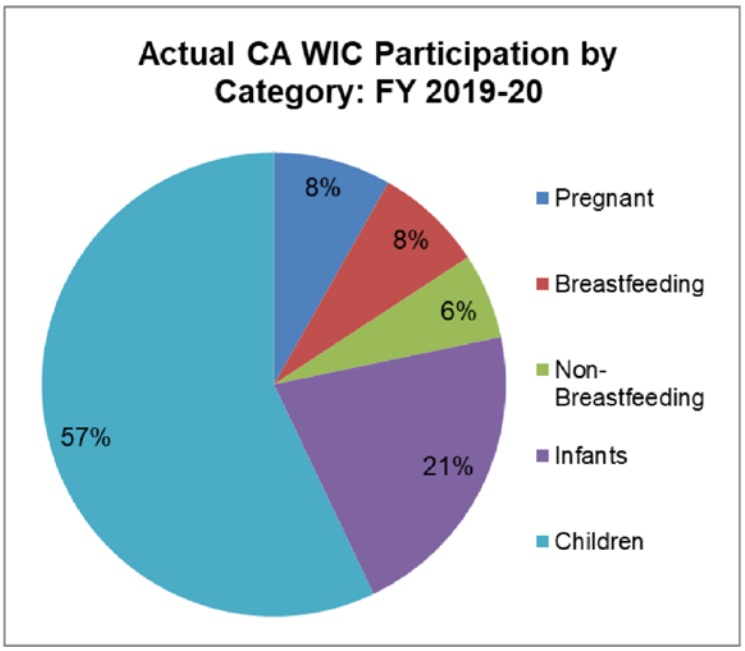
The WIC program's food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant formula. As infant formula is provided to WIC recipients, the program receives a rebate from the manufacturer which is used to fund additional food expenditures. In addition to food expenditures, the program receives federal funds from the Nutrition Services and Administration (NSA) grant, which are used to contract with local agencies for direct services provided to WIC families including intake, eligibility determination, benefit issuance, nutrition education, breastfeeding support, and referrals to health and social services. The NSA grant also funds state operations for administering the WIC program.

**WIC Participant Caseload.** Food expenditures are divided into five participant categories, each with special nutrition needs that influence food costs:

- **Pregnant women** are eligible for the WIC program at any point in their pregnancy, and receive supplemental foods high in protein, calcium, iron, vitamin A, and vitamin C to support optimal fetal development.

- **Breastfeeding women** are eligible for benefits up to their infant's first birthday, and receive an enhanced supplemental food package with foods high in protein, calcium, iron, vitamin A, and vitamin C to support caloric needs during breastfeeding.
- **Non-breastfeeding women** are eligible for benefits up to six months after the birth of their infants, and receive a supplemental food package to help in rebuilding nutrient stores, especially iron and calcium, and achieving a healthy weight after delivery.
- **Infants** are eligible until one year of age. The WIC Program promotes breastfeeding as the optimal infant feeding choice due to its many health, nutritional, economical, and emotional benefits to mother and baby. Infants may also receive supplemental foods that are rich in protein, calcium, iron, vitamin A, and vitamin C during this critical period of development.
- **Children** are eligible from age one up to age five, and receive supplemental foods rich in protein, calcium, iron, vitamin A, and vitamin C. These nutrients have been shown to be lacking in the diets of children who qualify for WIC benefits and are needed to meet nutritional needs during critical periods of development. The food package also provides foods lower in saturated fat to reduce the risk of childhood obesity.

According to the WIC program Estimate, WIC participation by category, as of 2019-20, was as follows:




**Caseload Estimates.** The budget assumes 951,755 average monthly WIC participants in 2020-21, an increase of 133,208 or 16.3 percent from the assumptions in the 2020 Budget Act. The budget assumes 979,983 average monthly WIC participants in 2021-22, an increase of 28,228 or three percent from the revised 2020-21 caseload estimate. According to DPH, the significant increase in participants is due to the economic impacts of the pandemic-induced recession. DPH also reports increases in participation may partially be attributable to the implementation of its electronic benefit transfer (EBT) delivery system and the auto-issuance of WIC benefits during the pandemic, both of which reduce barriers to participation in the program.

**Food Expenditures Estimate.** The budget includes $773.8 million in 2020-21 for WIC program food expenditures, an increase of $113.7 million or 17.2 percent, compared to the 2020 Budget Act. According to DPH, this increase in costs is due to increased participation related to the pandemic-induced recession, as well as potential impacts of implementation of EBT and auto-issuance of benefits. Of these expenditures, federally funded food expenditures are $577 million, an increase of $105.9 million from the 2020 Budget Act, and WIC Manufacturer Rebate Fund food costs are $196.8 million, an increase of $7.8 million from the 2020 Budget Act.

The budget includes $821.1 million in 2021-22 for WIC program food expenditures, an increase of $47.3 million or 6.1 percent from the revised 2020-21 food expenditures estimate. According to DPH, this increase in costs is also due to increased participation related to the pandemic-induced recession, as well as potential impacts of implementation of EBT and auto-issuance of benefits. Of these expenditures, federally funded food costs are $646.7 million, an increase of $69.7 million from the revised 2020-21 food expenditure estimate, and WIC Manufacturer Rebate Fund food costs are projected to be $174.4 million, a decrease of $22.4 million from the revised 2020-21 food expenditure estimate.

**Nutrition Services and Administration (NSA) Estimate.** The budget includes $304.2 million for other local assistance expenditures for the NSA budget in 2020-21 and 2021-22, which is unchanged from the level assumed in the 2020 Budget Act. The budget also includes $59.2 million for state operations expenditures in 2020-21 and 2021-22, also unchanged from the level assumed in the 2020 Budget Act.

**Implementation of Electronic Benefit Transfer (EBT) System.** The federal Healthy, Hunger-Free Kids Act of 2010 requires all state WIC agencies to implement an electronic benefit transfer (EBT) benefits delivery system by October 1, 2020. DPH completed statewide implementation of EBT on July 22, 2020. The California WIC Card replaces the previous paper checks required for accessing WIC benefits. In addition to the WIC Card, DPH implemented the California WIC App, which allows participants to view their food benefit balances, scan food bar codes to determine if the item is in their food benefit balance, view upcoming WIC appointments, and find WIC offices and grocery stores. These improvements have made it easier for participants to access benefits and improved the shopping experience for both participants and grocers. According to DPH, since June 2019, approximately 765,000 cards have been issued, 10 million transactions have been completed, and 100 percent of WIC authorized stores are capable of processing EBT transactions.

**WIC Program COVID-19 Response.** On March 18, 2020, Congress approved the Families First Coronavirus Response Act (FFCRA), which allocated $500 million to state WIC programs to support the increased need for food benefits and increased costs for providing services. These funds are available until September 30, 2021, but have not been distributed yet. Once these funds are distributed, they may offset expenditures currently supported by rebate funds.

In addition, FFCRA provided administrative flexibility to states to assist the delivery of food benefits to WIC participants. These flexibilities include waiver of in-person enrollment or re-enrollment requirements, auto-issuance of benefits, food substitution if grocer availability of certain foods is limited, and administrative and budgetary flexibilities for local WIC agencies. These flexibilities are scheduled to expire 30 days after the end of the national emergency declaration for the COVID-19 pandemic.

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

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

1. Please provide a brief overview of the caseload and expenditure changes for the WIC program.

2. Please provide an update on participation in the program as a percentage of eligible individuals in the state.

3. Please briefly describe the program flexibilities and other actions taken by WIC to respond to the COVID-19 pandemic. Does DPH believe any of these flexibilities would benefit the program after the pandemic state of emergency ends?

## Issue 15: Books for Low-Income Children

**Budget Change Proposal – Governor's Budget.** DPH requests General Fund expenditure authority of $5 million in 2021-22. If approved, these resources would allow DPH to support an early childhood literacy program for participants in the Women, Infants, and Children (WIC) program.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23** |
| 0001 – General Fund | $5,000,000 | $- |
| **Total Funding Request:** | **$5,000,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** Several pilot projects over the last thirty years have demonstrated the effectiveness of coupling WIC sites or pediatric offices with efforts to enhance the development of literacy and school readiness in young children. In pediatric settings, the Reach Out and Read model developed by Boston City Hospital promotes reading aloud as an integral part of routine preventive care, provides a picture book at each provider visit between age 6 months and 6 years, and provides waiting room volunteers to read aloud with children. These pilot projects have demonstrated clinically meaningful increases in preschool vocabulary, parent-reported literacy promoting attitudes and practices, identification of books as a favorite activity, reading aloud thought of as leading to school success, use of books at bedtime, and reading aloud three or more days per week.[1] Parent involvement with early literacy, such as those encouraged by the Reach Out and Read model, has demonstrated significant positive impacts on future reading outcomes.

In February 2020, First 5 California conducted an online survey among 58 county First 5 Commissions to inventory literacy interventions, including key details and program designs. All First 5 Commissions support one or more literacy programs, including many that provide books to children either as the primary goal or bundled along with another effort. These efforts include the Little by Little program in Los Angeles, which provides books to children at WIC offices; the Dolly Parton Imagination Library, which provides free, high-quality books by mail to children at any income level between birth and the beginning of school; and the Kit for New Parents, which provides parenting resources for parents of newborns, and includes a free picture book.

In particular, the Little by Little program in Los Angeles has demonstrated success in improving literacy through its efforts at local WIC agencies. Little by Little was funded by First 5 Los Angeles in 2003 at six WIC centers and includes three components: 1) a brief individual counseling session regarding child development for WIC staff members, 2) a brief handout with information about developmental milestones and appropriate ways to interact with a child to encourage optimal development, and 3) gift of a children's book or developmentally appropriate toy (e.g. black, white, and red chart for newborns or building blocks for 2.5 year old children). The intervention begins in the mother's third trimester of pregnancy and continues until the child's fifth birthday, or the end of WIC eligibility. According to a controlled study

[1] Needlman, R., Toker, K., Dreyer, Benard., Klass, P., Mednelsohn, A., "Effectiveness of a Primary Care Intervention to Support Reading Aloud: A Multicenter Evaluation". Ambulatory Pediatrics. Jul-Aug 2005.

published in the journal *Pediatrics*, the Little by Little intervention demonstrated statistically significant improvements in school readiness, particularly among Spanish-speaking WIC participants.[2]

**Resource Request.** DPH requests General Fund expenditure authority of $5 million in 2021-22 to support an early childhood literacy program for participants in the WIC program. With the requested resources, DPH would develop a competitive grant process available to all 84 local WIC agencies. Local WIC agencies would apply for funds in coordination with their county's First 5 Commission and other local stakeholders to identify a preferred reading program, strategize acceptable adaptations, develop a plan for implementation and oversight, and distribute books and guidance directly to WIC participants and their families. DPH would provide technical assistance and conduct oversight to ensure adherence to the intervention and program expectations.

In addition, DPH indicates it would need to temporarily redirect **two Health Program Specialist I** positions to prepare the request for application process for grant funding, manage the competitive award process, and provide technical assistance and oversight for the grant program.

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

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

1. Please provide a brief overview of this proposal.

[2] Whaley, S., Jiang L., Gomez, J., Jenks, E. "Literacy Promotion for Families Participating in the Women, Infants and Children Program". Pediatrics. Feb 2011.

## Issue 16: Genetic Disease Screening Program (GDSP) Estimate

**Genetic Disease Screening Program Estimate – Governor's Budget.** The November 2020 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $140.8 million ($32.9 million state operations and $107.9 million local assistance) in 2020-21, and $145.3 million ($33.3 million state operations and $111.9 million local assistance) in 2021-22.

| Genetic Disease Screening Program (GDSP) Funding Summary | | | |
|---|---|---|---|
| | **2020-21** | **2021-22** | **BY to CY** |
| **Fund Source** | ***Revised*** | ***Proposed*** | ***Change*** |
| 0203 – Genetic Disease Testing Fund | | | |
| State Operations: | $32,873,000 | $33,322,000 | $449,000 |
| Local Assistance: | $107,885,000 | $111,939,000 | $4,054,000 |
| **Total GDSP Expenditures** | **$140,758,000** | **$145,261,000** | **$4,503,000** |

**Background.** According to DPH, the Genetic Disease Screening Program (GDSP) performs the following tasks to support its mission:

- Screens newborns and pregnant women for genetic and congenital disorders in a cost-effective and clinically effective manner. The screening programs provide testing, follow-up, and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.
- Ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance.
- Fosters informed participation in its programs in an ethical manner through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.
- Provides ongoing critical review, testing, and evaluation of existing programs to ensure program objectives and goals are being met.
- Develops programs to adopt new methods and implement new services that further enhance the effectiveness and efficiency of current and future prevention programs.
- Promotes use of high-quality consumer education materials on genetic disorders, screening for birth defects and genetic services.

GDSP operates two primary screening programs: the Newborn Screening Program and the Prenatal Screening Program. Caseload and expenditures for these programs are reflected in the GDSP Estimate along with operational support costs for the programs.

**Newborn Screening (NBS) Program.** Newborn screening, recognized nationally as an essential preventive health measure, began in California in 1966 with the testing of infants for phenylketonuria (PKU). In 1980, the program was expanded to include galactosemia, primary congenital hypothyroidism, and included a more comprehensive follow-up system. In 1990, screening for sickle cell disease was added to the screening program, which allows for identification of related non-sickling hemoglobin disorders, including beta-thalassemia major, and Hb E/beta thalassemia. In 1999, the program implemented screening for hemoglobin H and hemoglobin H - Constant Spring disease. In 2005 the screening panel

was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

According to DPH, disorders screened for by the program have varying degrees of severity and, if identified early, many can be treated before they cause serious health problems. Between 1980 and 2017, 18,920,529 babies were screened resulting in early identification of the following disorders:

| Disorder | Cases |
|---|---|
| Phenylketonuria (PKU) | 1,264 |
| Primary Congenital Hypothyroidism | 7,857 |
| Galactosemia | 1,018 |
| Sickle Cell Disease and other clinically significant Hemoglobinopathies | 5,006 |
| Biotinidase Deficiency (BD) | 209 |
| Cystic Fibrosis (CF) | 636 |
| Congenital Adrenal Hyperplasia (CAH) | 376 |
| Metabolic Fatty Acid Oxidation Disorders | 741 |
| Metabolic Amino Acid Disorders (other than PKU) | 203 |
| Metabolic Organic Acid Disorders | 518 |
| Other Metabolic Disorders | 62 |
| Severe Combined Immunodeficiencies | 75 |
| X-Linked Adrenoleukodystrophy (ALD) and Other Peroxisomal Disorders | 50 |
| **TOTAL** | **18,015** |

The NBS program currently screens infants in California for more than 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be added to the NBS program screening panel within two years. The current fee for screening in the NBS program is currently $177.25.

NBS Caseload Estimate: The budget estimates NBS program caseload of 444,234 in 2020-21, a decrease of 6,110 or 1.4 percent, compared to the 2020 Budget Act. The budget estimates NBS program caseload of 445,840 in 2021-22, an increase of 1,606 or 0.4 percent, compared to the revised 2020-21 estimate. These estimates are based on state projections of the number of live births in California. DPH assumes 100 percent of children born in California will participate in the NBS program annually.

**Prenatal Screening (PNS) Program.** The Prenatal Screening (PNS) program provides prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant women in California to detect birth defects during pregnancy. The program offers three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect:

- Sequential Integrated Screening – This screen combines first and second blood test results with nuchal translucency (NT) ultrasound results, which measure the back of a fetus' neck. This measurement helps screen for Down syndrome (trisomy 21).

- Serum Integrated Screening – This screen combines a first trimester blood test screening result with a second trimester blood test screening result.
- Quad Marker Screening - One blood specimen drawn at 15 weeks - 20 weeks of pregnancy (second trimester test).

The PNS program provides pregnant women with a risk assessment for open neural tube defects (NTD), Down syndrome (trisomy 21), trisomy 18 and Smith-Lemli-Opitz Syndrome (SLOS) through one or two blood tests. The screening test indicates risk, but does not diagnose fetal birth defects.

For women with screening results indicating a high risk for a birth defect, the program provides free follow-up diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs). Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation in the screening testing and follow-up services is voluntary and the fee for testing through the PNS program is $221.60.

PNS Caseload Estimate: The budget estimates PNS program caseload of 485,230 in 2020-21, a decrease of 10,782 or 2.2 percent, compared to the 2020 Budget Act. The budget estimates PNS program caseload of 477,386 in 2021-22, a decrease of 7,844 or 1.6 percent, compared to the revised 2020-21 estimate. These estimates are based on state projections of the number of live births in California. DPH estimates approximately 71 percent of mothers of children born in California will have participated in the PNS program.

**General Fund Loan – Genetic Disease Testing Fund.** The 2020 Budget Act included provisional language to provide for a loan of up to $3 million from the Genetic Disease Testing Fund to the General Fund. This fund, which receives fee revenue from NBS and PNS screening activities, supports expenditures in GDSP. The provisional language requires the repayment of all or a portion of the loan if the Director of Finance determines that either of the following circumstances exist: (a) the fund or account from which the loan was made has a need for the moneys, or (b) there is no longer a need for the moneys in the fund or account that received the loan.

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

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

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.

2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

## Issue 17: Improving the California Prenatal Screening Program

**Budget Change Proposal – Governor's Budget.** DPH requests three positions and expenditure authority from the Genetic Disease Testing Fund of $4.3 million ($449,000 for state operations and $3.9 million for local assistance) in 2021-22, and $20.6 million ($449,000 for state operations and $20.2 million for local assistance) annually thereafter. If approved, these positions and resources would allow DPH to meet current standards of care and improve the screening process for the California Prenatal Screening Program.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2021-22** | **2022-23*** |
| 0203 – Genetic Disease Testing Fund | $4,349,000 | $20,649,000 |
| **Total Funding Request:** | **$4,349,000** | **$20,649,000** |
| **Total Requested Positions:** | **3.0** | **3.0** |

* Positions and resources ongoing after 2022-23.

**Background.** The California Prenatal Screening (PNS) Program provides prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant women in California to detect birth defects during pregnancy. The program offers three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect:

- Sequential Integrated Screening – This screen combines first and second blood test results with nuchal translucency (NT) ultrasound results, which measure the back of a fetus' neck. This measurement helps screen for Down syndrome (trisomy 21).
- Serum Integrated Screening – This screen combines a first trimester blood test screening result with a second trimester blood test screening result.
- Quad Marker Screening - One blood specimen drawn at 15 weeks - 20 weeks of pregnancy (second trimester test).

The PNS program provides pregnant women with a risk assessment for open neural tube defects (NTD), Down syndrome (trisomy 21), trisomy 18 and Smith-Lemli-Opitz Syndrome (SLOS) through one or two blood tests. The screening test indicates risk, but does not diagnose fetal birth defects.

For women with screening results indicating a high risk for a birth defect, the program provides free follow-up diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs). Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation in the screening testing and follow-up services is voluntary and the fee for testing through the PNS program is $221.60.

**New Standard of Care for Prenatal Screening – Cell-Free DNA.** A new screening methodology, known as cell-free DNA (cfDNA), has demonstrated improved performance for prenatal screening. cfDNA screens for fetal chromosomal abnormalities through the extraction of fetal DNA that is contained in a maternal blood sample. Recent guidance from the American College of Obstetricians and Gynecologists (ACOG) indicates cfDNA is the most sensitive and specific screening test for detecting common fetal aneuploidies. Fetal aneuploidies are conditions in which a fetus has one or more extra or missing chromosomes, such as trisomy 21 or trisomy 18. The American College of Medical Genetics and

Genomics (ACMGG) indicates that cfDNA has been rapidly integrated into prenatal care and new evidence suggests it can replace conventional screening for chromosomal abnormalities.

Current screening for chromosomal abnormalities in the PNS program relies on analysis of maternal blood samples for levels of two to four pregnancy hormones. The results are used to calculate the risk for two chromosomal abnormalities and neural tube defects. This screening is only available during certain critical periods of pregnancy.

Compared to the current PNS screening methodology, cfDNA has demonstrated superior performance and accuracy, may be performed at any time during a pregnancy, and provides more flexibility in the timing of testing for pregnant women. In addition, because cfDNA screening is diagnostic, rather than a risk-assessment, DPH expects adoption of cfDNA to reduce costs for public and private health care payers, as well as consumers with out-of-pocket costs, due to reduced need for follow-up screenings for chromosomal abnormalities, such as nuchal translucency examinations or amniocentesis. DPH estimates Medi-Cal would experience General Fund savings in the hundreds of thousands of dollars annually compared to current costs, beginning in 2022-23.

**Staffing and Resource Request.** DPH requests three positions and expenditure authority from the Genetic Disease Testing Fund of $4.3 million ($449,000 for state operations and $3.9 million for local assistance) in 2021-22, and $20.6 million ($449,000 for state operations and $20.2 million for local assistance) annually thereafter to implement cfDNA screening in the California PNS program. According to DPH, cfDNA screening would be offered to all pregnant individuals in California from 10 through 20 weeks of gestation and neural tube defect screening would be offered to all pregnant individuals between 15 and 20 weeks of gestation. DPH indicates it would require **two Health Program Specialist I** positions to support redesign of the current program and for ongoing program maintenance, and **one Health Education Consultant II** position to lead a new and ongoing statewide communication and education effort to reach all prenatal care providers and pregnant individuals. The request includes expenditure authority from the Genetic Disease Testing Fund of $449,000 annually to support these positions.

In addition, the request includes expenditure authority from the Genetic Disease Testing Fund of $3.9 million in the first year, to cover launch preparation costs for the new screening program, and $20.2 million in 2022-23 and annually thereafter to support the new screening program. According to DPH, this estimated local assistance cost assumes annual expected savings of approximately $6 million due to decreases in referrals for follow-up services due to the diagnostic capacity of cfDNA. DPH indicates it intends to contract with private laboratories to conduct the new screening.

In addition, DPH indicates the PNS fee would remain $221.60 for cfDNA, which is its current level. However, DPH would assess a separate fee of $75 for neural tube defect screening for pregnant individuals between 15 and 20 weeks of gestation, which would be established through the program's existing rulemaking process.

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

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

1. Please provide a brief overview of this proposal.

2. Why is DPH contracting with a private laboratory for this screening, rather than utilizing its existing laboratory resources?