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, March 5th, 2021
9:00 a.m.
State Capitol - Room 3191

Consultant: Scott Ogus

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PUBLIC COMMENT

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling (916) 651-1505. Requests should be made one week in advance whenever possible.

0000 VARIOUS DEPARTMENTS

Issue 1: Proposals for Investment

Proposals for Investment. The subcommittee has received a number of proposals for investment that augment or modify the Governor's January Budget. Brief descriptions of these proposals by state department are presented in the table below. More extensive details of these proposals may be found on the pages following the table.

PROPOSALS FOR INVESTMENT	
CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY	
Project ECHO Children's Mental Health Grant Program	
Organizational Sponsor(s)	**Funding or Language Requested**
California Children's Hospital Association	$1.8 million General Fund (GF) in 2021-22
Brief Description:	
The California Children's Hospital Association (CCHA) requests General Fund expenditure authority of $1.8 million in 2021-22 to support the Project ECHO Pediatric Mental Health Grant Program, a competitive grant program to bridge the gap between children's mental health specialists and community providers and educators.	
CHHSA Working Group on Maximizing Federal Funding for Home Visiting	
Organizational Sponsor(s)	**Funding or Language Requested**
Nurse Family Partnership	$43,000 GF in 2021-22, $75,000 in 2022-23
Brief Description:	
The Nurse Family Partnership (NFP) requests General Fund expenditure authority of $43,000 in 2021-22 and $75,000 in 2022-23 to support a workgroup in the California Health and Human Services Agency (CHHSA) to assess the feasibility for California's potential to streamline Medi-Cal funding to counties for home visiting services.	
DEPARTMENT OF HEALTH CARE SERVICES	
Medi-Cal for All Income-Eligible Seniors Regardless of Immigration Status.	
Organizational Sponsor(s)	**Funding or Language Requested**
CA Immigrant Policy Center and Health Access California	$161 million ($128.4 million GF and $32.6 million federal funds) in 2021-22 $350 million ($320 million GF and $30 million federal funds) annually
Brief Description:	

The California Immigrant Policy Center (CIPC) and Health Access California request expenditure authority of $161 million ($128.4 million General Fund and $32.6 million federal funds) in 2022-23 and $350 million ($320 million General Fund and $30 million federal funds) annually thereafter to support expansion of Medi-Cal to all income-eligible seniors regardless of immigration status beginning July 1, 2022.

Eliminate the Medi-Cal Assets Test

Organizational Sponsor(s)	Funding or Language Requested
Western Center on Law and Poverty (WCLP) and Justice in Aging	$110 million ($52.9 million GF and $57.2 million federal funds) in 2021-22 $219.6 million ($105.4 million GF and $114.1 million federal funds) annually

Brief Description:

Western Center on Law and Poverty (WCLP) and Justice in Aging request expenditure authority of $110.1 million ($52.9 million General Fund and $57.2 million federal funds) in 2021-22 and $219.6 million ($105.4 million General Fund and $114.1 million federal funds) annually thereafter to eliminate the assets test for Medi-Cal eligibility determinations for seniors and persons with disabilities, effective January 1, 2022.

Medi-Cal LTSS Data Transparency

Organizational Sponsor(s)	Funding or Language Requested
California Collaborative for Long-Term Services and Supports (CCLTSS)	$250,000 GF in 2021-22

Brief Description:

The California Collaborative for Long-Term Services and Supports (CCLTSS) requests General Fund expenditure authority of $250,000 in 2021-22 to incorporate certain data elements regarding long-term services and supports (LTSS) into its managed care plan contracts.

Quality Incentive Pool (QIP) Transition Bridge Loan for District and Municipal Hospitals

Organizational Sponsor(s)	Funding or Language Requested
District Hospital Leadership Forum	$40 million GF in 2021-22 and 2022-23

Brief Description:

The District Hospital Leadership Forum (DHLF) requests General Fund expenditure authority of $40 million in 2021-22 and 2022-23 to make two bridge loans to the 34 district and municipal hospitals to aid in the transition from the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, a quality improvement program under the state's expiring 1115 waiver, to the Quality Incentive Pool (QIP) program.

Caregiver Resource Centers Infrastructure Funding Extension

Organizational Sponsor(s)	Funding or Language Requested

Association of California Caregiver Resource Centers	$12 million GF in 2021-22, 2022-23, and 2023-24
Brief Description:	
The Association of California Caregiver Resource Centers (CRC) requests General Fund expenditure authority of $12 million annually in 2021-22, 2022-23, and 2023-24 to continue infrastructure support and to build an Equity and Inclusion Core within the CRC system.	
Drug Medi-Cal Flexibility to Prevent Overdose and Support Public Health	
Organizational Sponsor(s)	**Funding or Language Requested**
California Opioid Maintenance Providers (COMP)	$9.2 million ($2.8 million GF and $6.4 million federal funds) annually Trailer bill language
Brief Description:	
The California Opioid Maintenance Providers (COMP) request expenditure authority of $9.2 million ($2.8 million General Fund and $6.4 million federal funds) annually and trailer bill language to grant authority to DHCS to evaluate and implement changes to the Narcotic Treatment Program (NTP), including allowing new drug and disease testing.	
Field Testing of Translated Medi-Cal Materials and Equity Dashboard	
Organizational Sponsor(s)	**Funding or Language Requested**
California Pan-Ethnic Health Network (CPEHN) and WCLP	$1 million GF in 2021-22 $30,000 GF annually
Brief Description:	
The California Pan-Ethnic Health Network (CPEHN) and the Western Center on Law and Poverty (WCLP) request General Fund expenditure authority of $1 million in 2021-22 and $30,000 annually thereafter to field test translations of Medi-Cal materials and collect additional demographic data as part of the Equity Dashboard.	
COVID-19 Reimbursement Rate Extension for Pediatric Subacute Facilities	
Organizational Sponsor(s)	**Funding or Language Requested**
Totally Kids Specialty Healthcare - Sun Valley	$1 million GF in 2021-22
Brief Description:	
Totally Kids Specialty Healthcare – Sun Valley requests General Fund expenditure authority of $1 million to extend the ten percent reimbursement rate increase implemented during the COVID-19 pandemic for free-standing pediatric subacute facilities through the 2021-22 fiscal year.	
COVID-19 Reimbursement Rate Extension for ICF-DDs	
Organizational Sponsor(s)	**Funding or Language Requested**

Developmental Services Network (DSN)	$18.6 million ($9.2 million GF and $9.3 million federal funds) in 2021-22
Brief Description:	
The Developmental Services Network (DSN) requests expenditure authority of $18.6 million ($9.3 million General Fund and $9.3 million federal funds) to extend for six months the ten percent reimbursement rate increase implemented during the COVID-19 pandemic for intermediate care facilities for individuals with developmental disabilities (ICF-DDs).	
CalAIM Workgroup on ICF-DD Transition to Managed Care	
Organizational Sponsor(s)	**Funding or Language Requested**
Developmental Services Network (DSN)	Budget bill language
Brief Description:	
DSN requests budget bill language to require DHCS and DDS to convene a workgroup to address governance, procedures and processes pertaining to the transition of ICF-DDs from the fee-for-service to the Medi-Cal managed care delivery system under the California Advancing and Innovating in Medi-Cal (CalAIM) initiative.	
Expand Access to STD Services Through Family PACT	
Organizational Sponsor(s)	**Funding or Language Requested**
End the Epidemics Coalition	$7 million GF annually
Brief Description:	
The End the Epidemics coalition requests annual General Fund expenditure authority of $7 million to expand access to sexually transmitted disease (STD) services covered by the Family Planning, Access, Care, and Treatment (Family PACT) program.	
Start-Up Funds for Medi-Cal Peer Support Specialist Certification	
Organizational Sponsor(s)	**Funding or Language Requested**
California Association of Mental Health Peer Run Organizations County Behavioral Health Directors Association (CBHDA) County of Los Angeles Steinberg Institute	$9.4 million ($4.7 million GF and $4.7 million federal funds) in 2021-22, available for encumbrance and expenditure until June 30, 2023.
Brief Description:	
The California Association of Mental Health Peer Run Organizations, the County Behavioral Health Directors Association, the County of Los Angeles, and the Steinberg Institute request expenditure authority of $9.4 million ($4.7 million General Fund and $4.7 million federal funds) to support initial implementation of the Peer Support Specialist (PSS) Certification Program, pursuant to SB 803 (Beall), Chapter 150, Statutes of 2020.	
PACE Awareness in CalAIM	

Organizational Sponsor(s)	Funding or Language Requested
CalPACE	Trailer bill language
Brief Description:	
CalPACE requests trailer bill language to ensure individuals potentially eligible for a Program for All-Inclusive Care for the Elderly (PACE) are aware that PACE is an option and have an opportunity to be assessed and enroll before being enrolled in a managed care plan under the managed care transition included in the California Advancing and Innovating in Medi-Cal (CalAIM) initiative.	
PACE Flexibilities	
Organizational Sponsor(s)	**Funding or Language Requested**
CalPACE	Trailer bill language
Brief Description:	
CalPACE requests trailer bill language to make permanent the regulatory flexibilities provided to PACE organizations during the COVID-19 public health emergency that have allowed PACE organizations to safely care for and provide services to the frail seniors that PACE organizations serve.	
Medi-Cal Reimbursement for Personal Protective Equipment	
Organizational Sponsor(s)	**Funding or Language Requested**
California Dental Association (CDA)	$80 million ($40 million GF and $40 million federal funds) in 2021-22
Brief Description:	
The California Dental Association (CDA) requests expenditure authority of $80 million ($40 million General Fund and $40 million federal funds) to provide reimbursement for Medi-Cal dental providers for pandemic-related costs of new, mandatory, medically necessary infection control.	
Extension of Behavioral Health Pilot Project	
Organizational Sponsor(s)	**Funding or Language Requested**
California Hospital Association	$40 million GF, available for encumbrance or expenditure until June 30, 2024
Brief Description:	
The California Hospital Association (CHA) requests General Fund expenditure authority of $40 million, available for encumbrance or expenditure until June 30, 2024, to continue the Behavioral Health Pilot Project (BHPP), which provides funding for behavioral health counselors in emergency departments.	
Increased Medi-Cal Reimbursement for Orthotic and Prosthetic Providers	

Organizational Sponsor(s)	Funding or Language Requested
California Orthotic and Prosthetic Association (COPA)	$9 million ($4.5 million GF and $4.5 million federal funds) annually

Brief Description:

The California Orthotic and Prosthetic Association (COPA) requests expenditure authority of $9 million ($4.5 million General Fund and $4.5 million federal funds) to increase Medi-Cal reimbursement for providers of orthotics and prosthetics.

Ensure Healthcare Access for Homeless Adults in California's Safety Net Hospitals

Organizational Sponsor(s)	Funding or Language Requested
Private Essential Access Community Hospitals (PEACH)	$120 million ($50 million GF and $70 million federal funds) annually

Brief Description:

Private Essential Access Community Hospitals (PEACH) requests expenditure authority of $120 million ($50 million General Fund and $70 million federal funds) to implement a socioeconomic status (SES) adjustment factor for reimbursement of claims paid to safety net hospitals that provide care for Medi-Cal beneficiaries.

Medi-Cal Coverage for 12 Months Postpartum and Children Zero to Five

Organizational Sponsor(s)	Funding or Language Requested
American College of Obstetricians and Gynecologists (ACOG) First 5 Center for Children's Policy March of Dimes The Children's Partnership (TCP) Maternal Child Health Access (MCHA) First 5 Association of California	$100 million ($55 million GF and $55 million federal funds) in 2022-23 $220 million ($110 million GF and $110 million federal funds) annually

Brief Description:

A coalition of organizations including the American College of Obstetricians and Gynecologists (ACOG), the First 5 Center for Children's Policy, the March of Dimes, the Children's Partnership (TCP), Maternal Child Health Access (MCHA), and the First 5 Association of California, request expenditure authority of $110 million ($55 million General Fund and $55 million federal funds) in 2022-23 and $220 million ($110 million General Fund and $110 million federal funds) annually thereafter to extend pregnancy-only Medi-Cal coverage from 60 days postpartum to 12 months, and to extend continuous coverage for all children up to age five.

Telephonic Attestation for Medi-Cal

Organizational Sponsor(s)	Funding or Language Requested
WCLP	Trailer bill language

Brief Description:

The Western Center on Law and Poverty (WCLP) requests trailer bill language to permit federally allowable flexibility in the acceptance of telephonic or electronic self-attestation of eligibility requirements for Medi-Cal.

Medically Tailored Meals Pilot Extension

Organizational Sponsor(s)	Funding or Language Requested
California Food is Medicine Coalition	$9.3 million GF annually

Brief Description:

The California Food is Medicine Coalition requests General Fund expenditure authority of $9.3 million annually to continue support for a pilot project that provides medically tailored meals to Medi-Cal beneficiaries.

Clinical Laboratory Reimbursement Methodology

Organizational Sponsor(s)	Funding or Language Requested
California Clinical Laboratory Association (CCLA)	$40 million GF in 2021-22

Brief Description:

The California Clinical Laboratory Association (CCLA) requests trailer bill language and General Fund expenditure authority of $40 million in 2021-22 to remove the cap on Medi-Cal reimbursement for clinical laboratories, forgive retroactive recoupment of reimbursement reductions, and delay other reductions until 2022.

Eliminate Ten Percent Rate Reduction for Complex Rehabilitation Technology

Organizational Sponsor(s)	Funding or Language Requested
National Coalition for Assistive and Rehab Technology (NCART)	$2 million GF annually

Brief Description:

The National Coalition for Assistive and Rehab Technology (NCART) requests General Fund expenditure authority of $2 million annually to eliminate the ten percent Medi-Cal reimbursement rate reduction enacted by AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, for complex rehabilitation technology (CRT).

Restore Crossover Payments for Behavioral Health Services for Dual Eligibles in Nursing Homes

Organizational Sponsor(s)	Funding or Language Requested
CHE Behavioral Health Services	$3 million GF annually Trailer bill language

Brief Description:

CHE Behavioral Health Services requests General Fund expenditure authority of $3 million annually and trailer bill language to improve access to behavioral health services for individuals dually eligible for both Medicare and Medi-Cal (dual-eligibles) and who reside in skilled nursing facilities.

Alameda Wellness Campus	
Organizational Sponsor(s)	**Funding or Language Requested**
Alameda Point Collaborative Lifelong Medical Care	$15 million GF in 2021-22
Brief Description:	
The Alameda Point Collaborative and Lifelong Medical Care request General Fund expenditure authority of $15 million in 2021-22 to support construction of a medical respite and health clinic building at the Alameda Wellness Campus to serve unhoused adults and seniors with complex health conditions.	
Housing Support Services Benefit for People Experiencing Homelessness	
Organizational Sponsor(s)	**Funding or Language Requested**
Corporation for Supportive Housing WCLP	$100 million ($24 million GF and $76 million federal funds) in 2021-22 $150 million ($36 million GF and $114 million federal funds) in 2022-23 $250 million ($60 million GF and $190 million federal funds) annually
Brief Description:	
The Corporation for Supportive Housing and the Western Center on Law and Poverty (WCLP) request expenditure authority of $100 million ($24 million General fund and $76 million federal funds) in 2021-22, $150 million ($36 million General Fund and $114 million federal funds) in 2022-23, and $250 million ($60 million General Fund and $190 million federal funds) annually thereafter to create a Medi-Cal benefit to fund housing support services for beneficiaries experiencing homelessness and people who were homeless and are now residing in supportive housing.	
Restoring Optional Medi-Cal Benefits for Chiropractic	
Organizational Sponsor(s)	**Funding or Language Requested**
California Chiropractic Association	$1.7 million GF annually
Brief Description:	
The California Chiropractic Association requests General Fund expenditure authority of $1.7 million annually to restore chiropractic benefits in the Medi-Cal program.	

DEPARTMENT OF PUBLIC HEALTH	
State Investment in Core Public Health Infrastructure and Workforce	
Organizational Sponsor(s)	**Funding or Language Requested**
SEIU California County Health Executives Association of California (CHEAC) California State Association of Counties (CSAC) Health Officers Association of California (HOAC) Rural County Representatives of California (RCRC) Urban Counties of California (UCC)	$200 million GF annually
Brief Description:	
A coalition of counties, county health organizations, and county public health workers, requests annual General Fund expenditure authority of $200 million to support investments in stabilization and addressing key needs and issues for local health departments.	
Public Health Infrastructure and Workforce Assessment	
Organizational Sponsor(s)	**Funding or Language Requested**
CHEAC HOAC SEIU California	$3.2 million GF in 2021-22 $150,000 GF annually
Brief Description:	
The County Health Executives Association of California (CHEAC), the Health Officers Association of California (HOAC), and SEIU California request General Fund expenditure authority of $3.2 million in 2021-22 and $150,000 annually thereafter to conduct an evaluation of local health department infrastructure and make recommendations for staffing, workforce needs, and resources, in order to accurately and adequately fund local public health.	
California Health Equity Fund	
Organizational Sponsor(s)	**Funding or Language Requested**
California Black Health Network Latino Coalition for a Healthy California Public Health Institute Roots of Change	$180 million GF in 2021-22, available for encumbrance or expenditure until June 30, 2024
Brief Description:	

A coalition of organizations including the California Black Health Network, the Latino Coalition for a Healthy California, the Public Health Institute, and Roots of Change request General Fund expenditure authority of $180 million, available for encumbrance and expenditure until June 30, 2024, to implement a California Health Equity Fund, which would provide increased funding for local health departments, community-based organizations, clinics, and tribes for community-based initiatives and programs that result in decreased risk for preventable illnesses and adverse childhood experiences (ACEs) exacerbated by COVID-19.

Sustaining the California Reducing Disparities Project

Organizational Sponsor(s)	Funding or Language Requested
Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) National Association of Social Workers-California Chapter (NASW-CA)	$50 million GF in 2021-22, available for encumbrance or expenditure until June 30, 2025

Brief Description:

The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) and the National Association of Social Workers-California Chapter (NASW-CA) requests General Fund expenditure authority of $50 million in 2021-22, available for encumbrance or expenditure until June 30, 2025, to extend and expand the California Reducing Disparities Project (CRDP).

Phase Out of Skilled Nursing Facility Staffing Waivers

Organizational Sponsor(s)	Funding or Language Requested
SEIU California	Trailer bill language

Brief Description:

SEIU California requests trailer bill language to phase out workforce shortage and patient acuity waivers for statutory staffing requirements in skilled nursing facilities.

All Children Thrive Expansion

Organizational Sponsor(s)	Funding or Language Requested
Public Health Advocates	$25 million GF in 2021-22

Brief Description:

Public Health Advocates requests General Fund expenditure authority of $25 million in 2021-22 to expand the All Children Thrive pilot project to 100 new cities over five years.

Amyotrophic Lateral Sclerosis (ALS) Wraparound Model of Care Funding Extension

Organizational Sponsor(s)	Funding or Language Requested
Golden West Chapter of the ALS Association	$3 million GF annually

Brief Description:

The Golden West Chapter of the ALS Association requests General Fund expenditure authority of $3 million annually to continue to allow the current ALS wraparound treatment model to improve access to an evidence-based model of care and keep pace with the growth in the number of people diagnosed with ALS, or Lou Gehrig's Disease.

PrEP-AP Navigation and Retention Services

Organizational Sponsor(s)	Funding or Language Requested
End the Epidemics Coalition	Annual funding from ADAP Rebate Fund

Brief Description:

The End the Epidemics coalition requests expenditure authority from the AIDS Drug Assistance Program (ADAP) Rebate Fund to support pre-exposure prophylaxis (PrEP) navigation and retention services.

Hepatitis C Test Kits and Associated Costs

Organizational Sponsor(s)	Funding or Language Requested
End the Epidemics Coalition	$1 million GF in 2021-22, available for encumbrance or expenditure until June 30, 2026

Brief Description:

The End the Epidemics coalition requests General Fund expenditure authority of $1 million, available over five years, to support the purchase of hepatitis C virus (HCV) test kits, associated materials and supplies, training for test counselors, and the staffing to support a test kit program.

STD Prevention and Control Activities

Organizational Sponsor(s)	Funding or Language Requested
End the Epidemics Coalition	$3 million GF annually

Brief Description:

The End the Epidemics Coalition requests General Fund expenditure authority of $3 million annually to increase funding for sexually transmitted disease (STD) prevention and control activities.

Syringe Exchange Supply Clearinghouse Funding

Organizational Sponsor(s)	Funding or Language Requested
End the Epidemics Coalition	$3 million GF annually

Brief Description:

The End the Epidemics Coalition Requests General Fund expenditure authority of $3 million annually to increase funding for the DPH office of AIDS Syringe Exchange Supply Clearinghouse.

Medical Legal Partnerships for COVID-19 Recovery	
Organizational Sponsor(s)	**Funding or Language Requested**
The Children's Partnership	$30 million GF in 2021-22
Brief Description:	
The Children's Partnership requests General Fund expenditure authority of $30 million in 2021-22 to support COVID-19 recovery efforts for communities deeply impacted by the pandemic through a grant program that encourages partnerships between community programs and legal service organizations that support families and children.	
Transgender Wellness and Equity Funding	
Organizational Sponsor(s)	**Funding or Language Requested**
Trans Latin@ Coalition	$15 million GF annually
Brief Description:	
The Trans Latin@ Coalition requests General Fund expenditure authority of $15 million annually to support organizations providing health care services to transgender, gender non-conforming, or intersex (TGI) individuals.	
Women Infants and Children (WIC) Program Public Contracting Code Exemption	
Organizational Sponsor(s)	**Funding or Language Requested**
California WIC Association	Trailer bill language
Brief Description:	
The California WIC Association requests trailer bill language to provide flexibilities for the 84 WIC local agency contracts with DPH through an exemption in the Public Contracting Code.	
Extend Repeal Date for California Parkinson's Disease Registry	
Organizational Sponsor(s)	**Funding or Language Requested**
Michael J. Fox Foundation	Trailer bill language
Brief Description:	
The Michael J. Fox Foundation requests trailer bill language to extend or repeal the sunset date for the California Parkinson's Disease Registry.	
DEPARTMENT OF STATE HOSPITALS	
Stop DSH Patient Billing	
Organizational Sponsor(s)	**Funding or Language Requested**
WCLP	Trailer bill language
Brief Description:	

The Western Center on Law and Poverty (WCLP) requests trailer bill language to prohibit the Department of State Hospitals from billing patients and their families for the cost of care during placement.
MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
Mental Health Student Services Act Augmentation

Organizational Sponsor(s)	**Funding or Language Requested**
Children Now	$80.5 million GF in 2021-22

Brief Description:

Children Now requests General Fund expenditure authority of $80.5 million in 2021-22 to provide additional grants for partnerships between schools and county mental health programs to provide mental health services to students.

COVERED CALIFORNIA

Covered California State Subsidy Extension

Organizational Sponsor(s)	**Funding or Language Requested**
Health Access California	$400 to $500 million GF annually for three years

Brief Description:

Health Access California requests General Fund expenditure authority of $400 to $500 million annually for three years to support extension of the state subsidy program to improve health insurance affordability in the Covered California health benefits exchange.

State Subsidies to Provide Zero Premiums for Covered California Plans

Organizational Sponsor(s)	**Funding or Language Requested**
Health Access California	$15 to $19 million GF annually Trailer bill language

Brief Description:

Health Access California requests annual General Fund expenditure authority of $15 to $19 million and trailer bill language to allow state-level premium subsidies to cover the $1 per member per month premiums for state-only coverage, for all Covered California marketplace enrollees.

DETAILED DESCRIPTIONS OF PROPOSALS:

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Project ECHO Children's Mental Health Grant Program. The California Children's Hospital Association (CCHA) requests General Fund expenditure authority of $1.8 million in 2021-22 to support the Project ECHO Pediatric Mental Health Grant Program, a competitive grant program to bridge the gap between children's mental health specialists and community providers and educators. According to CCHA, COVID-19 has exacerbated the state's existing mental health crisis, and children and adolescents have been particularly affected due to school closures, lack of access to their peers, and increased stress among family members at home. Those impacts are expected to persist long after the worst of the pandemic is over. Even before the pandemic, as many as 1.8 million California youth were living with a mental health diagnosis, and the vast majority of them were not receiving treatment until their issues reached crisis levels, if at all. Left untreated, mental health needs that manifest in childhood and adolescence can lead to lifelong challenges, increased mortality and morbidity, and long-term costs for individuals, their families, and their communities. In other words, mental illness is a disease of youth, with profound long-term implications for individuals and our society.

In order to increase the capacity of the state's mental health system quickly to try and address the growing needs of children and adolescents, the state must get more individuals involved in prevention and early interventions, to stave off the development of more severe mental health issues, which are harder to treat and would far exceed the current capacity of the state's specialty mental health system. School-based professionals and primary care providers are well-positioned to implement widespread, early interventions and mental health supports for children and adolescents; however, many do not have the training or expertise they need to address these mental health needs that youth will experience in the coming months and years.

Project ECHO connects health care and mental health specialists with general practitioners virtually to bridge health workforce gaps in rural communities and anywhere access is limited. This program brings best-practice health and mental health care to patients and students who can't get it where they live, using ongoing teleECHO clinics to equip practitioners with the knowledge they need to provide specialty care in their communities. Project ECHO is a proven, nationally-recognized model that moves knowledge, instead of people - providing practitioners in underserved areas with the expertise they need to treat patients with complex health problems and mental health issues.

CHHSA Working Group on Maximizing Federal Funding for Home Visiting. The Nurse Family Partnership (NFP) requests General Fund expenditure authority of $43,000 in 2021-22 and $75,000 in 2022-23 to support a workgroup in the California Health and Human Services Agency (CHHSA) to assess the feasibility for California's potential to streamline Medi-Cal funding to counties for home visiting services. According to NFP, maternal, infant, and early childhood home visiting is a service provided by counties, using different curricula and models, directly to families experiencing risk factors that can contribute to adverse experiences and health outcomes. Within the scope of services offered through different home visiting models, some are reimbursable through Medi-Cal, and the vast majority of families using home visiting services are enrolled in Medi-Cal.

States have authority to braid Medicaid funding with complementary federal funding streams authorized to finance home visiting services, including MIECHV, TANF, Title IV-E, maximizing those funds to help states extend home visiting to as many families as possible. Since Medicaid is typically the payer of last resort, clarity and uniformity about what services and activities delivered through home visiting are covered by Medicaid, and how to best integrate managed care-enrolled beneficiaries, will help counties maximize available funding.

As such, counties' ability to access uniform directions to consistently, equitably draw down Medi-Cal, including contracting with managed care plans to receive reimbursement for covered services offered in the home by home visitors, has been hard to achieve. CHHSA, which interacts with all state departments that administer home visiting, can provide some focus on assessing the feasibility for California's potential to streamline Medi-Cal funding to counties for these purposes.

DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal for All Income-Eligible Seniors Regardless of Immigration Status. The California Immigrant Policy Center (CIPC) and Health Access California request expenditure authority of $161 million ($128.4 million General Fund and $32.6 million federal funds) in 2022-23 and $350 million ($320 million General Fund and $30 million federal funds) annually thereafter to support expansion of Medi-Cal to all income-eligible seniors regardless of immigration status beginning July 1, 2022. According to CIPC and Health Access California, undocumented seniors continue to suffer and die without access to health care. These Californians, many who have been here for decades having raised families, paid taxes, and contributed to our society and economy, are excluded from basic health coverage in the years they are most likely to need it.

This coverage is even more urgent in a pandemic that has preyed upon this population, and that will have health after-effects long after the public health emergency. Undocumented immigrant seniors are one of the most vulnerable populations in this pandemic, disproportionately impacted by the pandemic due to age, income, language, and immigration status. Those seniors that are working are overrepresented in jobs deemed "essential" during the pandemic but are excluded from comprehensive health care coverage. Those who survive and benefit from the state's COVID-19 Uninsured Group coverage in Medi-Cal, despite the deterrent of questions on immigration status, will not be covered for the ongoing care and exacerbated comorbidities going forward. Furthermore, undocumented seniors who have gone decades without so much as a check-up may have myriad chronic conditions and need preventive care and treatment for all of their health issues, not just COVID-19.

In the same way Medi-Cal was extended to undocumented children in 2016 and young adults in 2020, this budget request would require DHCS to eliminate the immigration status eligibility requirement for Medi-Cal for all income-qualifying seniors ages 65 and older, making them eligible for full-scope, instead of restricted-scope, Medi-Cal. Undocumented seniors would be able to enroll in comprehensive health care coverage through Medi-Cal, which would allow them to see a health care provider, get needed prescription medications, and address all of their health care needs. This expansion would result in a reduction in California's uninsured rate, both generally and specifically among undocumented seniors; reduction in years of life lost due to illness among undocumented adults; and a reduction in economic hardship indicators among immigrant families, including debt, unpaid or delayed rent, utilities, and other bills, or evictions.

Eliminate the Medi-Cal Assets Test. Western Center on Law and Poverty (WCLP) and Justice in Aging request expenditure authority of $110.1 million ($52.9 million General Fund and $57.2 million federal funds) in 2021-22 and $219.6 million ($105.4 million General Fund and $114.1 million federal funds) annually thereafter to eliminate the assets test for Medi-Cal eligibility determinations for seniors and persons with disabilities, effective January 1, 2022. According to WCLP and Justice in Aging, low income seniors and persons with disabilities are forced to choose between savings and health coverage leading them to go without coverage or get rid of savings that can be used as a safety net. The asset test portion of the Medi-Cal program is a barrier to enrollment and remaining on the program without breaks in coverage due to the requirement to document assets every year, even when income has not changed. In addition, the assets test perpetuates racial inequality by: 1) privileging homeownership despite the barriers to homeownership that communities of color in California have faced due to racist housing and banking policies, and 2) prevents the intergenerational transfer of wealth thus perpetuating poverty among its recipients. No other health program in California requires the divesting of assets prior to enrollment and the majority of Medi-Cal enrollees are not subject to this test. Applying the assets test to only Medi-Cal applicants and recipients who are over age 65 or disabled perpetuates inequity among populations that already have barriers to generating income. The assets test requires county workers to spend considerable time verifying assets rather than helping people who need their services and requires the state to spend roughly $4 million ($2 million General Fund and $2 million federal funds) annually for an asset verification program that seeks to find unreported assets of beneficiaries.

This request would provide funding and statutory changes to exclude the consideration of assets in determining eligibility for Medi-Cal for those whose eligibility is determined under the non-MAGI rules. The state may then modify its Medicaid state plan using the available flexibility allowed as described in guidance from the federal Centers for Medicare and Medicaid Services. As a result of this change, more low-income seniors and persons with disabilities would have access to Medi-Cal, low-income seniors and persons with disabilities on Medi-Cal would be allowed to save more, and more low-income seniors and persons with disabilities would stay enrolled on the Medi-Cal program which would increase stability in their health care.

Medi-Cal LTSS Data Transparency. The California Collaborative for Long-Term Services and Supports (CCLTSS) requests General Fund expenditure authority of $250,000 in 2021-22 to incorporate certain data elements regarding long-term services and supports (LTSS) into its managed care plan contracts. According to CCLTSS, at the federal level, the Medicaid and Medicare programs operate independently and under different funding streams. At the state level, this fragmentation often prevents individuals eligible for both programs from accessing the full range of health and long-term services and supports (LTSS). There is little data sharing and coordinated policy development focused on the needs, priorities, and experiences of individuals and their circles of support. This results in the inability to identify, plan, and effectively deliver services to Californians who need LTSS. A truly person-centered care system relies on coordination of all services- including physical health, oral health, mental health, cognitive health and LTSS—alongside and on behalf of the person.

As the state is in the process of Medi-Cal Managed Care Plan (MCP) re-procurement, CCLTSS requests the state to incorporate the following elements into the new contracts:

1. *Community Based Organizations:* DHCS would require demonstrated and measurable engagement and contracts with community-based organizations. These elements should be included in all program and benefit designs for new or amended initiatives impacting LTSS for older adults and people with disabilities administered by MCPs.
2. *MLTSS Data:* DHCS would build into its MCP contracts starting on January 1, 2022 that cover Managed LTSS (MLTSS) a requirement to provide publicly-reported quarterly data in a standardized format on access to and utilization of MLTSS, including: 1) MLTSS data that is already being reported by MCPs but not currently made publicly available on a quarterly basis; 2) disaggregated quarterly data provided by MCPs by race, ethnicity, and language spoken whenever possible; 3) disaggregated data on dual eligible enrolled in integrated systems, traditional Medicare and a Medi-Cal plan, or a non-matching Medicare Advantage plan and Medi-Cal plan, and seniors and persons with disabilities receiving MLTSS.

   DHCS would work with MCPs and stakeholders to identify to identify if the following information can be publicly reported, in a standardized format, and by the identified populations: 1) access and referrals to LTSS and non-acute medical services, such as behavioral health and dental services; 2) aggregate results of the MLTSS questions completed during the Health Risk Assessment (HRA) and the number of referrals to specialty care or social services that resulted from the information obtained in the HRA process, including data specifically on non-dual SPDs and duals not enrolled in an integrated Medicare product.
   DHCS would also work with stakeholders to determine which data elements are currently available for public reporting that would provide a more accurate beneficiary profile including data on informal caregiving, specific diagnosis, and additional demographic data. This process will help identify data gaps to inform the Department as it develops reporting requirements and additional public transparency under CalAIM and the commercial MCP re-procurement process.

Quality Incentive Pool (QIP) Transition Bridge Loan for District and Municipal Hospitals. The District Hospital Leadership Forum (DHLF) requests General Fund expenditure authority of $40 million in 2021-22 and 2022-23 to make two bridge loans to the 34 district and municipal hospitals to aid in the transition from the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, a quality improvement program under the state's expiring 1115 waiver, to the Quality Incentive Pool (QIP) program. According to DHLF, the funding and similar incentive programs embodied in PRIME are transitioning to a component of Medi-Cal managed care, the Quality Incentive Pool (QIP). This transition includes a move to directed payments versus the recent PRIME fee-for-service approach. QIP, like PRIME, requires an investment on behalf of the participating hospitals. District and municipal hospitals have and continue to invest in meeting the goals of the program by hiring staff, investing in data systems and analyses, in some cases, implementing new innovative programs, and potentially putting in place partnerships with community providers to ensure the goals are met. The incentive payments have allowed hospitals to make these investments to improve the care provided to their communities and for individual patients, while reducing costs.

In PRIME, eligible hospitals provided a report to DHCS twice a year. Once the report was determined to be complete, the IGT was requested and the federal funds then obtained and distributed to the hospitals. The report was due 90 days after the end of the reporting period (September and March). The DHCS review was approximately 30 days and the IGT and federal matching process usually took another 60 days (as a maximum). Therefore, the hospitals had funding well within 90 days. Unfortunately, the new

approach of transitioning to directed payments takes significantly more time after the end of the reporting period which, especially now, will be a significant hardship on district and municipal hospitals by delaying cash flow, especially as these hospitals struggle to meet the needs of patients with COVID. For the program year 2021, instead of receiving funding in approximately November 2021 and May 2022, the funding will not be available until the summer of 2023.

This budget request would require DHCS to make two bridge loans to these 34 hospitals. The first loan would occur in approximately the 3rd quarter of CY 2021 and the second in the 2nd or 3rd quarter of CY 2022. Repayment would be done via Medi-Cal fee-for-service recoupments beginning in late 2023 and would be done in several installments.

Caregiver Resource Centers Infrastructure Funding Extension. The Association of California Caregiver Resource Centers (CRC) requests General Fund expenditure authority of $12 million annually in 2021-22, 2022-23, and 2023-24 to continue infrastructure support and to build an Equity and Inclusion Core within the CRC system. The 2019 Budget Act included General Fund expenditure authority of $10 million for three years to expand technology systems and service delivery to caregiver resource centers, which provide support to family caregivers of adults needing assistance to allow them to remain in the community. This request would extend and increase the appropriation for the next three years (2021-22 to 2023-24) with additional funding ($2M/year) to be targeted to building an Equity and Inclusion Core within the system that provides: 1) additional bi-cultural, bi-lingual staff for CRCs with highly diverse populations; 2) direct assistance for those CRCs that may need bi-lingual, bi-cultural staff on an intermittent basis; and 3) training all CRC staff in best practices for creating a culture of equity and inclusion, with input from relevant state and national organizations.

Drug Medi-Cal Flexibility to Prevent Overdose and Support Public Health. The California Opioid Maintenance Providers (COMP) request expenditure authority of $9.2 million ($2.8 million General Fund and $6.4 million federal funds) annually and trailer bill language to grant authority to DHCS to evaluate and implement changes to the Narcotic Treatment Program (NTP), including allowing new drug and disease testing. According to COMP, under current statute DHCS is unable to reimburse NTPs for new regulatory requirements that the department determines to be essential for overdose (OD) prevention and public health. For example, despite the surge of fentanyl ODs across the state, DHCS cannot reimburse NTPs for fentanyl testing which would result in better treatment and fewer ODs. In addition, providing HIV and hepatitis C (HCV) testing is an important public health initiative. CDPH, in a presentation to NTPs, indicated that drug treatment programs offer an ideal opportunity for HCV testing and treatment. The trailer bill language would authorize DHCS to consider these changes, while the expenditure authority would cover the costs of providing these services.

Field Testing of Translated Medi-Cal Materials and Equity Dashboard. The California Pan-Ethnic Health Network (CPEHN) and the Western Center on Law and Poverty (WCLP) request General Fund expenditure authority of $1 million in 2021-22 and $30,000 annually thereafter to field test translations of Medi-Cal materials and collect additional demographic data as part of the Equity Dashboard.

According to CPEHN and WCLP, strengthening language assistance services is particularly critical in the Medi-Cal program where at least one in three Medi-Cal beneficiaries speaks a language other than English as their primary language. Such individuals are more likely to have low reading literacy or low health literacy in comparison to their English-speaking counterparts. Translated materials are also not always

culturally sensitive to the diverse Medi-Cal population. These issues limit an individual's ability to communicate effectively with their healthcare provider and access their benefits. Therefore, using language that is plain, simple, and culturally appropriate in Medi-Cal documents will significantly increase healthcare access for all Medi-Cal beneficiaries.

When translations are not field tested, they may not be understood by the intended audience. This results in translated plan materials that simply are not accessible. Such review of documents is not unprecedented. Some Medi-Cal managed care plans have already undergone more extensive community reviews of some of their materials. Covered California included community review in its most recent translation contract. DHCS' Medi-Cal Managed Care policy division has strongly encouraged plans to conduct field testing of translated forms and materials since at least 1999, but it is still not a requirement. Additionally, the Department has at times sought input from volunteers within the consumer advocacy network to review translated materials, though advocates often do not have enough resources, lead time or internal capacity to adequately field test. There have been several years of attempted legislation on the issue and extensive input by the community into CHHS' listening sessions. The state likely has the data and information it needs to move forward.

CPEHN and WCLP also request that the Administration's budget proposal to create an Equity Dashboard also upgrade the Medi-Cal Eligibility Data System (MEDS) to allow for the collection and reporting of data on disability status and more granular demographic data on age, race, ethnicity, language, sexual orientation, gender identity and disability status by DHCS and Medi-Cal managed care plans using the federal 2015 Office of National Coordinator (ONC) for HIT standards for electronic health records. The 2015 ONC standards also include data on behavioral and social risk factors which includes but is not limited to data on behavioral health conditions, ACES, domestic violence, access to housing or nutrition supports. Collection and reporting of this data will allow DHCS to set year-over-year targets for quality improvement and disparities reduction in Medi-Cal managed care and provide greater oversight of managed care plans under the new Population Health Management requirements in Cal-AIM.

COVID-19 Reimbursement Rate Extension for Pediatric Subacute Facilities. Totally Kids Specialty Healthcare – Sun Valley requests General Fund expenditure authority of $1 million to extend the ten percent reimbursement rate increase implemented during the COVID-19 pandemic for free-standing pediatric subacute facilities through the 2021-22 fiscal year. According to Totally Kids, stand-alone pediatric subacute facilities care for children who are dependent on medical technology for their survival. These facilities help medically fragile children in California stay alive, and be as healthy as they can as they live with difficult medical conditions. This unique model of care allows facilities to provide necessary medical care to young patients in an extremely cost-effective way. However, for the last several years, operational viability has eroded with the freezing of state reimbursement rates over a decade ago. In the last few years, the state has helped temporarily shore up facility budgets with annual supplemental funding. The daily rate for subacute pediatric services remained unchanged for 11 years until the Legislature included these services in the Proposition 56 tobacco tax fund in the 2020-21 budget. This support has been instrumental in averting a financial crisis among Free-Standing Pediatric Subacute facilities. Now, of course, COVID-19 has emerged to worsen facilities' already precarious fiscal situation.

The supplemental funding that has allowed us to continue to operate is vital to support the care facilities provide. Along with the current Proposition 56 supplemental payments, Totally Kids is requesting the COVID-19 ten percent increase be maintained thru the 2021-22 fiscal year, with a state General Fund cost

of $1 million. The state will be dealing with the impacts of COVID 19 for years to come and allowing facilities to maintain the rate as it is now will help in providing appropriate care to the children these facilities serve. As DHCS expects to move this facility model into Medi-Cal managed care in 2023, this rate will help facilities go into that changed environment as fiscally sound as possible.

COVID-19 Reimbursement Rate Extension for ICF-DDs. The Developmental Services Network (DSN) requests expenditure authority of $18.6 million ($9.3 million General Fund and $9.3 million federal funds) to extend for six months the ten percent reimbursement rate increase implemented during the COVID-19 pandemic for intermediate care facilities for individuals with developmental disabilities (ICF-DDs). According to DSN, the COVID-19 ten percent rate increase for long-term care services, including for small ICF-DDs, currently expires as of December 31, 2021. This is the estimated date the Governor's January Budget assumes the public health emergency will end. A six month extension of the ten percent adjustment through June 30, 2022, is urgently needed in order to stabilize residential services and to continue to offer and provide specialized medical and habilitative services for ICF-DD residents. Without continuing the adjustment through the entire fiscal year, many ICF-DDs likely face the risk of closure due to a fiscal cliff and other financial stress, including increased costs due to staffing and compensation challenges, supplies and food expenditures, facility expenditures, communication costs for virtual services, and resident vacancies.

CalAIM Workgroup on ICF-DD Transition to Managed Care. DSN requests budget bill language to require DHCS and DDS to convene a workgroup to address governance, procedures and processes pertaining to the transition of ICF-DDs from the fee-for-service to the Medi-Cal managed care delivery system under the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. According to DSN, the CalAIM proposal would transition ICF-DDs located in residential neighborhoods, to be under the auspices of Medi-Cal managed care plans. DSN reports that, despite letters and brief telephone calls, there has never been full engagement on ICF-DD issues by the Administration.

The CalAIM change does not only affect Medi-Cal reimbursement, but it also creates questions within the underlying governance structure related to the DDS and the Regional Center system. ICF-DDs must meet DDS and Regional Center program requirements, including staffing hours, types of services to be offered, required staff education and training requirements and other aspects. Further, DDS requires potential ICF-DDs to complete a comprehensive DDS application package, and to work with Regional Centers in the geographic area to determine resource needs, prior to a potential ICF-DD proceeding with development.

In addition to DDS administration, ICF-DDs are also licensed and certified by DPH. The Medi-Cal program provides ICF-DDs reimbursement but is otherwise not engaged in the governance structure of this programmatic area. Any broad movement into Medi-Cal managed care requires a clear and direct process, as well as technical assistance from DHCS and DDS in order for any aspect of this proposal to have real success. Currently, only a small component of ICF-DDs presently contract with Medi-Cal managed care.

Enactment of this budget bill language would offer an opportunity to engage the Administration, Regional Centers, managed care plans, other advocates and ICF-DDs in a joint discussion through a time-limited workgroup to unpack and address the various issues at hand. Engagement on issues is necessary in order to have a smooth and constructive transition.

Expand Access to STD Services Through Family PACT. The End the Epidemics coalition requests annual General Fund expenditure authority of $7 million to expand access to sexually transmitted disease (STD) services covered by the Family Planning, Access, Care, and Treatment (Family PACT) program. Of this amount, $5 million would support direct services to newly eligible beneficiaries, and $2 million would support necessary administrative program changes. According to the coalition, California currently does not have a state-funded episodic coverage program for STD testing or treatment. The state's family planning program, Family PACT, covers STD prevention, counseling, testing and treatment for low-income and uninsured people, but only within the context of a family planning visit. Uninsured LGBT individuals that don't have family-planning needs lack coverage options for STD services and must pay out of pocket or forgo treatment. The groups most negatively impacted by this structural inequity are young-adult LGBT Californians of color, and men who have sex with men – many have reported being turned away or asked to pay for STD testing and treatment because they were not eligible for Family PACT services because they did not need contraception.

Although the STD public health crisis is affecting communities across the state, California youth, Black, Indigenous and people of color, and gay, bisexual, and transgender people are disproportionately impacted. Statewide data indicate over half of all STDs in the state are experienced among California youth ages 15 to 24 years old. Currently, African Americans are 500 percent more likely to contract gonorrhea and chlamydia than their white counterparts. These disparities are expected to worsen during the COVID-19 pandemic. Studies conducted by the CDC suggest a range of factors linked to social determinants of health likely contribute to STD rate disparities, including inequitable access to safe, culturally competent, quality health, mental health and substance use treatment services, as well as high rates of incarceration, lack of access to economic mobility and education opportunities, adequate housing, racial segregation, and racism.

The proposed funding will support the expansion of access to STD services for low-income and uninsured LGBT patients through the Family PACT program to address rising STD rates and improve health outcomes. The program already has a network of more than 2,200 culturally competent providers well-trained to deliver STD services. Expanding the eligibility for STD services under Family PACT provides a more feasible, cost-effective and equitable pathway to STD coverage than creating separate episodic program.

The Office of Family Planning (OFP) collects data on the number of patients enrolled in Family PACT and the services received. If Family PACT eligibility is expanded to cover STD services for people with non-family planning needs, the data for this population will be captured by OFP and could be used to evaluate the program's success in reducing STD rates. The California STD Control Branch estimates that there are approximately 13,000 men who have sex with men that are also uninsured and who fall within the Family PACT program's income eligibility requirements.

Start-Up Funds for Medi-Cal Peer Support Specialist Certification. The California Association of Mental Health Peer Run Organizations, the County Behavioral Health Directors Association, the County of Los Angeles, and the Steinberg Institute request expenditure authority of $9.4 million ($4.7 million General Fund and $4.7 million federal funds) to support initial implementation of the Peer Support Specialist (PSS) Certification Program, pursuant to SB 803 (Beall), Chapter 150, Statutes of 2020. According to these organizations, these start-up funds would help California become the 49th state in the nation to include a PSS as a Medi-Cal billable provider and to add peer support services as Medi-Cal

reimbursable services. California does include limited peer services in counties that opt to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) but does not maximize the integration of these services and peer providers. This lack of a distinct peer support services leads to a failure of maximizing federal funding for the state's public behavioral health system. Further the lack of a distinct peer support service results in confusion of who is a provider operating in a PSS role, which requires self-disclosure of a mental health or substance use condition, and a peer who has choice as to whether or not to disclose. It is the activity of self-disclosure in an evidence-based manner that yields outcomes for Peer Support Specialists.

Certifying PSS to provide peer support services in Medi-Cal is more important than ever with the COVID-19 pandemic and subsequent economic downturn wreaking havoc on the mental health of all Californians. Nearly 11 percent of American adults seriously considered suicide this June, according to CDC data. The June CDC data showed 30.9 percent of survey participants reported symptoms of an anxiety or a depressive disorder, 25.3 percent reported a traumatic or stressor-related disorder (TSRD), and 13.3 percent said they were using substances to cope with the pandemic's stressors. The CDC data exemplifies the need for an urgent response to the growing behavioral health crisis.

The sharp rise in behavioral health disorders triggered by COVID-19 is likely to linger long after the end of the pandemic itself, thus highlighting the need for an effective, comprehensive, and economically viable behavioral health care response. SB 803 is a critical component of that response. Peer Support Specialists have gone through crisis, learned resiliency tools to gain their own behavioral health wellbeing, and are trained to assist others in navigating and surviving crises. The ability of peers to connect with those in need and exemplify the path to wellness is vital in the aftermath of the pandemic.

PACE Awareness in CalAIM. CalPACE requests trailer bill language to ensure individuals potentially eligible for a Program for All-Inclusive Care for the Elderly (PACE) are aware that PACE is an option and have an opportunity to be assessed and enroll before being enrolled in a managed care plan under the managed care transition included in the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. According to CalPACE, PACE has operated as a Medi-Cal benefit since 2003 as a capitated, comprehensive care program for adults and seniors over age 55 with higher needs who qualify for nursing home placement but who wish to remain in the community. Medi-Cal beneficiaries enroll in PACE in lieu of receiving Medi-Cal services on a fee-for-service basis or through a managed care plan.

PACE organizations currently serve over 10,000 participants through 50 PACE Centers and Alternative Care Sites in 15 counties, including Alameda, Contra Costa, Fresno, Humboldt, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, and Stanislaus. PACE is expected to expand to several additional counties by 2021. Enrollment if PACE is voluntary on the part of beneficiaries.

Even though PACE is a model of care for frail seniors, many beneficiaries are unaware of PACE and how it may benefit them. The bulk of enrollment occurs through individual referrals from community sources including hospital discharge planning, senior housing, AAAs and other sources. As a result, many seniors with higher needs who could benefit from PACE are not aware of it.

As the state transitions to CalAIM and Medi-Cal managed care statewide, it is crucial that potential PACE eligible participants are aware of PACE as an option and have an opportunity to be assessed and enroll

before being enrolled in a managed care plan. This proposed CalAIM trailer bill language recognizes PACE as an option but the language does not require any type of referral or assessment.

PACE Flexibilities. CalPACE requests trailer bill language to make permanent the regulatory flexibilities provided to PACE organizations during the COVID-19 public health emergency that have allowed PACE organizations to safely care for and provide services to the frail seniors that PACE organizations serve. According to CalPACE, during the COVID-19 health emergency PACE organizations have modified the ways in which they deliver care to their participants in order to keep their participants safe. PACE organizations have successfully responded to the public health emergency by implementing rigorous infection control measures and quickly transitioning from providing center focused care to home based care. These modifications have been carried out with the approval of the CA Department of Health Care Services (DHCS) and federal Centers for Medicare and Medicaid Services (CMS). These modifications have enabled PACE to achieve significantly better health outcomes for PACE participants during the COVID-19 health emergency than comparable nursing home populations.

These flexibilities have included more extensive use of telehealth for participant assessments, monitoring and communication; deployment of PACE center nurses into participants' homes; and allowing referrals from hospital and nursing home discharge planners. The statutory changes proposed by the amendments would allow these flexibilities to continue beyond the end of the health emergency. The amendments would direct DHCS to make permanent PACE regulatory flexibilities pertaining to:

(1) Telehealth
(2) PACE enrollment agreements
(3) Adult Day Health Care (ADHC) services provided in the home
(4) Involuntary disenrollment – Out of Service Area
(5) Facility beds
(6) Marketing
(7) Marketing exams

The amendments also would direct DHCS to work with CMS to achieve waivers from the federal government where necessary.

Medi-Cal Reimbursement for Personal Protective Equipment. The California Dental Association (CDA) requests expenditure authority of $80 million ($40 million General Fund and $40 million federal funds) to provide reimbursement for Medi-Cal dental providers for pandemic-related costs of new, mandatory, medically necessary infection control. According to CDA, at the beginning of the COVID-19 pandemic, approximately 97 percent of dental offices completely closed or were only seeing emergency patients from March through May 2020. Since dental practices reopened, they have continued to have significantly increased overhead costs, combined with decreased patient volume due to COVID-19 safety guidelines and lingering public hesitation around receiving health care treatment. The high cost of personal protective equipment (PPE) is exacerbated by ongoing product scarcity and supply chain disruptions.

Dentists and dental team members have some of the highest risk of workplace exposure to airborne pathogens, especially COVID-19. These providers are in extremely close proximity every day to patients and the procedures that typically generate aerosols — which can spread COVID-19 more readily. The need for PPE in this current pandemic is especially critical — and incredibly costly to secure.

With the increased economic burden of safely operating in the current circumstances, there is a risk of providers being unable to reopen at full capacity due to unfunded costs, which could mean patients losing access to care and a constriction of the Medi-Cal dental network. Dental practices have been able to reopen and safely treat patients in this new environment, but only by implementing extensive new infection control methods and procedures. This includes changes to patient flow, addition of barriers within offices to prevent the spread of aerosols, purchase of air filtration systems and the expanded use of PPE, including N95 masks, face shields, surgical gowns and shoe coverings.

Despite the state's investment in the Medi-Cal dental program over the past several years, these dental practices cannot afford the additional overhead costs associated with the increased PPE necessary to provide care during the current public health emergency. The additional costs of treating patients during the ongoing pandemic might be the issue that tips the needle on significant improvements in the program and forces providers out of the Medi-Cal program after years of improvements. Providing PPE reimbursements to Medi-Cal dental providers would help ease the financial burden of safely providing treatment during the COVID-19 pandemic. Medi-Cal dental providers cannot raise their rates or pass along PPE surcharges or costs to Medi-Cal beneficiaries. The reimbursement would provide incentive for dentists to stay in the Medi-Cal Dental program.

Extension of Behavioral Health Pilot Project. The California Hospital Association (CHA) requests General Fund expenditure authority of $40 million, available for encumbrance or expenditure until June 30, 2024, to continue the Behavioral Health Pilot Project (BHPP), which provides funding for behavioral health counselors in emergency departments. According to CHA, over 200 hospitals currently participate in the BHPP, which has allowed them to hire a behavioral health provider or peer navigator for the emergency department to screen patients and offer intervention and referral to mental health or substance use disorder programs. An additional $40 million allocation would allow these positions to continue for the next two to three years.

Increased Medi-Cal Reimbursement for Orthotic and Prosthetic Providers. The California Orthotic and Prosthetic Association (COPA) requests expenditure authority of $9 million ($4.5 million General Fund and $4.5 million federal funds) to increase Medi-Cal reimbursement for providers of orthotics and prosthetics. According to COPA, Existing law authorizes the Medi-Cal Program to reimburse prosthetic and orthotic appliances at a rate that may not exceed 80 percent of the lowest maximum allowance for California established by Medicare for the same or similar services. These appliances are prescribed by an appropriately licensed practitioner to meet the medical equipment needs of Medi-Cal enrollees. The services for these appliances shall only be performed by an appropriately licensed practitioner or an orthotist and prosthetist nationally certified by either the Board for Orthotist Certification or the American Board of Certification in Orthotics and Prosthetics. Medi-Cal reimbursement for these appliances is fixed at a depreciating rate that does not keep pace with Medicare over time. On average, Medi-Cal currently reimburses at 51 percent of the prevailing Medicare allowable, which is unsustainable resulting in decreased access to care for people with limb loss or muscle weaknesses. This budget request would simply require that reimbursement for these appliances be set at 80 percent of the Medicare allowable rate as existing law is ambiguous and allows Medi-Cal to reimburse providers well below the actual cost of providing this medically necessary care.

Ensure Healthcare Access for Homeless Adults in California's Safety Net Hospitals. Private Essential Access Community Hospitals (PEACH) requests expenditure authority of $120 million ($50 million General Fund and $70 million federal funds) to implement a socioeconomic status (SES) adjustment factor for reimbursement of claims paid to safety net hospitals that provide care for Medi-Cal beneficiaries. According to PEACH, SES is a term sued by sociologists, economists, and other social scientists to describe the class standing of an individual or group. It is measured by la number of factors, including income, occupation and place of residence. Homelessness is a major contributor to the SES of individuals. While the number of homeless individuals is growing, the Medi-Cal program has not adjusted for the complexities that accompany this population. The 2018 data from the Office of Statewide Health Planning and Development (OSHPD) shows that – at a minimum – there were nearly 100,000 inpatient discharges of homeless adults. The preponderance of those discharges – more than 50 percent - were treated in California's safety net hospitals (those federally qualified as disproportional share hospitals – DSH). That's over half the adult homeless population treated in less than one-fourth of the hospitals. Research concludes that reimbursement mechanisms that fail to recognize the severity of SES impose a greater and disproportionate burden/penalties for safety net hospitals (Joynt, MD, MPH, Karen E.; Jha, MD, MPH, Ashish K. Characteristics of Hospitals Receiving Penalties Under the Hospital Readmissions Reduction Program, 2013. JAMA 2013:309(4): 342-343). Additionally, further research demonstrated that unadjusted reimbursement mechanisms may exacerbate disparities in care and that special attention should be devoted to safety net hospitals that are in a unique financial position and provide a disproportionate share of care to SES vulnerable adults. (Hoehn, MC, Richard S; Wima, MS, Koffi; Vestal, MHA, Matthew A. et. al. Effect of Hospital Safety Net Burden on Cost and Outcomes After Surgery, JAMA. 2016;151(2): 120-128).

The Medi-Cal fee-for-service reimbursement mechanism is a risk-based/incentive payment methodology (APR-DRG) that starts with a base rate for every discharge – the same rate for all hospitals. The base rate is then adjusted for area wage costs and medical severity. The higher the severity of illness, the higher the corresponding payment. The APR-DRG places risk on the hospital to provide efficient care and creates an incentive to keep the hospital stay only as long as is necessary to provide the appropriate level of care given the medical severity. Hospitals that cannot provide care effectively and efficiently within the standard length of stay are penalized because the level of reimbursement does not increase just because the patient is in the hospital longer. A recent study of SES impact on hospital length of stay (LOS) showed that for patients in the highest quintile of social deprivation had a mean LOS 1.1 to 1.8 days longer than those in the lowest quintile. Patients in the highest quintiles of both social and material deprivation have a mean LOS 1.8 to 3.5 days longer than those in the lowest quintile. This same study concluded that SES should be taken into account in hospital resource allocations to avoid unfairly penalizing hospitals that provide the majority of SES deprived individuals (Moore, Lynne; Cisse, Brahim, et. al.; Impact of Socio-economic Status on Hospital Length of Stay. 2015. BMC Health Serv Res. PMCID: PMC4513757).

The Medi-Cal APR-DRG formula fails to account for the social complexity of vulnerable SES patients, such as homeless adults, resulting in a payment penalty incurred from treating patients that result in higher unaccounted for costs. Further, the Medi-Cal base rate for the APR-DRG has not increased in 8 years, since the implementation of the risk-based methodology in 2013. To preserve access for the SES vulnerable homeless adult population and to mitigate, in part, the financial disparities to safety net hospitals that care for this population, the Legislature should consider an investment of $50 million General Fund ($120 million total funds) by directing the Department of Health Care Services to implement

a SES adjustment factor to the APR-DRG formula on all claims paid to safety net hospitals that provide care for the Medi-Cal adults.

Medi-Cal Coverage for 12 Months Postpartum and Children Zero to Five. A coalition of organizations including the American College of Obstetricians and Gynecologists (ACOG), the First 5 Center for Children's Policy, the March of Dimes, the Children's Partnership (TCP), Maternal Child Health Access (MCHA), and the First 5 Association of California, request expenditure authority of $110 million ($55 million General Fund and $55 million federal funds) in 2022-23 and $220 million ($110 million General Fund and $110 million federal funds) annually thereafter to extend pregnancy-only Medi-Cal coverage from 60 days postpartum to 12 months, and to extend continuous coverage for all children up to age five
. According to the coalition, under current federal and state law, those eligible for Medi-Cal because they are pregnant become ineligible for coverage on the last day of the month in which the 60th day following the end of pregnancy occurs. A recent state exception allows those postpartum beneficiaries with a mental health condition, to continue Medi-Cal coverage for 12 months postpartum. (The Governor's budget proposes continuing this 12-month coverage until December 2022.) While the remaining postpartum women may successfully transition to Covered California at this time, many cannot afford their share of the premiums or out-of-pocket costs and are left in the untenable position of being uninsured shortly after a major medical event. Those who can manage the costs will lose important continuity of care when their Medi-Cal providers do not participate in the Covered California network that is available in their area.

There are major risks to becoming uninsured shortly after experiencing pregnancy. For example, one in seven women experience symptoms of postpartum depression in the year after giving birth, and evidence suggests women with substance use disorder are more likely to experience relapse and overdose seven to 12 months postpartum. A study of maternal suicide in California found the majority of women (83 percent) died in the late postpartum period, 43 to 365 days following the end of pregnancy: 36 percent died between 43 days and 6 months and 47 percent died more than 6 months postpartum. Among other findings, approximately 85 percent of women had one or more psychosocial stressors documented near the time of death (e.g., interpersonal conflict with partner, financial hardship, and exposure to violence as a child or adult); screening and referral through Medi-Cal's Comprehensive Perinatal Services Program (CPSP) is intended to address such factors. 51 percent of these maternal suicide cases had a good to strong chance of preventability with missed opportunities to intervene—opportunities that are far more likely to be missed when the woman is dropped from Medi-Cal shortly after the end of a pregnancy.

Young children are also particularly vulnerable to the effects of gaps in coverage. In the first years of life, when 90 percent of brain development occurs, frequently scheduled well child care including visits, screenings and vaccinations are critical to ensure a healthy start. In 2000, California adopted the federal option to provide 12-months of continuous eligibility in Medicaid for children, which includes infants for their first year of life and then annual renewals thereafter. Despite this policy, coverage gaps occur, particularly after annual renewals. Such disruptions in coverage for young children are especially problematic in the first year of a child's life when children require frequent contact with the health care system.

Under the current national COVID Public Health Emergency (PHE), all Medi-Cal enrollees have temporary continuous enrollment through at least January 16, 2022. In 2021-2022, California will be required to develop a plan to unwind the federal PHE flexibilities and coverage protections for when the

PHE ends. Unless this "unwinding" plan includes these proposed policies, undoing the existing PHE continued coverage would cause major disruptions in care for postpartum women and children ages 0-5 currently enrolled in Medi-Cal. Without careful staging, the post pandemic redetermination process can result in unnecessary gaps in coverage and disorder for all Medi-Cal beneficiaries.

Cycling on and off health insurance coverage—or churning—is disruptive to continuity of health care, and is especially problematic postpartum and in early childhood when frequent contact with health care is necessary. In addition, churn disrupts a family's relationship with a pediatric health care home and postpartum care, which are important--and often the sole--sources of consistent support for families, particularly before children enter school.

Telephonic Attestation for Medi-Cal. The Western Center on Law and Poverty (WCLP) requests trailer bill language to permit federally allowable flexibility in the acceptance of telephonic or electronic self-attestation of eligibility requirements for Medi-Cal. According to WCLP, due to the pandemic, DHCS has relaxed the self-attestation requirements for situations where documentation is unavailable to someone applying for Medi-Cal. Federal law allows for self-attestation in many circumstances, save for citizenship/immigration status (though extra time is given to produce documentation) and social security numbers when they are required. DHCS guidance prior to the pandemic permits counties to accept attestation over the phone in many circumstances, but not when requiring penalty of perjury language in the attestation. This language is required most often for income discrepancies or when income documentation is unavailable. These flexibilities will expire when the public health emergency is declared over. At the same time, county workers will likely be busy with backlog of redeterminations and increased applications as the economic fallout will likely trail the pandemic for some time.

Since state and federal law already lays out when self-attestation is permitted, these amendments only aim to ensure that when it is used, the state can move away from paper to streamline the process. Federal law already requires electronic databases to be checked first for income – this proposal would not change that. DHCS would also be free to make changes as to how telephonic or electronic attestation is accepted by a county worker as needed (or as required by CMS, the federal Medicaid agency), including following the telephonic attestation procedures that already exist any time self-attestation is permitted.

These changes would make sure there is a way in all counties for people to self-attest electronically or over the phone whenever self-attestation is permitted. This would also serve as a bit of a stopgap on the application side as DHCS is working on a new procedure for accelerated enrollment that would allow for enrollment while income verification is pending, which DHCS indicates will take some time to program in on the county computer systems SAWS side. Counties have already been doing this during the pandemic, so there would likely not be implementation challenges and this would also make it easier for county workers to complete the renewals that will have to happen when the public health emergency is lifted but the emergency procedures are no longer in effect. DHCS would be required to modify its MAGI verification plan (delete the word "paper" from "paper documentation") with CMS and potentially its state plan.

Medically Tailored Meals Pilot Extension. The California Food is Medicine Coalition requests General Fund expenditure authority of $9.3 million annually to continue support for a pilot project that provides medically tailored meals to Medi-Cal beneficiaries. According to the coalition, food and nutrition insecurity – the inability to access enough high quality, nutritious foods – is a root cause of poor health

outcomes, and contributes to several chronic illnesses, costing the state more than $7.2 billion annually. 86 percent of healthcare spending nationally is for patients with at least one chronic disease condition, many of which are linked to inadequate nutrition. In California, $98 billion is spent annually on treating chronic conditions, which is 42 percent of all healthcare costs in the state. Of the chronic disease conditions, chronic vascular disease (including congestive heart failure, chronic heart disease, and stroke) is associated with the greatest expense, accounting for $37 billion annually, or 16 percent of all health care costs in California, followed by cancer at $13.9 billion, and diabetes at $12.9 billion. People of color and older adults are disproportionately impacted by these diseases in the state. COVID-19 impacts have greatly exacerbated health challenges, and have impeded the access to nutritious food, for medically-fragile people who have chronic illnesses and need to shelter at home.

Medically tailored meal (MTM) programs, which include home delivery of nutritious meals recommended by registered nutrition experts and nutrition education by registered dietitians, have proven to reduce health care costs and improve health outcomes of these vulnerable people. MTM providers in the California Food Is Medicine Coalition members are non-profit organizations in the state that have capacities to serve over 3.3 million medically tailored meals annually, if funding is assured. They have experienced a more than 50 percent increase in meal deliveries and clients, to people whose needs are not met by other programs. The need for MTMs is expected to continue growing, for low-income people who require nutrition support for their health, and their needs are not met by other program. However, MTM providers have projected funding gaps, and require consistent state support to content to meet these needs.

This request for $9.3 million is for implementation and direct service of MTM programs, to cover:
a) Costs of food/meals and materials for food preparation and packaging;
b) Staff time for food preparation, deliveries, and nutrition education;
c) Other essential operational costs, such as food safety measures and fuel for meal delivery.

The funding would be administered through the Department of Health Care Services, and contracted to one of the coalition agencies. The funding would be subcontracted to the member agencies, according to numbers of meals delivered monthly and the funding gaps in budgets for each agency, in order to provide direct services and meet increased demand by clients/patients whose costs are not covered by other funding sources. The CA Food is Medicine Coalition will continue to coordinate the program and oversee quality standards, data sharing systems, financial teams, and other systems and capacities to ensure smooth and effective implementation, service and accountability.

Clinical Laboratory Reimbursement Methodology. The California Clinical Laboratory Association (CCLA) requests trailer bill language and General Fund expenditure authority of $40 million in 2021-22 to remove the cap on Medi-Cal reimbursement for clinical laboratories, forgive retroactive recoupment of reimbursement reductions, and delay other reductions until 2022. According to CCLA, AB 1494 (Committee on Budget), Chapter 28, Statutes of 2012, called for the creation of a new methodology for the determination of Medi-Cal fee-for-service laboratory rates. The new methodology requires laboratories to submit private payer data to DHCS which uses the data to set rates based on prices other third-party payers are paying. In 2018, implementation of the Protecting Access to Medicare Act (PAMA) required a new federal methodology for determining laboratory rates for Medicare. The new federal methodology adopts the California approach and requires laboratories to report private payer data to the Centers for Medicare & Medicaid Services (CMS) which uses the data to set Medicare laboratory rates based on private payer rate information.

The problem is that during the 2003 state budget crisis the state put language in statute that no Medi-Cal laboratory rate can be more than 80 percent of the Medicare rate for the same test. This is a cap and not a benchmark. Any test that was reimbursed below 80 percent of Medicare was left at that lower rate. This provision of law, the "80 percent of Medicare cap" has stayed in statute ever since.

Laboratories have lived with this cap since 2003. However, when CMS changed the methodology for calculating laboratory rates in 2018 it drastically lowered the Medicare rates on all tests to the federal market rate. Now, to apply the "80 percent of Medicare cap" will cause an automatic trigger that will cut Medi-Cal rates up to 20 percent depending on the test. This cut is not something that DHCS was planning on doing nor was it part of any state budget plan.

California has spent years implementing its laboratory rate methodology to establish the correct reimbursement rate for each test. This automatic trigger cut caused by the federal government reducing Medicare reimbursement rates is very problematic. If the rate for certain tests drop below the California market rate the test may be taken off the testing menu at certain labs. This will lead to access issues for Medi-Cal patients.

In addition, labs will leave California and we will no longer have the testing capacity located in state when we need it. We saw this happen with the COVID-19 pandemic. Laboratory testing capacity fell drastically below what was needed to respond to the pandemic. Businesses were closed, schools were closed, and people were under a stay at home order because there was not enough capacity for laboratory testing to detect COVID-19. For these reasons we are asking for removal of the 80 percent of Medicare cap.

With everything that labs are doing to provide COVID-19 testing CCLA is also requesting forgiveness of the retroactive recoupments of cuts from 2019 and 2020, and to delay the implementation of the 2019 and 2020 cuts until July 1, 2022.

Eliminate Ten Percent Rate Reduction for Complex Rehabilitation Technology. The National Coalition for Assistive and Rehab Technology (NCART) requests General Fund expenditure authority of $2 million annually to eliminate the ten percent Medi-Cal reimbursement rate reduction enacted by AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. According to NCART, the AB 97 cuts were put in place in 2009 to deal with the Great Recession and subsequent budget deficit. This was meant to be temporary, but instead, is still in place for certain providers including durable medical equipment (DME), which is the category CRT falls under. A recently approved state plan amendment has further cut these DME rates by pegging the fee schedule to a declining Medicare rate. Now DHCS is doing a rate "claw back" for payments dating back to 2009-11. This ongoing cut on top of additional cuts, coupled with a declining Medicare fee schedule has made it difficult in the short term and impossible in the long term for CRT providers to serve the Medi-Cal population. CRT is much different from regular DME, as it is a labor-intensive process that requires a team of providers and travel out to the patient's home, neither of which are reimbursed. Therefore, CRT is disproportionately impacted by the cumulative cuts to DME. Forgiving the AB 97 cuts for CRT providers would improve reimbursement rates to CRT providers and improve delivery of care for adults and children with severe physical disabilities.

Restore Crossover Payments for Behavioral Health Services for Dual Eligibles in Nursing Homes. CHE Behavioral Health Services requests General Fund expenditure authority of $3 million annually and

trailer bill language to improve access to behavioral health services for individuals dually eligible for both Medicare and Medi-Cal (dual-eligibles) and who reside in skilled nursing facilities. According to CHE Behavioral Health Services, as many as 370,000 Californians are cared for annually in licensed long-term care facilities and women make up 61 percent of nursing home residents. Over two-thirds of California's nursing facility residents rely solely on Medi-Cal to pay for their care in a skilled nursing facility (three out of five residents). While quality behavioral health services are a fundamental need for California's vulnerable elderly population, low Medi-Cal reimbursement rates have reduced access to mental healthcare. Patients with behavioral health conditions in nursing facilities often have challenges finding access to services and can suffer with lack of evaluation and care.

Medi-Cal rates are among the lowest in the country, failing to adequately cover the cost of daily care for nursing home seniors. As a result, nursing home operators and medical professionals are providing services that go uncompensated. The funding shortfall will no doubt result in fewer facilities, leaving more senior citizens homeless, and a potentially significant collapse in the health care delivery system for aging Californians. Additionally, failure to identify and treat behavioral health disorders could result in loss of federal reimbursement opportunities for California.

There are approximately 1,200 licensed long-term care skilled nurse facilities in California and the profession employs more than 141,000 workers with payroll and benefits exceeding $5.6 billion annually. Healthcare providers of all kinds across California are adversely affected by the tremendous lack of parity between the Medi-Cal and Medicare rate structure. The majority of nursing home patients have dual eligibility (eligible for both Medicare and Medi-Cal), and in order to provide the behavioral health services our senior citizens need and deserve, fee structures must be more in line across government-funded programs at the state and federal level, and this includes crossover claims.

One way to ensure funding supports care for this vulnerable population is the establishment of a crossover claim. A crossover claim is where Medicare pays a portion of a claim for a dual eligible beneficiary and since it is prohibited to bill that beneficiary, Medi-Cal pays for the rest. For example, if Medicare reimburses the provider at 80 percent of the actual cost of the service, Medi-Cal will cover the remaining 20 percent coinsurance. Unfortunately, California state law has limited Medi-Cal's reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum payment for similar services. Consequently, if the Medi-Cal rate is 80 percent or less than the Medicare rate for the service rendered, Medi-Cal will not pay anything on these crossover claims. With Medi-Cal rates consistently much lower than Medicare, this law essentially eliminates the crossover payment in California. Given the tremendous need for services in our nursing homes, especially during the time of public health emergency, we need to invest in these most vulnerable citizens and ensure they receive the care they deserve.

This proposal would amend existing law to allow Medi-Cal to pay for all or part of the remaining coinsurance from a Medicare payment for behavioral health services provided to dual eligible beneficiaries residing in skilled nursing homes. The request also includes an appropriation of $3 million to fund all or part of the coinsurance that is the Medi-Cal share of the cost.

Alameda Wellness Campus. The Alameda Point Collaborative and Lifelong Medical Care request General Fund expenditure authority of $15 million in 2021-22 to support construction of a medical respite and health clinic building at the Alameda Wellness Campus to serve unhoused adults and seniors with

complex health conditions. According to these organizations, if this request is approved the Wellness Campus would offer the state and nation a new model of integrated care for unhoused individuals with a focus on seniors and those with complex medical and behavioral health conditions. The Wellness Campus co-locates: 120 permanent supportive housing units, a 50-bed medical respite program; an on-site health care clinic; intensive homeless prevention and housing placement services; and hospice-level care for homeless adults, with an emphasis on serving unhoused seniors. The medical respite center will prevent worsening health conditions as well as unaccompanied and difficult deaths among unhoused adults in Alameda County.

The medical respite will serve homeless adults who are (a) discharged from local hospitals but are too sick to recover on the streets or a shelter, (b) undergoing intensive outpatient medical treatment such as chemotherapy, (c) identified through street medicine, or (d) seeking hospice care.

The project will realize the following beneficial outcomes:

- Provide recuperative care stays and housing placement assistance for 400 unhoused Alameda County residents with acute health conditions annually, with an estimated 50% or 200 seniors that participate in the medical respite program annually. The Wellness Campus anticipates that at least 90 percent of respite clients will have co-occurring mental health conditions.
- Provide 120 units of permanent supportive housing units for unhoused seniors in Alameda County to age in place with case management, on-site medical and behavioral health services, in-home support, and end-of-life-care.
- Provide homelessness prevention services and housing placement assistance for another 200 City of Alameda residents annually.
- Of the 720 unduplicated unhoused clients served annually, the Wellness Campus will serve an estimate 320 unhoused seniors annually.

This request would further the state's commitment to help end homelessness; reduce preventable emergency care and hospital readmissions; implement the Master Plan for Aging; and serve as a model for the new Enhanced Care Management benefit and In Lieu of Services under the state's CalAIM project to redesign Medi-Cal services.

Housing Support Services Benefit for People Experiencing Homelessness. The Corporation for Supportive Housing and the Western Center on Law and Poverty (WCLP) request expenditure authority of $100 million ($24 million General fund and $76 million federal funds) in 2021-22, $150 million ($36 million General Fund and $114 million federal funds) in 2022-23, and $250 million ($60 million General Fund and $190 million federal funds) annually thereafter to create a Medi-Cal benefit to fund housing support services for beneficiaries experiencing homelessness and people who were homeless and are now residing in supportive housing. According to these organizations, homelessness dramatically impacts health outcomes, costs, and access to care. Health costs for Medicaid beneficiaries experiencing chronic homelessness averages over $33,459 per year. Beneficiaries experiencing homelessness who are frequent hospital users often incur Medicaid costs of well over $100,000 per person. People experiencing homelessness die, on average, 25 to 30 years younger than housed people with similar health conditions.

Housing support services help people access housing and remain stably housed, and are essential for beneficiaries experiencing homelessness to access meaningful care. Thirty years of data demonstrate these

services not only dramatically improve health outcomes, but significantly decrease Medicaid costs. Data also shows that, without these services to help people stabilize in housing first, care management and other healthcare interventions are ineffective and wasteful. Outcomes remain poor, while health costs continue to increase.

The Department of Health Care Services (DHCS) created two programs to fund housing support services for people experiencing homelessness: the Whole Person Care pilot and the Health Homes Program. Though DHCS acknowledges beneficiaries experiencing homelessness need housing support interventions, the Administration's CalAIM proposal would eliminate these programs and instead providing housing support services as an option that plans may or may not choose to offer as "in lieu of services." In so doing, CalAIM proposals would halt California's progress in addressing the needs of people experiencing homelessness.

This request proposes to create a Medi-Cal benefit to fund housing support services for beneficiaries experiencing homelessness and people who were homeless and are now residing in supportive housing. In June 2015, the federal government issued an Informational Bulletin that clarified that Medicaid can pay for the housing support services people experiencing homelessness need. Through CalAIM, California should offer a separate, mandatory housing supports benefit to pay for services to help people get and stay housed. Other states are taking advantage of this federal funding match, and so should California.

This can be done through a supplemental per member, per month rate for housing transition navigation and tenancy sustaining services for beneficiaries experiencing homelessness. A benefit should be administered through a set of standardized guidelines and through funding that would attract providers with deep experience and expertise in providing services to people experiencing homelessness.
Housing support services help people access housing and remain stably housed, and are essential for beneficiaries experiencing homelessness to access meaningful health care. These services include:

- Housing transition & navigation services, to find people on the streets, form trusting relationships, assist people in completing paperwork needed to access housing subsidies, connect tenants to landlords, and help people move into and stabilize in housing;
- Housing deposits to help people gain access to housing through one-time costs of moving into housing; and
- Housing tenancy and sustaining services, to provide intensive supports to help people maintain leases, take care of their homes, and connect to treatment they need and to community supports.

Restoring Optional Medi-Cal Benefits for Chiropractic. The California Chiropractic Association requests General Fund expenditure authority of $1.7 million annually to restore chiropractic benefits in the Medi-Cal program. According to the association, the expansion of Medi-Cal made possible by the Affordable Care Act has been successful in providing many of the most vulnerable populations in California health care coverage. Additionally, we are seeing more individuals become eligible for Medi-Cal as the COVID-19 induced recession has caused many Californians to lose employer sponsored care. Medi-Cal is a vital coverage component in our healthcare system as it assists our most low-income and vulnerable populations gain access to health care providers and services. As part of ensuring that more Californians have access to adequate health services, the California Legislature has been working towards restoring Medi-Cal Optional Benefits that were cut over a decade ago. The state most recently restored services such as optical services, podiatry, speech therapy, and incontinence creams and washes. However,

chiropractic benefits have yet to be restored for the adult population of Medi-Cal beneficiaries. Chiropractic is the only optional benefit that has not been restore, thus, hindering the ability for Medi-Cal beneficiaries to fully access the breadth of health professionals at a time when our health care system is strained.

Restoring the chiropractic Medi-Cal option comes at a low cost but yields cost savings and increased access to health providers. The 2018 state estimate for restoring chiropractic benefits on an annual basis would cost $1,707,000 million - chiropractic is the second to least costly benefit to restore. For this modest investment, millions of Medi-Cal beneficiaries will have access to Doctors of Chiropractic (DCs) that have proven to be effective in providing non-pharmacological treatments to pain, reducing the need for prescription drugs such as opioids, and reducing the need for costly surgical interventions.
Additionally, populations that do retain a chiropractic benefit often are forced to settle for inadequate treatment options due to the Medi-Cal two-visit per month limitation. Therefore, we also ask that you consider adjusting the chiropractic benefit in a manner that maintains a 24 visit annual limit but removes the two visit per month cap so that Medi-Cal beneficiaries may receive clinically appropriate interventions in a timely fashion.

DEPARTMENT OF PUBLIC HEALTH

State Investment in Core Public Health Infrastructure and Workforce. A coalition of counties, county health organizations, and county public health workers, requests annual General Fund expenditure authority of $200 million to support investments in stabilization and addressing key needs and issues for local health departments. The coalition of organizations includes SEIU California, the County Health Executives Association of California (CHEAC), the California State Association of Counties (CSAC), the Health Officers Association of California (HOAC), the Rural County Representatives of California (RCRC), and the Urban Counties of California (UCC). According to the coalition, while a direct link between public health investment and improved community health or healthcare savings can take years to quantify, there is strong existing evidence of highly successful public health interventions. A 2017 systemic review of the return on investment of public health interventions in higher-income countries found a median return of 14 to 1. Another key analysis found that an additional $10 per capita in public health spending can decrease premature mortality and increase the proportion of the population in excellent health. Using these academic analyses, it is reasonable to assume that the state can invest $5 per capita towards a critical public health grant. Using recent Department of Finance population statistics for 2020, a $5 per capital equates to about $200 million. Further, this investment is likely to garner additional federal funding, such as a federal Medicaid match for some services (like Targeted Case Management services). It is foundational support that can be used to attack and retain additional federal grant dollars or even other non-governmental contracts and grants.

Under this proposal, each California local health department would be awarded a base allocation with the remaining funds distributed on the proportion that each jurisdiction contributes to:

- 2019 population (50 percent of the allocation);
- 2019 population in poverty (25 percent of the allocation); and
- 2019 population proportion each that is Black/African/American, Latinx, or Native Hawaiian/Pacific Islander (25 percent of allocation)

These funds would facilitate the stabilization of local health departments to address the following key needs and issues:

- Recruiting and retaining a modern public health workforce;
- Improving and expanding communicable disease monitoring, epidemiology, and outbreak mitigation
- Addressing health equity issues and health disparities through a wide-variety of action-oriented approaches using meaningful engagement with diverse communities who are impacted by systemic racism and through integrating public health as a core partner in addressing the social determinants of health;
- Improving and expanding environmental health and environmental justice capabilities for detecting and protecting communities from hazardous conditions in air, water, food, and other settings, and to address the impact of climate change on the diverse communities of California;
- Serving as an integral partner with the state and Medi-Cal managed care plans through CalAIM initiative that addresses population health, enhanced case management, in-lieu of services, social determinants of health, public education and other components for improving the health of Californians;
- Addressing linkages to health-related social needs, including housing instability and homelessness, family and social supports, food insecurity, nutrition education, and community violence mitigation.
- Improving access to and linkage with clinical care, including maternal, child, and family health;
- Improving and expanding chronic disease prevention functions related to asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco, alcohol, and other factors;
- Supporting the use of public health nurses, health/ peer educators, and community health workers for public education, outreach, resource referral, and other functions in order to protect health, prevent disease and injury, and promote health and well-being;
- Helping to implement more fully the "Health in All Policies" approach, as adopted by the California Health and Human Services Agency; and
- Improving California's overall ranking of "middle tier" ranking by the Trust for America's Health for public health emergency preparedness (25 states are ranked above CA).

Public Health Infrastructure and Workforce Assessment. The County Health Executives Association of California (CHEAC), the Health Officers Association of California (HOAC), and SEIU California request General Fund expenditure authority of $3.2 million in 2021-22 and $150,000 annually thereafter to conduct an evaluation of local health department infrastructure and make recommendations for staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. According to these organizations, California needs to prepare for the workforce challenges facing public health – and for the next emergency or pandemic – by creating a comprehensive plan to address urgent workforce and resource needs of local health departments. California's local public health workforce faced several challenges before the outbreak of COVID-19:

- Year after year of underfunding of federal, state and local public agencies left the United States ill-prepared for the COVID-19 pandemic. The Trust for America's Health estimated in April 2019 that public health efforts nationally were underfunded by $4.5 billion and that nationally 55,000 positions were eliminated from public health between 2008 and 2017.
- According to the California Future Healthcare Workforce Commission February 2019 report, the public health workforce in California is chronically underfunded, and most local public health

agencies lack personnel with expertise in key areas such as epidemiology and the essential skills to design, implement, and evaluate comprehensive approaches to community health improvement.

- In California, both state and local public health agencies face increasing competition with the private sector, which provides higher pay, and amenities such as updated technology. Additionally, many public health leaders are nearing retirement.
- There are no federal or state guidelines for public health staffing; nor does any state or national organization provide information and data on the composition and training levels of the governmental public health workforce.
- Many local health departments in California report challenges in recruiting and retaining well-qualified workers, citing a lack of tools for recruiting, limited options for advancement, and instability of funded positions.

Public health nurses require additional education and certification, above and beyond what is required to become a registered nurse. Public health nurse certification fees in California increased by several hundred dollars recently. Rural areas of California face more difficulty recruiting the specialized staff required for public health work. It is not uncommon for rural counties to have public health nurse recruitments open for several months and have no candidates apply. The public health worker shortage has received little attention and there is not a focus on public health pipeline in California's higher education systems. Additionally, while public health work is rewarding, it is also quite challenging and the difficulty of the work may lead to burn out in the public sector.

Specifically, the funding in this request would be provided to DPH to contract with an appropriate entity to conduct an evaluation of local health department infrastructure and make recommendations for staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. The funding would also support the submission of this report by DPH to the Legislature.

The evaluation and resulting recommendations of local public health workforce needs will better prepare California to address both day-to-day public health needs and pandemics and other emergencies that threaten the health of California residents.

California Health Equity Fund. A coalition of organizations including the California Black Health Network, the Latino Coalition for a Healthy California, the Public Health Institute, and Roots of Change request General Fund expenditure authority of $180 million, available for encumbrance and expenditure until June 30, 2024, to implement a California Health Equity Fund, which would provide increased funding for local health departments, community-based organizations, clinics, and tribes for community-based initiatives and programs that result in decreased risk for preventable illnesses and adverse childhood experiences (ACEs) exacerbated by COVID-19. According to the coalition, this budget request is in direct response to the heartbreaking inequities that have been wrought by COVID-19. Communities of color and low-income communities are contracting and dying at disproportionately high rates as well as bearing the brunt of social inequities caused by the pandemic including loss of income, insecure housing, and food insecurity. Children in these communities, who were already at increased risk of adverse childhood experiences, are now at increased risk due to family stress, school closure, and loss of support networks. Much of this suffering is due to largely preventable, inequitable rates of illnesses that preceded COVID-19, such as hypertension, heart disease and diabetes. In addition, the pandemic has amplified a legacy of structural racism leading to dramatically increased social and environmental risks, including food insecurity, lack of affordable housing, unstable employment, and other harmful conditions that are risks

for poor health outcomes and ACEs. Without immediate action, California's communities of color and low-income communities face a future of increasing rates of preventable, premature illness and death due to worsening social injustices. We must step in now to stop the cycle.

Local health departments, community-based organizations, clinics and tribes are acutely aware of these needs and pre-COVID-19, many implemented successful programs, using both evidence–based and community-determined strategies, to address the social determinants of health that drive inequities in chronic disease and ACEs. However, insufficient, sporadic funding prevented organizations from taking successful programs to scale or initiating new programs to meet community needs documented by state and local data. Today, the pandemic has amplified those needs many times over. In addition, existing categorical state revenue streams, as well as CARES dollars administered by government organizations, may not allow communities to effectively address key drivers of health and social inequities at the local level.

This budget request is inspired by CDPH's COVID-19 Health Equity Playbook for Communities, published in December 2020, which recognizes that because, "there is no single solution or strategy for the response and recovery to COVID-19, this document provides a collection of options for locals to select from to support customized approaches for the assets and needs of each community." The report further goes on to say, "COVID-19 requires a comprehensive 'all of government' and multi-sectoral approach. Recovery needs to be community and data driven, both through use of quantitative data and qualitative data from community insight and experience." In recognition of these precepts, this budget request includes funding for community-based organizations, community clinics, tribes, and local health departments to use local data to identify local priorities and work together to effectively respond to today's crises.

Sustaining the California Reducing Disparities Project. The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) and the National Association of Social Workers-California Chapter (NASW-CA) requests General Fund expenditure authority of $50 million in 2021-22, available for encumbrance or expenditure until June 30, 2025, to extend and expand the California Reducing Disparities Project (CRDP). According to REMHDCO and NASW-CA, California's people of color and LGBTQ+ communities are suffering significant mental health disparities as a result of the generational lack of mental health programs that appropriately serve racial, ethnic, and LGBTQ+ communities throughout California. Decades of data have well-documented that consumers and families from these communities in every county experience disparities with regards to mental health services. Originally funded by the Proposition 63 funding, the California Reducing Disparities Project (CRDP) has served these communities since 2019 and is a beacon of hope for the state, offering a solution that addresses the needs of a majority of Californians.

However, CRDP services to communities will end in April 2022 if additional funding is not secured. The CRDP strives not only to prove the effectiveness of 35 individual pilot projects, but to promote the use of Community Defined Evidence Practices that are often preferred by people in underserved communities and will go towards reducing mental health disparities in this state. This request would allocate $50 million dollars to extend Phase 2 of the project, bring the pilot project to scale at both the state and local levels, and to plan for Phase 3 of the project.

Preliminary results from local evaluations indicate that the implementation pilot projects show success at improving mental health among the African American, Asian Pacific Islander, Latinx, LGBTQ+, and Native American populations served, however, with no additional funding, these would be based on three years of data. (Traditional "evidenced based practices" take ten years to be considered successful.) Successful programs based on six years of data would further build the evidence base and be more accepted by counties and other funders. Additional funding would allow for the lessons learned from the CRDP Phase II to be captures and disseminated to inform the larger field on the state and national level. Lessons learned would include the strategies used by the IPPs to address the unprecedented need created by the global pandemic. The power of the data collected has the potential to change the discourse on serving historically underserved, unserved, and inappropriately served Californians. Community defined practices more generally would also be more likely to scale and create systems changes resulting in greater accessibility and utilization of culturally appropriate mental health prevention programs for underserved communities and improve health and wellness outcomes.

The state must make a commitment to support CDEPs to reduce disparities. Intergenerational mental health disparities will remain intractable without a sustained and aggressive level of State investment. The State of California's support should go beyond Phase II funding of the CRDP, it must address the new mental health crisis resulting from COVID-19. The state will not reduce disparities if it continues to fund the same strategies, but must do things differently if it wants to produce different results for marginalized communities.

The funding in this request would extend the operation of CRDP individual pilot projects (IPPs) of Phase 2 for another three years. Funding would also extend the corresponding technical assistance component, and the evaluation of this project both at the local and statewide levels. In addition, there would be a component to ensure scalability of the IPPs at the county level and planning for Phase 3 of this project to reach additional underserved communities. The success and viability of these IPPs would be based on 6 years of data instead of 3 years, encouraging investment at the local, state, and federal levels not only their replication but more widespread acceptance and use of community defined practices to increase access to critical behavioral health services and prevention of the onset of more serious mental illness. Finally, the funding extension would address the disproportionate impact of COVID-19 on CRDP populations and strengthen the state's response in marginalized communities.

Phase Out of Skilled Nursing Facility Staffing Waivers. SEIU California requests trailer bill language to phase out workforce shortage and patient acuity waivers for statutory staffing requirements in skilled nursing facilities. According to SEIU California, prior to the COVID-19 pandemic, hundreds of skilled nursing facilities (SNF) received a waiver from the state mandated minimum staffing requirements that were implemented in July 2018, with many facilities receiving these waivers in consecutive years, and even more facilities have been granted temporary waivers during the COVID-19 emergency period.

SNFs have been at the epicenter of the COVID-19 pandemic, with close to 6,000 resident deaths and over 43,000 positive cases, and 169 worker deaths and over 35,000 positive worker cases as of December 19th. The nursing home employees are risking their lives daily with limited personal protective equipment (PPE) to care for the sickest people in our state, and are left to handle an overabundance of residents due to the lack of investment in the workforce by employers, with no repercussions from the state. In fact, SNFs actually received a 10 percent Medi-Cal rate increase this year to assist them with their COVID-19 related expenses in addition to federal provider relief payments, yet we have not seen evidence of hazard

pay, increased PPE, paid sick leave, or other benefits that would support the existing workforce or attract new workers to the field.

This request seeks to address issues of low staffing and the subsequent devastating impacts to workplace safety and resident care by eliminating unnecessary and over-utilized waivers, motivating operators to make greater efforts to adequately staff up, and to make waiver application standards more stringent to only allow for such waivers in specific and exceptional cases. The workforce shortage and patient acuity waivers would both be phased out by June 30th, 2022. By that date, every skilled nursing facility would be required to meet the minimum staffing levels established by SB 97: 2.4 certified nursing assistants/3.5 direct care hours per resident day. Additionally, from July 1st, 2021 through June 30th, 2022, SNFs would have to meet a number of requirements during the waiver application process and if they are approved for one, would have to abide by accountability reporting requirements throughout the duration of their waiver period.

All Children Thrive Expansion. Public Health Advocates requests General Fund expenditure authority of $25 million in 2021-22 to expand the All Children Thrive pilot project to 100 new cities over five years. According to Public Health Advocates, in 2018 the Legislature funded the successful pilot of All Children Thrive–California (ACT), a statewide initiative that supports California cities to mitigate the disparate effects of adverse childhood experiences (ACEs) on California children, especially low-income children and children of color. This request would move this initiative from the pilot to the implementation phase. ACEs are a fundamental contributor to many of California's most urgent and costly social problems, including violence, poor academic performance, homelessness, drug addiction, mental illness, and chronic health conditions like heart disease and diabetes. A source of trauma and toxic stress, ACEs are so damaging—and their causes so deeply woven into our social fabric—that their prevention and intervention have been made a top public health priority. Just as germ theory transformed our ability to treat and prevent deadly infectious diseases a century ago, we must now address childhood trauma to remedy today's most pressing public health challenges. Focusing attention at their traumatic roots can help California to reduce the prevalence of physical and behavioral health problems and their harmful impact on health care, social service, and criminal justice costs and outcomes.

ACT is a statewide initiative helping California cities prevent and mitigate the impact of Adverse Childhood Experiences (ACEs). The ACT Pilot initiated a community-led movement that has established local community-led teams that are already designing resident-initiated local policies and sharing lessons learned to ensure that all California children can thrive. In the three-year pilot funded through a $10 million budget allocation, ACT has successfully engaged communities across the state to set goals, design a roadmap for success, and adopt action plans. The initiative was implemented through a partnership between the California DPH Essentials for Childhood Initiative, Community Partners, Public Health Advocates, and the UCLA Center for Healthier Children, Families and Communities.

This proposed budget allocation would take ACT from pilot to broad-based implementation: using an overlapping cohort model, this allocation would bring 100 new California cities into ACT over the next five years. ACT cities would be eligible for grants of up to $100,000 per year to support their efforts. The ACT Equity Advisory Group would continue to meet quarterly to guide the initiative in partnership with the DPH Essentials for Childhood Initiative.

Amyotrophic Lateral Sclerosis (ALS) Wraparound Model of Care Funding Extension. The Golden West Chapter of the ALS Association requests General Fund expenditure authority of $3 million annually to continue to allow the current ALS wraparound treatment model to improve access to an evidence-based model of care and keep pace with the growth in the number of people diagnosed with ALS, or Lou Gehrig's Disease. According to the Golden West Chapter, people with ALS are at the highest risk for the most severe effects of COVID-19, as respiratory failure due to complications from a respiratory infection is the leading cause of death among those diagnosed with ALS. It is common for ALS patients to experience severely compromised respiratory function as the disease progresses. As a result of COVID-19, the chapter is experiencing new and increased demand related to every aspect of the community based wraparound program delivery model. Immediately upon understanding the nature and implications of COVID-19, the chapter began to share important information, through a variety of socially distanced efforts, including online webinars and resources related to preventing individual infection, containing virus spread and addressing the disease progression and treatment needs of people living with ALS. The chapter rapidly increased its capacity to utilize technology to deliver a wide-array of clinical and home-based programs and services which enabled the multidisciplinary team to stay connected with clients, constituents, and stakeholders. There are only two drugs approved by the FDA for ALS, neither are proven to extend life by more than 2-4 months. The only way to meaningfully extend the length and quality of life for people diagnosed with ALS is to provide them with access to this evidence-based model of care. The wraparound model of care involves the seamless integration of community and clinic based multidisciplinary services. The model is proven to help people diagnosed with ALS to live significantly longer and better than either of the two FDA approved drugs.

PrEP-AP Navigation and Retention Services. The End the Epidemics coalition requests expenditure authority from the AIDS Drug Assistance Program (ADAP) Rebate Fund to support pre-exposure prophylaxis (PrEP) navigation and retention services. According to the coalition, despite the availability of highly effective prevention and treatment tools, HIV continues to be a significant public health challenge in California. Data from the California Department of Public Health indicate that 4,747 people were newly diagnosed with HIV in 2018 – a modest 9.6 percent decrease since 2014.

While the overall number of new HIV diagnoses has declined, significant inequities remain. The rate of new HIV diagnoses among Black Californians is 4.8 times higher than whites. Latinx Californians are diagnosed with HIV at a rate 1.9 times higher than whites. Black and Latinx gay and bisexual men, Black cisgender women, transgender women and youth continue to be the populations most impacted by HIV in California. Reducing and ultimately eliminating these inequities must remain a top priority even as the state responds to the COVID-19 pandemic.

Pre-exposure prophylaxis (PrEP) is one of the most effective tools available to reduce new HIV infections. The medication, first approved by the FDA in 2012, can reduce the risk of HIV infection by over 99 percent when taken as prescribed. PrEP is a central pillar of federal, state and local efforts to end the HIV epidemic.

California has been a nationwide leader in improving access to PrEP. The state was among the first to establish a PrEP financial assistance program – known as PrEP-AP – which helps low-income Californians cover out-of-pocket costs for PrEP medication and related clinical services. California's PrEP-AP is funded through the ADAP Rebate Fund. California also allocates roughly $10 million general

fund annually for comprehensive HIV prevention services, including $2 million annually to support PrEP navigation services at nine community-based organizations across the state.

Although the number of Californians using PrEP has increased dramatically in recent years, uptake remains far below what is needed to significantly reduce HIV infections and eliminate health inequities. Current estimates suggest that just over 20 percent of people who could benefit from PrEP in California were taking it in 2018. PrEP use is lowest among populations most impacted by HIV, including Black and Latinx gay and bisexual men, Black cisgender women, transgender women and youth.

This proposal would build upon the state's existing PrEP-Assistance Program (PrEP-AP) by funding PrEP navigation and retention coordinators at local health departments and community-based organizations contracted with the Office of AIDS to provide PrEP-AP enrollment and/or clinical services. PrEP navigation and retention coordinators would be responsible for conducting PrEP outreach and education, health care and financial assistance program navigation and enrollment, care coordination and adherence support, and linkage to behavioral health, substance use and social service programs. Indirect costs would include supervision, data collection, evaluation and reporting. The Office of AIDS would also contract with an outside entity to provide staff training, program technical assistance and capacity building to all of the funded programs.

Hepatitis C Test Kits and Associated Costs. The End the Epidemics coalition requests General Fund expenditure authority of $1 million, available over five years, to support the purchase of hepatitis C virus (HCV) test kits, associated materials and supplies, training for test counselors, and the staffing to support a test kit program. This proposal would support community-based HCV prevention, testing, and linkage to care and treatment efforts. According to the coalition, driven by the opioid and other drug use crises, the HCV epidemic continues to grow among young Californians – those under age 30 – at an alarming rate, with over a third (12,373) of new cases reported in 2018 occurring in this group. From 2014 to 2016, a total of 13,683 HCV cases were reported among people ages 15-29, and the rate increased 50 percent over this time period. This population is greatly in need of HCV education, testing and treatment, with just 1 in 3 youth reporting that they thought they were at risk for HCV, and only 2 percent having received HCV treatment.

HCV also disproportionately affects Black Californians. Although Black individuals make up only 6 percent of California's population, they account 11 percent of those living with HCV. Native Americans are also disproportionately affected by HCV.

Although COVID-19 has dramatically slowed data collection, it is likely that transmission of HCV has worsened, particularly for those most vulnerable to HCV infection, during the pandemic due to increases in drug use, decreases in HCV testing, delays and disruptions in health care delivery, and disruptions in needed services for people who are using drugs.

HCV is a serious public health issue in California, but one that we can dramatically improve with an investment in testing. Left untreated, HCV can cause scarring of the liver (cirrhosis), end-stage liver disease, liver cancer and death. People with chronic liver disease, especially those with decompensated cirrhosis, are also at increased risk for hospitalization and mortality from COVID-19. The American Association for the Study of Liver Disease has stated that there is compelling data from both within the United States and internationally that demonstrate this fact.

Funding for HCV prevention, screening, and linkage to and retention in care is woefully inadequate. The U.S. Department of Health and Human Services issued the Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025) in early 2021. The report provides a framework to eliminate viral hepatitis as a public health threat in the United States. The plan calls for the strategy, in part, to address the fact that HCV rates nearly tripled from 2011 to 2018, in spite of the fact that HCV is curable in one short course of treatment. Unfortunately, the report did not call for new investments in prevention, care and treatment for viral hepatitis. Prior to COVID-19, HCV was widely recognized to be the leading infectious disease killer in the United States, with the CDC reporting at that time that HCV is responsible for more deaths than the next 59 infectious diseases combined. Despite the significant morbidity and mortality that comes from HCV, the federal government invests only approximately $39 million for viral hepatitis as a whole and California only slightly more than $5 million in HCV prevention services.

This budget request does not attempt to fill that gap, but asks for a small investment to support the community-based safety net that would ensure that some of the most vulnerable Californians, those uninsured or underinsured, unhoused or marginally housed, people using drugs and others who have limited access to traditional health care systems due to stigma and discrimination, are supported in knowing their HCV status and getting linked to care and treatment.

STD Prevention and Control Activities. The End the Epidemics Coalition requests General Fund expenditure authority of $3 million annually to increase funding for sexually transmitted disease (STD) prevention and control activities. According to the coalition, this investment would combine with previous investments for a total of $10 million for DPH's STD Control Branch to dispense throughout the state to support a comprehensive, evidence-informed approach to STD prevention and improve the capacity of local health jurisdictions to address rising STD rates in their region. Funding would be prioritized to serve communities disproportionately impacted by STDs, and would be distributed through a competitive grant process to local health jurisdictions (LHJs). Once the funds are received, LHJs would be required to sub-grant out at least 50 percent of the funding to community-based organizations.

New data released by the Centers for Disease Control and Prevention (CDC) estimates that 1 in 5 people in the U.S. have an STD. The COVID-19 pandemic has exacerbated STD rates in California and across the country that were already skyrocketing to crisis levels prior to the public health emergency. According to the latest data available, in 2018, nearly 68 million STD infections were reported nationwide with rates of syphilis, chlamydia, or gonorrhea up 40 percent since 2013. California also had the second highest syphilis rates in the nation in 2018. While 90 percent of all male syphilis cases in 2013 were among bisexual and gay men, the epidemic has spread among women. Between 2008 and 2018, the syphilis rate among women of reproductive age increased by 743 percent. In 2018, more than 329 babies were born with congenital syphilis in California and there were 20 stillbirths associated with the disease. More than 100 babies were born with congenital syphilis in Los Angeles County alone in 2020 during the COVID-19 pandemic.

Federal funding for STD prevention in the state dropped by roughly 40 percent over the last 15 years. As funding withered, county public health departments and local health jurisdictions adjusted by shutting down stand-alone STD clinics, reducing staff levels and suspending surveillance and case management programs. The timeframe in which STD rates have increased correlates with the timeline of when funding

for STD prevention public health programs began to decrease. The COVID-19 crisis has further depleted public health resources and the limited STD prevention workforce across the state have been re-assigned to COVID duty.

This request would allocate $3 million ongoing General Fund dollars – in addition to the $7 million already allocated in the state budget, for a total of $10 million – to DPH's STD Control Branch to dispense to LHJs throughout the state to support a comprehensive, evidence-informed approach to STD prevention while combatting COVID-19 and beyond. Once the funds have been fully expended the ETE Coalition would work with LHJs and community-based organizations to evaluate how the funds were spent and see if there is a correlated decrease in STD cases. The scope of the STD crisis requires a larger investment and a $10 million annual allocation is just a starting point to tackle the issue.

Syringe Exchange Supply Clearinghouse Funding. The End the Epidemics Coalition Requests General Fund expenditure authority of $3 million annually to increase funding for the DPH office of AIDS Syringe Exchange Supply Clearinghouse. According to the coalition, California syringe service programs (SSPs) distribute supplies to program participants who use drugs to prevent transmission of HIV, hepatitis B and C, skin and soft tissue infections, and other health conditions. Supplies include sharps containers for the safe recovery and disposal of syringes, syringes, fentanyl test strips, sterile water, and other materials to provide for sterile injection and safer sex. This is consistent with CDC guidelines for HIV prevention among people who use drugs. In 2016, naloxone kits to reverse overdoses were added to the Clearinghouse and in 2019 harm reduction supplies for other routes of administration were added, enabling harm reduction providers to connect to people at risk who may not be injection drug users.

SSPs have been at the forefront of the COVID-19 pandemic, quickly adapting their protocols to remain open and fill gaps in other services while also providing PPE such as face masks and hand sanitizer. SSPs access some of these supplies through the Clearinghouse and distribute them to community members at increased risk for COVID-19, including people experiencing homelessness, people living with HIV, and Black, Indigenous and people of color.

Since 2016, when the Clearinghouse was established, 18 new SSPs have been authorized in California, reaching 13 additional counties. This growth in programs represents the implementation of legislative intent and is meeting the growing need for services, particularly in rural areas with high rates of overdose and HCV. A 2020 survey administered to SSPs as part of CDPH's California Harm Reduction Initiative showed that the median increase in new participants enrolled in services at SSPs was 189 per year. There are now more programs than ever before, and the average amount of syringes distributed by programs has also increased by 51 percent since 2016. Many programs are rationing out supplies due to shortage and there is no money available for any future SSPs. Recent data from Office of AIDS shows that 8 programs completely ran out of supplies last year and 2 experienced major service disruption due to a lack of supplies.

This change is urgently needed to meet the rapid expansion of programs, and the increased number of people seeking assistance to prevent fatal overdose and the transmission of potentially deadly infections. The Clearinghouse provides harm reduction supplies and PPE for the state's syringe service programs, but it is now completely maxed out at a time when demand for supplies is increasing due to COVID-19. These funds will provide hundreds of thousands of Californians with the tools they need to protect themselves and their families.

In 2019, $15 million over four years was included in the state budget to support staffing at SSPs and provide ongoing technical assistance and program administration. These funds allow for critical expansion of services for harm reduction programs, but they cannot be used for supplies. Without a similar increase in the Clearinghouse budget, these programs will not be able to provide the full range of the supplies that their participants need. This requested budget increase would enable California to experience the full benefits of the $15 million already invested in these essential services.

Medical Legal Partnerships for COVID-19 Recovery. The Children's Partnership requests General Fund expenditure authority of $30 million in 2021-22 to support COVID-19 recovery efforts for communities deeply impacted by the pandemic through a grant program that encourages partnerships between community programs and legal service organizations that support families and children. According to the Children's Partnership, children are able to thrive when their families have access to the tools and resources necessary for a healthy and nurturing environment. During times of crisis, a team of providers, legal advocates, and family specialists offers a family the concrete support and services that address a family's needs and help minimize stress caused by challenges, particularly those that have arisen as a result of the pandemic. The COVID-19 pandemic continues to disproportionately devastate California's Latinx, Black, Pacific Islander, and immigrant families, while these very communities shoulder the front-line work keeping our state's economy running. For example, among children, Latinx, Black, Native American and Pacific Islander children make up nearly 70 percent of cases, despite making up slightly over 50 percent of the state's population of children. Further, California's immigrant communities have been devastated by the pandemic, both in job loss as well as being exposed to COVID-19 risk by working on the frontlines: one in three undocumented workers in California is employed in an industry negatively affected by the COVID-19 economic shutdown while also making up about 33 percent of the state's essential workforce. In addition, multiple surveys distributed to families across the state with partners like Parent Institute for Quality Education and the Education Trust West highlight the numerous struggles that families continue to face, including food and housing insecurity, eviction, lack of broadband access, lack of child care, and lack of mental health and health supports. Additionally, a recent report from the Legislative Analyst's Offices highlights how the Governor's 2021-22 budget proposal does not include a specific plan or strategy within the California Department of Public Health (CDPH) for COVID-19-related spending through the end of 2020-21. The integration of legal partners into family-serving system is a community-level intervention to advance health equity and address the social determinants of health in response to COVID-19. Prohibiting patient billing would allow patients to have more financial resources for independence and community integration after institutionalization, provide parity with the provision of health care within the criminal justice system, and eliminate anxiety caused from notices.

Transgender Wellness and Equity Funding. The Trans Latin@ Coalition requests General Fund expenditure authority of $15 million annually to support organizations providing health care services to transgender, gender non-conforming, or intersex (TGI) individuals. According to the coalition, the Williams Institute estimates that at least 218,400 individuals in California identify as transgender. Despite representing a significant portion of the state's population, TGI people are often left out of conversations regarding medical and mental healthcare. In a 2015 survey, 33 percent of transgender people who saw a health care provider reported having at least one negative experience related to being transgender, with higher rates of negative experiences reported by transgender people of color and transgender people with disabilities. These negative experiences include refusal of treatments, verbal harassment, physical and

sexual assault, or having to educate the provider about transgender people in order to receive appropriate and necessary care. Within that statistic, 24 percent of people that shared negative experiences with health care providers identified as non-binary. Additionally, in a national study of intersex adults in the U.S., 43 percent of participants rated their physical health as fair/poor and 53 percent reported fair/poor mental health. Prevalent health diagnoses included depression, anxiety, arthritis, and hypertension, with notable differences by age. Nearly a third reported difficulty with everyday tasks and over half reported serious difficulties with cognitive tasks.

Stigma and discrimination in healthcare practices further contribute to the dire experiences faced by TGI people. Lack of access to health care often leads TGI people, especially transgender women of color, to rely on underground economies as their primary source of transition-related care. For non-binary transgender people, access to gender affirming care is especially difficult because of provider unfamiliarity with genders beyond the traditional gender binary. As a result, gender based care is limited to cisgender care.

The significant barriers in society experienced by TGI people have only been exacerbated by the current public health crisis. Homelessness, economic instability, and difficulties in accessing health care are only a few of the barriers that have worsened during the pandemic. Lack of access to safe and stable housing is one of the primary factors that increases the risk of TGI people contracting COVID-19. Additionally, like millions of Californians, many TGI people are more likely to have lost jobs or had their work hours severely reduced, leading to financial instability. Community based TGI-serving organizations provide life-affirming critical services that help address the needs of the TGI community during this crisis. This funding is necessary to continue providing basic resources such as food, shelter, mental and emotional support programming, and much more during and following the COVID-19 pandemic and the economic downturn California now faces.

Access to safe, competent, and TGI-inclusive medical care is increasingly critical during a time when strong public health is key to controlling the spread of COVID-19 and preventing an overwhelmed health care system. While California has historically provided funding for LGBTQI+ programs and services, California would be the first state to specifically fund TGI communities. State funding is necessary for TGI-serving organizations across the state to increase their capacity and expertise to provide TGI people with appropriate care and to assist TGI people in recovery following the COVID-19 pandemic.

Women Infants and Children (WIC) Program Public Contracting Code Exemption. The California WIC Association requests trailer bill language to provide flexibilities for the 84 WIC local agency contracts with DPH through an exemption in the Public Contracting Code. According to the California WIC Association, an exemption in the Public Contracting Code would allow DPH and the WIC program to provide flexibilities in the contracts with the 84 WIC local agencies, reducing unspent WIC funds returned annually to the US Department of Agriculture. The current onerous contract process results in the inability of WIC local agencies to fully use funds during the fiscal year. As a result, there are losses for services for participants and costs to community programs that are already stretched.

Extend of Repeal Sunset Date for California Parkinson's Disease Registry. The Michael J. Fox Foundation requests trailer bill language to extend or repeal the sunset date for the California Parkinson's Disease Registry. According to the foundation, last year the Michael J. Fox Foundation for Parkinson's Research (MJFF) made the decision to fund California's Parkinson's Disease Registry for the 2020-21

fiscal year since California was facing an unprecedented budget shortfall due to COVID-19. The foundation is currently providing roughly $380,000 to fund the Registry through June 2021.

The Governor's 2021-22 budget proposal provides $409,000 in General Fund dollars to continue the California Parkinson's Disease Registry but deferred to the Legislature the decision on an appropriate repeal date for the Registry since current law sunsets the Registry on January 1, 2022. The foundation supports the Governor's funding proposal and requests that the Legislature either delete the repeal date on the Registry or extend it to June 30, 2030.

The Parkinson's research community is relying on the Registry's data for critical treatment advancements and should not be distracted every year by the uncertainty of whether or not the repeal date for the Parkinson's Registry will be extended or not. Certainty around the sunset date will increase the likelihood that state and/or private funds will be made available in the future.

DEPARTMENT OF STATE HOSPITALS

Stop DSH Patient Billing. The Western Center on Law and Poverty (WCLP) requests trailer bill language to prohibit the Department of State Hospitals from billing patients and their families for the cost of care during placement. According to WCLP, State Hospitals are charging patients for the full amount of their medical care, with bills reaching over $1 million. It is cruel and unfair to recover money from patients and patients' family members who are subject to involuntary treatment in state hospitals. Inmates in jails and prison are not subject to this, yet when transferred or awaiting trial in a State Hospital, they are charged for their medical care. These differences in treatment raise equity concerns for people with mental health disabilities. Very few people with severe mental illness can absorb the full costs of their medical care at state hospitals, especially when they often cannot work jobs that could support the payment of these bills.

Frightening notices can cause anxiety and fear among patients and their family members, with very little being actually collected. The notices are frightening as former patients are informed that they owe significant amounts, in some cases over a million dollars, for their care in a State Hospital. The bill also informs former patients that the state can go after their spouse, children, parents, and their estates for payment, which may have unintended consequence of weakening patients' family support system. There is no reason family member liability should be treated any differently for people with significant mental health problems. This also undermines state efforts to support the re-entry population and even efforts by DSH to help people enroll in health care and other public assistance prior to release.

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Mental Health Student Services Act Augmentation. Children Now requests General Fund expenditure authority of $80.5 million in 2021-22 to provide additional grants for partnerships between schools and county mental health programs to provide mental health services to students. According to Children Now, school-county partnerships are meant to prevent student mental health concerns from becoming severe and disabling; increase timely access to services; participate in outreach to recognize early signs; reduce stigma; reduce discrimination; and prevent negative outcomes. During a 2019 Request for Proposal Process, the MHSOAC was able to fund 18 of the 38 county applicants. The remaining unfunded 20

county applications, like Los Angeles, Contra Costa, Sacramento, Imperial, Mariposa and Nevada, represent turn-key partnerships ready for implementation once funded and would allow schools in those counties to begin providing much needed supports to school age children.

COVERED CALIFORNIA

Covered California State Subsidy Extension. Health Access California requests General Fund expenditure authority of $400 to $500 million annually for three years to support extension of the state subsidy program to improve health insurance affordability in the Covered California health benefits exchange. According to Health Access California, because California's premium subsidies were initially granted for only three years, without further budgetary action the additional financial assistance that Covered California enrollees rely upon will run out at the end of calendar year 2022. Because Covered California implements changes during 2020-21 and 2021-22 for open enrollment for the calendar year 2022 that commences on Oct. 1, 2021, action this year is necessary to assure smooth implementation.

Though federal proposals currently moving through the reconciliation process may result in even more federal premium assistance, the current federal proposals are also time-limited to the end of 2022. Given the context of the pandemic and ongoing issues of affordability for low- and middle-income Californians, it is important to secure California's subsidies for at least another three-year term. This is the year to extend the affordability assistance: Covered California and health insurers will need to prepare and price health plans for 2023 well before the 2022 budget is passed and signed into law.

Two years ago, California took unprecedented action to provide premium subsidy assistance to over one million low- and middle-income Covered California enrollees. The state subsidies have augmented existing federal premium subsidies for those in between 400 percent and 600 percent of the federal poverty level (FPL), about $48,000 to $75,000 for an individual, and provided more help to those 200 percent to 400 percent of the FPL, about $24,000 to $48,000 for an individual, while imposing a state-level individual mandate. As of May 2020, nearly 600,000 low to moderate income Californians earning below 400 percent of the FPL benefitted from the new state subsidies, and nearly 38,000 middle class consumers in the 400 to 600 percent FPL range received the new state subsidies.

State Subsidies to Provide Zero Premiums for Covered California Plans. Health Access California requests annual General Fund expenditure authority of $15 to $19 million and trailer bill language to allow state-level premium subsidies to cover the $1 per member per month premiums for state-only coverage, for all Covered California marketplace enrollees. According to Health Access California, affordability remains a significant barrier to enrollment in the Covered California marketplace. Despite the economic crisis resulting from the pandemic, and record numbers of Californians facing unemployment, Covered California has seen only modest increases in enrollment. Recent research has shown that any premiums, regardless of amount, play a role in deterring enrollment, particularly for those in lower income ranges. Under current law, California is not able to offer true zero premium plans, but instead health plans charge a minimum of $1 per member per month for every enrollee in Covered California. It's been estimated that 2019 enrollment in Covered CA would have increased by about 60,000 enrollments if true zero premium plans had been offered (Health Affairs, Jan. 2020).

By changing statute to provide for state subsidy coverage of the $1 per month premiums for state-only coverage, the state could offer true zero premium plans in the Covered California marketplace. This

change would potentially increase enrollment for consumers who are deterred by the presence of any premium, regardless of how low, by improving affordability and removing the administrative barrier of the separate $1 premium. In addition, by allowing true zero premium coverage, it would facilitate enrollment of those who are moving from Medi-Cal to Covered California as the minimum wage rises, and also other approaches to auto-enrollment, such as those subject to the California individual mandate penalty.

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

Questions. The subcommittee has requested LAO to briefly present each of these proposals for investment.