*Senate Budget and Fiscal Review—Scott Wiener, Chair*

# SUBCOMMITTEE NO. 3 Agenda

**Senator Caroline Menjivar, Chair**
**Senator Susan Talamantes Eggman, Ph.D.**
**Senator Shannon Grove**
**Senator Richard D. Roth**

**Thursday, March 14th, 2024**
**9:30 am, or upon adjournment of session**
**1021 O Street – Room 1200**

Consultant: Scott Ogus



## PUBLIC COMMENT

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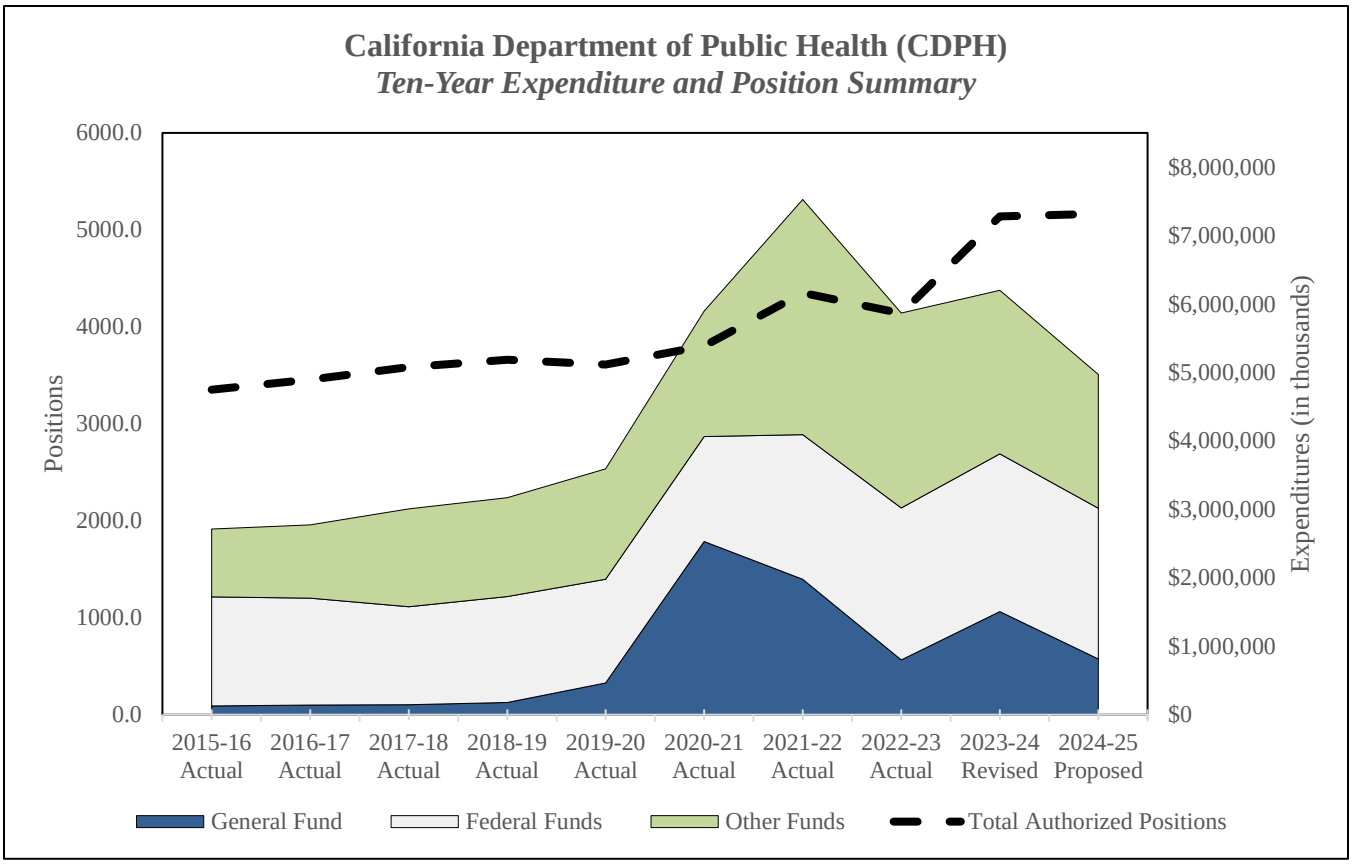
## 4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

### Issue 1: Overview




| California Department of Public Health - *Department Funding Summary* *(dollars in thousands)* | | | | |
|---|---|---|---|---|
| **Fund Source** | ***2022-23 Actual*** | ***2023-24 Budget Act*** | ***2023-24 Revised*** | ***2024-25 Proposed*** |
| **General Fund** | $802,439 | $997,168 | $1,507,755 | $815,317 |
| **Federal Funds** | $2,218,300 | $2,249,494 | $2,301,540 | $2,200,573 |
| **Other Funds** | $2,847,002 | $2,288,817 | $2,393,217 | $1,955,278 |
| **Total Department Funding:** | **$5,867,741** | **$5,535,479** | **$6,202,512** | **$4,971,168** |
| **Total Authorized Positions:** | **4140.4** | **5084.0** | **5139.6** | **5165.4** |
| **Other Funds Detail:** | | | | |
| ***Breast Cancer Research Account (0007)*** | $2,095 | $718 | $385 | $587 |
| ***Nuclear Planning Assessment Acct (0029)*** | $762 | $1,078 | $1,087 | $1,091 |
| ***Motor Vehicle Acct, Trans. Fund (0044)*** | $1,291 | $1,709 | $1,721 | $1,723 |
| ***Sale of Tobacco to Minors Ctrl Acct (0066)*** | $25 | $1,052 | $1,062 | $1,063 |

| | | | | |
|---|---|---|---|---|
| ***Occup. Lead Poisoning Prev Acct (0070)*** | $1,743 | $4,174 | $2,600 | $3,100 |
| ***Medical Waste Management Fund (0074)*** | $2,909 | $3,180 | $3,266 | $3,276 |
| ***Radiation Control Fund (0075)*** | $29,423 | $31,349 | $31,832 | $31,902 |
| ***Tissue Bank License Fund (0076)*** | $463 | $1,629 | $1,670 | $1,675 |
| ***Childhood Lead Poisoning Prev Fund (0080)*** | $29,246 | $47,438 | $47,857 | $47,922 |
| ***Export Document Program Fund (0082)*** | $412 | $624 | $569 | $706 |
| ***Clinical Lab. Improvement Fund (0098)*** | $13,081 | $16,110 | $16,579 | $16,607 |
| ***Health Statistics Special Fund (0099)*** | $20,618 | $32,362 | $33,509 | $33,686 |
| ***Dept. of Pesticide Regulation Fund (0106)*** | $291 | $359 | $362 | $363 |
| ***Air Pollution Control Fund (0115)*** | $302 | $317 | $320 | $320 |
| ***CA Health Data and Planning Fund (0143)*** | $240 | $240 | $240 | $240 |
| ***Food Safety Fund (0177)*** | $10,523 | $12,288 | $12,189 | $13,305 |
| ***Genetic Disease Testing Fund (0203)*** | $162,288 | $187,608 | $167,770 | $181,545 |
| ***Health Education Account, Prop 99 (0231)*** | $37,317 | $42,992 | $43,106 | $39,040 |
| ***Research Account, Prop 99 (0234)*** | $2,790 | $4,274 | $4,300 | $4,003 |
| ***Unallocated Account, Prop 99 (0236)*** | $1,890 | $1,715 | $1,812 | $1,803 |
| ***Infant Botulism Treatment/Prev Fund (0272)*** | $6,514 | $14,041 | $14,072 | $18,278 |
| ***Child Health and Safety Fund (0279)*** | $485 | $551 | $551 | $551 |
| ***Registered Enviro. Health Spec Fund (0335)*** | $438 | $503 | $509 | $510 |
| ***Indian Gaming Spec Dist Fund (0367)*** | $8,064 | $8,497 | $8,514 | $8,519 |
| ***Vectorborne Disease Account (0478)*** | $141 | $209 | $213 | $195 |
| ***Toxic Substances Control Acct (0557)*** | $351 | $584 | $585 | $586 |
| ***Domestic Violence Training/Ed Fund (0642)*** | $295 | $685 | $706 | $709 |
| ***CA Alzheimer's Research Fund (0823)*** | $618 | $680 | $686 | $687 |
| ***Special Deposit Fund (0942)*** | $8,015 | $8,971 | $9,012 | $9,016 |
| ***Reimbursements (0995)*** | $518,797 | $873,972 | $1,013,709 | $575,977 |
| ***Drug and Device Safety Fund (3018)*** | $6,624 | $7,873 | $8,423 | $7,461 |
| ***WIC Manufacturer Rebate Fund (3023)*** | $194,081 | $217,313 | $189,616 | $190,373 |
| ***Medical Marijuana Program Fund (3074)*** | $0 | $0 | $0 | $0 |
| ***AIDS Drug Assistance Program Fund (3080)*** | $240,742 | $308,186 | $258,146 | $273,357 |
| ***Cannery Inspection Fund (3081)*** | $4,344 | $4,342 | $4,493 | $4,511 |
| ***Mental Health Services Fund (3085)*** | $1,953 | $2,598 | $2,743 | $2,767 |
| ***Licensing and Certification Fund (3098)*** | $263,399 | $296,881 | $307,875 | $313,858 |
| ***Gambling Addiction Program Fund (3110)*** | $150 | $150 | $150 | $350 |
| ***Birth Defects Monitoring Prog Fund (3114)*** | $2,310 | $2,556 | $2,576 | $2,579 |
| ***Lead-Related Construction Fund (3155)*** | $948 | $1,363 | $1,394 | $1,401 |
| ***Cost/Impl Acct, Air Poll. Ctrl Fund (3237)*** | $401 | $400 | $408 | $410 |
| ***Cannabis Control Fund (3288)*** | $467 | $601 | $601 | $601 |
| ***State Dental Program Acct., Prop 56 (3307)*** | $26,886 | $32,954 | $33,068 | $35,100 |
| ***Tobacco Law Enforcement Acct. Prop 56 (3308)*** | $0 | $0 | $0 | $0 |

| | | | | |
|---|---|---|---|---|
| ***Tobacco Prev/Control Prog Acct. Prop 56 (3309)*** | $0 | $0 | $0 | $0 |
| ***DPH Tobacco Law Enforc, Prop 56 (3318)*** | $6,397 | $4,647 | $4,656 | $4,071 |
| ***DPH, Tobacco Prev/Ctrl, Prop 56 (3322)*** | $98,366 | $85,041 | $85,217 | $100,491 |
| ***TGI Wellness and Equity Fund (3385)*** | ($12,729) | $0 | $12,729 | $0 |
| ***Industrial Hemp Enroll/Oversight Fund (3396)*** | $0 | $1,253 | $0 | $2,113 |
| ***Opioid Settlement Fund (3397)*** | $8,221 | $22,750 | $60,329 | $16,850 |
| ***California Emergency Relief Fund (3398)*** | $1,143,015 | $0 | $0 | $0 |

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

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

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

The department is composed of seven major program areas:

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

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

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

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

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

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

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

**State of the State's Public Health.** The 2018 Budget Act included the following supplemental reporting language requiring CDPH to provide information on the State of the State's Public Health.

**Item 4265-001-0001—Department of Public Health**

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

SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, codified the annual State of the State's Public Health report, delivered by the State Public Health Officer, into the Health and Safety Code (Section 101320.3).

**Sexual Orientation and Gender Identity (SOGI) Data Collection.** As part of its public health mission, CDPH collects data regarding Californians' health and well-being, incidence of infectious and chronic disease, vital records, among other data collection efforts. AB 959 (Chiu), Chapter 565, Statutes of 2015 requires state departments, including CDPH, to collect and report voluntarily provided self-identification about sexual orientation and gender identity (SOGI) when collecting ancestry or ethnic origin information. Despite these requirements, a recent audit by the California State Auditor found that CDPH has been slow to adopt and enforce standardized definitions, guidelines, and training to ensure the consistent collection, analysis, and reporting of SOGI data. As a result, CDPH has limited ability to identify and address health disparities that exist in the LGBTQ population in California.

The audit identified 129 forms collected by CDPH that collect ancestry or ethnic origin information and may be required by state law to also collect SOGI data. However, CDPH asserted that 105 of those forms are subject to an exemption that permits, but does not require, CDPH to collect SOGI data because the forms are collected by a third-party entity, such as a local health jurisdiction or a health care provider. Among the 24 remaining forms not subject to the exemption, the audit found seven do not collect complete SOGI data because of a lack of clear and consistent policies regarding collection of the data. Examples

of data forms that do not collect SOGI information due to the third party exemption are the California Cancer Registry, the Adult HIV/AIDS Case Report Form, and most infectious disease case report forms.

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

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

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

2. Please present the State of the State's Public Health report, pursuant to the provisions of SB 184.

3. Please respond to the findings of the 2023 state audit regarding the collection of SOGI data by CDPH.

4. The audit reported that the vast majority of forms collected by CDPH are exempt from mandatory SOGI collection because they are collected by a third party. However, CDPH is permitted to collect SOGI data on these forms. Why did CDPH choose not to collect SOGI data for 105 of the 129 forms identified by the auditor?

5. In the absence of collecting SOGI information in the vast majority of its data streams, how does CDPH identify public health issues that specifically impact the LGBTQ community?

6. How does CDPH plan to address these gaps in its data collection efforts to effectively respond to public health issues for LGBTQ Californians?

## Issue 2: The Future of Public Health – Investments in State and Local Public Health Infrastructure

**The Future of Public Health - Legislative Oversight.** In response to years of inadequate funding of the state's public health system that left Californians vulnerable during the COVID-19 pandemic, the 2022 Budget Act included trailer bill language to authorize the Future of Public Health program at CDPH, and included 404 positions and General Fund expenditure authority of $300 million annually, to modernize California's public health system with the goal of protecting and improving the health of all Californians. Of these resources, $200.4 million provides direct support for California's 61 local health jurisdictions and $99.6 million supports statewide public health priorities at CDPH. In addition to these long overdue investments, the Legislature approved other resources to address state and local public health infrastructure, including investments in information technology, workforce development, and post-pandemic review. As the state continues its exit from the acute phase of the COVID-19 pandemic, the subcommittee would like to examine how recent budget investments are improving the delivery of essential public health services to Californians, fostering improvements in population health, and preparing the state for future pandemics and other public health emergencies. The subcommittee would also like to examine the work that remains to be done, including necessary funding, to achieve the goal of a complete, equitable, and functional public health system.

**Background.** "The governmental public health infrastructure has suffered from political neglect and from the pressure of political agendas and public opinion that frequently override empirical evidence." These words were printed, not in any recent publication discussing pre- and post-COVID-19 public health infrastructure, but more than 20 years ago in the Institutes of Medicine's (IOM) "The Future of the Public's Health in the 21st Century"[1]. This report was published in 2003 after the anthrax and bioweapons scares the nation experienced after the terrorist attacks of September 11th, 2001. The report itself was a follow-up to the IOM's 1988 publication "The Future of Public Health" which was initiated to address a growing perception that "this nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray."[2]

The decades-long inattention and underfunding of our public health system typically is laid bare during public health emergencies. The 2002 IOM report was prompted by a public health emergency related to a terrorist attack involving anthrax and the United States Postal Service, as well as the potential for other use of bioweapons to harm Americans. The current inquiry by this subcommittee will cover recent investments in public health infrastructure that were implemented in response to the gaps in our public health system that were made apparent by the state's response to the COVID-19 pandemic.

**The Impact of Public Health.** Public health is often invisible to those who most benefit from its work and influence. Many of the advances in civilized society Californians take for granted are made possible by the efforts of public health workers operating in the background of their lives. Public health workers monitor and track outbreaks of infectious diseases, most notably and recently the COVID-19 pandemic, but also outbreaks of measles, hepatitis A, and sexually transmitted infections (STIs). Public health workers make sure the food Californians eat is free of food-borne pathogens and other dangerous

[1] Institute of Medicine. "The Future of the Public's Health in the 21st Century". 2003. The National Academies Press. Washington, D.C.

[2] Institute of Medicine. "The Future of Public Health". 1988. The National Academies Press. Washington, D.C.

contaminants. Public health workers regulate the quality of health facilities, including hospitals, clinics, and nursing homes to ensure the places Californians go to seek medical care are safe, clean, and are capable of providing high-quality services. Public health engages in a wide variety of population health interventions, from the Black Infant Health programs that seek to reduce vast disparities in maternal and infant morbidity and mortality, to Childhood Lead Poisoning Prevention programs that ensure California's kids have a safe place to grow up, to tobacco prevention programs that reduce smoking and lung-related diseases.

Public health becomes most visible to policymakers and the public when it is unsuccessful: an uncontrolled disease outbreak, a failure to protect the food supply, or the persistence of health disparities. As a result, there is a limited constituency to advocate for maintaining adequate funding for essential public health services, often public health workers themselves, healthcare providers, or community-based organizations focused on public health or health disparities. For decades, the level of public investment in public health at the national, state, and local level has been significantly below what is needed for a truly equitable public health system that can keep Californians healthy and safe.

**California's Public Health System.** The federal Centers for Disease Control and Prevention (CDC) has identified 10 Essential Public Health Services. These services provide a framework for public health systems to protect and promote the health of all people in all communities. The 10 Essential Public Health Services are as follows[3]:

1) Assess and monitor population health status, factors that influence health, and community needs and assets.
2) Investigate, diagnose, and address health problems and hazards affecting the population.
3) Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it.
4) Strengthen, support, and mobilize communities and partnerships to improve health.
5) Create, champion, and implement policies, plans, and laws that impact health.
6) Utilize legal and regulatory actions designed to improve and protect the public's health.
7) Assure an effective system that enables equitable access to the individual services and care needed to be healthy.
8) Build and support a diverse and skilled public health workforce.
9) Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement.
10) Build and maintain a strong organizational infrastructure for public health.

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

[3] Centers for Disease Control and Prevention. Ten Essential Public Health Services (Revised 2020). http://cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html. Accessed March 2, 2024.

In addition to the state department, 61 local health jurisdictions from each of California's 58 counties and from three cities (Berkeley, Long Beach, and Pasadena) support public health interventions at the local level. Local health jurisdictions are funded by 1991 Realignment funds, local county General Fund, and a variety of state and federal funding streams for specific programs.

**Public Health Workforce Shortages.** The COVID-19 pandemic has laid bare the decades-long underinvestment in public health in California, the nation, and the world, particularly in developing the public health workforce. Since the height of the pandemic, many public health officers identified additional staff resources as the most important resource they would have wanted to be available before the pandemic began. According to the California Future Health Workforce Commission, 61 percent of managers and supervisors, and 44 percent of non-supervisory staff at the California Department of Public Health are eligible for retirement, and the department estimates two-thirds of its workforce will retire in the next five years. At the local level, county and city health departments 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.[4] The instability of funding is a particular problem the Legislature attempted to address in the Future of Public Health investment included in the 2022 Budget Act. Most local public health funding is categorical, tied to specific programs or activities, with no flexibility to support comprehensive public health strategies. In addition, the Legislature attempted to address challenges in public health workforce development with a package of workforce initiatives aimed at improving recruitment, retention, and training of public health professionals.

**The Future of Public Health.** The 2022 Budget Act included 404 positions and annual General Fund expenditure authority of $300 million to support the Future of Public Health, a long overdue investment in strengthening state and local public health systems. Of these resources, $99.6 million is available annually for CDPH to address statewide public health priorities, and $200.4 million is available to local health jurisdictions.

*CDPH Investments – Six Foundational Services.* The Future of Public Health investments in the state public health system are categorized into six foundational services identified by the Future of Public Health Work Group established in 2021 to evaluate public health infrastructure investments. CDPH received 404 positions and $99.6 million in the following areas:

- *Workforce.* 270 positions and General Fund expenditure authority of $58 million annually to increase staffing capacity and to attract, develop, and retain a diverse, multi-disciplinary public health workforce. According to CDPH, these positions and resources support the following initiatives:

    - A multi-channel, proactive, and digitally-enabled recruitment and hiring functions to attract top talent that reflects the diversity of California's population.
    - A simplified, aligned job classification system within CDPH that can be used as a model for local health jurisdictions.
    - A holistic organizational culture transformation at CDPH and at the local level to promote inclusiveness and support employees, incentivizing them to stay and grow into leadership through development support, career pathways, sufficient staffing, salary and non-salary incentives.

[4] California Future Health Workforce Commission. *Meeting the Demand for Health.*

- A culture of growth and learning via a well-structured, up-to-date, and highly accessible training program.
- A comprehensive competency-based performance management system to define necessary competencies across public health roles, assess gaps in skillsets, and track competency development along career progression pathways.
- An operational planning function to develop staffing benchmarks, make sure minimum recommended staffing standards are met at the state and local level, and support agile, strategic workforce deployment based on need.
- An Office of Policy and Planning to conduct strategic planning to address current and emerging threats to public health, be accountable for effective and efficient use of funds, establish clear and quantifiable performance targets, and ensure actions are aligned with strategic priorities and increased equity.

- *Emergency Preparedness and Response.* 77 positions and General Fund expenditure authority of $27.6 million annually for a scalable and sustainable structure that can rapidly identify hazards and deploy resources to mitigate and contain public health threats. These positions and resources support the following initiatives:

  - Developing a 24 hour intelligence hub and surveillance network
  - A dedicated core team to support regular refreshes of planning, training, and exercises
  - Developing a regional resourcing model to support regional coordination with Regional Disaster Medical Health Specialists.
  - Developing a dedicated recovery unit to establish public health recovery guidance after public health events.

- *IT, Data Science, and Informatics.* 133 positions and $235.2 million in 2022-23, 144 positions and $156.6 million in 2023-24, and $61.8 million annually thereafter to support maintenance and operations of information technology systems established during the COVID-19 pandemic. These resources were authorized by a companion proposal specific to these components in the 2022 Budget Act.

- *Communications and Public Education.* 26 positions and General Fund expenditure authority of $4.5 million annually to achieve a proactive, personalized, and highly coordinated communication strategy that meets the varying demands of California's diverse population and provides capacity to tailor messages to effectively reach all Californians. These positions and resources support the following initiatives:

  - Creation of a core public health communications strategy and deployment plan.
  - Bolster operational capabilities and adequate capacity to effectively disseminate communications.

- *Community Partnerships.* Five positions and General Fund expenditure authority of $2.9 million to achieve a holistic partnership network engaged to support California's state and local public health efforts. These positions and resources support the following initiatives:

  - Development of a community partnership strategy and plan to outline roles and intended capabilities of community partners in supporting California's public health mission.

- Dedicated community engagement personnel to deliver personalized outreach and uptake of an overarching community partnership strategy.

- *Community Health Improvement.* 23 positions and General Fund expenditure authority of $6.1 million annually to provide a comprehensive community health improvement strategy that emphasizes a life-course approach, resiliency, equity, and prevention. These positions and resources support the following initiatives:

  - Community health financing strategies that emphasize a life-course approach to health and public health prevention.
  - Dedicated community health improvement team to support policy making across agencies.
  - Development and implementation of a behavioral mental health program to address the current behavioral and mental health crisis in the state.

*Local Health Jurisdiction Funding.* The Future of Public Health investments in the state's 61 local health jurisdictions provide $200.4 million allocated annually based on the following methodology:

- Each jurisdiction receives a base funding amount of $350,000 per year. After this allocation, the remaining balance of the annual funding will be provided proportionally as follows:

  - 50 percent based on most recent population data
  - 25 percent based on most recent poverty data
  - 25 percent based on most recent share of the population that is Black/African American, Latinx, or Native Hawaiian/Pacific Islander

According to CDPH, the distribution of funds for 2023-24 through 2025-26 by local health jurisdiction were as follows:

| **Future of Public Health Funding – Local Health Jurisdictions** | | | | |
|---|---|---|---|---|
| **Local Health Jurisdiction** | **Amount Funded** | | **Local Health Jurisdiction** | **Amount Funded** |
| Alameda | $6,537,374 | | Orange | $13,351,733 |
| Alpine | $354,669 | | Pasadena | $1,033,025 |
| Amador | $487,482 | | Placer | $1,661,462 |
| Berkeley | $912,213 | | Plumas | $420,397 |
| Butte | $1,224,383 | | Riverside | $11,782,061 |
| Calaveras | $515,889 | | Sacramento | $7,072,450 |
| Colusa | $459,468 | | San Benito | $647,267 |
| Contra Costa | $4,844,667 | | San Bernardino | $11,284,416 |
| Del Norte | $474,087 | | San Diego | $14,356,108 |
| El Dorado | $1,015,644 | | San Francisco | $3,639,888 |
| Fresno | $6,126,172 | | San Joaquin | $4,031,505 |
| Glenn | $482,368 | | San Luis Obispo | $1,459,610 |
| Humboldt | $938,349 | | San Mateo | $3,141,653 |
| Imperial | $1,568,105 | | Santa Barbara | $2,433,999 |

| | | | | |
|---|---|---|---|---|
| Inyo | $423,621 | | Santa Clara | $7,296,326 |
| Kern | $5,381,815 | | Santa Cruz | $1,475,452 |
| Kings | $1,175,830 | | Shasta | $1,031,180 |
| Lake | $641,433 | | Sierra | $362,059 |
| Lassen | $481,278 | | Siskiyou | $538,801 |
| Long Beach | $2,807,624 | | Solano | $2,186,187 |
| Los Angeles | $47,328,331 | | Sonoma | $2,174,091 |
| Madera | $1,217,976 | | Stanislaus | $2,975,808 |
| Marin | $1,241,952 | | Sutter | $787,927 |
| Mariposa | $421,598 | | Tehama | $642,801 |
| Mendocino | $723,894 | | Trinity | $405,254 |
| Merced | $1,882,112 | | Tulare | $3,085,604 |
| Modoc | $394,124 | | Tuolumne | $543,960 |
| Mono | $403,629 | | Ventura | $3,857,269 |
| Monterey | $2,563,477 | | Yolo | $1,397,659 |
| Napa | $896,612 | | Yuba | $707,793 |
| Nevada | $690,079 | | **TOTAL** | **$200,400,000** |

Once local health jurisdictions receive the funding, they must certify that the funding will only be used to supplement, rather than supplant, existing levels of services supported by local funds. These funds must also be used in the following proportions:

- 70 percent of the funds must support the hiring of permanent city or county staff, including benefits and training.
- 30 percent may be used for equipment, supplies, and other administrative purposes, such as facility space, furnishings and travel.

Each local health jurisdiction must also submit a three-year Local Public Health Workplan and yearly Spend Plan, beginning in the 2023-24 fiscal year, with the following requirements:

1) Each Workplan should be informed by a Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and/or a Strategic Plan.
2) If a CHA or CHIP has not been completed, the Workplan should describe how the local health jurisdiction will identify and address relevant community health issues and provide a plan and target data for completion of a CHA and CHIP.
3) The Workplan and Spend Plan should describe what positions the local health jurisdiction plans to hire and how it will support local objectives in which it has direct influence.
4) The Workplan should include an evaluation plan and metrics.
5) Local health jurisdictions will be required to measure and evaluate the process and outcome of hiring permanent staff.

In addition to the three-year planning requirements, a local health jurisdiction must annually present updates to its Board of Supervisors or City Council on the state of the jurisdiction's public health. This update must identify the most prevalent current cases of morbidity and mortality, causes of morbidity and mortality with the most rapid three-year growth rate, and health disparities. The presentation must also

provide an update on progress addressing these issues through the strategies and programs identified in the Workplan, as well as identify policy recommendations for addressing these issues.

**Public Health Workforce Investments.** The 2022 Budget Act included significant investments in health workforce development in the areas of behavioral health, primary care, public health, and reproductive health. The public health investments in the package were as follows:

- *Waive Public Health Nurse Certification Fees* - $3.3 million annually for three years to waive public health nurse certification fees for three years to reduce barriers to registered nurses entering the field of public health.

- *Public Health Incumbent Upskilling* - $3.2 million annually for four years to establish the Public Health Workforce Career Ladder Education and Development Program to provide education and training for existing employees within the public health workforce, including stipends to offset up to 12 hours per week to complete educational requirements and grants for local health departments for additional hiring.

- *California Public Health Pathways Training Corps* - $8 million annually for three years to expand the California Public Health Pathways Training Corps, which provides a workforce pathway for early-career public health professionals from diverse backgrounds and disproportionately impacted communities.

- *California Microbiologist Training* - $3.2 million annually for three years to increase the number of Public Health Microbiologist Trainee spots, which is a requirement to become certified in California as a public health microbiologist.

- *Public Health Lab Aspire* - $3.2 million annually for three years to restore funding for the Lab Aspire Program, to address the severe shortage of trained and qualified public health laboratory directors.

- *California Epidemiologic Investigation Service (Cal-EIS) Training* - $3.2 million annually for three years to increase the number of Cal-EIS fellows, and train epidemiologists for public health leadership positions.

**Panel Discussion.** The subcommittee has convened the following panelists to discuss recent investments in public health infrastructure and the status of our state and local public health systems:

- **Sara Bosse**, Public Health Director, Madera County
- **Sara Rudman, M.D., M.P.H.,** Deputy Health Officer, Santa Clara County
- **Kim Saruwatari,** Public Health Director, Riverside County
- **Ronald Coleman Baeza,** Managing Director of Policy, California Pan-Ethnic Health Network
- **Melissa Stafford-Jones,** President and CEO, Public Health Institute

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

**Discussion Questions.** The subcommittee has requested CDPH and panelists to respond to the following:

CDPH

1. The 2021 Budget Act included resources to conduct both a Post-COVID Equity Analysis and a Pandemic Response Review. Please provide an update on the status of these two reports.

2. The 2022 Budget Act authorized the Future of Public Health program, with six major program areas:

   a. Workforce – The Workforce area included 270 positions and $57.9 million to increase staffing capacity. Please provide an overview of the following:

      i. The primary classifications and activities to which the 270 positions allocated in this area were assigned.
      ii. Hiring status of these positions, including vacancy rates.
      iii. A description of how these positions have contributed to attracting, developing, and retaining a diverse, multi-disciplinary public health workforce, including any available outcomes measures, metrics, or other data.

   b. Emergency Preparedness and Response – The Emergency Preparedness and Response area included 77 positions and $27.6 million to support a scalable and sustainable structure that can rapidly identify hazards and deploy resources to mitigate and contain public health threats. Please provide an overview of the following:

      i. The primary classifications and activities to which the 77 positions allocated in this area were assigned.
      ii. Hiring status of these positions, including vacancy rates.
      iii. Status of development of the 24/7 intelligence hub, and whether this effort is distinct from the syndromic surveillance efforts currently underway to connect to CDC's BioSense Platform.
      iv. Planning, training and exercises that have occurred to date, or are being planned, including the expected cycle and content of these activities to prepare for emergency response.
      v. How these positions have supported the development of a regional resourcing model and deployment of Regional Disaster Medical Health Specialists.
      vi. Implementation status of the Dedicated Recovery Unit, and any deployments of the units to date.

   c. Information Technology (IT), Data Science, and Informatics – The IT, Data Science, and Informatics area included a total of 133 positions and $235.2 million in 2022-23, 144 positions and $156.6 million in 2023-24, and $61.8 million annually thereafter to support maintenance and operations of IT systems, including those established during the COVID-19 pandemic. Please provide an overview of the following:

      i. The IT systems supported by these investments.
      ii. How these IT systems have changed since they were established, including consolidation, elimination, or obsolescence as the COVID-19 pandemic has receded.
      iii. Any gaps remaining in the IT, data science, and informatics infrastructure.

d. Communications and Public Education to Promote Healthy Behavior – The Communications and Public Education to Promote Healthy Behavior area included 26 positions and $4.5 million to achieve a proactive, personalized, and highly coordinated communications strategy to meet the varying demands of California's diverse population and provide capacity to tailor messages effectively to reach all Californians. Please provide an overview of the following:

   i. How these positions and resources have improved public health communications capabilities at CDPH.
   ii. How these positions and resources have improved tailored messages to specific populations of Californians.
   iii. What types of messaging is being developed and deployed utilizing these resources.

e. Community Partnerships – The Community Partnerships area included five positions and $2.9 million to develop a community partnership strategy and plan with dedicated community engagement personnel. Please provide an overview of the following:

   i. How these positions and resources have strengthened relationships with community partners.
   ii. How community partners work with CDPH and local health departments to extend the reach of the public health system.

f. Community Health Improvement – The Community Health Improvement area included 23 positions and $6.1 million to provide a comprehensive community health improvement strategy that emphasizes a life course approach, resiliency, equity, and prevention. Please provide an overview of the following:

   i. Development or implementation of any community health financing models.
   ii. Development or implementation of a Behavioral Mental Health Program.

3. Please describe the department's administration of the Future of Public Health local health jurisdiction funding allocations, including a brief overview of how funding is distributed to each jurisdiction.

4. Please describe the details and requirements of the three year Local Public Health Workplan process. How does CDPH ensure those Workplans are responsive to evidence-based public health needs in each jurisdiction?

5. Please describe the status of the public health workforce investments included in the 2022 Budget Act and maintained in the 2023 Budget Act.

Local Health Officers/Representatives (Madera, Riverside, Santa Clara)

1. Please provide a brief overview of the programs and services your local public health system delivers to local residents, including infectious disease prevention, population and community health, and other interventions.

2. What funding challenges did your local public health system encounter most frequently prior to the COVID-19 pandemic?

3. Given the benefit of hindsight as we emerge from the COVID-19 pandemic, what specific resources or investments, had they been in place, would have improved the ability of your local public health system to respond to the public health emergency?

4. What is your local public health department's annual allocation from the $200.4 million ongoing investment in the Future of Public Health?

5. How has your local public health department used this funding to date to improve the delivery of essential public health services?

6. What are the most common classifications of personnel that have been hired with the 70 percent allocation for hiring permanent staff? To which programs have those personnel been assigned, and what is the capacity for redirection of those staff to other programs during public health emergencies?

7. What types of additional investments have been made with the remaining 30 percent allocation for equipment, supplies, and other administrative purposes?

8. Please describe at a high-level the components of your local public health department's Workplan submitted to CDPH as a condition of Future of Public Health funding, as well as the process that led to its completion (e.g. stakeholder engagement, surveys, evaluations/analysis, etc..).

9. In what other local public health planning is your department engaged (e.g. CHA, CHIP, accreditation, etc..) and how will this planning help guide your efforts under the Future of Public Health?

10. How have investments made by the state CDPH in information technology infrastructure helped assist your public health department to deliver essential public health services? How could these investments be improved?

11. How does your local public health department utilize resources and programming to address health disparities that exist on either a statewide basis, or are unique to your community? How do you identify those disparities and what types of interventions are deployed?

12. What gaps remain in your ability to deliver essential public health services, prepare for public health emergencies, address inequities, and improve population health? How should the state, as well as local health departments and community partners be thinking long-term about addressing these remaining gaps?

<u>California Pan-Ethnic Health Network (CPEHN)</u>

1. Please describe CPEHN's view of the challenges facing our state and local public health system.

2. What do you see as the primary failures of the public health system during the COVID-19 pandemic? What investments would help address these issues and prevent similar problems during a future public health emergency?

3. What could the state or local public health systems be doing to better address health disparities statewide and in local communities?

4. Where are state and local public health systems falling short in collecting the necessary data to identify existing and emergent public health needs at a community level? Have any of the recent investments helped improve the ability to collect the necessary data? What additional steps should be taken or resources invested to ensure the public health system has the necessary data to inform interventions?

5. How does CPEHN view the necessary relationship between the public health system and community-based organizations? Please describe some examples of organizations CPEHN works with that help extend the reach of public health interventions in local communities.

6. How should the state approach delivering on critical statewide public health priorities given the differences in priorities of local public health departments and counties in our decentralized public health system?

Public Health Institute (PHI)

1. Please provide a brief overview of the work PHI does to improve our public health system.

2. What are the critical challenges facing the delivery of essential public health services, addressing health disparities, and improving population and community health in a post-pandemic California?

3. In your view, how have the recent state and local investments through the Future of Public Health and other information technology investments helped improve the public health system?

4. Please describe how the organizations PHI works with support and extend the reach of the public health system.

5. How could state and local public health systems better support those organizations to improve the delivery of essential public health services, address health disparities, and improve population and community health?

6. In the long-term, what types of investments or areas of focus should be prioritized by state and local governments to develop a complete, functional public health system that can meet future public health challenges and respond to emergent public health threats?

## Issue 3: Maintenance and Operations Support for SaPHIRE System

**Budget Change Proposal – Governor's Budget.** CDPH requests General Fund expenditure authority of $26.9 million in 2024-25. If approved, these resources would support maintenance and operations for the Surveillance and Public Health Information Reporting and Exchange (SaPHIRE) system.

| Multi-Year Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2024-25** | **2025-26** |
| 0001 – General Fund | $26,900,000 | $- |
| **Total Funding Request:** | **$26,900,000** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** The Surveillance and Public Health Information Reporting and Exchange (SaPHIRE), previously known as the California COVID Reporting System (CCRS), was implemented in October 2020 to address the challenges of managing COVID-19 laboratory data, providing upgraded capabilities for managing all communicable disease laboratory data sent electronically. During the COVID-19 pandemic, CDPH data systems were not able to manage the high volume of data associated with COVID-19. According to CDPH, there were also substantial quality problems with the data, including: incomplete fields such as race and ethnicity, duplicate reports, incorrect or incomplete information for accurate patient matching, inconsistent use of codes and test labels for laboratory test and result values, system limitations to ingest and handle the rapid surge in lab result submissions, and architecture limitations that prevented adequate system performance monitoring.

In August 2020, during the height of the pandemic, CDPH conducted a challenge-based procurement to develop and implement the CCRS system. For the maintenance and operations phase of this project, CDPH engaged in a new, challenge-based procurement process in March 2022, resulting in a contract with a new vendor. A transition between the old and new vendor was completed by December 31, 2022.

The 2022 Budget Act included General Fund expenditure authority of $26.3 million in 2022-23 to provide maintenance and operations for one year to support and operate CCRS. The one-year funding strategy was designed to allow CDPH to obtain updated maintenance and operations costs through a competitive process and include these costs in a proposal for 2023-24. As part of the transition, CCRS was renamed to SaPHIRE to recognize that the system receives data for all reportable conditions, not just COVID-19.

The 2023 Budget Act included General Fund expenditure authority of $30.9 million in 2023-24 for maintenance and operations costs for SaPHIRE. These resources were approved to support integration and critical data exchange between SaPHIRE and other core CDPH systems, including the California Reportable Disease Information Exchange (CalREDIE) and the California Confidential Network for Contact Tracing (CalCONNECT).

The SaPHIRE system receives laboratory results for COVID-19 and other infectious diseases related to California residents from laboratories across the United States in accordance with state regulations. The great majority of laboratory results are submitted electronically and managed by the system. More than 350 entities are connected directly to this system and submit results on behalf of thousands of other entities, including laboratories that report their own results, and aggregators or hubs that report results for

multiple laboratories. Incoming laboratory results are compared against existing laboratory results to identify, match, and remove duplicate records. Processed laboratory results are transferred to CDPH's Enterprise Rhapsody Gateway for routing to downstream public health systems, including CalREDIE, and the Los Angeles and San Diego County disease surveillance systems. Data processed through SaPHIRE is used to monitor infectious disease and testing trends.

**Resource Request.** CDPH requests General Fund expenditure authority of $26.9 million in 2024-25 to support maintenance and operations for the Surveillance and Public Health Information Reporting and Exchange (SaPHIRE) system. According to CDPH, maintenance and operations services for the SaPHIRE system include system operations, system monitoring, and ensuring compliance with the latest security and privacy policies, including vulnerability monitoring, intrusion detection, and firewall management. Of the $26.9 million requested, $26.3 million is for technology service contracts, software licenses, and interdepartmental services, and $622,000 is for personnel costs to support redirected staff. CDPH's Information Technology Services division reports having permanently redirected **one Information Technology (IT) Associate**, **one IT Technology Specialist I** position**,** and **one IT Technology Specialist II** position to provide SaPHIRE operations management and support.

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

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

1. Please provide a brief overview of this proposal.

2. The requested maintenance and operations resources are only for 2024-25. What is the plan for ongoing maintenance and operations of these systems?

3. What would be the consequences of allowing the contract for maintenance and operations for SaPHIRE to expire?

## Issue 4: Information Technology Savings and Reversions

**General Fund Budget Solution – Governor's Budget.** CDPH requests reversion of three-year General Fund expenditure authority approved in the 2023 Budget Act of $900,000 that would have supported continuation of the COVID-19 information website. CDPH also estimates one-time General Fund savings of $1.7 million in 2024-25 due to unfilled positions for the Disease Surveillance Readiness, Response, Recovery and Maintenance of Information Technology Operations proposal, also approved in the 2023 Budget Act.

| Multi-Year Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2023-24** | **2024-25*** |
| 0001 – General Fund | ($2,600,000) | ($900,000) |
| **Total Funding Request:** | **($2,600,000)** | **($900,000)** |
| **Total Requested Positions:** | **0.0** | **0.0** |

* Additional savings by fiscal year: 2025-26: ($900,000).

**Background.** During the COVID-19 pandemic, the state improved or created multiple information technology systems to support the state's pandemic response efforts. Among these systems was the COVID-19 website, covid19.ca.gov, established by the Office of Digital Innovation using approximately $2.3 million of one-time emergency funding. According to CDPH, the COVID-19 website aims to enable users to find the information they need, understand it quickly, and act accordingly. Information included on the COVID-19 website includes current safety measures, vaccines, vaccination records, masks, travel, testing, financial help, education and childcare, and safety in the workplace. The website offers answers to COVID-19 questions, data on COVID-19 impacts and response measures, and guidance about how to prevent getting sick or having a severe illness, reopen and operate businesses and facilities safely, and access relief. At the end of the 2021-22 fiscal year, maintenance and support for the COVID-19 website was transferred to CDPH. CDPH reports it currently supports the site using contractor resources.

The 2023 Budget Act included General Fund expenditure authority of $900,000 in 2023-24, 2024-25, and 2025-26, to support security and translation services to optimize maintenance of the COVID-19 website, including three contract staff (a Product Manager, a Content Designer, and a Web Engineer), translation services, software licensing, and IT security tools.

The 2022 Budget Act included 130 positions and General Fund expenditure authority of $235.2 million in 2022-23, ten additional positions and General Fund expenditure authority of $156.1 million in 2023-24, and $61.8 million annually thereafter to maintain and operate a dozen technology platforms and applications necessary to support both COVID-19 response activities and other potential disease outbreaks.

**General Fund Budget Solution.** CDPH requests reversion of three-year General Fund expenditure authority approved in the 2023 Budget Act of $900,000 that would have supported continuation of the COVID-19 information website. CDPH also estimates one-time General Fund savings of $1.7 million in 2024-25 due to unfilled positions for the Disease Surveillance Readiness, Response, Recovery and Maintenance of Information Technology Operations proposal, also approved in the 2023 Budget Act.

According to CDPH, the COVID-19 website will be redirected to a CDPH-hosted site in June 2024. CDPH indicates there will be minimal to no changes in the user experience of the website. CDPH reports it never filled the contract positions nor procured the services, licenses and other tools included in the 2023 budget proposal. In addition, CDPH reports its savings reported from the 2022 budget proposal is due to positions that were unfilled or delayed.

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

ADAP is funded by federal funds and the ADAP Rebate Fund (Fund 3080). The federal government began funding state programs to assist people living with HIV to purchase antiretroviral medications in 1987. Since 1990 with the passage of the Ryan White Comprehensive AIDS Resources Emergency Act, now known as the Ryan White Program, the federal Health Resources and Services Administration (HRSA) provides funding to states for ADAP programs. In addition to federal funds, ADAP receives significant funding from mandatory and voluntary manufacturer rebates for ADAP drug expenditures.

**ADAP Estimate – Governor's Budget.** The November 2023 ADAP Local Assistance Estimate reflects revised 2023-24 expenditures of $353.9 million ($245.6 million ADAP Rebate Fund and $108.3 million federal funds), a decrease of $44.1 million or 11.1 percent compared to the 2023 Budget Act. According to CDPH, this decrease is primarily due to lower than expected projected medication expenditures for medication-only clients and lower than expected medical out-of-pocket expenditures for insured client groups. For 2024-25, CDPH estimates ADAP expenditures of $366 million ($260.8 million ADAP Rebate Fund and $105.2 million federal funds), an increase of $8 million or 3.4 percent compared to revised expenditures for 2023-24. According to CDPH, the continued relative reduction of expenditures between 2024-25 and 2023-24, compared to the 2023 Budget Act, is similarly due to lower than expected medication and out-of-pocket expenditures.

| ADAP Local Assistance Funding Summary | | |
|---|---|---|
| **Fund Source** | **2023-24** | **2024-25** |
| 0890 – Federal Trust Fund | $108,293,000 | $105,189,000 |
| 3080 – AIDS Drug Assistance Program Rebate Fund | $245,631,000 | $260,794,000 |
| **Total ADAP Local Assistance Funding** | **$353,923,000** | **$365,983,000** |

ADAP tracks caseload and expenditures by client group. CDPH estimates ADAP caseload and expenditures for 2023-24 and 2024-25 will be as follows:

| **Caseload by Client Group** | **2023-24** | **2024-25** |
|---|---|---|
| **Medication-Only** | 8,642 | 7,594 |
| **Medi-Cal Share of Cost** | 50 | 50 |
| **Private Insurance** | 9,215 | 9,168 |
| **Medicare** | 6,879 | 6,648 |
| **PrEP Assistance Program** | 7,720 | 8,921 |
| **TOTAL** | **32,506** | **32,380** |

| **Expenditures by Client Group** | **2023-24** | **2024-25** |
|---|---|---|
| **Medication-Only** | $218,915,786 | $205,757,740 |
| **Medi-Cal Share of Cost** | $497,082 | $497,082 |
| **Private Insurance** | $87,980,854 | $97,708,573 |
| **Medicare** | $27,116,761 | $29,672,877 |
| **PrEP Assistance Program** | $15,472,841 | $21,213,732 |
| **TOTAL** | **$349,983,324** | **$354,850,003** |

Costs for administration of ADAP are estimated to be $4.6 million in 2023-24 and $9.2 million in 2024-25. Costs for administration of PrEP-AP are estimated to be $3.9 million in 2023-24 and $4.9 million in 2024-25. Enrollment costs are estimated to be $7.3 million in 2023-24 and $7.5 million in 2024-25. Beginning in 2017-18, ADAP introduced a new reimbursement methodology for enrollment sites which

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

In addition, ADAP's pharmacy benefit manager, Magellan Rx Management, contracts with a safety net recovery vendor, Health Management Systems (HMS) to pursue recovery of paid claims when a liable third party is identified post-payment. CDPH estimates recoveries of $13.9 million in 2023-24 and $12.5 million in 2024-25.

**ADAP Rebate Fund Loan to the General Fund.** The Governor's January budget proposes to loan $500 million from the ADAP Rebate Fund to the General Fund to support the General Fund shortfall. The 2023 Budget Act similarly included a $400 million loan from the fund to the General Fund. According to CDPH, the fund is expected to maintain a reserve of $176.7 million after program expenditures and the loans to the General Fund in 2024-25. According to CDPH, these resources were available for loan to the General Fund due to higher than expected rebate collections from drug manufacturers providing medications for the ADAP program.

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

**Questions.** The subcommittee has requested CDPH and Department of Finance to respond to the following:

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

2. Please provide an overview of the two loans to the General Fund from the ADAP Rebate Fund, including the terms of repayment, and contingency language proposed to ensure the loan does not undermine the ADAP program.

## Issue 6: Clinical Dental Rotations

**General Fund Budget Solution and Trailer Bill Language – Governor's Budget.** CDPH requests to shift General Fund expenditure authority of $9.7 million to the Proposition 56 Tobacco Tax Fund's State Dental Account. These resources, originally approved in the 2022 Budget Act, support clinical dental rotations in underserved areas. CDPH also proposes trailer bill language to include program requirements originally included in budget bill language in state statute.

| Multi-Year Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2024-25** | **2025-26** |
| 0001 – General Fund | ($9,700,000) | $- |
| 3307 – State Dental Account, Prop 56 Tobacco Tax Fund | $9,700,000 | $- |
| **Total Funding Request:** | **$-** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** The 2022 Budget Act included General Fund expenditure authority of $10 million, and the Legislature approved provisional budget bill language, for the Office of Oral Health to establish community-based clinical education rotations for dental residents or for dental students in their final year. The language requires the office to establish the program in consultation with the California Dental Association, California dental schools, and other stakeholders. Eligible community clinical settings include federally qualified health centers, private dental offices, and mobile dentistry offices located in a designated dental health professional shortage area.

**General Fund Budget Solution and Trailer Bill Language.** CDPH requests to shift General Fund expenditure authority of $9.7 million to the Proposition 56 Tobacco Tax Fund's State Dental Account. These resources, originally approved in the 2022 Budget Act, support clinical dental rotations in underserved areas. CDPH also proposes trailer bill language to include program requirements originally included in budget bill language in state statute. The funding shift is intended to address the General Fund shortfall and, according to CDPH, makes use of an unexpended fund balance available in the State Dental Account of the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund (Prop 56 Tobacco Tax Fund). According to CDPH, the codification of the governing budget bill language in statute is necessary as the budget bill language is tied to a General Fund appropriation, which would change with the proposed fund shift.

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

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

1. Please provide a brief overview of this proposal.

2. After accounting for the use of the unexpended fund balance in the State Dental Account, is the Office of Oral Health still receiving the $30 million allocation required by statute, or does this fund shift offset some of that required allocation?

3. What is the remaining fund balance in the State Dental Account?

## Issue 7: Syndromic Surveillance

**Trailer Bill Language – Governor's Budget.** CDPH proposes trailer bill language to collect syndromic surveillance data for the purposes of administering a syndromic surveillance program and system.

**Background.** The 2022 Budget Act included 30 positions and General Fund expenditure authority of $10 million annually to provide near real-time notification for public health departments, first responders, and the community for emerging or intensified climate-sensitive diseases. In addition, the 2022 Budget Act included resources to support information technology, data science, and informatics, including implementation of a syndromic surveillance system. CDPH indicated at the time that it planned to implement the Center for Disease Control and Prevention's (CDC) National Syndromic Surveillance Program (NSSP), known as the BioSense platform. California is currently the only state not actively engaged in BioSense.

According to the CDC, syndromic surveillance provides public health officials with a timely system for detecting, understanding, and monitoring health events. By tracking symptoms of patients in emergency departments, the public health system can detect unusual levels of illness to determine whether a response is warranted. Syndromic surveillance data can be used for infectious disease outbreaks like flu, COVID-19, respiratory syncytial virus (RSV), or West Nile virus, as well as other illnesses related to opioid use, e-cigarette or vaping product use, or the impacts of natural disasters.

The NSSP is a collaboration among the CDC, other federal agencies, state and local public health departments, and academic and private sector partners. These entities collect, analyze, and share electronic patient encounter data received from emergency departments, urgent and ambulatory care centers, inpatient healthcare settings, and laboratories. These data are integrated through the BioSense platform, which allows the public health community to use analytic tools and timely availability of data to detect, characterize, monitor, and respond to events of public health concern.

According to CDPH, while resources were provided in the 2022 Budget Act to participate in BioSense, statutory authority is needed to allow CDPH to collect syndromic surveillance data and establish a statewide syndromic surveillance system. CDPH proposes to use the BioSense platform as the state's syndromic surveillance system, with hospitals providing visit data using automated interoperable data feeds for data elements such as chief complaints, diagnosis codes, and demographics. CDPH and local health departments will be able to monitor the data to analyze and respond to health- and climate-related outcomes.

**Trailer Bill Language – Syndromic Surveillance.** CDPH proposes trailer bill language to collect syndromic surveillance data for the purposes of administering a syndromic surveillance program and system. Specifically, the proposed language would do the following:

1) Authorizes CDPH to develop and administer a syndromic surveillance program, which will collect public health and medical data in near real-time to detect and investigate changes in the occurrence of disease in the population and support emergency response or responses to emerging public health threats and conditions impacting California residents.

2) Authorizes CDPH to designate an existing syndromic surveillance system or create a new surveillance system to which entities will report.

3) Requires the system to, at a minimum, provide public health practitioners access to and use of a secure, integrated electronic health system with standardized analytic tools and processes to rapidly collect, evaluate, share, and store syndromic surveillance data.

4) Requires general acute care hospitals with emergency departments to submit electronic data to the syndromic surveillance system as required by CDPH.

5) Notwithstanding any other privacy laws, authorizes CDPH, at its discretion, to approve sharing submitted data with: 1) the CDC, 2) state government entities, 3) local health departments, and 4) persons with a valid scientific interest under certain circumstances who agree to maintain confidentiality.

**Broad Privacy Exemptions Included in Proposed Language.** CDPH reports that the department is a hybrid entity under the Health Information Portability and Accountability Act (HIPAA), with some parts of the department considered covered entities and others not covered by the act's privacy and other provisions. CDPH's Center for Infectious Diseases, which would administer the syndromic surveillance system, is not a covered entity under HIPAA, but is governed by the California Information Practices Act of 1977 (IPA). CDPH reports the IPA does not allow the sharing of personally identifiable information (PII), such as the information that would be collected in the syndromic surveillance system, with the federal government. The proposed language notwithstanding any other privacy law is meant to notwithstand that portion of the IPA to allow sharing of PII with the federal government. The Legislature may wish to consider whether more finely tailored exemption language would be appropriate to address this specific data sharing challenge, rather than the broad exemption from all California privacy laws proposed by CDPH.

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

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

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

2. Please describe the specific privacy provisions that are barriers to the implementation of the syndromic surveillance system that require notwithstanding all of California's privacy laws.

3. Would any other entities besides general acute care hospitals with emergency departments be required to report data to the system?

## Issue 8: Office of Problem Gambling Community Based Organization Grants

**Budget Change Proposal – Governor's Budget.** CDPH requests annual expenditure authority from the Gambling Addiction Program Fund of $200,000. If approved, these resources would allow CDPH's Office of Problem Gambling to provide community grants to expand prevention and treatment services to priority populations.

| Multi-Year Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2024-25** | **2025-26*** |
| 3110 – Gambling Addiction Program Fund | $200,000 | $200,000 |
| **Total Funding Request:** | **$200,000** | **$200,000** |
| **Total Requested Positions:** | **0.0** | **0.0** |

* Resources ongoing after 2025-26.

**Background.** The Office of Problem Gambling (OPG) is responsible for developing and providing quality statewide prevention and treatment programs and services to address gambling disorder and deliver services to the people of California. OPG provides training of health care professionals, educators, and nonprofit organizations in the identification of problem gambling behavior and the knowledge of referral services for gambling disorder treatment programs. OPG is funded by an annual allocation of $8 million supported by gaming revenue deposited in the Indian Gaming Special Distribution Fund.

According to CDPH, OPG provides treatment services to people who gamble, including the California Gambling Education and Treatment Services (CalGETS), which offers no cost services to problem gamblers and affected individuals by licensed health providers specially trained in the treatment of gambling disorder behavior. CalGETS provides services to Californians 18 and over through outpatient, intensive outpatient, Problem Gambling Telephone Intervention, and residential treatment programs. OPG has developed relationships with community organizations, but has never provided direct support to these organizations.

In a 2022 audit, the California State Auditor reported that OPG has not adequately measured prevalence nor disparities by demographics, and recommended that OPG improve its data collection and surveillance of demographic disparities in problem gambling in California to inform the locations and populations most in need of program services and to evaluate how well it is serving those populations. In response, OPG has expanded its surveillance and identified that the majority of people receiving treatment from the CalGETS treatment services network are White, non-Hispanic, and Asian/Pacific Islander. The data suggests that White, Non-Hispanic Californians are over-represented in the treatment population and Hispanic/Latinos are under-represented. Treatment data indicate tribal populations may also be under-represented.

**Resource Request.** CDPH requests annual expenditure authority from the Gambling Addiction Program Fund of $200,000 to allow OPG to provide community grants to expand prevention and treatment services to priority populations. OPG proposes to release a Request for Applications (RFA) for community-based organizations to apply for funding, including specific criteria such as reporting and evaluation activities. OPG would build upon its history of strong relationships with community-based organizations, such as the National Asian Pacific American Families Against Substance Abuse, NICOS Chinese Health Coalition, Visión y Compromiso, and the Riverside-San Bernardino County Indian Health, Inc.

OPG indicates the initial funding cycle would be for three years, with $50,000 per year available to four community-based organizations. Evaluations would be conducted at the end of each grant cycle to inform program design and priority populations.

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

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

1. Please provide a brief overview of this proposal.

## Issue 9: Climate and Health Surveillance Program Reversion

**General Fund Budget Solution – Governor's Budget.** CDPH requests reversion of General Fund expenditure authority of $3.1 million previously authorized in the 2022 Budget Act, due to expected one-time savings related to delays in implementation of information technology contracting.

| Multi-Year Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2024-25** | **2025-26** |
| 0001 – General Fund | ($3,085,000) | $- |
| **Total Funding Request:** | **($3,085,000)** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** The 2022 Budget Act included 30 positions and General Fund expenditure authority of $10 million annually to provide near real-time notification for public health departments, first responders, and the community for emerging or intensified climate-sensitive diseases. According to CDPH, California is one of the few states that lack a statewide syndromic surveillance mechanism for heat illness. As a result, CDPH is currently unable to provide a count of deaths and illnesses during heat waves. With the 2022 Budget Act allocation, development of syndromic surveillance methods for heat illness will provide near real-time data from hospitals and other data sources to identify heat illness events early, monitor trends, and track illnesses and deaths, in order to support public health officials to respond quickly to minimize health risks from heat waves. Development of a syndromic surveillance system will also allow for surveillance of the many other negative public health impacts that have been increasing or are projected to increase due to climate change, such as asthma, chronic obstructive pulmonary disease, respiratory infections, cardiovascular effects, and other impacts of wildfire smoke. Researchers estimate that wildfire smoke during August and September 2020 may have led to as many as 3,000 excess deaths among elderly Californians. Syndromic surveillance can provide a near real-time alert about the number, location, and other characteristics of people affected by these conditions.

**National Syndromic Surveillance Program and BioSense Program.** The federal Centers for Disease Control and Prevention (CDC) administers the National Syndromic Surveillance Program (NSSP), a collaboration among CDC, federal partners, state and local health departments, and academic and private sector partners who have formed a national syndromic surveillance and data collection system and community of practice. Participants in the NSSP collect, analyze, and share electronic patient encounter data received from emergency departments, and in some cases urgent and ambulatory care centers, inpatient healthcare settings, and laboratories. The NSSP also leads the BioSense Program and the technological platform on which the data collection for BioSense is built, known as ESSENCE. The public health community uses the ESSENCE platform to view data received as early as 24 hours after a patient's visit to a participating facility. Public health officials use these timely and actionable data to detect, characterize, monitor, and respond to events of public health concern.

BioSense is active in 49 states with more than 6,000 healthcare facilities contributing data daily. Approximately 71 percent of all emergency departments in the country contribute data to the NSSP.

CDPH reports it does not have a syndromic surveillance system and does not actively engage in the BioSense Program and ESSENCE platform at the state level. CDPH has multiple, condition specific, siloed systems with variable degrees of ability for reporting and access to sharing data between the state

and local levels. While CDPH has not yet engaged in the development of an official, unified 24 hour syndromic surveillance system, 55 counties in California are eligible to participate in the NSSP's BioSense Program. At present, 14 percent, or 46 out of 320, of California's emergency departments contribute data to the BioSense Platform. In a separate request, CDPH is proposing trailer bill language to implement a syndromic surveillance program, based on the BioSense Platform, utilizing resources adopted in the 2022 Budget Act.

**General Fund Budget Solution.** CDPH requests reversion of General Fund expenditure authority of $3.1 million previously authorized in the 2022 Budget Act, due to expected one-time savings related to delays in implementation of information technology contracting. According to CDPH, these are one-time savings as the contracting process is expected to be completed later in the current fiscal year.

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

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

1. Please provide a brief overview of this proposed reversion.

2. Please describe how this project differs from the department's other syndromic surveillance efforts?

3. Why are additional resources and positions necessary for climate-specific conditions? Is the BioSense system not equipped to detect these conditions without additional support?

## Issue 10: Women, Infants, and Children (WIC) Program Estimate

**WIC Program Estimate – Governor's Budget.** The November 2023 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.4 billion ($1.1 billion federal funds and $213.8 million WIC manufacturer rebate funds) in 2022-23 and $1.3 billion ($1.1 billion federal funds and $221.9 million WIC manufacturer rebate funds) in 2023-24. The federal fund amounts include state operations costs of $64.5 million in 2022-23 and 2023-24.

| **Women, Infants, and Children (WIC) Funding Summary** | | | |
|---|---|---|---|
| | **2023-24** | **2024-25** | **BY to CY** |
| **Fund Source** | ***Revised*** | ***Proposed*** | ***Change*** |
| 0890 – Federal Trust Fund | | | |
| State Operations: | $66,266,000 | $69,483,000 | $3,257,000 |
| Local Assistance: | $1,143,465,000 | $1,199,006,000 | $55,541,000 |
| 3023 – WIC Manufacturer Rebate Fund | | | |
| Local Assistance: | $189,616,000 | $190,373,000 | $757,000 |
| **Total WIC Expenditures** | **$1,399,347,000** | **$1,458,862,000** | **$59,515,000** |

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

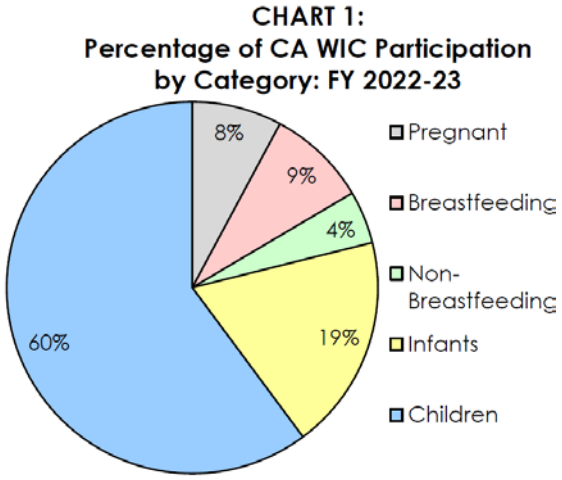
The WIC program's food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant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

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

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

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

According to the WIC program Estimate, WIC participation by category, as of 2022-23, was as follows:




| Participant Category | Annual Average Monthly Participation 2022-23 |
|---|---|
| Pregnant | 74,933 |
| Breastfeeding | 82,969 |
| Non-Breastfeeding | 43,831 |
| Infants | 179,014 |
| Children | 575,089 |
| **TOTAL** | **955,836** |

**Caseload Estimates.** The budget assumes 992,640 average monthly WIC participants in 2023-24, an increase of 36,804 or 3.9 percent compared to the average monthly actual WIC participants in 2022-23, and an increase of 1,021 or 0.1 percent, compared to estimates in the 2023 Budget Act. The budget assumes 1,029,734 average monthly WIC participants in 2024-25, an increase of 37,094 or 3.7 percent from the revised 2023-24 caseload estimate.

**Food Expenditures Estimate.** The budget includes $1 billion ($821.5 million federal funds and $189.6 million WIC Manufacturer Rebate Fund) in 2023-24 for WIC program food expenditures, an increase of $7.2 million or 0.7 percent, compared to estimates included in the 2023 Budget Act. According to CDPH, the increase in costs is due to a slight increase in estimated participation, an inflationary increase to the fruits and vegetables benefit levels, offset by a slight decrease in food inflation. Food inflation is estimated to be 2.55 percent in 2023-24 compared to 3.28 percent estimated in the 2023 Budget Act. In addition, WIC manufacturer rebate revenue is projected at $189.6 million, which is a decrease of $27.7 million or 12.8 percent compared to estimates in the 2023 Budget Act. According to CDPH, this decrease in rebate revenue is attributable to a reduction in formula purchased per infant following the formula shortage and lower rebate received per can following the transition to a new infant formula contractor.

The budget includes $1.1 billion ($877 million federal funds and $190.4 million WIC Manufacturer Rebate Fund) in 2024-25 for WIC program food expenditures, an increase of $56.3 million or 5.6 percent compared to the revised 2023-24 food expenditures estimate. According to CDPH, this increase in costs is driven by an increase in participation, an estimated food inflation rate of 1.4 percent, and an inflationary increase to the fruits and vegetables benefits level. In addition, WIC manufacturer rebate revenue is projected at $190.4 million, an increase of $757,000 or 0.4 percent compared to the revised 2023-24 estimate.

**Nutrition Services and Administration (NSA) Estimate.** The budget includes $322 million for other local assistance expenditures for the NSA budget in 2023-24 and 2024-25, unchanged from the 2023 Budget Act. The budget also includes $66.2 million for state operations expenditures in 2023-24, an increase of $1.8 million or 2.7 percent from the level assumed in the 2023 Budget Act, and $69.5 million in 2024-25, an increase of $3.3 million or 4.9 percent from the revised 2023-24 estimate.

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

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

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

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

## Issue 11: WIC Modernization

**Budget Change Proposal and Trailer Bill Language – Governor's Budget.** CDPH requests 18 positions and federal fund expenditure authority of $3 million in 2024-25, and an additional nine positions and federal fund expenditure authority of $4.4 million annually thereafter. If approved, these positions and resources would support modernization of the WIC program services and operations including implementation of online ordering for WIC participants. CDPH also proposes trailer bill language to: 1) provide the WIC program with a regulatory exemption for establishing retail food delivery systems, vendor management, and online shopping program requirements; and 2) update WIC bulletin regulation authority.

| Multi-Year Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2024-25** | **2025-26*** |
| 0890 – Federal Trust Fund | $2,964,000 | $4,444,000 |
| **Total Funding Request:** | **$2,964,000** | **$4,444,000** |
| **Total Requested Positions:** | **18.0** | **27.0** |

* Positions and resources ongoing after 2025-26.

**Background.** According to CDPH, pursuant to a directive from the White House National Strategy on Hunger, Nutrition, and Health, released in September 2022, the United States Department of Agriculture (USDA) has launched the WIC Modernization Initiative with the goals of investing in community-based outreach, streamlining the participant experience, improving the in-store experience, expanding access to farmer's markets, and increasing the diversity and cultural competency of the WIC workforce.

As part of the USDA investment, California's WIC program received $5.7 million in non-competitive federal funds through the 2023 WIC Modernization Grant. This new funding will supplement the existing WIC Nutrition Services and Administration Grant to support the WIC Modernization Initiative.

In February 2023, USDA proposed regulations to remove barriers to online ordering and internet-based transactions by allowing state WIC programs to authorize and manage new types of vendor entities. The proposed regulations also streamline WIC food delivery to support opportunities for WIC participants to benefit from innovations such as mobile ordering and touch payment platforms. In anticipation of these proposed regulations, CDPH is proposing trailer bill language to authorize expedited regulatory authority to approve online shopping and vendor management in the California WIC program.

**Modernizing the Shopping Experience for WIC Families.** According to CDPH, the retail grocery industry has changed significantly in recent years and the pandemic accelerated the use of alternative shopping options, such as online ordering, online purchasing, and home food delivery. The federal Supplemental Nutrition Assistance Program (SNAP), known as CalFresh in California, allows recipients to use online shopping at nearly 40 grocery chains that comprise hundreds of stores throughout the state, to order and purchase food items using their CalFresh electronic benefit transfer (EBT) cards. The USDA proposed regulation for WIC, coupled with the CDPH WIC Modernization proposal, would provide these additional options for WIC families, as well. CDPH estimates 170 new internet vendors would seek authorization after implementation of this program upon state and federal approval. There are currently 3,700 brick-and-mortar stores authorized to accept the California WIC Card.

**Potential for Negative Impacts on Food Access in Certain Communities.** Although the expansion of consumer choices in the WIC program with the implementation of online shopping would improve WIC families' experience, there are some potentially negative impacts that could occur in communities in which a brick-and-mortar grocery store may be difficult to site or maintain. In certain, low-income communities, the decision of a grocery chain to open or maintain a brick-and-mortar store may be dependent on the expectation that CalFresh and WIC participants will utilize their food benefits at the store. CDPH and the Legislature may wish to evaluate strategies to avoid undermining the sustainability of brick-and-mortar stores and other local food options with the implementation of online shopping modalities.

**Staffing and Resource Request.** CDPH requests 18 positions and federal fund expenditure authority of $3 million in 2024-25, and an additional nine positions and federal fund expenditure authority of $4.4 million annually thereafter to support modernization of the WIC program services and operations including implementation of online ordering for WIC participants. Specifically, CDPH requests the following positions and resources:

Vendor Operations and Monitoring Support – Six positions (One in 2024-25; five in 2025-26)

- **One Health Program Specialist (HPS) I** position, beginning in 2024-25, would serve as the lead and subject matter expert for the integration of new WIC vendor types, such as internet and mobile vendors to support online ordering and internet-based shopping transactions; coordinate process and procedure development for the ongoing management of new vendor types; provide continued support to ongoing project coordination and maintenance and operations of technical enhancements to shopping transaction systems.
- **One Associate Governmental Program Association (AGPA)** in the Vendor Intake Unit beginning in 2025-26 would support processing and determination of eligibility for new brick and mortar vendor applications including application review, data entry, document preparation, and correspondence with vendor applicants to address deficiencies.
- **One AGPA** in the Vendor Support Unit beginning in 2025-26 would support the anticipated increase and change in CDPH authorized vendors, including technical assistance and outreach, developing peer group reassessments for brick and mortar and online, and online-only vendors, and serve as a resource for newly authorized online vendors to maintain compliance with program requirements.
- **One AGPA** in the Field Monitoring Unit beginning in 2025-26 would conduct annual monitoring and compliance inspections for a minimum of five percent of authorized vendors, pursuant to USDA requirements.
- **One AGPA** in the Vendor Authorization and Management Unit beginning in 2025-26 would support ongoing contract management and technical support for more than 3,700 authorized brick and mortar vendor stores and support newly authorized internet and mobile vendor stores and corporate contract ownerships.
- **One AGPA** in the Vendor Training Unit beginning in 2025-26 would support USDA mandated vendor training requirements.

Data and Integrity Branch – Four positions (One in 2024-25; three in 2025-26)

- **One Research Scientist (RS) II** position in the Vendor Analysis, Research, and Evaluation Section beginning in 2024-25 would lead the addition of new internet and mobile vendor types, develop new

vendor peer group classifications with associated new food price reimbursement models and statistical techniques for assuring price competitiveness, develop performance measures and a monitoring and evaluation plan to verify that new vendors are meeting program goals and requirements, and sharing results with management to support data-informed decision making.

- **One HPS I** position in the Program Integrity and Audits Section beginning in 2025-26 would analyze data and collaborate with staff to design and implement new oversight strategies to prevent, detect, and respond to potential program abuse strategies associated with the new business processes and vendor types; coordinate with other staff and law enforcement agencies to investigate cases and recommend actions; provide subject matter expertise in the development of social media materials and other communications to educate WIC participants how to avoid theft and loss of benefits through online shopping activities and vendor suspicious behaviors.
- **One RS Supervisor I** position beginning in 2025-26 will lead a new Accountability, Integrity, Research, and Evaluation Section to strengthen accountability and program integrity research activities.
- **One RS II** position in the Accountability, Integrity, Research, and Evaluation Section beginning in 2025-26 would support research staff focusing on conducting data analyses, visualizations, evaluation, and research to enhance program integrity and accountability.

Modernization of Nutrition and Breastfeeding Educational Tools and Resources, and Support for Local Agency Training – Nine positions (All in 2024-25)

- **One Staff Services Manager (SSM) II** position would lead a newly created Program Development Section and would oversee completion of modernization projects to enhance nutrition and breastfeeding education program development for WIC families and update staff training as it relates to more modes and interactive learning opportunities to meet the needs of virtual and in-person WIC Program services.
- **One Public Health Nutrition Consultant (PHNC) III** position would serve as the nutrition subject matter expert and help create nutrition and breastfeeding education for participants pursuant to federal regulations, develop mobile content for mobile friendly education handouts, interactive individual education supports, and new interactive lesson plans and scripts that are engaging for the learner in remote appointments; and assist with development of breastfeeding education and staff training projects.
- **One SSM I** position would serve as chief of the Program Development Unit to oversee workflow for existing redirected staff and two newly proposed positions.
- **One HPS I** position in the Program Development Unit would coordinate new and ongoing development of CDPH communication strategies such as organizing and producing local agency education webinars and trainings that include nutrition and breastfeeding content; develop program content for mobile friendly education handouts, interactive individual education supports, and new interactive lesson plans and scripts that are engaging for the learner in remote appointments.
- **One AGPA** in the Program Development Unit would provide administrative support due to the increased workload to plan and coordinate collaborative meetings with local agencies.
- **One HPS I** position in the Breastfeeding Support Unit would develop content focused on breastfeeding support for mobile friendly education handouts, interactive individual education supports, and new interactive lesson plans and scripts that are engaging for the learner in remote appointments.

- **Two AGPAs** in the Local Policy and Regulations Unit would assist local agency transition to modern practices and processes, collaborate with program staff to develop new policy, implementation practices, training plans, and communications; and participate in ongoing user acceptance training for upgrades to systems resulting from modernization flexibilities, maintenance and operational updates.
- **One Public Health Nutrition Consultant (PHNC) III** position in the Local Services Branch would serve as subject matter expert to lead and coordinate modernization efforts with a focus on rural counties where access to WIC resources is limited.

Statewide Communication, e-Learning, and Graphic Design – Three positions (All in 2024-25)

- **One HPS I** position in the Outreach Specialist Team would plan, implement, and evaluate a wide variety of highly complex, technical and comprehensive statewide communications and outreach efforts for the program; lead projects to support ongoing enhancements for the California WIC App, the California WIC online application, and the California WIC Family Portal; and coordinate ongoing improvements to the MyFamily.WIC.ca.gov website.
- **One HPS I** and **one AGPA** in the Strategic Planning and Innovation Unit would support technical development of e-learning and graphic design development across education, training, and communication projects.

Systems Modernization and Support – Two positions (Both in 2024-25)

- **One HPS II** position and **one HPS I** position in the WIC Change Management Section would support documenting, designing, and testing changes as well as ongoing maintenance and operations due to the modernization changes.

Administrative Support – Three positions (Two in 2024-25, one in 2025-26)

- **Two AGPAs** beginning in 2024-25 and **one AGPA** beginning in 2025-26 would support increased program staffing needs and ongoing assistance including contract and procurement preparations, monitoring appropriation and revenue balances, technical assistance on expenditure and revenue transactions, and guidance and assistance on a variety of personnel policies, standards, and procedures.

**Proposed Trailer Bill Language – WIC Modernization.** CDPH also proposes trailer bill language to: 1) provide the WIC program with a regulatory exemption for establishing retail food delivery systems, vendor management, and online shopping program requirements; and 2) update WIC bulletin regulation authority.

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

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

1. Please provide a brief overview of this proposal.

2. If this proposal is approved, will the WIC program conduct any analyses to determine the impact of online shopping on the availability of brick-and-mortar food options in communities?

## Issue 12: Genetic Disease Screening Program (GDSP) Estimate

**Genetic Disease Screening Program Estimate – Governor's Budget.** The November 2023 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $167.8 million ($38.7 million state operations and $129.1 million local assistance) in 2023-24, and $181.5 million ($38.8 million state operations and $142.8 million local assistance) in 2024-25.

| Genetic Disease Screening Program (GDSP) Funding Summary | | | |
|---|---|---|---|
| | **2023-24** | **2024-25** | **BY to CY** |
| **Fund Source** | ***Revised*** | ***Proposed*** | ***Change*** |
| 0203 – Genetic Disease Testing Fund | | | |
| State Operations: | $38,670,000 | $38,761,000 | $91,000 |
| Local Assistance: | $129,100,000 | $142,784,000 | $13,684,000 |
| **Total GDSP Expenditures** | **$167,770,000** | **$181,545,000** | **$13,775,000** |

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

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

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

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

in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

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

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

The NBS program currently screens infants in California for more than 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be added to the NBS program screening panel within two years. The current fee for screening in the NBS program is currently $211.

NBS Caseload Estimate: The budget estimates NBS program caseload of 409,041 in 2023-24, a decrease of 920 or 0.2 percent, compared to 2022-23 actual total caseload of 409,961. The budget estimates NBS program caseload of 409,299 in 2024-25, an increase of 258 or 0.1 percent, compared to the revised 2023-24 estimate. These estimates are based on state projections of the number of live births in California. CDPH assumes 100 percent of children born in California will participate in the NBS program annually.

**Prenatal Screening (PNS) Program.** The Prenatal Screening (PNS) program provides prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant individuals in California to detect birth defects during pregnancy. The program offers two types of prenatal screening:

- Cell-free DNA (cfDNA) Screening - Cell-free DNA (cfDNA) is a non-invasive screening test for fetal chromosomal abnormalities that relies on extraction of maternal and fetal cells from a pregnant individual's blood sample. cfDNA can detect chromosomal abnormalities and birth defects including trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome), and trisomy 13 (Patau syndrome). Compared to the metabolic screening methods previously used by PNS, cfDNA screening results in

fewer false positives and better accuracy resulting in fewer pregnant individuals being referred for diagnostic follow-up services.

- Maternal Serum Alpha-Fetoprotein (MSAFP) Screening – Alpha-fetoprotein (AFP) is a protein mainly produced in the fetal liver and released into the maternal serum (MSAFP) and amniotic fluid. A small amount crosses the placenta and becomes measurable in the maternal serum towards the end of the first trimester. Levels rise steadily through the second trimester. This screening detects neural tube defects, such as open spina bifida or anencephaly, which result in higher than normal MSAFP in maternal serum.

For pregnant individuals with screening results indicating a high risk for a birth defect, the program provides free follow-up diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs). Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation in the screening testing and follow-up services is voluntary and the fee for testing through the PNS program is $344. This represents an increase of $112 from the previous fee level to support cfDNA screening and the addition of prenatal screening for sex chromosome aneuploidy (SCA).

PNS Caseload Estimate: The budget estimates PNS program caseload of 227,937 cfDNA specimens in 2023-24, an increase of 37,408 or 20 percent, compared to 2022-23 actual total caseload of 190,529 specimens. The budget estimates PNS program caseload of 227,973 cfDNA and sex chromosome aneuploidy (SCA) specimens in 2024-25, an increase of 36 or 0.02 percent, compared to the revised 2023-24 estimate. These estimates are based on state projections of the number of live births in California.

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

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

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

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

## Issue 13: Center for Health Care Quality Estimate

**Center for Health Care Quality Program Estimate – Governor's Budget.** The budget includes expenditure authority for the Center for Health Care Quality of $481.8 million ($14.8 million General Fund, $107.2 million federal funds, and $326.5 million special funds and reimbursements) in 2023-24, an increase of $19.8 million or 4.3 percent compared to the 2023 Budget Act, and $473.7 million ($8.3 million General Fund, $107.2 million federal funds, and $320.6 million special funds and reimbursements) in 2024-25, a decrease of $8.1 million or 1.7 percent compared to the revised 2023-24 estimate. According to CDPH, the increase in 2023-24 is attributable to baseline adjustments and a projected increase in federal grant expenditures, while the decrease in 2024-25 is attributable primarily to a decrease in federal expenditure authority, offset by an increase of special fund authority for expansion of application and fee processing, and various baseline adjustments.

| CHCQ Funding Summary, November 2023 Estimate | | |
|---|---|---|
| **Fund Source** | **2023-24** | **2024-25** |
| 0001 – General Fund | $9,960,000 | $4,969,000 |
| 0890 – Federal Trust Fund | $139,335,000 | $130,189,000 |
| 0942 – Special Deposit Fund | | |
| Internal Departmental Quality Improvement Account | $716,000 | $718,000 |
| State Health Facilities Citation Penalty Account | $2,144,000 | $2,144,000 |
| Federal Health Facilities Citation Penalty Account | $6,152,000 | $6,154,000 |
| 0995 – Reimbursements | $15,614,000 | $15,693,000 |
| 3098 – Licensing and Certification Program Fund | $307,876 ,000 | $313,858,000 |
| **Total CHCQ Funding** | **$481,797,000** | **$473,725,000** |
| **Total CHCQ Positions** | **1534.4** | **1542.2** |

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

**CHCQ Oversight of Hospital Nurse-Patient Ratios.** SB 227 (Leyva), Chapter 843, Statutes of 2019, imposes certain requirements on CDPH's oversight of hospital compliance with regulatory requirements regarding maintaining certain nurse-patient ratios. These ratios were authorized by AB 394 (Kuehl), Chapter 945, Statutes of 1999, and promulgated in regulations by CDPH. General acute care hospitals are expected to maintain ratios of 1:1 for operating rooms; 1:2 for intensive care, labor and delivery, intensive care unit patients in the emergency room, and neonatal care; 1:3 for step down; 1:4 for emergency rooms, postpartum/antepartum, and telemetry units; 1:5 in medical-surgical units; and 1:6 in

postpartum and psychiatry units. SB 227 requires CDPH to do the following: 1) periodically conduct unannounced inspections to ensure compliance with nurse-patient ratios; 2) assess administrative penalties of $15,000 for first violations and $30,000 for subsequent violations; 3) exempts hospitals from penalties if the fluctuation in staffing was unpredictable and uncontrollable, prompt efforts were made to maintain required staffing levels, and the hospital immediately used and exhausted its on-call list of nurses and the charge nurse.

During the COVID-19 pandemic, implementation of SB 227 enforcement of staffing ratios was paused. The pause was tied to the COVID-19 public health emergency, which expired on February 28th, 2023. In September 2023, CDPH issued an all facility letter advising hospitals regarding the resumption of enforcement activities related to SB 227. However, labor advocates representing nurses have reported that no administrative penalties have been issued, despite numerous substantiated violations of nurse-patient ratios by hospitals.

**Panel Discussion.** The subcommittee has requested the following panelists to discuss CDPH enforcement of SB 227 requirements:

- California Department of Public Health (CDPH), Center for Health Care Quality
- Service Employees International Union (SEIU) Local 121RN
- California Hospital Association

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

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

1. Please provide a brief overview of the Center for Health Care Quality, including regulatory responsibilities, organizational structure, funding, and performance.

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

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

<u>For the SB 227 Panel Discussion</u>:

4. Please describe how the program is currently enforcing the provisions of SB 227.

5. Have any unannounced inspections occurred since the release of the September all facility letter? Have any violations been substantiated or penalties issued?

6. Have any hospitals been exempted from penalties by the department by meeting the exemption criteria included in SB 227?

## Issue 14: Center for Health Care Quality Application and Fee Processing Expansion

**Budget Change Proposal and Trailer Bill Language – Governor's Budget.** CDPH requests 11.5 positions and expenditure authority from the Licensing and Certification Fund of $1.1 million in 2024-25 and $1.6 million annually thereafter. If approved, these positions and resources would support expansion of application and fee processing activities for health facilities. CDPH also proposes trailer bill language to authorize implementation of a new fee schedule and impose deadlines and penalties for late submission of applications for licensure or licensure changes.

| Program Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2024-25** | **2025-26*** |
| 3098 – Licensing and Certification Fund | $1,078,000 | $1,611,000 |
| **Total Funding Request:** | **$1,078,000** | **$1,611,000** |
| **Total Requested Positions:** | **11.5** | **11.5** |

* Positions and resources ongoing after 2025-26.

**Background.** The Center for Health Care Quality's Centralized Applications Branch (CAB) processes all applications submitted by health facilities for licensure changes, including changes of ownership, location, name, beds, and key personnel such as administrators or medical directors. According to CDPH, CAB processes over 10,000 change applications from facilities in over 20 different types of licensure change categories. However, only a few of these application types, including annual licensing and change of ownership (CHOW), are associated with a fee. As CHCQ is primarily supported by fee revenue from the Licensing and Certification Fund, workload not associated with a fee must be supported by fees imposed on other processes or applications.

According to CDPH, CHCQ conducted a joint review of its workload with the Department of Finance's Research and Analysis Unit. This review uncovered opportunities to update the application fee schedule to provide a more equitable distribution of costs among the facilities, align application fee revenue with application workload costs, address stakeholder concerns regarding the CHOW fee, reduce some cost pressures from the annual licensing fee, and disincentivize the practice among some facilities of failing to submit required change applications. The review recommended implementing a fee for all licensure changes processed by the department, as well as imposing late fees when these changes are not submitted timely. According to CDPH, the proposed expansion of fees to other licensure changes would allow the reduction of certain other fees, such as the CHOW fee, to be more consistent with the actual workload required to process the applications associated with the fee. For example, under the proposal, a CHOW fee for a 99-bed skilled nursing facility would be reduced from $105,039 to $39,700. These adjustments to existing fees and the amounts of newly proposed fees were based on a fee schedule methodology that took into account onsite survey timekeeping data, initial findings from a time study for CAB workload, self-reported estimates of workload, and average position costs derived from the department's salaries and wages galley.

**Staffing and Resource Request.** CDPH requests 11.5 positions and expenditure authority from the Licensing and Certification Fund of $1.1 million in 2024-25 and $1.6 million annually thereafter to support expansion of application and fee processing activities for health facilities. Specifically, CDPH requests the following positions:

CAB Administration Section – Five positions

- **Four Staff Services Analysts (SSA)** and **one Staff Services Manager (SSM) I** position would support the increased health facility application and licensure renewal volume, which have increased 28 percent and 16 percent, respectively, as well as the increased time required to process annual license renewals due to the validation of the information in the renewal application against the information in the Electronic Licensing Management System.

Revenue Collection Unit – 4.5 positions

- **3.5 Associate Governmental Program Analysts (AGPAs)** and **one SSM I** position would support the projected 75 percent increase in fee payment processing volume due to the addition of new fees on various types of applications, including an estimated 8,000 additional payments per year for licensure changes and processing of late penalty assessments.

Administration Division – One position

- **One AGPA** would support the additional check deposit workload from collection of additional payments and late penalty assessments.

Hospice Workload – One position

- **One AGPA** would support increased workload related to hospice application volumes associated with the requirements of AB 2673 (Irwin), Chapter 797, Statutes of 2022, which requires CHCQ to verify the status of professional licensure for hospice management personnel and validate relevant work history.

**Trailer Bill Language Proposal.** CDPH also proposes trailer bill language to authorize implementation of a new fee schedule and impose deadlines and penalties for late submission of applications for licensure or licensure changes.

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

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

1. Please provide a brief overview of this proposal.

2. Please characterize, if possible, the average net impact on a typical health facility of these proposed changes to the fee schedule.

## Issue 15: Skilled Nursing Facility Staffing Audits Fund Shift

**General Fund Budget Solution – Governor's Budget.** CDPH requests to shift General Fund expenditure authority of $4 million in 2024-25, previously approved in the 2023 Budget Act as an ongoing General Fund appropriation, to the Licensing and Certification Fund, to support audit activities related to the monitoring and enforcement of skilled nursing facility minimum staffing requirements.

| Multi-Year Funding Request Summary | | |
|---|---|---|
| **Fund Source** | **2024-25** | **2025-26** |
| 0001 – General Fund | ($4,000,000) | $- |
| 3098 – Licensing and Certification Fund | $4,000,000 | $- |
| **Total Funding Request:** | **$-** | **$-** |
| **Total Requested Positions:** | **0.0** | **0.0** |

**Background.** The Staffing Audits Section in the Center for Health Care Quality (CHCQ) at CDPH audits skilled nursing facility compliance with state and federal law governing minimum staffing requirements. Audits of all freestanding skilled nursing facilities are conducted annually and include the review of 24 days of staffing data. Included in these requirements are minimum ratios of direct care service hours per patient day, updated in 2017. SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, requires skilled nursing facilities to have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for certified nursing assistants (CNAs). Previously, the minimum staffing requirement had been 3.2 hours per patient day, with no minimum requirements for CNAs. CDPH is responsible for auditing skilled nursing facilities for compliance with these minimum staffing requirements. Failure to comply may result in administrative penalties assessed by CDPH, or ineligibility for payments in the Medi-Cal Quality and Accountability Supplemental Payment (QASP) program.

Until December 31, 2022, DHCS, under an interagency agreement with CHCQ, reimbursed staffing audit costs of $8 million ($4 million Quality and Accountability Special Fund and $4 million federal funds) annually. Audits conducted by CHCQ were included in the criteria for the Medi-Cal QASP program, an incentive payment program to ensure performance of quality metrics incorporated into the Skilled Nursing Facility Quality Assurance Fee (SNF QAF) originally established by AB 1629 (Frommer), Chapter 875, Statues of 2004.

According to CDPH, CHCQ's minimum staffing audits responsibilities, administrative penalty authority and the Medi-Cal QASP program expired on December 31, 2022. The 2022 Budget Act included trailer bill language implementing Nursing Facility Financing Reform, and established a new Workforce and Quality Incentive Program (WQIP) financed directly by the General Fund and to replace the QASP.

The 2023 Budget Act included General Fund expenditure authority of $4 million annually to support audits of skilled nursing facilities to verify compliance with minimum staffing requirements.

**General Fund Budget Solution – Fund Shift.** CDPH requests to shift General Fund expenditure authority of $4 million in 2024-25, previously approved in the 2023 Budget Act as an ongoing General Fund appropriation, to the Licensing and Certification Fund, to support audit activities related to the

monitoring and enforcement of skilled nursing facility minimum staffing requirements. The General Fund expenditure authority previously approved for 2023-24, as well as ongoing General Fund authority in 2025-26 and annually thereafter, would be maintained.

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

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

1. Please provide a brief overview of this proposed fund shift.

2. Why is this fund shift only proposed for one year, and not for the current year and subsequent fiscal years after the budget year, given the General Fund shortfall?

## Issue 16: Proposals for Investment

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

**End the Epidemics.** The End the Epidemics Coalition, a coalition of 11 organizations, request the following investments in reducing disparities, Getting to Zero, and reducing sexually transmitted infections:

1) ADAP Rebate Fund Loan – Reduce the Governor's proposed loan from the AIDS Drug Assistance Program (ADAP) Rebate Fund from $500 million to $250 million.
2) Expand Eligibility for ADAP and PrEP-AP – Expenditure authority from the ADAP Rebate Fund of $3.5 million in 2024-25 and $2.7 million in 2025-26 to increase ADAP and Pre-Exposure Prophylaxis Assistance Program (PrEP-AP) eligibility from 500 percent of the federal poverty level to 600 percent of the federal poverty level.
3) ADAP Open Formulary – Trailer bill language to transition the ADAP formulary to an open formulary, to allow patients with HIV to initiate potentially safer and more efficacious regimens based on their proclivity to adverse events, yield better outcomes, and reduce costs.
4) Harm Reduction Clearinghouse – Expenditure authority from the ADAP Rebate Fund of $10 million in 2024-25 to support the harm reduction clearinghouse, a cost-effective strategy for bulk purchasing, reducing costs, and streamlining ordering of supplies for harm reduction programs to reduce transmission of infectious diseases, prevent injury and overdose, and improve access to treatment and harm reduction services.
5) Increase HIPP Cap – Expenditure authority from the ADAP Rebate Fund of $3.5 million in 2025-26 and $7 million in 2026-27 to increase the program cap on payments in the ADAP Health Insurance Premium Payment (HIPP) program from $1,938 per month to $2,996 per month.
6) TGI Wellness and Equity Fund – Annual expenditure authority from the ADAP Rebate Fund of $5 million to support the Transgender, Gender Nonconforming, and Intersex (TGI) Wellness and Equity Fund, which provides funding to organizations that serve people that identify as TGI, creates or funds TGI-specific housing programs and partnerships with hospitals, health care clinics, and other medical providers to provide TGI-focused health care and related education programs for health care providers.
7) Needs Assessment and Gap Analyses – Expenditure authority from the ADAP Rebate Fund of $400,000 in 2024-25 to support two needs assessment and gap analyses for: 1) current needs for client navigation and retention services, and 2) the PrEP-AP navigation program.
8) Youth Health Equity and Safety Act – General Fund expenditure authority of $5 million in 2024-25 to support the Youth Health Equity and Safety Act for three years, which seeks to address sexually transmitted infections among California youth and improve equitable public health outcomes statewide by expanding teen access to condoms in schools and communities.
9) California Overdose Prevention Harm Reduction Initiative – Expenditure authority from the Opioid Settlements Fund of $6 million in 2024-25 to reverse the proposed reduction to the Harm Reduction Initiative proposed in the Governor's January budget.

**California Cancer Registry.** The American Cancer Society Cancer Action Network, the City of Hope, the Public Health Institute, and the University of Southern California request General Fund expenditure authority of $7 million annually to protect and restore funding for the California Cancer Registry (CCR), which is suffering from a funding shortfall due to reductions in Proposition 99 tobacco tax revenues. The CCR is the largest population-based state cancer registry in North America (including Canada and

Mexico) and plays a critical role in analyzing geographic, racial, ethnic, and socioeconomic differences in cancer incidence, mortality, and survival. CCR is a population-based cancer registry that has been described as "the eyes with which we see the cancer problem" – without it, we would be blind to how a major cause of illness and death impacts the people of California.

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