Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 16, 2023
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultant: Scott Ogus

Item **Department** **Page**

PUBLIC COMMENT

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4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Oversight – Implementation of Recent Expansions of Medi-Cal Eligibility

Oversight and Panel Discussion – Implementation of Recent Expansions of Medi-Cal Eligibility. The subcommittee has requested the following panelists to participate in a discussion of recent expansions of Medi-Cal eligibility:

- **Department of Health Care Services** – Status Update on Implementation of Medi-Cal Expansions

- **Cathy Senderling-McDonald**, Executive Director, County Welfare Directors Association of California
- **Sarah Dar**, Director of Health and Public Benefits Policy, California Immigrant Policy Center
- **Kim Selfon,** Medi-Cal and IHSS Policy Specialist, Bet Tzedek Legal Services
- **Linda Nguy**, Senior Policy Advocate, Western Center on Law and Poverty
- **Kristen Golden-Testa**, Health Policy Director, The Children's Partnership

Recent Expansions of Medi-Cal Eligibility. Since 2019, the Legislature has approved several significant expansions of Medi-Cal eligibility for undocumented individuals, seniors and persons with disabilities, and young children. These expansions include:

1. *Full-Scope Medi-Cal Expansion to Undocumented Young Adults*. The 2019 Budget Act included expenditure authority of $98 million ($74.4 million General Fund and $23.3 million federal funds) for expansion of full-scope Medi-Cal coverage to undocumented young adults age 19 to 25. This eligibility expansion began on January 1, 2020.

2. *Elimination of the Senior Penalty – Medi-Cal Aged and Disabled to 138 Percent FPL*. The 2019 Budget Act included expenditure authority of $63 million ($31.5 million General Fund and $31.5 million federal funds) to eliminate the senior penalty and expand eligibility for Medi-Cal's aged and disabled program up to 138 percent of the federal poverty level. This eligibility expansion began on December 1, 2020.

3. *Eliminate Assets Test in Medi-Cal*. The 2021 Budget Act included expenditure authority of $394 million ($197 million General Fund and $197 million federal funds) annually beginning in 2022-23, and the Legislature approved trailer bill language, to increase the Medi-Cal asset limit to $130,000 for an individual (plus $65,000 for each additional household member) no sooner than July 1, 2022, and to fully eliminate the asset limit no sooner than January 1, 2024. The phase-out schedule of the asset limit began on July 1, 2022, and the asset test will be fully eliminated on January 1, 2024.

4. *Full-Scope Medi-Cal Coverage Age 50 and Older Regardless of Immigration Status*. The 2021 Budget Act included expenditure authority of $67.3 million ($48 million General Fund and $19.3 million federal funds) in 2021-22 and $1.5 billion ($1.3 billion General Fund and $200 million federal funds) when fully implemented, and the Legislature approved trailer bill language, to expand full-scope Medi-Cal coverage for income-eligible adults age 50 years of age and older regardless of immigration status. This eligibility expansion began on May 1, 2022.

5. *Medi-Cal Coverage for All Income-Eligible Californians*. The budget includes expenditure authority of $835.6 million ($626.1 million General Fund and $209.5 million federal funds) in 2023-24, growing to $2.6 billion ($2.1 billion General Fund and $500 million federal funds) when fully implemented, and the Legislature approved trailer bill language, to expand full-scope Medi-Cal eligibility to all income-eligible adults regardless of immigration status, beginning no later than January 1, 2024.

6. *Share of Cost Reform*. The Legislature approved trailer bill language to reform calculations of share of cost and expand eligibility for Medi-Cal for medically needy older adults and persons with disabilities, if a determination is made in the spring of 2024 that General Fund over the multiyear forecast is available to support this program.

7. *Continuous Coverage for Children Up to Age 5*. The Legislature approved trailer bill language to provide continuous Medi-Cal coverage for children up to age five, if a determination is made in the spring of 2024 that General Fund over the multiyear forecast is available to support this program.

Medi-Cal Eligibility. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 14.4 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases. As of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level are also eligible for services in Medi-Cal.

The Affordable Care Act, in addition to expanding income-eligibility for Medi-Cal, also established a new methodology for determining income eligibility, based on Modified Adjusted Gross Income (MAGI). MAGI is used to determine Medi-Cal eligibility for most children, pregnant women, parents, and adults. The methodology considers taxable income and tax filing relationships to determine financial eligibility for Medi-Cal. MAGI-based eligibility does not allow income disregards or asset or resource tests.

Some populations eligible for Medi-Cal are exempt from the MAGI-based eligibility methodology, including those whose eligibility is based on age or disability. Individuals in these categories, known as non-MAGI, are determined using income eligibility methodologies for the Supplemental Security Income (SSI) program. To qualify (as of April 2022), an individual's countable monthly income must be below $1,546 or $2,106 for a couple. Countable income excludes certain expenses and other income disregards to determine eligibility. In addition, non-MAGI beneficiaries are subject to limits on assets ("asset test") and are responsible for a "share of cost" to be eligible for Medi-Cal coverage. The asset test is in the process of phasing out for this population by January 1, 2024. Previously, individuals could not possess countable assets (excluding certain assets like a house and a car) in excess of $2,000. Currently, the asset test limit is set at $130,000. As of January 1, 2024, the asset test limit will be eliminated.

Non-MAGI beneficiaries are also subject to a share of cost, which is the difference between an individual's countable income and the amount the federal government calculates an individual needs to cover daily expenses. The monthly maintenance need allowance is $600 for one person and $1,100 for four people. For example, if a single non-MAGI beneficiary has monthly countable income of $2,000, then the beneficiary is responsible for $1,400 as a share of cost ($2,000 countable income - $600 maintenance need

allowance). Non-MAGI beneficiaries must pay their share of cost towards medical costs before Medi-Cal will cover any medically necessary health care services.

Restricted-Scope Medi-Cal Coverage. Prior to the expansions of Medi-Cal regardless of immigration status, income-eligible Californians without satisfactory immigration status or who are pregnant have been eligible for restricted-scope Medi-Cal coverage. Restricted-scope Medi-Cal, which is offered on a fee-for-service basis, covers emergency medical services, pregnancy-related services, long-term care (in certain cases), the Medi-Cal Access Program (for pregnant people with incomes between 213 and 322 percent of the federal poverty level), the Breast and Cervical Cancer Treatment Program, and the Child Health and Disability Prevention Program. Federal Medicaid law allows federal matching funds for these restricted scope services, but does not provide matching funds for full-scope coverage for these populations under the state's recent and planned expansions of eligibility regardless of immigration status.

Health4All – Full-Scope Medi-Cal Coverage Regardless of Immigration Status. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015, expanded full-scope Medi-Cal coverage to income-eligible children age 18 and under, beginning May 1, 2016. This expansion was the first time the state offered full-scope Medi-Cal coverage to undocumented Californians. SB 104 (Committee on Budget and Fiscal Review), Chapter 67, Statutes of 2019, further expanded coverage for young adults ages 19 through 25, which began on January 1, 2020. AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, expanded coverage for older Californians age 50 and older beginning May 1, 2022, and SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, completes the expansion of coverage by authorizing coverage of the remaining population, ages 26 to 49, beginning January 1, 2024. The Governor's January budget maintains the implementation schedule for the 26 to 49 expansion. According to DHCS, 714,295 individuals age 26 to 49 are expected to receive full-scope Medi-Cal coverage by the end of 2023-24.

Non-MAGI Changes – "Senior Penalty", Asset Test, and Share of Cost Reform. Prior to recent expansions to eligibility requirements, non-MAGI individuals with income under 100 percent of the federal poverty level (FPL) and who are over age 65 or are disabled were eligible for the Aged and Disabled Program. With certain income disregards, income eligibility for this program was approximately 124 percent of the FPL. Because this income eligibility level was below the MAGI income eligibility level of 138 percent of the FPL, individuals that aged into the Aged and Disabled Program when they turned 65 would be subject to more stringent Medi-Cal eligibility requirements, known as the "senior penalty".

SB 104 (Committee on Budget and Fiscal Review), Chapter 67, Statutes of 2019, eliminated the "senior penalty" by increasing the income eligibility levels in the Aged and Disabled Program to 138 percent of the FPL, consistent with eligibility under MAGI rules. This expansion of eligibility, which was implemented on December 1, 2020, ensured that Californians would not be subject to stricter income eligibility requirements for Medi-Cal once they turned 65 or became disabled.

AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, phases out asset limits for non-MAGI Medi-Cal eligibility. Previously, beneficiaries could only have $2,000 of countable assets (not including a home or a car) to be eligible for Medi-Cal. AB 133 increased the asset limit to $130,000 beginning July 1, 2022, and eliminates the limit entirely on January 1, 2024.

SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, conditionally authorizes reform to the calculation of "share of cost" for non-MAGI Medi-Cal beneficiaries. SB 184 would increase the maintenance need allowance to be equal to the income limit for Medi-Cal without a share of cost, beginning on January 1, 2025. However, this reform would only be implemented if the Department of Finance finds the state has sufficient General Fund resources to support ongoing implementation of the program.

Continuous Coverage for Children Ages Zero to Five. SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, also conditionally authorizes continuous Medi-Cal coverage for children ages zero to five, regardless of income, beginning on January 1, 2025. This reform would allow for greater care coordination and continuity of care for children in their critical, formative, first five years. However, similar to Share of Cost reform, this reform would only be implemented if the Department of Finance finds the state has sufficient General Fund resources to support ongoing implementation of the program.

Subcommittee Staff Comment. This is an informational item.

Questions. The subcommittee has requested DHCS and panelists to respond to the following:

DHCS

1. Please provide a brief overview and update of implementation, or planning for implementation, of the following expansions of Medi-Cal eligibility:

    a. Medi-Cal Eligibility Regardless of Immigration Status (including young adults, older adults, and 26-49)
    b. Elimination of the "Senior Penalty" for the Aged and Disabled Program
    c. Phase-out of the Asset Test for non-MAGI Medi-Cal Eligibility
    d. Share of Cost Reform (future implementation)
    e. Continuous Coverage for Children 0-5 (future implementation)

2. For future expansions, how is the department reaching out to affected populations to ensure they are aware of their newly available eligibility for Medi-Cal and, once enrolled, how to access benefits and services?

3. What are the operational challenges to any of these expansions posed by the unwinding of the federal public health emergency's continuous coverage requirement?

4. Although the Share of Cost Reform and Continuous Coverage for Children expansions are contingent on Finance findings of sufficient General Fund resources, what advance planning has DHCS done to be ready in the event these expansions move forward?

5. These recent expansions of Medi-Cal eligibility, as well as similar changes to other public benefit programs, have been phased in to account for the migration of the three county eligibility systems into a single system, CalSAWS. When CalSAWS is fully implemented in January 2024, will it be easier

to implement new expansions of Medi-Cal eligibility, or will expanding Medi-Cal coverage still be subject to the ability of the technology platform to accommodate new changes?

County Welfare Directors Association of California (CWDA)

1. From the perspective of county eligibility workers, how have these expansions impacted volume and complexity of eligibility workload?

2. Are counties well-resourced to implement these expansions, in addition to the unwinding of the public health emergency's continuous coverage requirement?

3. How are counties and their community partners reaching out to populations that are newly eligible for Medi-Cal under these expansions to ensure they are aware of the opportunity to receive Medi-Cal coverage, as well how to access benefits and services?

4. These recent expansions of Medi-Cal eligibility, as well as similar changes to other public benefit programs, have been phased in to account for the migration of the three county eligibility systems into a single system, CalSAWS. When CalSAWS is fully implemented in January 2024, will it be easier to implement new expansions of Medi-Cal eligibility, or will expanding Medi-Cal coverage still be subject to the ability of the technology platform to accommodate new changes?

California Immigrant Policy Center (CIPC)

1. What has full-scope Medi-Cal coverage meant to the immigrant communities that have received coverage thus far under the young adult and older adult expansions? How has utilization, prevention, and coordination of care changed since these expansions were implemented?

2. How have outreach efforts been going for the upcoming expansion for ages 26 to 49?

3. How should the state's outreach or messaging change to immigrant communities once all income-eligible Californians can receive full-scope Medi-Cal coverage regardless of immigration status? What type of opportunities or investments could the state undertake to ensure coverage translates to better health and well-being?

Bet Tzedek

1. How have the end of the "senior penalty" and the phase-out of the asset test impacted the ability of seniors and persons with disabilities to enroll in and maintain Medi-Cal coverage, as well as continuity of care?

2. How have these expansions of eligibility improved care coordination and overall well-being for seniors and persons with disabilities?

3. As the state unwinds the public health emergency's continuous coverage requirement and begins redeterminations of Medi-Cal eligibility, how do you expect seniors and persons with disabilities that

have aged into non-MAGI Medi-Cal categories, or those who have not had to undergo redeterminations in two to three years, to navigate the redetermination process?

4. How would the Share of Cost reform improve access to Medi-Cal coverage, and improve the health and well-being of seniors and persons with disabilities, if the Department of Finance allows this expansion to proceed?

5. Are there any challenges for seniors and persons with disabilities in accessing newly expanded coverage that the Legislature should examine further?

Western Center on Law and Poverty (WCLP)

1. How have the new expansion populations fared in attempting to enroll in coverage or access benefits and services?

2. How well are DHCS, counties, and community partners doing to engage populations that will soon have access to full-scope Medi-Cal coverage to make them aware of expanded eligibility and how to access benefits and services?

3. Do you expect any significant challenges or disruptions to care from the unwinding of the public health emergency's continuous coverage requirement?

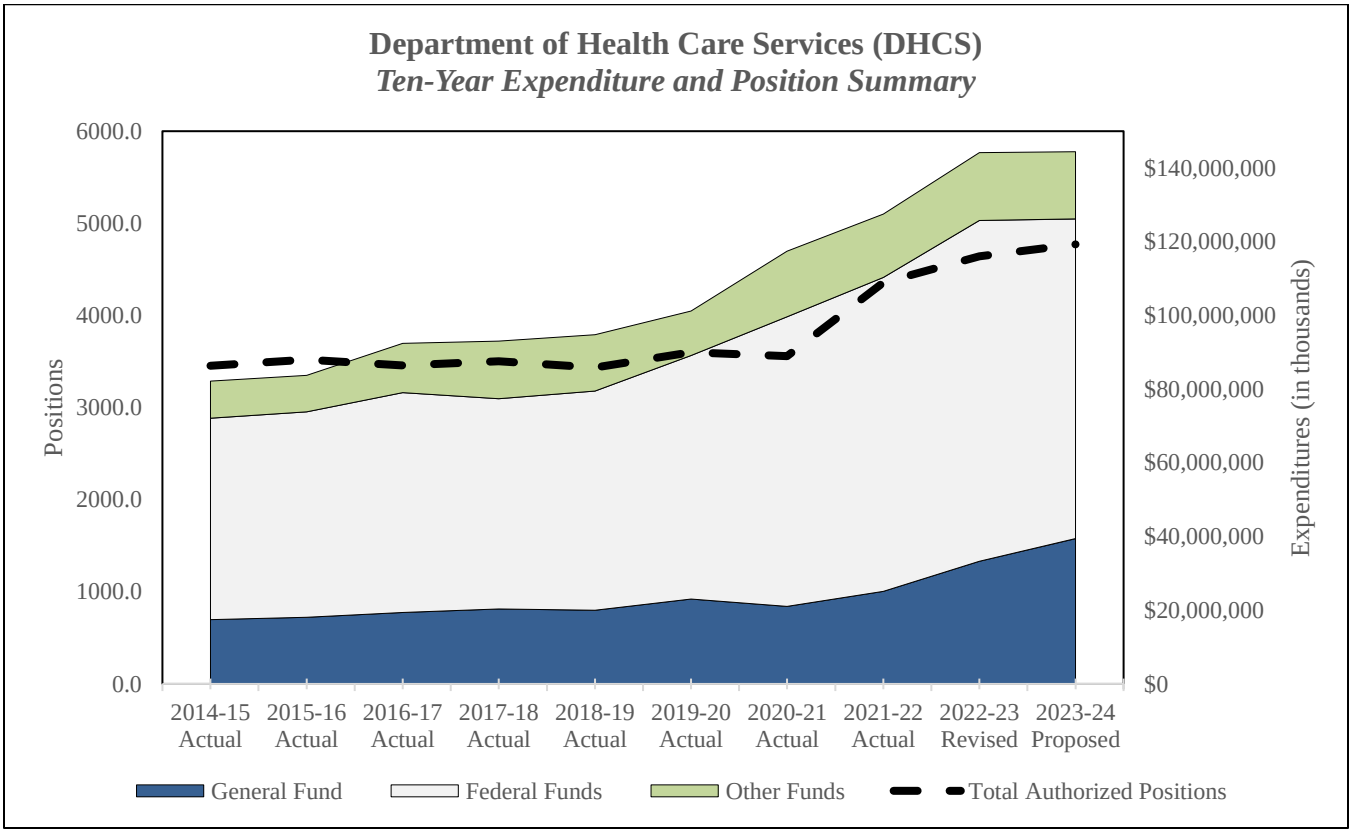
4. What additional reforms or administrative changes would improve the unwinding and redetermination process, particularly for populations that will have expanded eligibility in January 2024?

The Children's Partnership (TCP)

1. How would continuous coverage of children zero to five improve continuity of care, and the health and well-being of California children, if the Department of Finance allows this expansion to proceed?

2. What evidence exists of improvements to health and well-being for children offered continuous coverage ages zero to five, either during the public health emergency's continuous coverage requirement or in other states that have implemented such an expansion?

Issue 2: Overview



Department of Health Care Services - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2021-22 Actual**	**2022-23 Budget Act**	**2022-23 Revised**	**2023-24 Proposed**
General Fund	$25,165,081	$37,332,644	$33,244,352	$39,408,906
Federal Funds	$85,186,603	$89,460,329	$92,517,734	$86,753,329
Other Funds	$17,124,382	$17,418,078	$18,392,223	$18,265,494
Total Department Funding	$127,476,066	$144,211,051	$144,154,309	$144,427,729
Total Authorized Positions	4357.2	4640.5	4640.5	4771.5
Other Funds Detail:	$0	$0	$0	$0
Breast Cancer Control Account (0009)	$8,950	$10,946	$9,219	$10,340
Childhood Lead Poisoning Prev Fund (0080)	$0	$1,003	$989	$989
DUI Program Licensing Trust Fund (0139)	$687	$1,350	$1,385	$1,444
Prop 99 - Hospital Services Acct (0232)	$95,588	$77,350	$77,350	$73,748

Prop 99 - Physician Services Acct (0233)	$26,595	$22,249	$22,249	$21,842
Prop 99 - Unallocated Acct (0236)	$63,619	$47,024	$47,024	$45,469
Narcotic Treatment Program Lic Fund (0243)	$1,784	$1,792	$1,913	$1,903
Perinatal Insurance Fund (0309)	$537	$19,600	$11,072	$13,388
Major Risk Medical Insurance Fund (0313)	$0	$0	$0	$0
Audit Repayment Trust Fund (0816)	$0	$41	$41	$41
Medi-Cal Inpatient Payment Adj Fund (0834)	$102,369	$112,221	$104,548	$121,576
Special Deposit Fund (0942)	$58,092	$73,022	$57,890	$80,144
Reimbursements (0995)	$1,022,946	$2,003,688	$2,295,961	$2,091,698
County Health Initiative Matching Fund (3055)	$0	$174	$174	$174
Children's Medical Services Rebate Fund (3079)	$10,604	$5,762	$9,600	$30,632
Mental Health Services Fund (3085)	$6,252,908	$3,733,693	$3,360,305	$3,293,238
Nondesignated Public Hospital Suppl Fund (3096)	($656)	$4,258	($177)	$0
Private Hospital Supplemental Fund (3097)	($9,859)	$192,941	$11,261	$25,325
Mental Health Facility Licensing Fund (3099)	$30	$373	$373	$373
Residential and Outpatient Prog Lic Fund (3113)	$7,569	$8,208	$2,748	$11,797
Children's Health and Human Svcs Special Fund (3156)	$0	$0	$416,000	$0
Hospital Quality Assurance Revenue Fund (3158)	$3,483,282	$3,810,863	$3,659,400	$5,188,271
SNF Quality and Accountability Fund (3167)	($5,202)	$20,500	$21,697	$0
Emergency Medical Air Transportation Fund (3168)	$4,351	$1,120	$4,011	$1,076
Public Hosp Investment, Imp, Incentive Fund (3172)	$0	$0	$0	$0
Long-Term Care Quality Assurance Fund (3213)	$444,025	$495,668	$517,203	$501,312
Health and Human Services Special Fund (3293)	$0	$0	$0	$0
Healthcare Treatment Fund (3305)	$884,802	$570,491	$652,615	$745,788

Health Care Service Plan Fines/Penalties Fund (3311)	$7,570	$12,382	$12,382	$12,487
Medi-Cal Emergency Med Transport Fund (3323)	$70,107	$65,868	$62,368	$63,001
Medi-Cal Drug Rebate Fund (3331)	$1,474,916	$1,841,255	$1,788,007	$1,853,824
Health Care Services Special Fund (3334)	$2,517,457	$2,065,534	$2,065,534	$0
YEPEITA - Cannabis Tax Fund (3350)	$343,191	$401,766	$574,920	$401,766
PACE Oversight Fund (3362)	$0	$748	$748	$748
Loan Repayment Acct, Healthcare Treatment Fund (3375)	$23,168	$40,780	$42,028	$52,466
Opioid Settlement Fund (3397)	$0	$78,029	$78,029	$34,617
California Emergency Relief Fund (3398)	$0	$0	$1,083,000	$0
988 State Suicide and BH Crisis Svcs Fund (3414)	$0	$0	$0	$4,773
Medi-Cal County BH Fund (3420)	$0	$0	$0	$1,048,717
Managed Care Enrollment Fund (3428)	$0	$0	$0	$784,450
Whole Person Care Pilot Special Fund (8107)	$307,289	$0	$0	$0
Global Payment Program Special Fund (8108)	$1,430,221	$1,272,004	$1,235,912	$1,145,301
DPH GME Special Fund (8113)	$231,910	$220,597	$282,297	$268,943
Suicide Prevention Vol Contribution Fund (8124)	$0	$1,093	$1,093	$250
Federal Temporary High Risk Health Ins Fund (8500)	$0	$0	$0	$0
LIHP Fund (8502)	$0	$0	$0	$0
Coronavirus Fiscal Recovery Fund of 2021 (8506)	$303,719	$220,000	$226,281	$0
Home- and Comm-Based Svcs ARP Fund (8507)	($2,038,187)	($16,315)	($345,227)	$333,583

Department of Health Care Services – *Changes to State Operations and Local Assistance*				
Fiscal Year:	**2021-22**	**2022-23 (CY)**	**2023-24 (BY)**	**CY to BY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$292,900,000	$549,327,000	$350,622,000	($198,705,000)
Federal Funds[1]	$472,963,000	$655,745,000	$597,047,000	($58,698,000)
Spec. Funds/Reimb	$354,653,000	$602,697,000	$397,591,000	($205,106,000)
Total Expenditures	**$1,120,516,000**	**$1,807,769,000**	**$1,345,260,000**	**($462,509,000)**
Total Positions	**4357.2**	**4640.5**	**4771.5**	**131.0**
LOCAL ASSISTANCE (*MEDI-CAL AND OTHER PROGRAMS)*				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$24,872,181,000	$32,695,025,000	$39,058,284,000	$6,363,259,000
Federal Funds[1]	$85,013,640,000	$92,080,489,000	$86,156,282,000	($5,924,207,000)
Spec. Funds/Reimb	$16,469,729,000	$17,571,026,000	$17,867,903,000	$296,877,000
Total Expenditures	**$126,355,550,000**	**$142,346,540,000**	**$143,082,469,000**	**$735,929,000**
[1]*Federal Funds include Funds 0890, 7502, 7503, and 8506.*				

Background. The Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering health care services to eligible individuals. DHCS programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost-effective manner. DHCS programs include:

- ***Medi-Cal.*** DHCS serves as the single state agency for Medi-Cal, California's Medicaid program. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 14.4 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases. As of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level are also eligible for services in Medi-Cal.

- ***Children's Medical Services.*** Children's Medical Services coordinates and directs the delivery of health care services to low-income and seriously ill children and adults. Its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Child Health and Disability Prevention Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations. Its programs include: Indian Health Program, Rural Health Services Development Program, Seasonal Agricultural and Migratory Workers

Program, State Office of Rural Health, Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program, Small Rural Hospital Improvement Program, and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. As adopted in the 2011 through 2013 Budget Acts, DHCS oversees the delivery of community mental health and substance use disorder services, reflecting the elimination of the Departments of Alcohol and Drug Programs and Mental Health.

- ***Other Programs*.** DHCS oversees family planning services, cancer screening services to low-income under-insured or uninsured women, and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program, and the Prostate Cancer Treatment Program.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of DHCS programs and budget.

Issue 3: November 2022 Medi-Cal Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2022 Medi-Cal Local Assistance Estimate includes $138.1 billion ($36.5 billion General Fund, $88.6 billion federal funds, and $12.9 billion special funds and reimbursements) for expenditures in 2022-23, and $137.7 billion ($32.3 billion General Fund, $91.4 billion federal funds, and $14 billion special funds and reimbursements) for expenditures in 2023-24.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2022-22 (CY)**	**2023-24 (BY)**	**CY to BY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$30,504,060,000	$37,138,247,000	$6,634,187,000
Federal Funds	$86,355,273,000	$80,779,714,000	($5,575,559,000)
Special Funds/Reimbursements	$13,942,780,000	$14,330,038,000	$387,258,000
Total Expenditures	**$130,802,113,000**	**$132,247,999,000**	**$1,445,886,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$1,633,678,000	$1,411,565,000	($222,113,000)
Federal Funds	$4,685,310,000	$4,576,589,000	($108,721,000)
Special Funds and Reimbursements	$99,598,000	$89,168,000	($10,430,000)
Total Expenditures	**$6,418,586,000**	**$6,077,322,000**	**($341,264,000)**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$162,403,000	$163,925,000	$1,522,000
Federal Funds	$362,920,000	$427,949,000	$65,029,000
Special Funds and Reimbursements	$0	$0	$0
Total Expenditures	**$525,323,000**	**$591,874,000**	**$66,551,000**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$32,300,141,000	$38,713,737,000	$6,413,596,000
Federal Funds	$91,403,503,000	$85,784,252,000	($5,619,251,000)
Special Funds and Reimbursements	$14,042,378,000	$14,419,206,000	$376,828,000
Total Expenditures	**$137,746,022,000**	**$138,917,195,000**	**$1,171,173,000**

Caseload. In 2022-23, the budget assumes annual Medi-Cal caseload of 15.2 million, an increase of six percent compared to assumptions in the 2022 Budget Act. The department estimates 91 percent of Medi-Cal beneficiaries, or 13.9 million, will receive services through the managed care delivery system while nine percent, or 1.4 million, will receive services through the fee-for-service delivery system.

In 2023-24, the budget assumes annual Medi-Cal caseload of 14.4 million, a decrease of 5.2 percent compared to the revised caseload estimate for 2022-23. The department estimates 97.6 percent of Medi-Cal beneficiaries, or 14.1 million, will receive services through the managed care delivery system while 2.4 percent, or 349,247, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The November 2022 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

Current Year (2022-23) Savings – The Estimate includes total expenditures of $137.7 billion ($32.3 billion General Fund, $91.4 billion federal funds, and $14 billion special funds and reimbursements) for the Medi-Cal program in 2022-23, a 12.9 percent decrease in General Fund expenditures compared to the assumptions included in the 2022 Budget Act. According to DHCS, the primary drivers of these decreased General Fund expenditures are as follows:

- *State Only Claiming*. $2.4 billion General Fund savings from updated estimates of federal repayments for inappropriate claims related to state only populations, as well as shifts of portions of those repayments into future fiscal years.
- *COVID-19 Impacts*. $773.8 million General Fund savings as a net result of additional quarters of enhanced federal matching funds related to the continuation of the federal public health emergency (PHE), offset by increased caseload costs. The budget does not reflect the impact of the federal Consolidated Appropriations Act and its gradual phase-down of enhanced federal matching funds and schedule for eligibility redeterminations for state Medicaid programs.
- *Delay of Behavioral Health Continuum Infrastructure Program Grants*. $480.7 million General Fund savings as a result of the delay of the final round of grant awards in the Behavioral Health Continuum Infrastructure Program (BHCIP) from 2022-23 to 2025-26 and 2026-27.
- *Delay Elimination of Checkwrite Hold*. $309.4 million General Fund savings from shifting the elimination of the two-week checkwrite hold for Medi-Cal fee-for-service claims from 2022-23 to 2024-25.
- *Impact of Federal Deferrals*. $425.3 million General Fund savings as a result of recent decisions and updated estimates of deferrals of federal matching funds for Medi-Cal expenditures.
- *Prior Year MCO Tax Reconciliation*. $308 million General Fund savings as a net result of updated estimates of payments to and recoveries from managed care plans related to risk corridor calculations for the previous tax on managed care organizations (MCO Tax).
- *Proposition 56 Impacts*. $295.5 million General Fund savings as a result of updated Proposition 56 revenue projections reducing the estimated need to backfill supplemental provider payments with General Fund resources.
- *Hospital Quality Assurance Fee Transfers*. $139.2 million General Fund savings from updated savings estimates from the Hospital Quality Assurance Fee.
- *Medi-Cal Drug Rebate Fund Transfer*. $43.6 million General Fund savings from transfer of prescription drug manufacturer rebate funding from the Medi-Cal Drug Rebate Fund to the General Fund.

- *Designated State Health Programs*. $40.4 million General Fund savings from the federal reauthorization of the Designated State Health Program, which will help cover the costs of the justice components of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.
- *Nursing Facility Rate Adjustment*. $41 million General Fund costs due to updated estimates of costs for the Workforce and Quality Incentive Program for nursing facility days and federal PHE-related add-on costs.
- *Coordinated Care Initiative Reconciliation*. $86 million General Fund costs due to reconciliations of payments for in-home supportive services in the Coordinated Care Initiative (CCI).
- *Medicare Eligibility Update*. $95.7 million General Fund costs for updated estimates of state Medicare costs for individuals for whom federal matching funds are not available.
- *Medi-Cal Rx Updated Rebates Amounts*. $124.2 million General Fund costs due to a decrease in estimated supplemental rebates from transition of pharmacy claims from managed care to fee-for-service as part of Medi-Cal Rx.
- *Shift of BHCIP Expenditures from Prior Years*. $160.6 million General Fund costs related to the delay of BHCIP expenditures previously estimated to be spent in 2021-22 into the 2022-23 fiscal year.
- *Various Other Changes*. $439.6 million General Fund costs from various other changes to the Medi-Cal program.

Budget Year (2023-24) Adjustments – The Estimate includes total expenditures of $138.9 billion ($38.7 billion General Fund, $85.8 billion federal funds, and $14.4 billion special funds and reimbursements) for the Medi-Cal program in 2023-24, a 19.9 percent increase compared to the revised General Fund expenditure assumptions for 2022-23. According to DHCS, the primary drivers of these increased General Fund expenditures are as follows:

- *End of One-Time Expenditures*. $2.8 billion General Fund savings due to the end of one-time expenditures, including BHCIP, the Children and Youth Behavioral Health Initiative, Behavioral Health Bridge Housing, and funding for Los Angeles County Justice-Involved Populations Services and Supports.
- *Hospital Quality Assurance Fee Transfers*. $690.9 million General Fund savings from updated savings estimates from the Hospital Quality Assurance Fee.
- *Proposed 2024 MCO Tax*. $316.5 million General Fund savings from the proposed reauthorization of the MCO Tax beginning January 1, 2024.
- *Medi-Cal Rx Updated Rebates Amounts*. $690.9 million General Fund savings due to an increase in estimated supplemental rebates from transition of pharmacy claims from managed care to fee-for-service as part of Medi-Cal Rx.
- *Disproportionate Share Hospital Funding Reduction*. $124.3 million General Fund savings from reduction of state spending on disproportionate share hospitals pursuant to provisions of the federal Affordable Care Act.
- *Designated State Health Programs*. $112.6 million General Fund savings from the federal reauthorization of the Designated State Health Program, which will help cover the costs of the justice components of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.
- *Impact of Federal Deferrals*. $69 million General Fund savings as a result of recent decisions and updated estimates of deferrals of federal matching funds for Medi-Cal expenditures.

- *County Behavioral Health Recoupments*. $63.5 million General Fund savings from recoupments from county behavioral health systems related to inpatient psychiatric hospital claims and state only programs.
- *CARE Act Implementation*. $16.5 million General Fund costs to support county implementation of the Community Assistance, Recovery, and Empowerment (CARE) Act.
- *Proposition 56 Impacts*. $88.4 million General Fund costs as a result of updated Proposition 56 revenue projections and the estimated need to backfill supplemental provider payments with General Fund resources.
- *Growth in Fee-for-Service Costs*. $223.3 million General Fund costs as a result of fee-for-service delivery system expenditures, primarily attributable to growth in pharmacy spending.
- *Increase in Retroactive Managed Care Payments*. $251.6 million General Fund costs related to retroactive payments to managed care plans, primarily attributable to the ten percent add-on for skilled nursing facilities.
- *Growth in Medicare Costs*. $260.1 million General Fund costs related to increases in costs for Medicare for dual eligible beneficiaries.
- *Nursing Facility Rate Adjustment*. $302.4 million General Fund costs due to updated estimates of costs for the Workforce and Quality Incentive Program for nursing facility days and federal PHE-related add-on costs, as well as including a full 12 months of the facility reimbursement rate increase.
- *Medi-Cal Drug Rebate Fund Transfer*. $363.7 million General Fund costs from decreased transfers from the Medi-Cal Drug Rebate Fund to the General Fund due to establishment of an estimated reserve in the fund.
- *Expansion of Full-Scope Medi-Cal Regardless of Immigration Status*. $634.8 million General Fund costs to expand full-scope Medi-Cal to all income-eligible Californians regardless of immigration status, beginning January 1, 2024.
- *Growth in Managed Care Costs*. $664 million General Fund costs due to growth in costs for managed care coverage of health care services for Medi-Cal beneficiaries.
- *End of Prior MCO Tax*. $1.5 billion General Fund costs related to the expiration of the previous MCO Tax.
- *COVID-19 Impacts*. $2.7 billion General Fund costs as a net result of loss of enhanced federal matching funds due to expiration of the federal PHE offset by savings from redeterminations of eligibility for Medi-Cal beneficiaries retained in the program under the federal continuous coverage requirement. The budget does not reflect the impact of the federal Consolidated Appropriations Act and its gradual phase-down of enhanced federal matching funds and schedule for eligibility redeterminations for state Medicaid programs.
- *State Only Claiming*. $3.4 billion General Fund costs from updated estimates of federal repayments for inappropriate claims related to state only populations, as well as shifts of portions of those repayments from prior fiscal years into 2023-24.
- *Various Other Changes*. $15.2 million General Fund savings from various other changes to the Medi-Cal program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open as updated estimates of caseload and expenditures will be provided at the May Revision.

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

1. Please provide a brief overview of the significant General Fund changes in the Medi-Cal program in the 2022-23 and 2023-24 fiscal years.

Issue 4: November 2022 Family Health Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2022 Family Health Local Assistance Estimate includes $252.1 million ($212.5 million General Fund, $5 million federal funds, and $34.6 million special funds and reimbursements) for expenditures in 2022-23, and $260.7 million ($198.6 million General Fund, $5.2 million federal funds, and $56.9 million special funds and reimbursements) for expenditures in 2023-24.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2022-23 (CY)**	**2023-24 (BY)**	**CY to BY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$76,431,000	$78,650,000	$2,219,000
Federal Funds	$0	$0	$0
Special Funds/Reimbursements	$7,692,000	$8,704,000	$1,012,000
County Funds [non-add]	[$79,716,000]	[$81,918,000]	[$2,202,000]
Total CCS Expenditures	**$84,123,000**	**$87,354,000**	**$3,231,000**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$125,669,000	$109,883,000	($15,786,000)
Special Funds and Reimbursements	$6,248,000	$26,362,000	$20,114,000
Total GHPP Expenditures	**$131,917,000**	**$136,245,000**	**$4,328,000**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$10,437,000	$10,083,000	($354,000)
Federal Funds	$4,970,000	$5,219,000	$249,000
Special Funds and Reimbursements	$20,667,000	$21,796,000	$1,129,000
Total EWC Expenditures	**$36,074,000**	**$37,098,000**	**$1,024,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$212,537,000	$198,616,000	($13,921,000)
Federal Funds	$4,970,000	$5,219,000	$249,000
Special Funds and Reimbursements	$34,607,000	$56,862,000	$22,255,000
County Funds [non-add]	[$79,716,000]	[$81,918,000]	[$2,202,000]
Total Family Health Expenditures	**$252,114,000**	**$260,697,000**	**$8,583,000**

Background. The Family Health Estimate forecasts the current and budget year local assistance expenditures for three state-only funded programs that provide services for low-income children and adults with special health care needs who do not qualify for enrollment in the Medi-Cal program.

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 198,898 in 2022-23, an increase of 19,337 or 10.8 percent, compared to the 2022 Budget Act. The budget estimates Medi-Cal CCS caseload of 190,305 in 2023-24, a decrease of 8,593 or 4.3 percent, compared to the revised 2022-23 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 9,192 in 2022-23, a decrease of 3,620 or 28.3 percent, compared to the 2022 Budget Act. The budget estimates state-only CCS caseload of 11,488 in 2023-24, an increase of 2,296 or 25 percent compared to the revised 2022-23 estimate.
- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 922 in 2022-23, an increase of 117 or 14.5 percent, compared to the 2022 Budget Act. The budget estimates Medi-Cal GHPP caseload of 904 in 2023-24, a decrease of 18 or two percent, compared to the revised 2022-23 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 654 in 2022-23, an increase of two or 0.3 percent, compared to the 2022 Budget Act. The budget estimates state-only GHPP caseload of 656 in 2023-24, an increase of two or 0.3 percent, compared to the revised 2022-23 estimate.
- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).
  Caseload Estimate: The budget estimates EWC caseload of 25,010 in 2022-23, an increase of 689 or 2.8 percent, compared to the 2022 Budget Act. The budget estimates EWC caseload of 24,305 in 2023-24, a decrease of 705 or 2.8 percent compared to the revised 2022-23 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 DHCS to respond to the following:

1. Please provide a brief overview of the significant changes in Family Health Estimate programs in the 2022-23 and 2023-24 fiscal years.

2. Please provide a status update of the stakeholder process and transition plan for the Child Health and Disability Program (CHDP)? Does the Administration plan to include the transition plan in its 2024-25 proposed budget for consideration by the Legislature, prior to commencing the transition?

Issue 5: Post Eligibility Treatment of Income – Trailer Bill Language

Trailer Bill Language – Governor's Budget. DHCS requests trailer bill language to align state law with federal guidelines regarding Medi-Cal eligibility cost-sharing provisions for individuals subject to post-eligibility treatment of income and spend-down of excess income.

Background. The Medi-Cal program has two primary pathways to be determined eligible for coverage. Modified Adjusted Gross Income (MAGI) uses federal tax rules to determine eligibility based on countable income and applies to children, parents and caretakers of children, adults 19 through 64 years old, and pregnant people. The other pathway, non-MAGI, applies to those who do not qualify through MAGI, and includes seniors and persons with disabilities, individuals in long-term care and other individuals not eligible for MAGI. For non-MAGI individuals to become eligible for Medi-Cal coverage, they must meet asset limit requirements, currently set at $130,000 or below, and meet share of cost requirements. A non-MAGI individuals share of cost is calculated by determining the difference between the individual's non-exempt income level and the "maintenance need level", or a fixed amount allowable for living expenses and based on the size of the individual's household. In a long-term care setting, the maintenance need level is referred to as a "personal needs allowance", and all income above this level must be paid to the individual's long-term care facility as a share of cost.

Trailer Bill Language Proposal. DHCS requests trailer bill language to align state law with federal guidelines regarding Medi-Cal eligibility cost-sharing provisions for individuals subject to post-eligibility treatment of income and spend-down of excess income. DHCS reports it is moving away from the term "share of cost" and, to address concerns raised by the federal Centers for Medicare and Medicaid Services (CMS) and consumer advocates, seeks to change references in statute and program notices to include "spenddown of excess income" to refer to non-MAGI income requirements in the Medically Needy program, and "post-eligibility treatment of income" for income liability in the long-term care context. This trailer bill proposal would replace references to "share of cost" in state Medi-Cal law with the appropriate references to "spenddown of excess income" and "post-eligibility treatment of income".

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: Health Care Coverage: Contraceptives (SB 523)

Budget Change Proposal – Governor's Budget. DHCS requests three positions and expenditure authority of $455,000 ($228,000 General Fund and $227,000 federal funds) in 2023-24 and $428,000 ($214,000 General Fund and $214,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to identify contraceptive-related services that must be carved out of managed care and into a fee-for-service, state-only program, due to unavailability of federal matching funds, consistent with the requirements of the Contraceptive Equity Act of 2022, SB 523 (Leyva), Chapter 630, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$228,000	$214,000
0890 – Federal Trust Fund	$227,000	$214,000
Total Funding Request:	**$455,000**	**$428,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2024-25.

Background. The Contraceptive Equity Act of 2022, SB 523 (Leyva), Chapter 630, Statutes of 2022, among several other provisions, requires health plans, including Medi-Cal managed care plans, to provide all contraceptive drugs, devices, and products approved by the Food and Drug Administration (FDA) without restrictions or delays, including prior authorization, step therapy, and other utilization management or control techniques. According to DHCS, existing law and contract provisions require Medi-Cal managed care plans to provide members of childbearing age with access to the following services, both in and out-of-network, without prior authorization:

- Health education and counseling
- Limited history and physical examination
- Laboratory tests if medically indicated for the contraceptive decision-making process
- Diagnosis and treatment of a sexually transmitted disease
- Screening, testing, and counseling of at-risk individuals for human immunodeficiency virus (HIV) and referral for treatment
- Follow-up care for complications associated with contraceptive methods
- Provision of contraceptive pills, devices, and supplies
- Tubal ligation
- Vasectomies
- Pregnancy testing and counseling

Medi-Cal currently covers all FDA-approved drugs, devices and products without cost-sharing, when provided by an authorized Medi-Cal provider acting under their scope of practice.

According to DHCS, federal financial participation (FFP) is only available for sterilization procedures if the individual is at least 21 years of age, the individual is not mentally incompetent, the individual has given voluntary consent, and at least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization (except in certain emergency situations). FFP is also not available for a hysterectomy if performed solely for the purpose of rendering an individual

permanently incapable of reproducing. SB 523 does not allow for these types of restrictions or delays of coverage for these services. As a result, DHCS reports it is not able to distinguish between instances of the same services that are and are not eligible for FFP. DHCS indicates it would need to treat all such procedures as ineligible for FFP and, pursuant to authorization provided by SB 523, would carve out all affected services from managed care into fee-for-services with 100 percent General Fund support.

Staffing and Resource Request. DHCS requests three positions and expenditure authority of $455,000 ($228,000 General Fund and $227,000 federal funds) in 2023-24 and $428,000 ($214,000 General Fund and $214,000 federal funds) annually thereafter to identify contraceptive-related services that must be carved out of managed care and into a fee-for-service, state-only program, due to unavailability of federal matching funds, consistent with the requirements of the Contraceptive Equity Act of 2022, SB 523 (Leyva), Chapter 630, Statutes of 2022. Specifically, DHCS requests the following positions:

Managed Care Quality and Monitoring Division – Three positions

- **One Health Program Specialist II** positions would develop and lead policy development and implementation activities; analyze covered services for fee-for-service carve-out in collaboration with other departmental staff; facilitate carve outs in collaboration other departmental staff; lead work to update any necessary managed care regulations; identify and lead updates to any necessary policy documents; oversee initial and ongoing monitoring activities; assist in development of public health and health care projects; gather, analyze, and organize data related to managed care; analyze proposed legislation, regulations, and health program standards; and provide consultation and technical assistance to local agencies.
- **Two Associate Governmental Program Analysts** would draft and update applicable policy documents or guidance; perform ongoing monitoring activities; respond to relevant inquiries; provide support in the drafting of applicable managed care regulations; track and facilitate the movement of regulation updates through the regulation update process; utilize a variety of analytical techniques to resolve complex governmental problems; and analyze data and present ideas and information effectively both orally and in writing.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 7: California Cancer Care Equity Act (SB 987)

Budget Change Proposal – Governor's Budget. DHCS requests three positions and expenditure authority of $1.1 million ($458,000 General Fund and $604,000 federal funds) in 2023-24, $726,000 ($292,000 General Fund and $434,000 federal funds) in 2024-25 through 2026-27, and $581,000 ($219,000 General Fund and $362,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to ensure Medi-Cal managed care plans make good faith efforts to contract with cancer centers or related programs, pursuant to the requirements of SB 987 (Portantino), Chapter 608, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$458,000	$292,000
0890 – Federal Trust Fund	$604,000	$434,000
Total Funding Request:	**$1,062,000**	**$726,000**
Total Requested Positions:	**3.0**	**3.0**

* Additional fiscal year resources requested – 2025-26 and 2026-27: $726,000; 2027-28 and ongoing: $581,000.

Background. SB 987 (Portantino), Chapter 608, Statutes of 2022, requires Medi-Cal managed care plans to improve access to cancer care for Medi-Cal beneficiaries. Plans are required to make a good faith effort to contract with at least one National Cancer Institute (NCI)-designated comprehensive cancer center, a site affiliated with the NCI Community Oncology Research Program (NCORP), or a qualifying academic cancer center. Plans are also required to allow members with a complex cancer diagnosis to request a referral to one of these entities, whether or not they have successfully executed a contract to enroll the entity as a network provider. SB 987 also requires DHCS to, in consultation with stakeholders, develop a process for updating and further defining a "complex cancer diagnosis" on a periodic basis.

Staffing and Resource Request. DHCS requests three positions and expenditure authority of $1.1 million ($458,000 General Fund and $604,000 federal funds) in 2023-24, $726,000 ($292,000 General Fund and $434,000 federal funds) in 2024-25 through 2026-27, and $581,000 ($219,000 General Fund and $362,000 federal funds) annually thereafter to ensure Medi-Cal managed care plans make good faith efforts to contract with cancer centers or related programs, pursuant to the requirements of SB 987 (Portantino), Chapter 608, Statutes of 2022). Specifically, DHCS requests the following positions:

Managed Care Quality and Monitoring Division – Two positions, resources equivalent to one position and consultant resources

- **One Health Program Specialist II** position would serve as administrative lead on the internal and external stakeholder workgroup effort; communicate regularly with executive staff on issues and implementation progress; collaborate with the Medical Consultant II (MC II) and the advisory group of applicable stakeholders to develop a process to continually update the definition of "complex cancer diagnosis"; assist in further defining "complex cancer diagnosis" per the developed process and working with the MC II to facilitate a contract with an appropriate, external consultant; oversee and coordinate the development, implementation, maintenance, evaluation and health plan oversight of plans who contract with cancer centers, including updating and revising policies, regulations, assessment tools, templates and checklists; develop processes to standardize policy requirements for

plans' contracted and sub-contracted provider networks; advise management on the development of policy and data reports that will be useful to DHCS, plans and stakeholders; prepare APLs, memos, and contract language in collaboration with clinical programmatic staff to communicate policy requirements and promising practices related to the cancer diagnosis and treatment strategies for plans; and support division leadership when coordinating efforts with other state and federal agencies, internal and external stakeholders, and other divisions within DHCS.

- **One Associate Governmental Program Analysts** would support drafting updates to plan contracts, evidence of coverage, All Plan Letters (APL) and other policy guidance; review plan responses on a quarterly basis for instances of non-compliance; provide technical assistance to plans when issues of noncompliance are found; compose analytical reports, and develop and present data-informed recommendations; monitor the execution of developed planning activities processes and procedures within the developed timeframes; manage activities of internal and external stakeholder workgroups; and assist with the collection, analysis, and review of stakeholder input regarding updating and further defining "complex cancer diagnosis" on a periodic basis.
- Resources equivalent to **one Health Program Specialist I** position would contribute to the development of implementation timelines, roles and responsibilities, processes and procedures, and other planning activities; support the development and further define the term "complex cancer diagnosis" on a periodic basis; support policy development related to plan requirements to contract with at least one eligible cancer center; draft and communicate policy guidance to the plans as well as ensuring the plan contract, evidence of coverage, and any applicable APLs reflect updated policy; provide technical assistance to plans; collaborate with appropriate stakeholders to develop a notice for notifying members of their right to access cancer treatment care through these cancer centers.
- **Contract resources** – DHCS also requests expenditure authority of $300,000 ($150,000 General Fund and $150,000 federal funds) to support a consultant to convene an advisory panel of external stakeholders on a regular basis to further define and update the definition of "complex cancer diagnosis".

Quality and Population Health Management – One position

- **One Medical Consultant II** position would provide professional advice to develop and implement the stakeholder workgroup process for updating, revising, and further defining "complex cancer diagnosis" on an ongoing basis as treatment advances and clinical standards change; provide clinical input to inform the activities of technical staff who will coordinate the convening of stakeholder workgroup meetings to update and further define "complex cancer diagnosis"; assist in the selection of a consultant vendor with the appropriate clinical expertise; advise department staff on the identification of stakeholders who should be included to provide clinical input for workgroup meetings; oversee, participate in and providing clinical input for workgroup meetings with stakeholders. The position will also be provide clinical guidance to stakeholders; maintain current knowledge of advances in the clinical care of cancer as well as formulating clinical policy documents relating to updates to the definition of "complex cancer diagnosis"; and provide technical assistance to department staff in cases where clarification of the "complex cancer diagnosis" definition is needed to formulate new policies and procedures, or to monitor plan compliance with state laws, regulations and policies.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 8: Maternal and Pandemic-Related Mental Health Conditions (SB 1207)

Budget Change Proposal – Governor's Budget. DHCS requests two positions and expenditure authority of $310,000 ($155,000 General Fund and $155,000 federal funds) in 2023-24 and $292,000 ($146,000 General Fund and $146,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to expand requirements for Medi-Cal managed care plans to develop a maternal mental health program, pursuant to SB 1207 (Portantino), Chapter 618, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$155,000	$146,000
0890 – Federal Trust Fund	$155,000	$146,000
Total Funding Request:	**$310,000**	**$292,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2024-25.

Background. SB 1207 (Portantino), Chapter 618, Statutes of 2022, expands the requirements for health plans, including all Medi-Cal managed care plans, to develop a maternal mental health program designed to promote quality and cost-effective outcomes. While previous requirements applied to Medi-Cal managed care plans with a Knox-Keene license, county organized health systems (COHS) were not covered. SB 1207 expands these requirements to COHS and clarifies that the programs for all plans must include quality measures to encourage screening, diagnosis, treatment, and referral. SB 1207 encourages plan programs to include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate enrollees about the program.

Staffing and Resource Request. DHCS requests two positions and expenditure authority of $310,000 ($155,000 General Fund and $155,000 federal funds) in 2023-24 and $292,000 ($146,000 General Fund and $146,000 federal funds) annually thereafter to expand requirements for Medi-Cal managed care plans to develop a maternal mental health program, pursuant to SB 1207 (Portantino), Chapter 618, Statutes of 2022. Specifically, DHCS requests the following positions:

Managed Care Quality and Monitoring Division – Two positions

- **One Health Program Specialist II** position would serve as a highly specialized expert program advisor, subject matter expert and program consultant; collaborate on implementation activities; contribute to the development of timelines, roles and responsibilities, processes and procedures, and other implementation activities; assist in designing program requirements, implementation plan, and long-term monitoring policy guidance; identify initial monitoring data elements, and create and implement a long-term program monitoring plan, and design program-specific corrective action process including sanctions; manage the long-term program monitoring plan to oversee plan compliance; take part in planning and conducting programmatic all-plan webinars; provide ongoing overall program expertise and technical assistance to internal and external stakeholders; and manage the corrective action process for plan program non-compliance.
- **One Associate Governmental Program Analysts** would review, track, and monitor deliverables related to program implementation; assist with the ongoing monitoring of the plans operationalization of developed program activities, processes, and procedures; provide technical assistance to plans;

assist in the development of policy guidance for plans; develop timelines, and other planning activities; and issue corrective action plans when non-compliance is identified.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal

Issue 9: Whole Child Model – Trailer Bill Language

Trailer Bill Language– Governor's Budget. DHCS proposes trailer bill language to expand the Whole Child Model for California Children's Services (CCS) to the 15 counties converting to County Organized Health System or Single Plan models, and to mandatorily enroll foster children in Single Plan counties in the Whole Child Model.

Background. SB 586 (Hernandez), Chapter 625, Statutes of 2016, authorized DHCS to establish the Whole Child Model program in designated County Organized Health System (COHS) or Regional Health Authority counties. Services previously provided to CCS beneficiaries on a fee-for-service basis are delivered by Medi-Cal managed care plans in Whole Child Model counties. The Whole Child Model program has been implemented in 21 counties with 5 health plans, with the goal to improve care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.

The 21 counties and 5 health plans that participate in the Whole Child Model are as follows:

- Participating Counties: San Luis Obispo, Santa Barbara, Merced, Monterey, Santa Cruz, San Mateo, Orange, Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Siskiyou, Shasta, Solano, Sonoma, Trinity, and Yolo
- Participating Health Plans: CenCal Health, Central California Alliance for Health, Health Plan of San Mateo, CalOptima, Partnership Health Plan of California

Whole Child Model Pilot Evaluation. SB 586 also requires DHCS to contract with an independent entity to conduct an evaluation to assess Medi-Cal managed care plan performance and the outcomes and experience of CCS-eligible children and youth participating in the Whole Child Model program. The evaluation is required to: (1) compare plan performance to performance of the CCS program prior to implementation in each county; (2) compare plan performance in participating counties to CCS program performance in non-participating counties; and (3) evaluate whether inclusion of CCS services in managed care improves access, quality, and the patient experience. The evaluation must also, when possible, disaggregate results based on the child's or youth's race, ethnicity, and primary language spoken at home.

The 2019 Budget Act included expenditure authority of $1.6 million ($800,000 General Fund and $800,000 federal funds), available for expenditure or encumbrance until June 30, 2021 to conduct the program evaluation of the Whole Child Model required pursuant to SB 586.

As of March 2023, the department has not yet released the evaluation of the Whole Child Model Pilot.

Managed Care Procurement and Model Changes. On February 9, 2022, DHCS released a Request for Proposal (RFP) for its commercial managed care plan contracts, seeking managed care plans committed and able to advance equity, quality, access, accountability, and transparency to reduce health disparities and improve health outcomes for Californians. While the RFP is only for commercial plans, DHCS indicated the updated contract released with the RFP would be executed with all Medi-Cal managed care plans, including local initiatives and County Organized Health Systems, as of January 1, 2024.

During the procurement process, counties were permitted to change their model for Medi-Cal managed care plans. The following counties made changes to their plan models:

- Alameda – From Two Plan Model to a Single Plan with Alameda Alliance
- Contra Costa – From Two Plan Model to a Single Plan with Contra Costa Health Plan
- Imperial – From Regional Model to a Single Plan with California Health and Wellness
- Mariposa – From Regional Model to County Organized Health System with Central California Alliance for Health
- San Benito – From Regional Model to County Organized Health System with Central California Alliance for Health
- Butte – From Regional Model to County Organized Health System with Partnership Health Plan
- Colusa – From Regional Model to County Organized Health System with Partnership Health Plan
- Glenn – From Regional Model to County Organized Health System with Partnership Health Plan
- Nevada – From Regional Model to County Organized Health System with Partnership Health Plan
- Placer – From Regional Model to County Organized Health System with Partnership Health Plan
- Plumas – From Regional Model to County Organized Health System with Partnership Health Plan
- Sierra – From Regional Model to County Organized Health System with Partnership Health Plan
- Sutter – From Regional Model to County Organized Health System with Partnership Health Plan
- Tehama – From Regional Model to County Organized Health System with Partnership Health Plan
- Yuba – From Regional Model to County Organized Health System with Partnership Health Plan
- Alpine – From Regional Model to Two Plan Model with Health Plan of San Joaquin
- El Dorado – From Regional Model to Two Plan Model with Health Plan of San Joaquin

Trailer Bill Language Proposal – Expand Whole Child Model and Mandatory Enrollment for Foster Children. DHCS proposes trailer bill language to expand the Whole Child Model for California Children's Services (CCS) to the 15 counties converting to County Organized Health System (COHS) or Single Plan models, and to mandatorily enroll foster children in Single Plan counties in the Whole Child Model. According to DHCS, because the Whole Child Model was implemented in COHS counties, expansion to new COHS and Single Plan counties after model plans change would allow alignment across the state. The expansion would be phased in, depending on the plan model type and CCS county designation, as follows:

- Phase 1 – Whole Child Model would be implemented no sooner than January 1, 2024, in the ten counties becoming COHS that have a dependent county designation in the CCS program. These counties include Colusa, Glenn, Nevada, Plumas, Sierra, Sutter, Tehama, Yuba, Mariposa, and San Benito.
- Phase 2 – Whole Child Model would be implemented no sooner than January 1, 2025, in the two additional counties becoming COHS that have an independent county designation, as well as the three counties becoming Single Plan counties. These counties include Alameda, Butte, Contra Costa, Imperial, and Placer.

In addition, DHCS proposes to mandatorily enroll foster children in COHS and Single Plan counties in the expanded Whole Child Model. According to DHCS, foster children in counties becoming COHS or Single Plan counties would already be mandatorily enrolled in managed care. DHCS seeks to also mandatorily enroll foster children eligible for CCS into the Whole Child Model.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

2. When will the department release the evaluation of the Whole Child Model Pilot?

3. What evidence exists of benefits to CCS-eligible children of improvements in care in the Whole Child Model compared to the existing, fee-for-service CCS system?

4. What changes to CCS provider reimbursement would occur when counties transition from fee-for-service to the Whole Child Model? How will those changes affect access to specialty care for CCS-eligible children?

Issue 10: Proposals for Investment

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

For presentation

- **Supportive Services During Pregnancy and 12 Months Postpartum.** Maternal and Child Health Access, the March of Dimes, and the Children's Partnership request expenditure authority of $7.5 million ($2.4 million General Fund and $5.1 million federal funds) annually to extend the Comprehensive Perinatal Services Program (CPSP) benefit from 60 to 365 days postpartum and to reimburse for Comprehensive Perinatal Health Workers (CPHWs) services when rendered in the community instead of only at a medical facility during pregnancy or the postpartum period.

Other Requests Received by the Subcommittee

- **Medi-Cal Health Enrollment Navigators Project Budget Augmentation.** The California Primary Care Association (CPCA) requests General Fund expenditure authority of $60 million in 2023-24 to support Medi-Cal Health Enrollment Navigators. According to CPCA, ensuring that local county offices have adequate resources to complete Medi-Cal determinations of eligibility, manage active cases, and renew eligibility is critical. The role of community health centers (CHCs) and community-based organizations (CBOs) in the patient navigation aspect of these efforts, particularly to support communities of color cannot be overlooked as a vital component of this process. COVID education and vaccination efforts were a stark example of patients' distrust interacting with government agencies. CHCs are critical, trusted messengers to support their patients in maintaining coverage through health navigation services. These include supporting patients in completing complex applications, providing in-language services, connecting patients with accurate information regarding immigration-related questions, and acting as an Authorized Representative in order to interact directly with county staff on behalf of a patient to ensure the application process is completed.

  Some counties use out-stationed enrollment workers, who set up in the field – at a CHC or CBO on a regular basis. This streamlines the enrollment process and facilitates a faster processing timeline. Out-stationed workers are less prevalent than they used to be, and many counties no longer fund them. Augmented funding for local county offices should be directed towards out-stationed workers in CHC settings to expedite Medi-Cal processing in these settings.

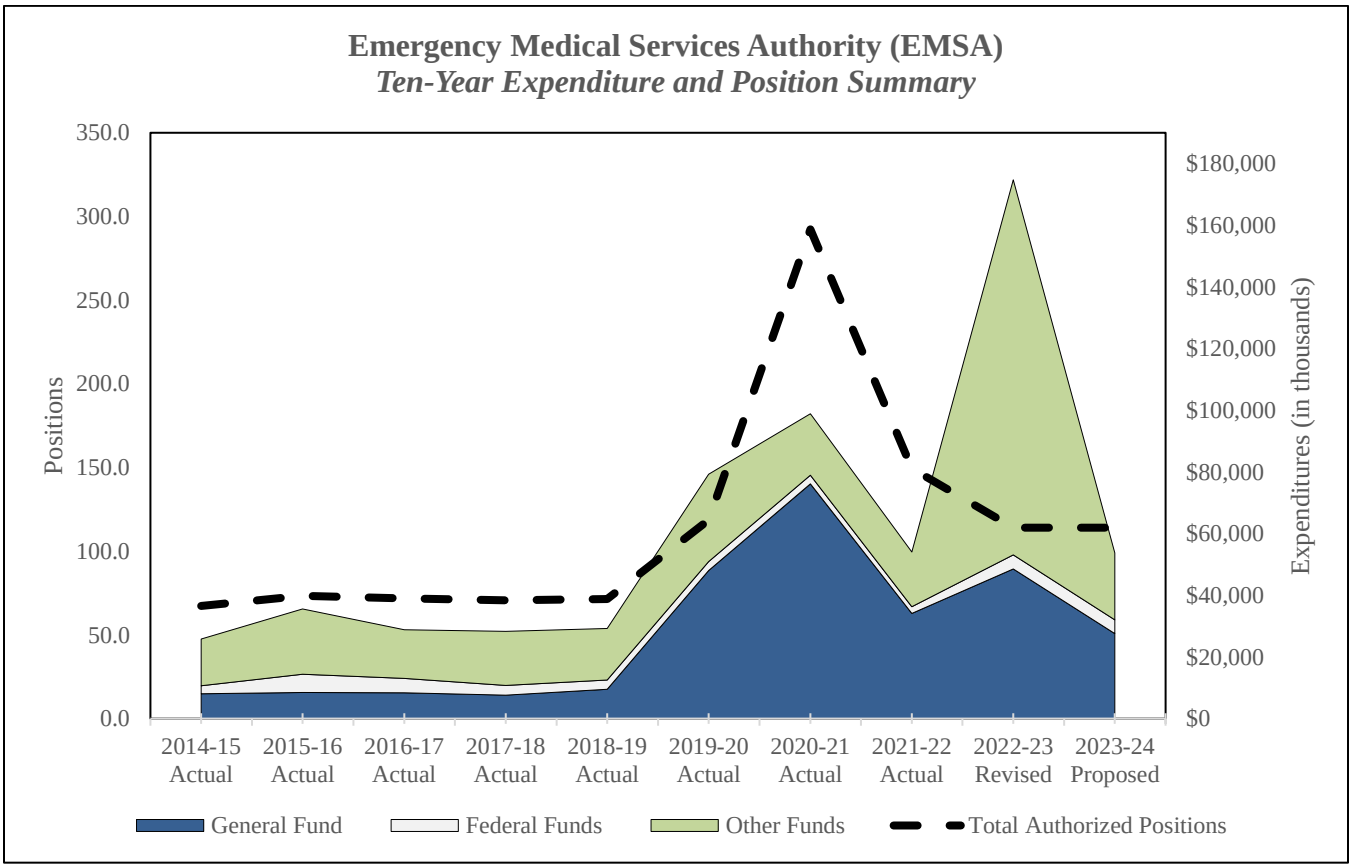
  Many counties have local coverage programs that have solely relied on health centers for enrollment services, and serve as these patients' medical home (MyHealthLA, HealthySF, Contra Costa CARES, HealthPAC in Alameda County, CMSP Path to Health and Connect to Care programs). These CHCs across the state will be critical to the adult expansion enrollment, to both ensure a smooth transition to full-scope Medi-Cal, and minimize disruptions in where they receive care. Health centers are where the majority of the undocumented adult population has been receiving care, and are trusted providers who will be critical in the adult expansion transition.

- **Housing Preservation for Long-Term Care Residents.** Justice in Aging, California Advocates for Nursing Home Reform, and Disability Rights California request expenditure authority of $44 million

($22 million General Fund and $22 million federal fund) annually to support increasing the home upkeep allowance (HUA) from $209 per month to actual housing costs up to 138 percent of the federal poverty level for Medi-Cal enrollees in long-term care, for long-term care stays not longer than six months. According to the proponents, individuals with Medi-Cal in long-term care facilities are at risk of losing their homes because they have to spend their income towards the facility share-of-cost, instead of using that money to cover their housing in the community. This proposal would make it easier for long-term care residents with Medi-Cal coverage to preserve their housing while they receive the care needed to return to the community. Because the HUA is not tied to the true cost of housing, it is inadequate to pay the rent or mortgage and other costs needed to actually maintain a home or apartment. If an individual has any family living in the home, they cannot use the HUA, even if their family members cannot pay for the upkeep of the home. This results in people staying in nursing facilities indefinitely because they lose their home and are unable to transition back to the community. These permanent nursing home stays are also expensive for the state.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Overview



Emergency Medical Services Authority - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2021-22 Actual**	***2022-23 Budget Act***	***2022-23 Revised***	***2023-24 Proposed***
General Fund	$34,083	$45,243	$48,543	$27,598
Federal Funds	$2,205	$4,466	$4,534	$4,465
Other Funds	$17,754	$121,436	$121,660	$21,628
Total Department Funding:	**$54,042**	**$171,145**	**$174,737**	**$53,691**
Total Authorized Positions:	**149.5**	**114.0**	**114**	**114**
Other Funds Detail:				
EMS Training Prog. Approval Fund (0194)	*$147*	*$241*	*$246*	*$246*
EMS Personnel Fund (0312)	*$2,617*	*$3,644*	*$3,724*	*$3,688*
Reimbursements (0995)	*$14,121*	*$115,837*	*$115,954*	*$15,957*
EMT Certification Fund (3137)	*$869*	*$1,714*	*$1,736*	*$1,737*

Background. The Emergency Medical Services Authority (EMSA), authorized by the Emergency Medical Services System and Prehospital Emergency Care Act, administers a statewide system of coordinated emergency medical care, injury prevention, and disaster medical response that integrates public health, public safety, and health care services. Prior to the establishment of EMSA in 1980, California did not have a central state agency responsible for ensuring the development and coordination of emergency medical services (EMS) programs statewide. For example, many jurisdictions maintained their own certification requirements for paramedics, emergency medical technicians (EMTs), and other emergency personnel, requiring individuals certified to provide emergency services in one county to re-test and re-certify to new standards to provide emergency services in a different county. EMSA is organized into three program divisions: the Disaster Medical Services Division, the EMS Personnel Division, and the EMS Systems Division.

Disaster Medical Services Division. The Disaster Medical Services Division coordinates California's medical response to major disasters by carrying out EMSA's mandate to provide medical resources to local governments in support of their disaster response efforts. The division coordinates with the Governor's Office of Emergency Services, the Office of Homeland Security, the California National Guard, the Department of Public Health, and other local, state, and federal agencies, private sector hospitals, ambulance companies, and medical supply vendors, to promote and improve disaster preparedness and emergency medical response in California.

EMS Personnel Division. The EMS Personnel Division is responsible for the certification, licensing, and discipline of all active paramedics throughout the state. The division develops and implements regulations that set training standards and the scope of practice for various levels of personnel; sets standards for and approves training programs in pediatric first aid, cardiopulmonary resuscitation (CPR), and preventive health practices for child day care providers and school bus drivers; and develops standards for emergency medical dispatcher training, pre-arrival emergency care instructions, and epinephrine auto-injector training.

EMS Systems Division. The EMS Systems Division is in charge of developing and implementing EMS systems throughout California, including supporting local Health Information Exchange projects that will allow the state to collect more meaningful data so emergency medical services providers can deliver better patient care. The division oversees system development and implementation by the local EMS agencies, the statewide trauma system, and emergency medical dispatcher and communication standards. It establishes regulations and guidelines for local agencies, reviews and approves local plans to ensure they meet minimum state standards, coordinates injury and illness prevention activities with the Department of Public Health and the Office of Traffic Safety, manages the state's EMS data and quality improvement processes, conducts Ambulance Exclusive Operating Area evaluations, and oversees the operation of California's Poison Control System and EMS for Children programs.

Subcommittee Staff Comment—This is an informational item.

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

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

Issue 2: EMS Personnel Human Trafficking Training Implementation (AB 2130)

Budget Change Proposal – Governor's Budget. EMSA requests General Fund expenditure authority of $84,000 in 2023-24 through 2025-26. If approved, these resources would allow EMSA to coordinate and support implementation of emergency medical technician and paramedic training on human trafficking, pursuant to the requirements of AB 2130 (Cunningham), Chapter 256, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$84,000	$84,000
Total Funding Request:	**$84,000**	**$84,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2025-26: $84,000.

Background. AB 2130 (Cunningham), Chapter 256, Statutes of 2022, requires emergency medical technicians (EMTs) and paramedics to receive at least 20 minutes of training on issues related to human trafficking, beginning July 1, 2024. The United States Department of Homeland Security identifies EMTs, paramedics and other emergency services providers as the most likely to encounter human trafficking victims. California has the highest number of human trafficking cases in the nation reported to the National Human Trafficking Hotline. A study that surveyed EMS personnel in Florida regarding their awareness of issues of human trafficking found that those with training were significantly more likely to suspect human trafficking in situations that might increase suspicion, suggesting universal human trafficking training would help EMS personnel better identify victims of human trafficking.

The EMS Personnel Division is responsible for the certification, licensing, and discipline of all active paramedics throughout the state. The division develops and implements regulations that set training standards and the scope of practice for various levels of personnel; sets standards for and approves training programs in pediatric first aid, cardiopulmonary resuscitation (CPR), and preventive health practices for child day care providers and school bus drivers; and develops standards for emergency medical dispatcher training, pre-arrival emergency care instructions, and epinephrine auto-injector training.

EMSA is responsible for licensing EMT paramedics (EMT-Ps), and 69 certifying entities statewide are responsible for certifying EMT-Is and EMT-IIs. EMT-I applicants must complete a minimum of 170 hours of training, EMT-II applicants must complete a minimum of 160 hours for initial certification, and EMT-P applicants must complete a minimum of 1,094 hours of training. According to EMSA, some current EMT training programs may include issues related to human trafficking.

Resource Request. EMSA requests General Fund expenditure authority of $84,000 in 2023-24 through 2025-26 to coordinate and support implementation of emergency medical technician and paramedic training on human trafficking, pursuant to the requirements of AB 2130 (Cunningham), Chapter 256, Statutes of 2022. Specifically, these resources would allow EMSA to establish a working group to draft regulatory changes, coordinate and assist local entities to incorporate the new standard into EMT curricula, convene a workgroup and work with information technology staff to make system changes to include verification of human trafficking training, and train EMSA staff and provide resources to local EMS authorities and certifying entities to verify the new human trafficking training requirement is met.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Diversity, Equity, and Inclusion Strategic Plan Development

Budget Change Proposal – Governor's Budget. EMSA requests General Fund expenditure authority of $100,000 in 2023-24. If approved, these resources would allow EMSA to contract with a consultant to develop a Diversity, Equity, and Inclusion Strategic Plan that aligns with CalHHS initiatives to reduce health inequities and disparities.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25**
0001 – General Fund	$100,000	$-
Total Funding Request:	**$100,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. According to EMSA, as part of CalHHS equity initiatives it was tasked with achieving the following goals to address prehospital EMS patient and workforce inequities:

1. Participate in a newly-established Justice, Equity, Diversity, and Inclusion (JEDI) subcommittee within the CalHHS Interdepartmental Advisory Council by appointing a Chief Equity Office as a member.
2. Join the Capitol Collaborative on Race and Equity (CCORE) 2024-25 Learning Cohort Program of government officials to learn about, plan for, and implement activities that embed racial equity approaches into institutional culture, policies and practices.
3. Incorporate equity priorities in department strategic planning for internal and external stakeholders.
4. Contribute to the development of the CalHHS Equity Dashboard and enhance EMS workforce equity training and inclusion in services.

Resource Request. EMSA requests General Fund expenditure authority of $100,000 in 2023-24 to contract with a consultant to develop a Diversity, Equity, and Inclusion Strategic Plan that aligns with CalHHS initiatives to reduce health inequities and disparities. Specifically, the consultant would lead the development of an EMSA Equity Workgroup to develop and implement the plan, which would include the following components:

- Maximize community partnerships and stakeholder collaboration
- Incorporate health equity concepts and measures into EMSA programs and policies
- Conduct a strengths, weaknesses, opportunities, and threats analysis
- Develop a mission, a vision, objectives, strategic goals, tasks, and action items
- Establish key performance indicators and baseline metrics
- Develop mechanisms to collect detailed EMS Personnel workforce data
- Develop mechanisms to collect detailed patient demographic and health outcomes data
- Secure training and host forums for EMSA staff on the impact of EMS workforce diversity and cultural competency training on patient health outcomes

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

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

1. Please provide a brief overview of this proposal.

Issue 4: California POLST eRegistry Act – Trailer Bill Language

Trailer Bill Language – Governor's Budget. EMSA requests trailer bill language to repeal the requirement that the California POLST eRegistry incorporate the Advanced Health Care Directive Registry administered by the California Secretary of State.

Background. The 2021 Budget Act included General Fund expenditure authority of $10 million in 2021-22 and $750,000 annually thereafter to implement a statewide electronic registry system to collect information about Physician Orders for Life Sustaining Treatment (POLST) received from health care providers. Accompanying the 2021 Budget Act was AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, the health omnibus trailer bill. Within AB 133 was the California POLST eRegistry Act, which required EMSA to establish a POLST eRegistry in consultation with stakeholders to collect patients' POLST information received from a physician, nurse practitioner, or other providers. AB 133 provides that the eRegistry would be implemented in conjunction with EMSA's California EMS Data Resource System (CEDRS), and requires POLSTs to be submitted electronically.

AB 133 also required EMSA to incorporate the Advance Health Care Directive Registry, administered by the California Secretary of State, into the POLST eRegistry. The Advance Health Care Directive Registry allows a person who has executed an advance health care directive to register information regarding the directive with the Secretary of State. This information is made available upon request to the registrant's health care provider, public guardian, or legal representative.

Trailer Bill Language – Amend California POLST eRegistry Act. EMSA requests trailer bill language to repeal the requirement that the California POLST eRegistry incorporate the Advance Health Care Directive Registry administered by the California Secretary of State. According to EMSA, the POLST form is a medical order, signed by both a patient and physician, nurse practitioner, or physician assistant, that give seriously ill patients more control over their care by specifying the type of medical treatment they wish to receive toward the end of life. An Advance Health Care Directive, on the other hand, is a legal document administered under the Probate Code. EMSA reports there is no existing electronic registry for the Advance Health Care Directive registry, which makes integration of this data into the POLST electronic registry not technically feasible without creating significant delays to implementation. As a result, EMSA requests eliminating the requirement to incorporate the Advance Health Care Directive registry in to the POLST eRegistry.

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

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

1. Please provide a brief overview of this proposal.

2. Please briefly describe the operational challenges to including data from the Advanced Health Care Directive Registry in the POLST registry.

3. How will EMSA and the Secretary of State navigate potential confusion that may arise from having two options for an individual to register their preferences for life sustaining care?

Issue 5: EMSA Director and Chief Medical Officer – Trailer Bill Language

Trailer Bill Language – Governor's Budget. EMSA requests trailer bill language to repeal the requirement that the EMSA Director be a medical doctor (MD) and establish the position of Chief Medical Officer within EMSA's leadership team.

Background. State law requires the director of EMSA to be a licensed physician or surgeon with substantial experience in the practice of emergency medicine. According to EMSA, this requirement limits the eligibility pool and made it more challenging to recruit candidates for this role. EMSA believes removing this requirement would allow for a broader candidate pool and a focus on a public administration skillset. Acknowledging the importance of having physicians as part of the leadership team, EMSA is also proposing to create a Chief Medical Officer position to address the clinical components needed for patient safety and care while bringing substantial experience in the practice of emergency medicine.

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

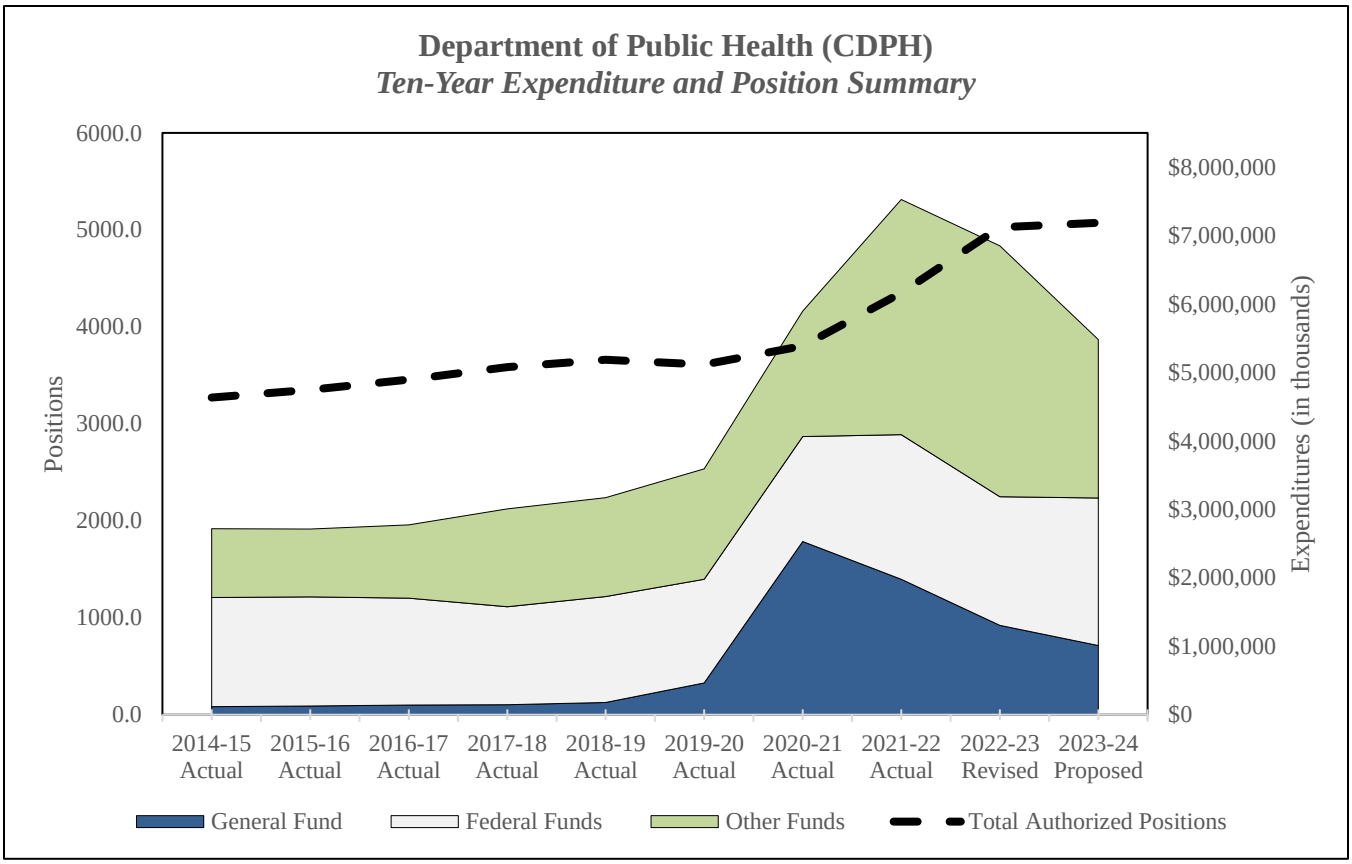
Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the proposed division of responsibilities between the EMSA Director and the Chief Medical Officer.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Overview



Department of Public Health - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	***2021-22 Actual***	***2022-23 Budget Act***	***2022-23 Revised***	***2023-24 Proposed***
General Fund	$1,981,029	$1,204,560	$1,303,874	$1,008,922
Federal Funds	$2,110,615	$1,668,994	$1,880,931	$2,159,343
Other Funds	$3,435,447	$3,895,608	$3,664,269	$2,312,862
Total Department Funding:	**$7,527,091**	**$6,769,162**	**$6,849,074**	**$5,481,127**
Total Authorized Positions:	**4348.9**	**5028.0**	**5028**	**5073.0**
Other Funds Detail:				
Breast Cancer Research Account (0007)	$965	$2,095	$2,095	$745
Nuclear Planning Assessment Acct (0029)	$736	$1,052	$1,080	$1,078
Motor Vehicle Acct, Trans. Fund (0044)	$1,283	$1,667	$1,709	$1,709
Sale of Tobacco to Minors Ctrl Acct (0066)	$138	$969	$1,056	$1,052
Occup. Lead Poisoning Prev Acct (0070)	$2,242	$3,580	$3,680	$4,174

Medical Waste Management Fund (0074)	$2,516	$3,070	$3,183	$3,180
Radiation Control Fund (0075)	$29,220	$30,308	$31,381	$31,349
Tissue Bank License Fund (0076)	$454	$1,580	$1,631	$1,629
Child. Lead Poisoning Prev Fund (0080)	$32,867	$43,714	$44,241	$37,720
Export Document Program Fund (0082)	$547	$575	$446	$624
Clinical Lab. Improvement Fund (0098)	$13,840	$17,023	$17,514	$16,110
Health Statistics Special Fund (0099)	$28,969	$31,313	$32,269	$32,362
Dept. of Pesticide Regulation Fund (0106)	$277	$349	$360	$359
Air Pollution Control Fund (0115)	$261	$310	$318	$317
CA Health Data and Planning Fund (0143)	$240	$240	$240	$240
Food Safety Fund (0177)	$11,250	$11,859	$12,300	$12,288
Genetic Disease Testing Fund (0203)	$143,424	$173,046	$173,945	$187,842
Health Education Account, Prop 99 (0231)	$53,775	$37,181	$37,317	$37,686
Research Account, Prop 99 (0234)	$3,979	$2,801	$2,836	$4,292
Unallocated Account, Prop 99 (0236)	$2,306	$1,832	$1,895	$1,772
Infant Botulism Treatment/Prev Fund (0272)	$7,587	$6,575	$6,642	$14,041
Child Health and Safety Fund (0279)	$550	$551	$551	$551
Registered Enviro. Health Spec Fund (0335)	$347	$487	$502	$503
Indian Gaming Spec Dist Fund (0367)	$8,050	$8,436	$8,499	$8,497
Vectorborne Disease Account (0478)	$117	$141	$141	$141
Toxic Substances Control Acct (0557)	$578	$578	$585	$584
Domestic Violence Train/Ed Fund (0642)	$431	$672	$686	$685
CA Alzheimers Research Fund (0823)	$618	$675	$680	$680
Special Deposit Fund (0942)	$6,041	$12,949	$12,971	$8,971
Reimbursements (0995)	$1,006,060	$669,750	$723,749	$873,033
Drug and Device Safety Fund (3018)	$6,290	$8,034	$8,082	$7,873
WIC Manufacturer Rebate Fund (3023)	$184,529	$190,012	$213,809	$221,918
Medical Marijuana Program Fund (3074)	$0	$0	$0	$0
AIDS Drug Assist. Program Fund (3080)	$273,615	$368,058	$345,699	$350,855
Cannery Inspection Fund (3081)	$3,343	$4,247	$4,344	$4,342
Mental Health Services Fund (3085)	$13,755	$5,115	$5,202	$2,598
Licensing and Certification Fund (3098)	$222,022	$294,343	$300,164	$297,820
Gambling Addiction Program Fund (3110)	$150	$150	$150	$150
Birth Defects Monit. Prog Fund (3114)	$2,486	$2,489	$2,558	$2,556
Lead-Related Construction Fund (3155)	$956	$1,333	$1,363	$1,363
Cost/Impl Acct, Air Poll. Ctrl Fund (3237)	$347	$394	$401	$400
Cannabis Control Fund (3288)	$876	$595	$602	$601
State Dental Program Acct., Prop 56 (3307)	$7,398	$28,929	$29,068	$33,771

Tobacco Law Enforc. Acct. Prop 56 (3308)	$0	$0	$0	$0
Tobacco Prev/Ctrl Prog Acc Prop 56 (3309)	$0	$0	$0	$0
DPH Tobacco Law Enforc, Prop 56 (3318)	$6,269	$5,595	$6,095	$4,798
DPH, Tobacco Prev/Ctrl, Prop 56 (3322)	$93,857	$93,100	$93,570	$90,850
Ind. Hemp Enroll/Oversight Fund (3396)	$0	$0	$0	$1,253
Opioid Settlement Fund (3397)	$0	$45,800	$45,800	$7,500
California Emergency Relief Fund (3398)	$1,259,886	$1,782,036	$1,482,860	$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.

Supplemental Reporting Language – 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.

CDPH has expressed a willingness to continue to provide an annual State of the State's Public Health report to the Assembly and Senate budget subcommittees during the budget process.

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 supplemental reporting language included in the 2018 Budget Act.

Issue 2: COVID-19 Response

Budget Change Proposal – Governor's Budget. CDPH requests General Fund expenditure authority of $101.3 million in 2023-24. If approved, these resources would allow CDPH to continue the state's efforts to protect public health and safety against the spread of COVID-19, including vaccinations, testing, and operations support, as well as implementing the state's SMARTER Plan.

Program Funding Request Summary		
Fund Source	**2023-24**	**20245-25**
0001 – General Fund	$101,300,000	$-
Total Funding Request:	**$101,300,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. According to CDPH, its efforts during the COVID-19 pandemic have played a crucial role in slowing community transmission and saving the lives of many Californians by providing vaccinations, diagnostic testing, contact tracing, medical surge staff support for facilities in need, and emergency response activities at the border. The changing nature of the COVID-19 pandemic and the end of certain state and federal policies enacted in response to the pandemic, have resulted in evolution of the state's response, including implementation of the SMARTER Plan approach to COVID-19. The components of the SMARTER Plan are as follows:

- **Shots** – Individuals are recommended to stay up to date with COVID-19 vaccinations and boosters.
- **Masks** – Individuals are recommended to wear a good fitting mask with good filtration, according to masking recommendations based on COVID-19 Community Levels published by the federal Centers for Disease Control and Prevention (CDC).
- **Awareness** – The state will maintain the ability to promote vaccination, masking, and other mitigation measures in all 58 counties, while supporting engagement with at least 150 community-based organizations.
- **Readiness** – The state will maintain wastewater surveillance in all regions and enhance respiratory surveillance in the healthcare system while continuing to sequence at least 10 percent of positive COVID-19 test specimens. The state will also maintain the ability to add 3,000 clinical staff within two to three weeks of need across various healthcare facility types.
- **Testing** – The state will maintain commercial and local public health capacity statewide to perform at least 500,000 tests per day for COVID-19.
- **Education** – Expand school-based vaccination sites by 25 percent as eligibility for vaccines expands.
- **Rx -** Ensure local entities can order effective therapeutics within 48 hours.

According to CDPH, to continue the critical work of responding and maintaining preparedness, the state will continue to supply test kits to high-risk populations, promote the bivalent booster campaign with a focus on vulnerable individuals who are at risk for severe disease and hospitalizations, and work with healthcare systems to improve their incorporation of testing and treatment for their patients. Several efforts are winding down, such as the gradual demobilization of community testing sites as demand decreases, the Public Testing Lab Network, staffing deployments, and COVID-19 therapeutics initiatives as this work will eventually transition to the health care system. CDPH's 2023-24 budget request prioritizes the most critical activities that need to continue, including vaccinations, testing, operations support, and

information technology, so that California's most vulnerable populations are protected and to maintain a state of readiness.

Resource Request. CDPH requests General Fund expenditure authority of $101.3 million in 2023-24 to continue the state's efforts to protect public health and safety against the spread of COVID-19, including vaccinations, testing, and operations support, as well as implementing the state's SMARTER Plan. The specific allocations, compared to those adopted in the 2022 Budget Act, are as follows:

Areas of Expenditure	2022 Budget Act	2023-24 Proposal
Vaccinations (including boosters)	$93,000,000	$8,000,000
Testing	$530,000,000	$28,000,000
Operations Support	$165,133,000	$15,000,000
Public Health Readiness and Response	$18,284,000	$0
Enhanced Surveillance	$16,465,000	$0
Test to Treat Therapeutics	$158,129,000	$0
Border Operations	$411,025,000	$0
IT Pandemic Response	$0	$300,000
Staffing	$140,000,000	$0
Emergency Contingency Funds	$250,000,000	$50,000,000
TOTAL	**$1,782,036,000**	**$101,300,000**

Of these amounts, CDPH reports the following would comprise the components of these expenditures:

- $28 million to purchase 12 million test kits in support of the SMARTER Plan
- $9 million for consultants to continue CDPH's response to COVID-19 through activities related to county monitoring, testing strategies, and support for CDPH's COVID-19 website and public information campaign services
- $3 million for redirection of CDPH staff funded by special funds and non-COVID allowable federal funds to continue COVID-19 response efforts, an 85 percent reduction in redirected staff
- $3 million for MHCC and RSS costs related to service agreements to provide specialized business, and technical services to support response to and recovery from the pandemic, in addition to legal settlements for COVID-19-related litigation including challenges to state public health orders and guidance
- $5 million for grant incentive programs to provide support to pediatric providers to administer vaccines for ages 0-5
- $3 million for vaccine staffing to validate and mitigate errors in CAIR data, the provider call center that will continue to give support to providers enrolled in the MyCAVax program, and program management and communication activities for LHDs and providers
- $300 thousand for IT Infrastructure, and
- $50 million for emergency contingency funds to support pandemic response efforts that exceed identified areas of expenditure.

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 describe the rationale for the reductions in expenditures from previous augmentations for COVID-19 Response activities compared to this request.

Issue 3: Maintenance and Operations of Infectious Disease Data Systems - SMARTER Plan

Budget Change Proposal – Governor's Budget. CDPH requests General Fund expenditure authority of $74.4 million in 2023-24. If approved, these resources would allow CDPH to support the maintenance and operations of critical infectious disease data systems established during the COVID-19 pandemic and will continue to support the state's emergency preparedness and response efforts, consistent with the SMARTER Plan.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25**
0001 – General Fund	$74,400,000	$-
Total Funding Request:	**$74,400,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. In February 2022, the Administration released its SMARTER Plan, intended to transition the state to the next phase of the COVID-19 pandemic response by outlining key activities, building on lessons learned, and leveraging those lessons which can be adapted to future emergency response activities. The SMARTER plan includes the following components:

- **Shots** – Individuals are recommended to stay up to date with COVID-19 vaccinations and boosters.
- **Masks** – Individuals are recommended to wear a good fitting mask with good filtration, according to masking recommendations based on COVID-19 Community Levels published by the federal Centers for Disease Control and Prevention (CDC).
- **Awareness** – The state will maintain the ability to promote vaccination, masking, and other mitigation measures in all 58 counties, while supporting engagement with at least 150 community-based organizations.
- **Readiness** – The state will maintain wastewater surveillance in all regions and enhance respiratory surveillance in the healthcare system while continuing to sequence at least 10 percent of positive COVID-19 test specimens. The state will also maintain the ability to add 3,000 clinical staff within two to three weeks of need across various healthcare facility types.
- **Testing** – The state will maintain commercial and local public health capacity statewide to perform at least 500,000 tests per day for COVID-19.
- **Education** – Expand school-based vaccination sites by 25 percent as eligibility for vaccines expands.
- **Rx -** Ensure local entities can order effective therapeutics within 48 hours.

Implementation, Maintenance and Operations of COVID-19 Related IT Systems. According to CDPH, during the COVID-19 pandemic, extensive upgrades to data systems were implemented and new systems launched to manage large data volumes, facilitate data flow, support case investigation and contact tracing data, collect outbreak investigation data, enable digital exposure notification, provide data automation, and provide advanced analytic tools. These systems include the following:

- **CA Notify** – CA Notify provides notification if a person receives a positive test result for certain highly infectious diseases and accelerates initiation of contact tracing.

- **CAIR2 Message Broker** – The California Immunization Registry 2 (CAIR2) message broker is a secure gateway to hospitals and labs for exchanging reportable vaccination records with CDPH. CDPH believes this tool will be useful for supporting data exchange for a variety of vaccines in the future.
- **CalCONNECT** – The California Confidential Network for Contact Tracing (CalCONNECT) is California's contact tracing system used to manage case and contact records and notify individuals of possible exposure to people who test positive for infectious diseases. This system provides the foundation for developing future contact tracing capacity for other diseases.
- **CalREDIE/HIE Gateway** – The California Reportable Disease Information Exchange (CalREDIE) is CDPH's infectious disease reporting and surveillance system of record, and is used statewide by 61 local health jurisdictions and over 350 laboratories for reporting notifiable conditions via the Health Information Exchange (HIE) Gateway.
- **CERT (emergency)** – The CDPH Employee Redirection Tracker (CERT) enables human resources staff to receive, assign, redirect, and manage departmental requests for staff resources where an unmet business need exists due to emergency and rapid response.
- **CCRS** – The California COVID-19 Reporting System (CCRS) is an integrated software-as-a-service (SaaS) that provides 24 hour processing of lab results for all reportable infectious diseases. CCRS maintains the flow of information to sustain the operations of downstream systems, including CalREDIE, Los Angeles and San Diego County disease surveillance systems, and Office of AIDS. Collectively, these systems provide information regarding COVID-19 testing, infection, hospitalization, death, and vaccinations rates needed to support the Governor's Blueprint for a Safer Economy.
- **Enterprise Infrastructure/Security** – Maintenance and operations of remote access services, and new rapid response cloud services applications, including ongoing licensing and software for various services and software solution tools to address the foundational, operational and governance needs for cloud providers such as Salesforce, Azure, and Amazon Web Services (AWS).
- **LIMS** – The Laboratory Information Management System (LIMS) provides for the management, processing, and collection of samples and associated data on public health risks.
- **LTM** – The Lab Testing Metrics (LTM) application provides a platform for CDPH's Lab Field Services (LFS) to collect and manage a variety of public health data from laboratories.
- **myCAvax (Vaccine Management, My Turn, and DVR)** – Vaccine Management is a suite of applications that allows for: 1) myCAvax, which is the enrollment and approval application for vaccine providers, vaccine allocation, vaccine ordering, and vaccine reporting; 2) My Turn Clinic, which enables providers and local health jurisdictions (LHJs) to run vaccination clinics, including mobile vaccination clinics, school vaccination clinics, mass vaccination clinics, and standard vaccinations clinics; 3) My Turn Public, which enables Californians to find and book vaccination appointments, including walk-in appointments and scheduled appointments; 4) Digital Vaccine Record (DVR), which is the state's secure proof of vaccination tool.
- **REDCap** – Research Electronic Data Capture (REDCap) is a survey tool used to respond to disease cluster and outbreak investigations to rapidly build, share, and manage standardized questionnaires and databases in a secure web application to assist with reporting to California LHJs, the CDC, and partner states.
- **IT OPS Center** – Provides 24 hour IT support, monitoring, rapid response, and problem resolution of all CDPH disease surveillance systems. This center was established to provide tracking and oversight of the many interoperable IT systems to ensure timely delivery of health data to downstream dashboards.

CDPH leveraged approximately $250 million of one-time emergency funding from a variety of sources to implement these systems in response to the COVID-19 pandemic, including necessary IT staff.

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 the technology platforms and applications necessary to support both COVID-19 response activities and other potential disease outbreaks. These systems included all of those referenced above.

CDPH reports there are additional needs beyond the 2022 Budget Act augmentation for two systems: 1) the California COVID Reporting System (CCRS) and CalCONNECT.

California COVID Reporting System (CCRS) for Electronic Lab Reporting. 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. CDPH receives laboratory results for COVID-19 and other infectious diseases related to California residents from laboratories across the U.S. in accordance with state regulations. The great majority of laboratory results are submitted electronically and managed by CCRS. More than 350 entities are connected directly to this system and submit results on behalf of thousands of entities. These entities include 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 the California Reportable Disease Information Exchange (CalREDIE), Los Angeles, and San Diego County disease surveillance systems. Data processed through CCRS is used to monitor infectious disease and testing trends.

Additionally, CCRS is closely integrated with CalCONNECT. The functions of CCRS must be sustained and appropriately resourced for the ongoing operations of state and local public health surveillance efforts for COVID-19 and other infectious diseases that depend on laboratory reporting.

In August 2020, 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 augmentation included $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 the Surveillance and Public Health Information Reporting and Exchange (SaPHIRE) to recognize that the system receives data for all reportable conditions, not just COVID-19.

CalCONNECT. CalCONNECT is California's system for case and outbreak investigation, contact tracing, symptom monitoring of exposed individuals, and communication with affected persons, including

the dissemination of isolation and quarantine guidance to cases and contacts. CalCONNECT was developed during the COVID-19 pandemic and was recently expanded to support the Mpox response. CalCONNECT has also incorporated a new generic disease condition function that can be utilized for monitoring persons exposed to avian influenza, Ebola, and other infectious diseases. CalCONNECT also supports outbreak investigations by providing workplaces and schools streamlined ways to report exposure events directly to their LHD and CDPH. As a result of CalCONNECT's success related to COVID-19, numerous stakeholder groups, including local health jurisdictions, have requested that CDPH build upon the system and expand its functionality to support additional disease conditions that require case investigation and contact tracing, such as tuberculosis, human immunodeficiency virus (HIV), syphilis, perinatal hepatitis B, and measles.

The 2022 Budget Act augmentation included $39.6 million in 2022-23 to provide maintenance and operations for one year to support and operate CalCONNECT. The one-year funding strategy was designed to allow CDPH to obtain ongoing maintenance and operations costs for CalCONNECT through a competitive process and include these costs in a proposal for 2023-24. CDPH reports it engaged in a new challenge-based procurement process in March 2022, resulting in a new contract with the existing vendor.

Resource Request. CDPH requests General Fund expenditure authority of $74.4 million in 2023-24 to support the maintenance and operations of critical infectious disease data systems established during the COVID-19 pandemic and will continue to support the state's emergency preparedness and response efforts, consistent with the SMARTER Plan. Specifically, CDPH requests the following resources:

Surveillance and Public Health Information and Reporting (SaPHIRE, formerly CCRS) - $30.9 million

CDPH requests General Fund expenditure authority of $30.9 million in 2023-24 for maintenance and operations costs for SaPHIRE. CDPH would also utilize these resources to support integration and critical data exchange between SaPHIRE and other core CDPH systems, including CalREDIE and CalCONNECT.

CalCONNECT - $39.7 million

CDPH requests General Fund expenditure authority of $39.7 million in 2023-24 for necessary IT licenses and technology service costs to support maintenance and operations of CalCONNECT. These funds would support the technology infrastructure of CalCONNECT in its current state, support critical programmatic public health services statewide, prepare for and respond to future public health emergencies, and leverage the infrastructure developed for COVID-19 to address other conditions that impact the people of California.

IT Infrastructure and Security - $3.8 million

CDPH requests General Fund expenditure authority of $2.8 million in 2023-24 for licensing, maintenance, and support of the infrastructure and security protocols needed to support public health surveillance and response systems and departmental data, including security of protected health information (PHI) and personally identifiable information (PII).

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 2023-24. What is the plan for ongoing maintenance and operations of these systems?

Issue 4: Public Health Workforce Investments Reversion

Budget Solution – Governor's Budget. CDPH requests reversion of General Fund expenditure authority of $49.8 million over four years, approved in the 2022 Budget Act, to support public health workforce investments. If approved, these reverted resources would help address the state's General Fund problem.

Background. 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, which trains epidemiologists for public health leadership positions.

Reversion of Resources to Address General Fund Problem. CDPH requests reversion of General Fund expenditure authority of $49.8 million over four years, approved in the 2022 Budget Act, to support public health workforce investments, to help address the state's General Fund problem. Specifically, CDPH requests reversion of the Public Health Incumbent Upskilling, California Public Health Pathways Training Corps, California Microbiologist Training, Public Health Lab Aspire, and California Epidemiologic Investigation Service Training programs. The Administration proposes to retain the waiver of public health nurse certification fees.

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. Why did the Administration propose to eliminate these public health workforce programs, rather than delay them as in the case of those administered by HCAI?

Issue 5: COVID-19 Website Information Technology Resources

Budget Change Proposal – Governor's Budget. CDPH requests General Fund expenditure authority of $900,000 in 2023-24, 2024-25, and 2025-26. If approved, these resources would support security and translation services to optimize maintenance of the COVID-19 website.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$900,000	$900,000
Total Funding Request:	**$900,000**	**$900,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 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.

Resource Request. CDPH requests 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. Specifically, CDPH requests the following contract staff and resources:

- **Three contract staff** would perform the following functions:
    - Product Manager – The Product Manage would manage stakeholder of the COVID-19 website, serve as liaison between the team working on the site and department leadership, assign tasks within the team and track progress, and communicate with stakeholders regularly.
    - Content Designer – The Content Designer would write, edit, and simplify web-based guidance; redesign or create new content deriving from various state guidance; design new and edit existing COVID-19 response content for the website; improve navigation between webpages; participate in COVID-19 user research to understand how content can be improved; implement modern web content styles and standards; and review website analytics and user feedback for opportunities to improve content.
    - Web Engineer – The Web Engineer would monitor site integrity, site health statistics, and conduct continuous improvements; monitor the data pipeline; write and optimize back-end and front-end programming code; develop, modify, and support data visualizations and embedded data graphics; test website and page changes for errors; assist content team with website issues; maintain, update

and monitor search engine; and write server-side code for data processing and client-side code for interactive widgets.

CDPH also requests General Fund expenditure authority of $150,000 annually over the three years to support translation services, and $139,000 annually over the three years to support software licensing and IT security tools.

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 6: 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 Part D clients* are persons living with HIV enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group of clients receives services associated with medication co-pays, medical out-of-pocket costs, Medicare Part D health insurance premiums, and has the option for premium assistance with Medigap supplemental insurance policies, which cover medical out-of-pocket costs.
5. *Pre-exposure prophylaxis (PrEP) 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 2022 ADAP Local Assistance Estimate reflects revised 2022-23 expenditures of $440.5 million, a decrease of $14.5 million or 3.2 percent compared to the 2022 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 premiums for insured client groups. For 2023-24, CDPH estimates ADAP expenditures of $440.1 million, an increase of $393,000, or 0.09 percent compared to revised expenditures for 2022-23. According to CDPH, the continued relative reduction of expenditures between 2023-24 and 2022-23, compared to the 2022 Budget Act, is similarly due to lower than expected medication and premium expenditures, as well as expansions of Medi-Cal coverage to previously uninsured populations.

ADAP Local Assistance Funding Summary		
Fund Source	**2022-23**	**2023-24**
0890 – Federal Trust Fund	$107,076,000	$101,519,000
3080 – AIDS Drug Assistance Program Rebate Fund	$333,445,000	$338,609,000
Total ADAP Local Assistance Funding	**$440,521,000**	**$440,128,000**

ADAP tracks caseload and expenditures by client group. CDPH estimates ADAP caseload and expenditures for 2022-23 and 2023-24 will be as follows:

Caseload by Client Group	**2022-23**	**2023-24**
Medication-Only	11,648	10,668
Medi-Cal Share of Cost	90	90
Private Insurance	10,409	10,414
Medicare Part D	7,350	7,351
PrEP Assistance Program	6,305	8,105
TOTAL	**35,801**	**36,628**

Expenditures by Client Group	**2022-23**	**2023-24**
Medication-Only	$313,407,919	$299,195,054
Medi-Cal Share of Cost	$670,664	$658,655
Private Insurance	$86,602,374	$91,529,534
Medicare Part D	$26,476,046	$28,770,897
PrEP Assistance Program	$10,171,767	$13,233,295
TOTAL	**$437,328,771**	**$433,387,434**

Costs for administration of ADAP are estimated to be $5.4 million in 2022-23 and $5.8 million in 2023-24. Costs for administration of PrEP-AP are estimated to be $4.5 million in 2022-23 and $6.1 million in 2023-24. Enrollment costs are estimated to be $7.1 million in 2022-23 and $6.9 million in 2023-24.

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 $15.7 million in 2022-23 and $14.2 million in 2023-24.

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 major changes to the ADAP Estimate.

Issue 7: California Immunization Registry (AB 1797)

Budget Change Proposal – Governor's Budget. CDPH requests three positions and General Fund expenditure authority of $915,000 in 2023-24 and $453,000 annually thereafter. If approved, these positions and resources would allow CDPH to ensure health care providers and agencies provide required information to, and certain education and human services entities have access to, the California Immunization Registry (CAIR), pursuant to AB 1797 (Weber), Chapter 582, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$915,000	$453,000
Total Funding Request:	**$915,000**	**$453,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2024-25.

Background. AB 1797 (Weber), Chapter 582, Statutes of 2022, requires health care providers and other agencies to report administered immunizations to the California Immunization Registry (CAIR) and allows schools, childcare facilities, and human services agencies to look up COVID-19 immunizations for program participation purposes. Prior to AB 1797, reporting of vaccines has been largely voluntary. Only pharmacists, optometrists, dentists, podiatrists, and Medi-Cal managed care plans are required to report immunizations given to patients to CAIR. As a result, most vaccine providers are not required to report to CAIR. AB 1797 closes that gap by requiring all health care providers to report administered vaccinations.

CDPH reports that, as a result of AB 1797, the Division of Communicable Disease Control would need to manage enrollment and support for the thousands of new providers that are not currently reporting vaccinations to CAIR. In addition, the division would need to manage access to CAIR for schools, childcare facilities, and human services agencies.

Staffing and Resource Request. CDPH requests three positions and General Fund expenditure authority of $915,000 in 2023-24 and $453,000 annually thereafter to ensure health care providers and agencies provide required information to, and certain education and human services entities have access to, the California Immunization Registry (CAIR), pursuant to AB 1797 (Weber), Chapter 582, Statutes of 2022. Specifically, CDPH requests the following positions and resources:

Division of Communicable Disease Control – Three positions and resources equivalent to three positions

- **Two Information Technology Associates** and resources equivalent to **one Information Technology Associate** would serve as CAIR Help Desk staff, be responsible for supporting increased enrollment of providers manually reporting immunizations, schools, childcare facilities, and human services agencies in CAIR.
- **One Health Education Consultant II** position and resources equivalent to **two Health Education Consultant II** positions would serve as local CAIR representatives and be responsible for supporting additional physicians, schools, and childcare facilities' enrollment; assist help desk staff with complex user issues, evaluate CAIR user issues, and collaborate with program staff to resolve, train, and maintain new and existing clinic and physician users.

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 8: Fentanyl Program Grants (AB 2365) and Availability of Fentanyl Test Strips and Naloxone

Budget Change Proposal – Governor's Budget. CDPH requests expenditure authority from the Opioid Settlements Fund of $7.5 million in 2023-24, $3.5 million in 2024-25, and $1.5 million in 2025-26 and 2026-27. If approved, these resources would support six one-time competitive grants to reduce fentanyl overdoses and use, pursuant to AB 2365 (Patterson), Chapter 783, Statutes of 2022, and two one-time competitive grants to support innovative approaches to make fentanyl test strips and naloxone more widely available.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
3397 – Opioid Settlements Fund	$7,500,000	$3,500,000
Total Funding Request:	**$7,500,000**	**$3,500,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2025-26 and 2026-27: $1,500,000.

Background. AB 2365 (Patterson), Chapter 783, Statutes of 2022, requires the CDPH to establish a grant program to reduce fentanyl overdose and use throughout the state to increase local efforts in education, testing, recovery, and support services. Six, one-time grants would be awarded as part of this pilot, allocated by region: two in Northern California, two in the Central Valley, and two in Southern California. Grants would support any of the following activities: (1) education programs in local schools; (2) increasing testing abilities for fentanyl; (3) overdose prevention and recovery programs, including making naloxone or other overdose recovery drugs more available in the community; and (4) increasing social services and substance use recovery services to those addicted to fentanyl or other opioids. In addition, AB 2365 requires grantees to provide CDPH with information on how grant money was used, the number of people served, and data for the number hospitalizations, overdoses, and overdose deaths from fentanyl both the year prior to the grant and the year the grant was used.

Syringe Services Programs. According to CDPH, Syringe Services Programs (SSPs) are the primary vehicle for reaching people at greatest risk of experiencing or witnessing an overdose with overdose education and naloxone distribution services. State data show SSPs have received a third of the naloxone shipments in this fiscal year, but account for two-thirds of the reported reversals. Unlike many other types of types of programs that order naloxone through the DHCS Naloxone Distribution Project (NDP) and keep it available in case of onsite emergencies, SSPs actively work to distribute naloxone to people who use drugs, typically their program participants, then train them in its use and serve as sources of emotional support after they reverse an overdose. A 2022 CDPH-supported survey of 1,500 SSP participants found that 65 percent of respondents had witnessed an overdose in the previous six months, and 54 percent had used naloxone on someone to reverse an overdose. Although most of California's SSPs participate in the NDP, many also supplement their naloxone orders through other sources.

Recent changes to California law as a result of AB 1598 (Davies), Chapter 201, Statutes of 2022, exempted testing equipment designed, marketed, intended to be used, or used, to test a substance for the presence of fentanyl, ketamine, gamma hydroxybutyric acid, or any analog of fentanyl from being considered "drug paraphernalia." As of January 1, 2023, AB 1598 authorizes service providers throughout California to seek to distribute fentanyl test strips to their clients and patients to prevent overdose. Fentanyl test strips are a form of inexpensive drug testing technology that was originally developed for urinalysis, but which

have been shown to be effective at detecting the presence of fentanyl in drug samples prior to ingestion. A study involving a community-based program in North Carolina found that 81 percent of those with access to fentanyl test strips routinely tested their drugs before use. Those with a positive test result were five times more likely to change their drug use behavior to reduce the risk of overdose. In a Rhode Island study of young adults who reported using heroin, cocaine, or illicitly obtained prescription pills, "receiving a positive [fentanyl] result was significantly associated with reporting a positive change in overdose risk behavior." Increasing access to fentanyl test strips, potentially through the Naloxone Distribution Project, will assist many organizations looking to better serve the needs of their clients.

Resource Request. CDPH requests expenditure authority from the Opioid Settlements Fund of $7.5 million in 2023-24, $3.5 million in 2024-25, and $1.5 million in 2025-26 and 2026-27 to support six one-time competitive grants to reduce fentanyl overdoses and use, pursuant to AB 2365 (Patterson), Chapter 783, Statutes of 2022, and two one-time competitive grants to support innovative approaches to make fentanyl test strips and naloxone more widely available. Specifically, these resources would support the following grant programs, as follows:

AB 2365 Fentanyl Program Grants

CDPH requests expenditure authority from the Opioid Settlements Fund of $5 million in 2023-24, $3 million in 2024-25, and $1 million in 2025-26 and 2026-27 for AB 2365 Fentanyl Program Grants. Of these amounts, $479,000 each year would support personnel, including the following administratively established positions:

- **One Associate Governmental Program Analyst** would support administrative aspects of pilot grants; provide customer service to grantees on administrative issues; establish contracts and amendments; process invoices; monitor budgets and expenditures; and travel to grantee sites for site visits and monitoring.
- **Two Health Program Specialist I** positions would develop program documents; review applications and select awardees; monitor grantee progress; provide technical assistance; coordinate data tracking and reporting; collect, analyze, and interpret evaluation metrics; develop reports to the Legislature and Governor; coordinate all document review and approvals; and travel to grantee sites for site visits and monitoring.

Of these amounts, $4.5 million in 2023-24, $2.5 million in 2024-25, and $521,000 in 2025-26 and 2026-27 would support the six one-time fentanyl program grants, pursuant to AB 2365.

Improved Access to Fentanyl Test Strips and Naloxone

CDPH requests expenditure authority from the Opioid Settlements Fund of $2.5 million in 2023-24 and $500,000 in 2024-25, 2025-26, and 2026-27 to support improved access to fentanyl test strips and naloxone. Of these amounts, $165,000 each year would support personnel, including the following administratively established position:

- **One Health Program Specialist I** position would develop program documents and solicit information from potential naloxone and fentanyl test strip vendors; review responses to develop procurement for naloxone and fentanyl test strip distributors; set goals and objectives for successful distribution

programs; monitor progress; coordinate data tracking and reporting; collect, analyze, and interpret evaluation metrics; coordinate document review and approvals; and develop a technical assistance plan that focuses on gaps in jails, emergency departments, homeless service providers, and other community-based agencies.

Of these amounts, $217,000 in each year would support a technical assistance contract with a University of California campus, and $2.1 million in 2023-24 and $118,000 in 2024-25, 2025-26, and 2026-27 would support the two one-time grants to expand access to fentanyl test strips and naloxone.

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 these grant proposals.

Issue 9: BabyBIG Infant Botulism Treatment and Prevention Program

Budget Change Proposal – Governor's Budget. CDPH requests expenditure authority from the Infant Botulism Treatment and Prevention Fund of $7.4 million in 2023-24, $11.6 million in 2024-25, $7 million in 2025-26, $4.9 million in 2026-27, and $3.9 million annually thereafter. If approved, these resources would allow CDPH to meet manufacturing costs associated with the production of the most recent lot of its licensed orphan drug, BabyBIG (Human Botulism Immune Globulin), the only treatment for infant botulism.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0272 – Infant Botulism Treatment and Prevention Fund	$7,400,000	$11,600,000
Total Funding Request:	**$7,400,000**	**$11,600,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2025-26: $7,000,000; 2026-27: $4,900,000; 2027-28 and ongoing: $3,900,000.

Background. The Infant Botulism Treatment and Prevention Program was created to provide and improve the treatment of infant botulism and to prevent infant botulism and related diseases. BabyBIG is an orphan drug that consists of human-derived anti-botulism-toxin antibodies and is approved by the U.S. Food and Drug Administration (FDA) for the treatment of infant botulism types A and B. CDPH is the only producer of BabyBIG in the world, with only one facility, Shire Biotechnology located in Los Angeles, approved by the FDA for production of the drug.

Resource Request. CDPH requests expenditure authority from the Infant Botulism Treatment and Prevention Fund of $7.4 million in 2023-24, $11.6 million in 2024-25, $7 million in 2025-26, $4.9 million in 2026-27, and $3.9 million annually thereafter to meet manufacturing costs associated with the production of the most recent lot of its licensed orphan drug, BabyBIG (Human Botulism Immune Globulin), the only treatment for infant botulism. According to CDPH, a new lot of BabyBIG is made approximately every five years. The most recent lot of BabyBIG, Lot 7, will be completed in 2022-23, with the next lot, Lot 8, scheduled to begin by 2023-24 and provide an uninterrupted supply of BabyBIG for babies critically ill with infant botulism.

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 10: Licensure of Clinical Lab Geneticists and Clinical Reproductive Biologists (SB 1267)

Budget Change Proposal – Governor's Budget. CDPH requests one position and expenditure authority from the Clinical Laboratory Improvement Fund of $210,000 in 2023-24 and $176,000 annually thereafter. If approved, this position and resources would allow CDPH to implement the licensure of clinical laboratory geneticists and clinical reproductive biologists, pursuant to SB 1267 (Pan), Chapter 473, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0098 – Clinical Laboratory Improvement Fund	$210,000	$176,000
Total Funding Request:	**$210,000**	**$176,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2024-25.

Background. SB 1267 (Pan), Chapter 473, Statutes of 2022, creates a new clinical license category for clinical laboratory geneticists. According to CDPH, current law authorizes CDPH to license trainees, scientists, and specialists authorized to direct laboratories in the genetics subspecialties of clinical cytogenetics and clinical molecular biology, and to apply fees for application and license renewal. However, the American Board of Medical Genetics and Genomics (ABMGG) has recently consolidated to existing training and certification categories, cytogenetics and genetic molecular biology, into a single category, laboratory genetics and genomics. SB 1267 resolves this problem by creating the new clinical laboratory genetics subspecialty and authorizing CDPH to license and oversee the subspecialty.

In addition, SB 1267 creates a new licensure category for clinical laboratorians who provide clinical testing used in assisted reproductive technology techniques. CDPH does not currently license specialists in this discipline.

CDPH expects that approximately 660 people will qualify for licensure in 2023-24 and 435 annually thereafter. Specifically, CDPH estimates the following licensure workload:

- 20 new Laboratory Genetics Directors in 2023-24, with 20 annually thereafter
- 200 new Laboratory Geneticist Scientists in 2023-24, with 200 annually thereafter
- 70 new Clinical Reproductive Biologist Directors in 2023-24, with 15 annually thereafter
- 200 new Clinical Reproductive Biologist Scientists in 2023-24, with 100 annually thereafter
- 170 new Trainees in Laboratory Genetics and Reproductive Biology, with 100 annually thereafter

Resource Request. CDPH requests one position and expenditure authority from the Clinical Laboratory Improvement Fund of $210,000 in 2023-24 and $176,000 annually thereafter to implement the licensure of clinical laboratory geneticists and clinical reproductive biologists, pursuant to SB 1267 (Pan), Chapter 473, Statutes of 2022. Specifically, these resources would support **one Examiner II** position, who would oversee processing of licensure applications for trainees, clinical laboratory scientists, and master's and doctoral specialists in reproductive biology; oversee approval of training programs and certification examinations; serve as subject matter expert for development of policies, procedures, and regulations; provide support for personnel licensing and the regulated community; work with CDPH's Tissue Bank

program's regulations team as a subject matter expert on a rulemaking package to update tissue bank regulations.

In addition, CDPH requests expenditure authority of $34,000 to make minor changes to the program's electronic application program to accommodate the addition of new license categories.

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 11: CA Integrated Vital Records System Upgrades for Death Certificate Content (AB 2436)

Budget Change Proposal – Governor's Budget. CDPH requests General Fund expenditure authority of $563,000 in 2023-24. If approved, these resources would allow CDPH to make changes to information on death certificates, pursuant to AB 2436 (Bauer-Kahan), Chapter 966, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25**
0001 – General Fund	$563,000	$-
Total Funding Request:	**$563,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. AB 2436 (Bauer-Kahan), Chapter 966, Statutes of 2022, revises the information required on death certificates to include the current first and middle names, birth last names, and the birthplace of the parents, without reference to the parent's gendered relationship to the decedent. Prior to AB 2436, death certificates had fixed fields for "mother" and "father". Neither of these fields accounts for gender options available on other California vital records and do not reflect the diversity of modern families.

As the State Registrar, CDPH is responsible for registering each live birth, death, fetal death, and marriage that occurs in California, and for providing certified copies of vital records to the public. CDPH administers various electronic systems that maintain vital records, including the California Integrated Vital Records System (Cal-IVRS), in collaboration with the University of California, San Diego (UCSD). UCSD provides regular maintenance and operations functions and scheduled system enhancements for functionality and efficiency under a contract with CDPH.

Resource Request. CDPH requests General Fund expenditure authority of $563,000 in 2023-24 to make changes to information on death certificates, pursuant to AB 2436 (Bauer-Kahan), Chapter 966, Statutes of 2022. Specifically, CDPH requests the following:

- UCSD Staff – $88,000 would support one UCSD programmer and UCSD analyst for a period of three months to focus solely on system updates required to meet the changes in statute, including changes to the certificate template and user interface, and updates to data file mapping.
- Independent Contractors – $475,000 would support four independent contractor staff for a period of four and a half months to assist CDPH staff with requirements gathering, user acceptance testing, resource updating, training and outreach to system users, and implementation planning and tracking.

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 12: Proposal for Investment

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

For presentation

- **Hepatitis C Virus (HCV) Equity: Access to the Cure**. The End the Epidemics Coalition requests General Fund expenditure authority of $5 million annually in 2023-24, 2024-25, and 2025-26. If approved, these resources would support expansion of HCV public health services, including outreach, testing, linkage and engagement in care to support young people who use drugs (PWUD), Black, Indigenous, and People of Color (BIPOC) communities, and those experiencing homelessness in curing HCV. The Office of Viral Hepatitis Prevention in CDPH's STD Control Branch would administer funding to Local Health Jurisdictions (LHJ) using the current funding formula, or an updated version as appropriate. At least 50 percent of the award would support the maintenance and expansion of community-based services in priority settings, such as syringe exchange sites, mobile health vans, emergency rooms, and county jails.