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 2, 2023
9:30 am, or upon adjournment of session
1021 O Street – Room 1200

Consultant: Elizabeth Schmitt and Scott Ogus

PUBLIC COMMENT

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0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Office of Youth and Community Restoration and Division of Juvenile Justice Realignment

In addition to Judge Katherine Lucero, Director, Office of Youth and Community Restoration, the Subcommittee has requested Karen Pank, Executive Director, Chief Probation Officers of California, Frankie Guzman, Senior Director for Youth Justice, National Center for Youth Law, and Jasmine Dellafosse, Youth Advocate, to participate in this discussion.

Background. Youths accused of a crime that occurred before they turn 18 years of age start in juvenile courts. If the court determines the youth committed the crime, the court then determines where to place the youth based on statute, input from defense and prosecution, and factors such as the youth's offense and criminal history.

Depending on the circumstances of the case, the juvenile court can take several possible actions including placing the youth under county supervision or, prior to 2021, in the state Division of Juvenile Justice (DJJ). In addition, the court may choose to transfer certain youths' cases to adult court if a transfer request is filed with the court in cases where youths have committed very serious crimes.

Youths placed under county supervision are typically allowed to remain with their families with some level of supervision from county probation officers. However, some youths— typically those who have committed more serious crimes—are housed in county juvenile facilities, such as juvenile halls or camps. As of December 2022, 2,146 youth statewide are housed in juvenile facilities.

DJJ Closure and Realignment. The 2020-21 budget included a plan to close the Division of Juvenile Justice (DJJ) at the California Department of Corrections and Rehabilitation (CDCR) by June 30, 2023. While most youth were already housed or supervised locally, counties could choose to send those youths who had committed violent, serious, or sex offenses to state facilities operated by DJJ. There were typically about 650 youth statewide in DJJ facilities. The closure of DJJ means that the juvenile justice system will be completely realigned to the county level.

Youth housed in DJJ facilities largely did not have access to the types of rehabilitative programming and community connections that are necessary for a humane and successful juvenile justice system.[1] First, the location of DJJ facilities means that many youth offenders were moved far from home, making it difficult to maintain ties with their families and communities. Second, DJJ facilities were notorious for violence and had high recidivism rates.[2] Overall, the facilities operated more like adult prisons than as spaces where young people could develop and prepare for adult life outside the criminal justice system. In addition, due to decades of declining juvenile crime rates, both DJJ and county juvenile facilities have been operating under capacity.

[1] http://www.cjcj.org/uploads/cjcj/documents/unmet_promises_continued_violence_and_neglect_in_california_division_of_juvenile_justice.pdf, https://jjie.org/2020/05/19/californias-closure-of-djj-is-victory-with-significant-challenges/

[2] https://www.latimes.com/california/story/2021-02-15/california-youth-prisons-closing-criminal-justice-reform, https://www.mercurynews.com/2007/02/27/report-finds-cya-prison-still-fails-inmates/, https://www.latimes.com/archives/la-xpm-1999-dec-24-mn-47028-story.html

Realignment is intended to move juvenile justice in California toward a rehabilitative, trauma-informed, and developmentally appropriate system. The plans for realignment are outlined in SB 823 (Committee on Budget and Fiscal Review), Chapter 337, Statutes of 2020 and SB 92 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2021.

Per the realignment timeline, DJJ stopped accepting most transfers from counties on July 1, 2021, and will completely shut down by June 30, 2023. As of January 27, 2023, there were 399 youth at DJJ. Of those youth, 172 are potentially eligible for discharge before the closure date. The remaining youth, who are not eligible for discharge or are not discharged, will return to their counties over the next few months.

As a result of realignment, counties are responsible for caring for youth with more serious needs and who have committed more serious offenses. The realignment plan outlined a process for counties to establish Secure Youth Treatment Facilities (SYTFs) for high-level offenders who would have previously been housed at DJJ. To assist counties with their increased responsibility, the state provides block grant funding to counties for each realigned youth, and one-time funding for planning and juvenile facility infrastructure needs, which is described in detail in the funding section below.

Office of Youth and Community Restoration (OYCR). To support counties in this transition, the realignment plan included the creation of the OYCR to provide statewide assistance, coordination, and oversight. This new office is under the Health and Human Services Agency (HHS) rather than under CDCR or BSCC, reflecting the shift away from corrections toward services and treatment. The mission of the Office, as defined in statute, is "[T]o promote trauma responsive, culturally informed services for youth involved in the juvenile justice system that support the youths' successful transition into adulthood and help them become responsible, thriving, and engaged members of their communities."

Mandates of the OYCR include:

- Identify policy recommendations for improved outcomes for court-involved youth.
- Identify and disseminate best practices to inform rehabilitative and restorative youth practices.
- Provide technical assistance to develop and expand local youth diversion opportunities.
- Evaluate the efficacy of local programs being utilized for realigned youth and report to the Governor and Legislature by July 1, 2025.
- Develop a report on youth outcomes in the juvenile justice system based on the updated JCPSS (DOJ) System.
- Provide an ombudsperson to investigate complaints and resolve where possible and report regularly to the Legislature.
- Concur with the Board of State and Community Corrections on any juvenile grants.
- Assume administration of juvenile grants no later than January 1, 2025.

- Concur with the Board of State and Community Corrections (BSCC) on new standards for secure youth treatment facilities.

Funding. The 2020-21 budget included $9.6 million General Fund for planning and facilities, and the gradual implementation of block grants to counties at a rate of $225,000 per realigned youth per year. This will amount to $209 million statewide per year after full realignment. This funding is currently administered by BSCC but will transition to OYCR by 2025.

The 2022-23 budget included $100 million one-time General Fund for counties to invest in their juvenile facilities, in anticipation of the closure of DJJ. The funding could be used to support modifications, renovations, repairs, and maintenance for existing county-operated juvenile facilities, with a focus on providing therapeutic, youth-centered, trauma-informed, and developmentally appropriate rehabilitative programming for youth. This was not a competitive grant, and every county received some funding.

The state has also provided resources to counties for juvenile justice several times throughout the years, corresponding with changes in alignment and totaling over $200 million annually. These include:

- *Youth Offender Block Grants*. This provided counties with $117,000 per ward for lower-level offenders that were realigned to the county level in 2007, per SB 81 (Committee on Budget and Fiscal Review), Chapter 175, Statutes of 2007.

- *Local Youthful Offender Rehabilitative Facility Construction.* SB 81 also provided counties with lease-revenue funding to construct or renovate juvenile facilities. A total of $300 million was allocated.

- *Juvenile Re-entry Grants*. The state provided funding to the counties after juvenile parolees released from DJJ were realigned to the county level as part of the 2010-11 budget.

OYCR Funding. The 2021-22 budget included $27.6 million in 2021-22 and $7 million ongoing for the Office of Youth and Community Restoration. The 2021-22 funding included $20 million for technical assistance, disseminating best practices, and grants. The 2022-23 budget included an additional $10 million ongoing for the Office, and language detailing the duties and responsibilities of the Ombudsperson within OYCR.

County Realignment Plans. The Juvenile Justice Realignment Block Grant (JJRBG) program is designed to provide funding to counties to support youth returned to those counties. To be eligible for such funds, each county is required to convene a subcommittee of the multiagency juvenile justice coordinating council chaired by the chief probation officer and including representatives from the district attorney, public defender, department of social services, department of mental health, the county office of education or school district, and the court, along with at least three community members. The subcommittees develop a plan for juvenile justice realignment within the county. These plans must include information on how counties will provide trauma-informed, culturally responsive, and developmentally appropriate programs and a description of data collection and outcome measures, among other topics detailed in statute (Welfare and Institutions Code Section 1995(c)). Counties were required to submit their initial plans by January 1, 2022 and must submit the most recent plan by May 1 of each year moving forward. OYCR is required to

review these plans, return plans to counties for revision as necessary, and make the plans available on its website.

According to OYCR's 2022 County Plan Summary Report, requests for revision primarily fell within the following categories: expanded data, facility improvements, culturally responsive programming, family engagement and reentry, housing approach for secure treatment, and program effectiveness. Thirty-three counties are adapting existing facilities to serve as a SYTF, while other counties that have had historically low referrals to DJJ are entering into regional agreements. The report notes that some counties have indicated that they are not able to care for specific sub populations, such as youth who need specialized treatment related to mental health or sex abuse offenses. Twelve counties identified a step-down placement for youth in their plan, and other counties stated that they plan to establish relationships with community service providers to develop step down plans. OYCR's report notes the importance of step-down placements in supporting youth to successfully reenter society and not stay in maximum security facilities for extended periods of time.

OYCR's 2022 County Plan Summary Report also identified priority areas for OYCR to work with counties to support best practices and provide technical assistance. These areas include: addressing the unique challenges for small, rural communities; developing methods for measuring effectiveness and outcomes relating to court-involved youth; retaining youth in the juvenile system and not in the adult prison system; and developing therapeutic facilities and building capacity to develop step-down options from secure facilities to less restrictive environments with greater access to community-based activities.

OYCR Update. The OYCR Director was hired in January of 2022, and began hiring staff in spring 2022. OYCR has visited 33 SYTFs, met with all 58 Probation Chiefs, engaged with tribal court and tribal leadership, held over 200 stakeholder and community meetings, developed a strategic plan and funding strategies, and initiated an Educational Advisory Committee. In anticipation of the June 30, 2023 DJJ closure date, OYCR is providing technical assistance to courts and counties, including intensive case-by-case technical assistance to support counties who will receive former DJJ youth with various service needs, including behavioral health treatment and sex treatment.

Some of OYCR's current projects include: a collaboration with the Vera Institute of Justice to support four counties in reducing and ending the incarceration of girls and gender expansive youth; pilot projects that demonstrate best practices in expanding capacity of community-based organizations; pilot programs to implement OYCR's stepping home model of community-based alternatives to incarceration, and training probation officers on developmentally appropriate best practices, among others.

In August 2022, the OYCR Ombudsperson line was open; as of February 2023, the OYCR ombudsperson has opened 65 complaint investigations from youth and visited 15 facilities.

Staff Comment and Recommendation. Informational item. No action is needed.

Questions. The Subcommittee requests OYCR respond to the following:

1. Please provide an update on how OYCR is using funds designated for technical assistance, disseminating best practices, and grants.

2. Please provide an update on the implementation of the OYCR Ombudsperson office.

3. Please describe OYCR's activities leading up to the June 30, 2023 DJJ closure date. What is OYCR's focus as we near the DJJ closure and what technical assistance is OYCR providing counties to ensure youth in those counties receive developmentally appropriate services?

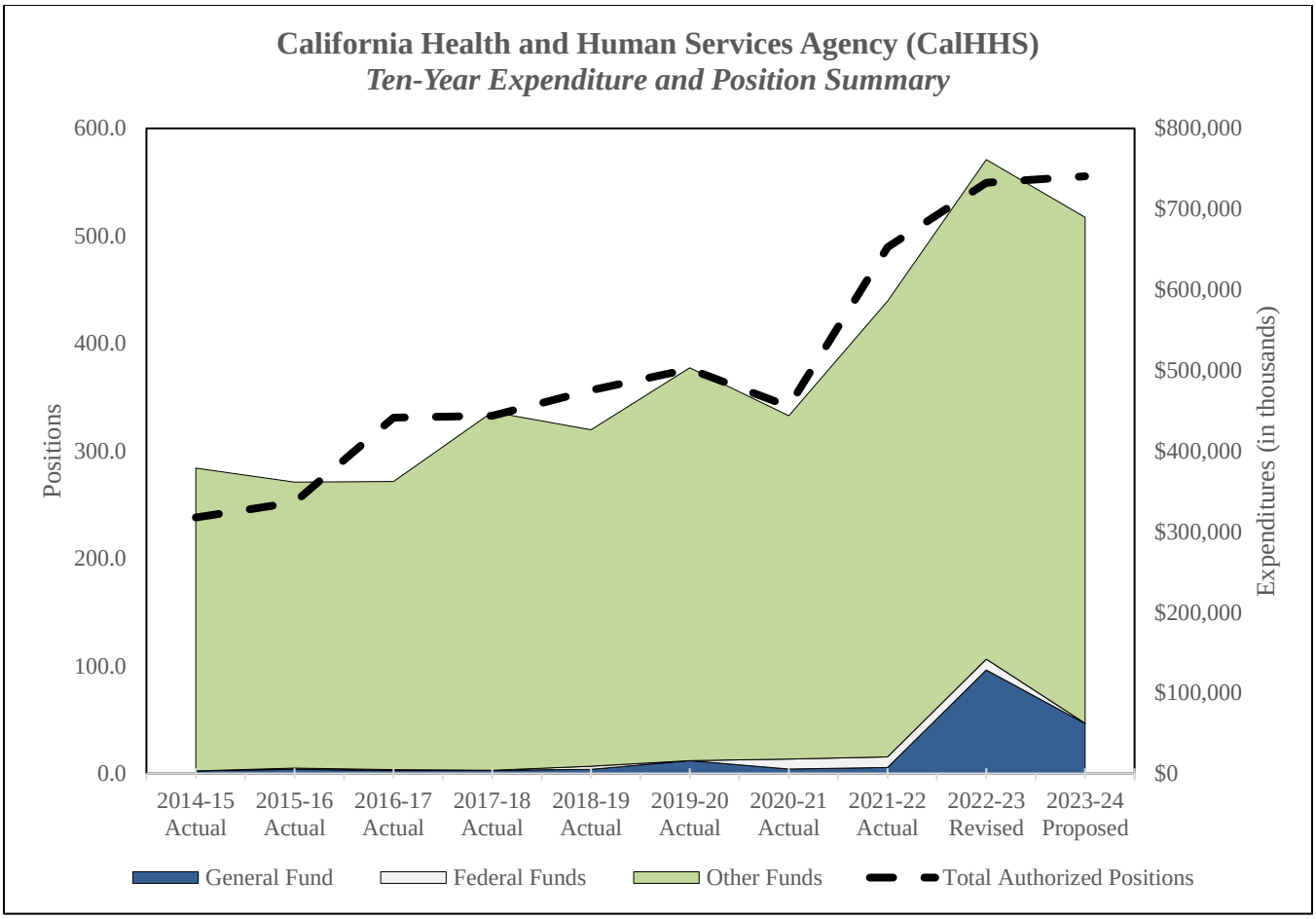
4. How are OYCR and counties addressing service gaps that may result from realignment for youth who need specialized programming, such as behavioral health treatment, sex offender treatment, and programming for female youth?

5. What types of settings and services are available to youth in county custody and youth who will return from DJJ? Do the county plans reflect new models of care for longer-term placements or are the counties primarily focusing on housing youth in juvenile halls?

6. How should the state and counties balance the desire to consolidate programs across counties with the original goals of realignment to bring youth closer to home?

7. The intent of SB 823 is to provide justice system-involved youth with age-appropriate treatment closer to their families and to build a continuum of community-based approaches in the least restrictive appropriate environment. What progress has been made in building this continuum, and what more needs to be done to realize the intent of SB 823?

Issue 2: Overview



California Health and Human Services Agency- *Department Funding Summary*				
Fund Source	**2021-22 Actual**	***2022-23 Budget Act***	***2022-23 Revised***	***2023-24 Proposed***
General Fund	$7,293	$122,098	$128,339	$62,104
Federal Funds	$13,415	$13,446	$13,446	$148
Other Funds	$565,022	$595,852	$619,517	$627,335
Total Department Funding:	**$585,730**	**$731,396**	**$761,302**	**$689,587**
Total Authorized Positions:	**489.5**	**621.5**	**549.5**	**555.5**
Other Funds Detail:				
Reimbursements (0995)	*$25,033*	*$4,785*	*$25,609*	*$4,894*
Office of Patient Advocate Trust Fund (3209)	*$1,909*	*$2,231*	*$2,298*	*$2,302*
Data Insights and Innovation Fund (3377)	*($175)*	*$0*	*$0*	*$0*
988 Suicide and BH Crisis Services Fund (3414)	*$0*	*$0*	*$0*	*$5,500*
Central Service Cost Recovery Fund (9740)	*$5,135*	*$2,894*	*$2,950*	*$11,367*
California HHS Automation Fund (9745)	*$533,120*	*$585,942*	*$588,660*	*$603,272*

Background. The California Health and Human Services Agency (CalHHS) oversees twelve departments and five offices that provide a range of health care services, social services, mental health services, alcohol and drug services, income assistance, and public health services to Californians. CalHHS is administered by a cabinet-level Secretary of Health and Human Services, appointed by the Governor and confirmed by the California State Senate. According to CalHHS, its primary mission is to provide policy leadership and direction to the departments, boards, and programs it oversees, to reduce duplication and fragmentation among departments in policy development and implementation, to improve coordination among departments on common programs, to ensure programmatic integrity, and to advance the Governor's priorities on health and human services issues.

The departments and other entities within CalHHS include:

- Department of Aging (CDA)
- Department of Public Health (CDPH)
- Department of Child Support Services (DCSS)
- Department of Community Services and Development (CSD)
- Department of Developmental Services (DDS)
- Emergency Medical Services Authority (EMSA)
- Department of Health Care Services (DHCS)
- Department of Managed Health Care (DMHC)
- Department of State Hospitals (DSH)
- Department of Rehabilitation (DOR)
- Department of Social Services (DSS)
- Department of Health Care Access and Information (HCAI)

Within CalHHS there are several other entities administered by appointed commissions or governing boards, including:

- State Council on Developmental Disabilities
- Commission on Aging
- California Senior Legislature
- California Children and Families Commission
- California Health Benefit Exchange (Covered California)
- State Independent Living Council

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

Within the organizational structure of CalHHS are five offices and the Center for Data Insights and Innovation.

Office of the Secretary of Health and Human Services. The Office of the Secretary formulates and coordinates policy among the Agency's departments, and communicates with the Legislature, stakeholders, and the public about issues relating to the state's health and human services programs. The Office of the Secretary is composed of six distinct offices or units, including:

- Office of Legislative Affairs – The Office of Legislative Affairs provides coordination, oversight, and management of proposed legislation and ensures the Administration's legislative priorities are developed and implemented. The office provides policy guidance, instruction, and direction to health and human services departments and entities, and coordinates with the Governor's Office on legislative positions.
- Office of External Affairs – The Office of External Affairs manages ongoing public information and public affairs functions and provides guidance and direction to public information officers in health and human services departments and entities. The office serves as the official Agency spokesperson to respond to media inquiries, and coordinates with the Governor's Office communication staff on significant and sensitive media issues.
- Office of the Agency General Counsel – The Office of the Agency General Counsel provides legal counsel to the Office of the Secretary and senior Agency staff, coordinates with the Governor's Office of Legal Affairs and with the Chief Counsels in health and human services departments and entities.
- Office of Program and Fiscal Affairs – The Office of Program and Fiscal Affairs is responsible for formulating, analyzing, revising, and evaluating the program and fiscal impacts of major health and human services policies of the Administration. This work includes assessment of all policy, legislative, fiscal, and other issues that have implications among health and human services departments and agencies, as well as other state agencies.
- Administration Unit – The Administration Unit manages personnel, human resources, training, and internal budget issues.
- Office of the Agency Information Officer – The Office of the Agency Information Officer supports health and human services departments and entities to successfully deliver data and technology solutions through portfolio support, enterprise architecture, information security, agency governance, and horizontal integration activities.
- Office of Policy and Strategic Planning – The Office of Policy and Strategic Planning is responsible for driving measurable outcomes on CalHHS guiding principles and strategic priorities through system alignment and program integration across the agency's departments and offices. The Office works on a set of initiatives to advance equity, address the social determinants of health, and ensure a whole person approach.

Office of Systems Integration (OSI). The Office of Systems Integration (OSI) procures, manages, and delivers technology systems that support the delivery of health and human services to Californians. OSI manages a portfolio of large, complex information technology (IT) projects, providing project management, oversight, procurement, and support services for these projects and coordinating communication, collaboration, and decision-making among project stakeholders and program sponsors. After the procurement phase, OSI oversees the design, development, governance, and implementation of IT systems that support the administration of health and human services programs in California.

Office of the Surgeon General (OSG). The Office of the Surgeon General (OSG) was established in 2019 to advise the Governor, serve as a leading spokesperson on matters of public health, and drive solutions to the state's most pressing public health challenges. The OSG has established early childhood, health equity, adverse childhood experiences (ACEs), and toxic stress as key priorities. The Surgeon General has set a goal to reduce ACEs and toxic stress by half in one generation.

Office of Law Enforcement Support (OLES). The Office of Law Enforcement Support (OLES) was established in 2014 to provide monitoring and oversight of law enforcement personnel serving in the

Office of Protective Services at DSH and DDS. OLES develops training protocols, policies, and procedures for law enforcement officers operating at DSH and DDS, and investigates incidents involving law enforcement personnel at state hospitals or developmental centers.

Office of Youth and Community Restoration (OYCR). The Office of Youth and Community Restoration (OYCR) supports the transition of justice involved youth being served in local communities by promoting a youth continuum of services that are trauma responsive and culturally informed, using public health approaches that support positive youth development, building the capacity of community-based approaches, and reducing the justice involvement of youth. The OYCR also assesses the efficacy of local programs, provides technical assistance and support, reviews local Juvenile Justice Realignment Grants, fulfills statutory obligations of an Ombudsperson, and develops policy recommendations.

Center for Data Insights and Innovation (CDII). The Center for Data Insights and Innovation (CDII) was established in 2021 to advance CalHHS data initiatives and help turn data into insights, knowledge, and action. The Center combines functions from the previous Office of Health Information Integrity (CalOHII), Committee for the Protection of Human Subjects (CPHS), Office of the Patient Advocate (OPA), and Office of Innovation. These functions include ensuring state department compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other related state and federal privacy laws, health plan and medical group report cards evaluating health care quality and the patient experience, and reporting on health care consumer and patient assistance centers by state agencies (Department of Managed Health Care, Medi-Cal, Department of Insurance, and Covered California). CDII also administers the CalHHS Open Data Portal, which provides public access to non-confidential health and human services data.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of the CalHHS mission and its oversight of key departments and other entities.

Issue 3: Statewide Automated Welfare System (CalSAWS) Ongoing Support

Budget Change Proposal – Governor's Budget. This joint proposal requests $852,000 total funds ($328,000 General Fund) for the conversion of five full-time positions (three Department of Health Care Services, one Department of Social Services, and one Office of Systems Integration) from limited term to permanent to support the Statewide Automated Welfare System (CalSAWS) consolidation. The requested position resources will continue to direct, govern, and oversee the planning and implementation of the CalSAWS.

Background. Per federal requirements by the Centers for Medicare and Medicaid Services (CMS) and Food and Nutrition Services (FNS), California is required to implement a single statewide automated welfare system (SAWS) by December 31, 2023 to ensure continuing receipt of federal financial participation (FFP) for SAWS development, implementation, and ongoing maintenance and enhancements (M&E). Currently there are two separate systems, now managed under a single CalSAWS Consortium governance structure: the 40-County CalSAWS supports Los Angeles County and the 39 former Consortium IV (C-IV) system counties, and the CalWORKS Information Network (CalWIN) system supports 18 counties. The CalSAWS project is a Joint Powers Authority developed and directed by the 58 counties.

On September 27, 2021, the CalSAWS project migrated the 39 C-IV counties to join Los Angeles County in forming a 40-county CalSAWS system. The remaining 18 CalWIN counties will migrate to CalSAWS to form a 58-county CalSAWS system in a series of conversion waves from October 2022 through October 2023.

Once the migration of the remaining CalWIN counties to the CalSAWS system is complete, the CalSAWS will be the eligibility determination and case management system for the entire state, in alignment with the federal mandate. County eligibility workers utilize CalSAWS to assist with eligibility determinations for over 14 million Californians seeking assistance with health coverage, access to food, cash assistance and supportive services. As new policy initiatives are implemented to support the needs of underserved populations in California, CalSAWS plays a critical role in developing automated processes.

The Office of Systems Integration (OSI) is responsible for state-level project management and oversight of the CalSAWS project, and the project sponsors, the California Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS), partner with OSI to verify project activities are conducted in accordance with contracted standards and adherence to information technology best practices.

Some examples of policy changes that the CalSAWS project is responsible for implementing include the expansion of Medi-Cal regardless of immigration status (AB 184, Chapter 47, Statutes of 2021); increasing the CalWORKs pregnancy special needs benefit; and implementing Food for All which expands access to the California Food Assistance Program (CFAP), among other changes. According to this proposal, CalSAWS has completed 22 automation policy changes in the past two years, with eight legislatively mandated policy changes pending implementation and at least 29 initiatives planned for future automation. This subcommittee has requested OSI provide a full inventory of CalSAWS projects slated for implementation, which was not available at the time of this writing.

Chapter 35, Statutes of 2018 (AB 1811) requires CDSS, DHCS, and OSI to increase their focus on engaging health and human services advocates, stakeholders, and clients. This requirement was incorporated in the development of the CalSAWS governance framework due to stakeholder concerns regarding participation in CalSAWS development and implementation.

Welfare and Institutions Code (WIC) 80123(c)(1) mandates that on February 1st of each year the OSI, in partnership with DHCS and CDSS, provide an annual report to the Legislature on the CalSAWS project, including the progress of state and consortia activities and any significant schedule, budget, or functionality changes in the project.

Staffing and Resource Request. After migration of all 58 counties in October 2023, CalSAWS will continue Agile developmental operations, or DevOps, which is a combination of organizational philosophies, practices, and tools that increases the ability of the project to deliver software solutions to better serve Californians. The requested positions will provide state oversight for timely implementation of policy and programmatic changes. As the project moves forward, staff will focus on assessing and identifying system gaps in the post-implementation phase of CalSAWS to confirm alignment with policy objectives and outcomes.

Additionally, the requested staff will support new interface connection tasks identified, day-to-day operational activities, mainframe network changes, and data release management. As new initiatives are introduced by the Legislature, staff will collaborate with CalSAWS leadership to determine the prioritization, cost, and time requirement to implement the proposed change. These resources will provide continued oversight of policy functionality in CalSAWS, which includes serving as the state sponsor representatives for the CDSS and DHCS programs; providing necessary policy guidance and technical assistance during SAWS activities related to migration; maintaining and enhancing BenefitsCal which is the state-wide consumer portal; and ongoing system enhancement efforts. This proposal notes that ongoing resources are necessary to collaborate with stakeholders in the ongoing enhancement of the BenefitsCal online portal to be a public facing portal that meets the cultural and linguistic needs of all Californians accessing services.

According to this proposal, the requested staff will be more adeptly positioned to make the most prudent and timely policy implementation decisions during the final implementation, and then ongoing M&E support of CalSAWS. With these positions securely in place, the state will be equipped to monitor future CalSAWS risks and issues and be able to respond promptly to mitigate any potential harm to participants in its programs. A breakdown of this resource request by department is as follows:

Department of Health Care Services (DHCS). DHCS is requesting 3.0 full time, limited-term positions, set to expire on June 30, 2023, to be made permanent. 1.0 Staff Services Manager (SSM) I and 1.0 Associate Governmental Program Analyst (AGPA) are in the Medi-Cal Eligibility Division (MCED) and 1.0 Information Technology Specialist (ITS) I is in the Business Operations and Technology Services Division (BOTSD) in the Medi-Cal Development Unit. The DHCS resources provide continued oversight of Medi-Cal eligibility policy functionality in CalSAWS, which includes serving as the state sponsor representatives for the Medi-Cal program, providing necessary policy guidance and technical assistance during SAWS activities related to migration, developing ancillary systems, and ongoing system enhancement efforts. DHCS representation confirms that policies are accurately programmed into all

systems, ensuring that eligibility is accurately determined for new and continuing Medi-Cal beneficiaries. DHCS resources also play an important role in the implementation of new legislative initiatives including obtaining system costs and timelines, coordinating policy guidance and clarifications, tracking progress of system changes, and supporting stakeholder involvement.

California Department of Social Services (CDSS). The CDSS is requesting 1.0 position, an ITS I in the Information Systems Division (ISD) that is set to expire on June 30, 2023, be made permanent. The ITS I represents CDSS in highly technical meetings and initiatives led by the CalSAWS project. The ITS I provides technical expertise to the CalSAWS project and is responsible for providing technical planning, preparation, review, documentation, and support on the project as it relates to various CDSS programs and applications. According to this proposal, CDSS will continue to address gaps in services based on race and language through a new "CDSS Caseload Dynamics Data Dashboard," which will provide monthly CalFresh and CalWORKs data, disaggregated by race and language, on CalFresh and CalWORKs applications, approvals and denials, application processing time, and discontinuances.

Office of Systems Integration (OSI). The OSI is requesting 1.0 ITS I position, set to expire on June 30, 2023, be made permanent. The position is in the SAWS Consortium Management Unit (CMU). The primary function of the ITS I is to coordinate with key state program sponsors to plan, develop, and manage a prioritization process which may include facilitating meetings and presentations involving problems and issues of considerable consequence and importance, and collaborate with project sponsor departments to resolve critical, complex and sensitive consortia management issues. This position provides the liaison support between the sponsor departments, CalSAWS, and both CMS and FNS. According to this proposal, OSI will continue monitoring the participation of key stakeholders in BenefitsCal, hosting sessions on language accessibility, and performing state oversight for CalSAWS.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff notes that an update on the CalSAWS project, in addition to other CDSS automation projects, will be included in the Subcommittee hearing scheduled for April 27, 2023.

Questions. The subcommittee has requested OSI, DHCS, and CDSS respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: Case Management Information and Payrolling System (CMIPS)

Budget Change Proposal – Governor's Budget. The Office of Systems Integration (OSI) requests two permanent positions and an increase of $10.7 million in expenditure authority in fiscal year 2023-24 and ongoing for the implementation and support of the Case Management Information and Payrolling System. This proposal reflects a requested increase in reimbursement authority (California Health and Human Service Automation Fund), General Funds for which were previously approved in the Department of Social Services' (CDSS) budget.

Program Funding Request Summary (CalHHS-OSI)		
Fund Source	**2023-24**	**2024-25***
9745 – CA Health and Human Services Automation Fund	$10,691,000	$10,691,000
Total Funding Request:	**$10,691,000**	**$10,691,000**
Total Requested Positions:	**2.0**	**2.0**

***** Positions and resources ongoing after 2024-25.

Background. CMIPS is an automated statewide system that performs case management, payroll processing, and reporting for the California Department of Social Services (CDSS) In-Home Supportive Services (IHSS) program. The IHSS program provides a Medi-Cal benefit for in-home personal care services to individuals with disabilities and older adults to allow them to stay at home and avoid institutionalization. CDSS contracts with OSI for project management and vendor contract oversight services to maintain and operate CMIPS. In addition to supporting IHSS, CMIPS also processes payroll for the Waiver Personal Care Services (WPCS) program administered by the Department of Health Care Services.

When CMIPS was originally implemented in 2014, it was designed to be used by about 5,000 staff in the county and state offices to administer the IHSS Program using only paper forms and timesheets. In 2017, the option to submit electronic timesheets for payrolling was introduced through a new Electronic Services Portal (ESP) that could be used by over one million IHSS recipients and providers. In 2021, the IHSS program started an initiative to implement electronic forms through the ESP for case management and additional payroll functions.

Electronic Visit Verification (EVV). In 2016, the Federal Government passed the 21st Century Cures Act to require EVV for Personal Care Providers and Home Health Care Providers. Part of the EVV requirement is that states will capture the provider's location when the service is provided. The 21st Century Cures Act includes penalties in the form of reduction of the federal matching assistance percentage (FMAP) if the state fails to comply with the EVV requirement. EVV was fully implemented for IHSS as of December 2020, however, CDSS received additional direction from the Center for Medicare and Medicaid Services (CMS) requiring electronic capture of the provider's location at the start and end of each workday. To fully comply with the CMS direction that CDSS electronically capture the location at the start time and end time of each service day for all non-live-in providers, the current system is being modified to electronically capture the provider's location when they log in and check in or check out. Because IHSS is not in compliance with EVV, a 0.50 percent FMAP reduction was applied in calendar year 2021, a 0.75 reduction was applied in calendar year 2022, and a one percent reduction is applied in calendar year 2023. The new implementation date for IHSS location services is July 1, 2023, at which point IHSS will be in full compliance and FMAP penalties will stop upon CMS approval.

Staffing and Resource Request. OSI requests two full-time, permanent Information Technology Specialist (ITS) II positions and an increase of $10.7 million in expenditure authority in fiscal year 2023-24 and ongoing for increased functionality and support for CMIPS. There are six components of this proposal:

CMIPS Office Information Technology Positions. In order to support various federally and state mandated system changes to CMIPS, the CMIPS Office established and filled two temporary positions using the OSI position blanket authority. This proposal requests permanent position authority for the two temporary help positions for operations and oversight activities of the system changes. The ITS II work includes approving contractor deliverables, invoices, and system service request reviews. It additionally includes the following tasks, which are ongoing and will continue through the activities included in this proposal:

- Agile team product owners.
- Technical oversight and coordination of county interfaces.
- Responsibility for system security.
- Technical guidance and oversight of the CMIPS network architecture.
- Participation in network architecture and technical review boards with stakeholders such as Department of Technology.
- Development and implementation of cloud architecture.
- Oversight of system integrator technical design development.

EVV. The expenditure authority requested will support additional service desk agents to implement the location services functionality and to establish dedicated Agile teams for location services. The implementation of EVV location services is critical to avoiding further federal penalties. CDSS continues to conduct numerous stakeholder outreach sessions with IHSS recipients and providers for the implementation of EVV location services to train and prepare providers for the new check in and check out requirements.

Electronic Forms. Currently, IHSS county staff use paper forms when managing IHSS cases and payroll, and IHSS providers and recipients use paper forms to apply for or request changes to existing services or case information. The IHSS program will be implementing an Electronic Forms solution in CMIPS for use by the counties, IHSS applicants, recipients, and providers. According to OSI, the transition to Electronic Forms will result in cost savings on office supplies and increase overall process efficacy through automated workflows and easy access to digital paper trails. The expenditure authority being requested will establish dedicated Agile teams and procure Adobe Experience Manager Forms licenses.

Language Support. The IHSS program forms and notices in CMIPS are currently produced in the four threshold languages required by California Code of Regulations, Title 9, Section 1810.410. The Language Support initiative in this proposal will support fourteen additional languages to match the total number of threshold languages supported by Medi-Cal. These program changes will standardize forms in the fourteen additional languages in CMIPS, make changes to Interactive Voice Recognition phone systems, and establish new IHSS and CMIPS service desk protocols and training. The expenditure authority being requested will establish service desk language line services, inter-active voice recognition set-up and changes, and language line testing services.

Security Compliance. According to OSI, implementation of the ESP, EVV, Electronic Forms and Language Support significantly increases the scope and complexity of CMIPS and requires additional tools and services to meet the security requirements that address new security risks as more self-service options are provided to IHSS recipients and providers online. The expenditure authority being requested will be used to obtain United States Industry Solutions (USIS) Cybersecurity professional consulting and advisory managed services for Amazon Web Services (AWS), establishing Dynamic Application Security Testing, establishing Static Application Security Testing, and procuring a secure artifact repository.

Program Support Efficiencies. To increase payroll processing capacity, the CMIPS operations team added more processing days when a peak timesheet submission day falls on a weekend or holiday. There are typically two peak periods per month. Previously, timesheets were only processed during the work week so if a peak day fell on the weekend or holiday, there would be a significant backlog of timesheets which could take multiple days to clear and potentially delay payments to IHSS providers. According to OSI, this proposal will streamline and automate system administration to improve operations and shorten time for development and deployment. On a parallel path, automated testing will expand coverage of CMIPS testing, improve quality and accuracy of testing, and increase Agile team velocity and test efficiency. The expenditure authority being requested will add new development and testing resources to the prime vendor contract.

The following table provides estimated costs for the six components of this proposal:

Description	Cost
OSI State Staff	$368,000
Electronic Visit Verification (EVV)	$3,615,000
Electronic Forms	$2,020,000
Language Support	$2,973,000
Security Compliance	$1,013,000
Program Efficiencies	$702,000
Total	**$10,691,000**

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

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

1. Please provide a brief overview of this proposal.

2. Please provide a description of how EVV location services for IHSS providers will be implemented leading up to the July 1, 2023 go-live date.

Issue 5: Electronic Visit Verification Phase II

Budget Change Proposal – Governor's Budget. The Office of Systems Integration (OSI), the Department of Health Care Services (DHCS), and the Department of Developmental Services (DDS) request three positions (within DHCS) and total expenditure authority of $2.5 million ($832,000 General Fund and $1.6 million federal funds) in 2023-24. If approved, these positions and resources would continue the multi-departmental effort for the second phase (Phase II) of implementation of Electronic Visit Verification for personal care services and home health care services.

Program Funding Request Summary (CalHHS-OSI)		
Fund Source	**2023-24***	**2024-25****
9745 – CHHS Automation Fund	$1,481,000	$1,770,000
Total Funding Request:	**$1,481,000**	**$1,770,000**
Total Requested Positions:	**0.0**	**0.0**

***** Transfers from other Departments (included below): DHCS: $741,000; DDS: $740,000
** Additional fiscal year resources requested for OSI: 2025-26: $1,770,000; 2026-27: $2,012,000; 2027-28: $2,012,000

Program Funding Request Summary (DHCS)		
Fund Source	**2023-24**	**2024-25****
0001 – General Fund	$340,000	$371,000
0890 – Federal Trust Fund*	$1,791,000	$1,966,000
Total Funding Request:	**$2,131,000**	**$2,337,000**
Total Requested Positions:	**3.0**	**3.0**

***** Federal Trust Fund appropriation includes transfer of federal Medicaid matching funds to DDS, reflected below as Reimbursements.
** Additional fiscal year resources requested for DHCS: 2025-26 and ongoing: $503,000.

Program Funding Request Summary (DDS)		
Fund Source	**2023-24**	**2024-25****
0001 – General Fund	$335,000	$335,000
0995 – Reimbursements*	$405,000	$405,000
Total Funding Request:	**$740,000**	**$740,000**
Total Requested Positions:	**0.0**	**0.0**

***** Reimbursements are the result of federal matching funds transferred from DHCS and are included in the totals attributed to the DHCS request.
** Resources ongoing after 2024-25.

Background. The federal 21st Century CURES Act[3] requires states to implement an electronic visit verification system for all Medicaid-funded Personal Care Services (PCS) by January 1, 2020, and for all Home Health Care Services (HHCS) by January 1, 2023. Federal law defines an electronic visit verification (EVV) system as a system under which PCS or HHCS visits are electronically verified, including the type of service performed, the individual receiving the service, the date of the service, the location of service delivery, the individual providing the service, and the time the service begins and ends. Programs serving Medi-Cal beneficiaries that are required to implement an EVV system include waiver services for individuals with developmental disabilities administered by DDS, In-Home Supportive Services (IHSS) administered by DSS, Waiver Personal Care Services and Home Health Care Services

[3] 42 United States Code Subsection (*l*), added by 21st Century CURES Act (HR 34, 114th Congress, 2015-16)

administered by DHCS, the Multipurpose Senior Services Program administered by DHCS and CDA, and AIDS Medi-Cal Waiver services administered by DHCS and DPH. These services are offered under one of two models:

- Self-Directed Model – Services provided under a self-directed model are those in which the service recipient is responsible for hiring and managing direct care workers.
- Agency Model – Services provided under an agency model use a provider agency or vendor to recruit, hire, and manage direct care workers.

The Administration has implemented EVV in two phases. Phase I included implementation for the self-directed model components of the IHSS (DSS) and Waiver Personal Care Services (DHCS) programs, which currently use the Case Management Information and Payrolling Systems (CMIPS II) and Electronic Time Sheet (ETS) System. DSS reported that, as of October 2020, 95 percent of IHSS and Waiver Personal Care Services providers and recipients were enrolled in the EVV system.

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

Electronic Visit Verification Phase II Programs

Department	Program	Self-Directed	Agency Model	PCS	HHCS
DDS	1915 (c) DD Waiver	X	X	X	X
DDS	1915 (i) State Plan Services	X	X	X	X
DDS	1915 (c) Waiver Self-Determination Program	X	X	X	X
DHCS	1915 (c) Home- and Community-Based Alternatives Waiver	X	X	X	X
DHCS	Home Health Care Services		X		X
DHCS	Waiver Personal Care Services Agency Model		X	X	X
CDA/DHCS	MSSP 1915 (c) and 1115 Waivers		X	X	
DPH/DHCS	1915 (c) AIDS Medi-Cal Waiver		X	X	X
DSS	IHSS Agency Model		X	X	

Under the 21st Century CURES Act, states that do not adopt EVV for PCS programs by January 1, 2020, are subject to an incremental decrease in the federal match available for these programs of 0.25 percent in 2020, 0.5 percent in 2021, 0.75 percent in 2022, and one percent annually thereafter. States that do not adopt EVV for HHCS by January 1, 2023, are subject to an additional decrease in federal match of 0.25 percent in 2023 and 2024, 0.5 percent in 2025, 0.75 percent in 2026, and 1 percent annually thereafter. The CURES Act allows a state to apply for a one-year exemption from the federal match reduction if the state made a good faith effort to comply and has encountered unavoidable delays. DHCS requested and the federal government approved a one-year exemption under this provision, delaying any reduction in federal matching funds until 2021. A state may only apply for a single, one-year exemption. According to DHCS, the state's failure to implement EVV by January 1, 2021, resulted in the following reductions in federal matching funds for Medi-Cal services:

Electronic Visit Verification Delay – Federal Matching Fund Penalties by Department			
Department	**2020-21**	**2021-22**	**2022-23***
DSS	($14,781,000)	($42,461,000)	($27,822,000)
DDS	($5,219,000)	($10,144,000)	$-
DHCS	($417,000)	($969,000)	($623,000)
CDA	($31,000)	($55,000)	$-
CDPH	($11,000)	($20,000)	$-
TOTAL	**($20,459,000)**	**($53,649,000)**	**($28,445,000)**

* No additional penalties are expected after 2022-23.

EVV Phase II Implementation Progress. According to OSI, the EVV Phase II project was implemented for PCS providers on January 1, 2022, and for HHCS providers on January 1, 2023. The EVV Phase II project will transition fully to maintenance and operations.

Resource Request. The Office of Systems Integration (OSI), the Department of Health Care Services (DHCS), and the Department of Developmental Services (DDS) request three positions (within DHCS) and total expenditure authority of $2.5 million ($832,000 General Fund and $1.6 million federal funds) in 2023-24. If approved, these positions and resources would continue the multi-departmental effort for the second phase (Phase II) of implementation of Electronic Visit Verification for personal care services and home health care services.

The resources included in this request are comprised of a conversion of limited-term resources to three permanent positions at DHCS, and replacement of implementation consulting services with ongoing management, maintenance, and operations consulting services. The allocation of funds and position equivalents in this request for each of these departments are as follows:

Department/Office	General Fund	Federal Funds/ Reimbursements	TOTAL FUNDS	Permanent Positions
OSI*	[$-]	[$-]	[$1,481,000]	0.0
DHCS	$497,000	$1,230,000	$1,727,000	3.0
DDS	$335,000	$405,000	$740,000	0.0
Total	**$832,000**	**$1,635,000**	**$2,467,000**	**3.0**

* OSI Allocation is non-add, as this allocation is the result of a transfer from DHCS and DDS of $741,000 and $740,000, respectively, for a total of $1,481,000 of the approved funding to OSI to fund contract costs. The remaining funds at DHCS support the requested conversion of positions. In addition, the DDS federal funds are reflected as reimbursements from DHCS, the single state Medicaid agency, which claims federal matching funds on behalf of DDS.

OSI

Maintenance and Operations (M&O) Support Contract. OSI requests expenditure authority from the CalHHS Automation Fund of $1.2 million in 2023-24, $1.4 million in 2024-25 and 2025-26, and $1.7 million annually thereafter. If approved, these resources would support maintenance and operations support consultants to ensure the EVV project continues to be in compliance with state and federal requirements. This contract will replace multiple implementation consultant contracts with a single M&O support contract.

Redirected Position Funding. OSI requests expenditure authority from the CalHHS Automation Fund of $183,000 annually. If approved, these resources would support redirection of state staff as part of the current federal Implementation Advanced Planning Document (IAPD). OSI and DHCS expect to continue to receive federal funding for these positions, which OSI receives as a reimbursement through DHCS, as the single state Medicaid agency.

DHCS

DHCS requests three positions and expenditure authority of $503,000 ($125,000 General Fund and $378,000 federal funds) annually. If approved, these positions and resources would be allocated to the EVV project as follows:

- *Program Manager*. **One Staff Services Manager II** position, converted from limited-term resources, would continue to serve as Program Manager for the EVV Unit within the Health Care Delivery Systems Division, acting as the primary point of contact between executive management and stakeholders, and managing and administering the EVV Training Program.
- *Technical Manager*. **One Information Technology Specialist II** position, converted from limited-term resources, would continue to serve as Technical Manager and would be responsible for ensuring the EVV solution meets state and federal technical requirements, both during the implementation phase, and during maintenance and operations throughout the life of the program.
- *Program Specialist.* **One Associate Governmental Program Analyst**, converted from limited-term resources, would continue to serve as program specialist, coordinating stakeholder meetings, developing and maintaining policies and procedures, helping to prepare and develop department bulletins and other notices, responding to inquiries from state departments and stakeholders, and supporting and monitoring contracts and other documents.

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

Questions. The subcommittee has requested OSI, DHCS, and DDS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: California Emergency Medical Services Data Resource System (CEDRS)

Budget Change Proposal – Governor's Budget. The CalHHS Office of Systems Integration (OSI) requests six positions and expenditure authority from the California Health and Human Services Automation Fund of $1.1 million annually. If approved, these positions and resources would allow OSI to provide project management support to the Emergency Medical Services Authority (EMSA) for the California Emergency Medical Services (EMS) Data Resource System Project.

Program Funding Request Summary (CalHHS-OSI)		
Fund Source	**2023-24**	**2024-25***
9745 – CHHS Automation Fund	$1,129,000	$1,129,000
Total Funding Request:	**$1,129,000**	**$1,129,000**
Total Requested Positions:	**6.0**	**6.0**

***** Positions and resources ongoing after 2024-25.

Background. Data related to the provision of emergency medical services (EMS) in California is currently recorded in Prehospital Care Reporting (PCR) software by prehospital care personnel, such as paramedics and emergency medical technicians (EMTs). EMS providers transfer this data to one of the 33 local EMS agencies (LEMSAs). EMSA provides funding to the Inland Counties EMS Agency to collect pre-hospital and trauma data in the California EMS Information System (CEMSIS), which collects voluntary data from 32 of 33 LEMSAs statewide. CEMSIS provides participating LEMSAs access to aggregate statewide data submitted to the CEMSIS data system and is a tool for local EMS system quality improvement, improved EMS system management, and a limited benchmarking against and compliance with existing EMS national standards. EMSA reports this data is not available in real-time for state policymakers and managers, leaving the state without complete or timely information on the EMS system.

The 2021 Budget Act included General Fund expenditure authority of $7.6 million for a grant program to onboard additional LEMSAs to the existing systems and connect all health information exchanges and health information organizations to EMS data. In addition, the 2021 Budget Act included General Fund expenditure authority of $2.4 million for a one-year planning period to begin the process of merging CEMSIS with EMSA's Health Information Technology for EMS system to create a statewide data hub, known as the California EMS Data Resource System (CEDRS).

The 2022 Budget Act included reappropriation of General Fund expenditure authority of $10 million approved in the 2021 Budget Act, available for encumbrance and expenditure until June 30, 2024, to continue and complete the project planning process for CEDRS and increase data interoperability. According to EMSA, project delays, staffing recruitment issues, emergency response efforts, effects of the COVID-19 pandemic, and the need to incorporate the Physician Orders for Life Sustaining Treatment (POLST) registry into the system led to delays in expenditure of these resources, requiring reappropriation of these resources until June 30, 2024.

Resource Request. The CalHHS Office of Systems Integration (OSI) requests six positions and expenditure authority from the California Health and Human Services Automation Fund of $1.1 million annually. If approved, these positions and resources would allow OSI to provide project management support to the Emergency Medical Services Authority (EMSA) for the California Emergency Medical Services (EMS) Data Resource System Project. Specifically, OSI requests the following positions:

Project Director

- **One IT Manager II** position would serve as Project Director, responsible for planning, directing, and overseeing the project and ensuring that expected deliverables and functionality are achieved. The Project Director would manage all staff and resources assigned to the project, serve as primary liaison between the project and project sponsor and Executive Committee, coordinate project-related issues with other efforts, and serve as principal interface to contractors and executive sponsors.

Project Manager

- **One IT Manager I** position would serve as Project Manager, assisting with the planning, directing, and oversight of the project; ensuring that expected deliverables and functionality are achieved; and managing day-to-day activities related to stakeholder management, risk management, scope and change management, and status reporting.

Fiscal and Contract Manager

- **One IT Manager I** position would serve as Fiscal and Contract Manager, managing the day-to-day operations of all budget and fiscal management, procurement, and contract management activities. This position would also develop and provide day-to-day oversight and supervision of all fiscal, budget, and accounting functions, and the development and execution of IT contract management and procurement processes.

Fiscal and Contract Analyst

- **One IT Specialist I** position would serve as Fiscal and Contract Analysts, supporting financial and procurement workload in accordance with state and federal law, regulations, and guidelines. This position would also assist in developing project budget and tracking reports, and coordinate with OSI and EMSA budget staff on fiscal control documents.

Project Support Analysts

- **Two IT Specialist I** positions would serve as Project Support Analysts, supporting the Project Manager with risk management, issue and action item management, requirements elicitation and management, schedule management, change management, cost management, and communications management. These positions would also develop content for control agency documents; ensure project activities are conducted in accordance with project planning, OSI and industry best practices; and facilitate the collection and documentation of business and technical requirements.

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

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

1. Please provide a brief overview of this proposal.

Issue 7: Gender Affirming Care (SB 923)

Budget Change Proposal – Governor's Budget. CalHHS, DMHC, and DHCS requests a total of 16 positions and expenditure authority of $4.3 million ($1.7 million General Fund, $1.3 million federal funds, and $1.2 million Managed Care Fund) in 2023-24, 18.5 positions and expenditure authority of $5.3 million ($1.8 million General Fund, $1.8 million federal funds, and $1.7 million Managed Care Fund) in 2024-25, 20.5 positions and expenditure authority of $4.4 million ($1 million General Fund, $1 million federal funds, and $2.3 million Managed Care Fund) in 2025-26, 20.5 positions and expenditure authority of $3.8 million ($788,000 General Fund, $787,000 federal funds, and $2.3 million Managed Care Fund) in 2026-27, and 20 positions and expenditure authority of 3.8 million ($788,000 General Fund, $787,000 federal funds, and $2.2 million Managed Care Fund) annually thereafter. If approved, these positions and resources would allow CalHHS, DMHC and DHCS to implement reforms to improve cultural competence for health plan staff and access to care for transgender, gender diverse, or intersex (TGI) health care services, pursuant to the requirements of SB 923 (Wiener), Chapter 822, Statutes of 2022.

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

Program Funding Request Summary (DMHC)		
Fund Source	**2023-24**	**2024-25***
0933 – Managed Care Fund	$1,196,000	$1,732,000
Total Funding Request:	**$1,196,000**	**$1,732,000**
Total Requested Positions:	**5.0**	**7.5**

***** Additional fiscal year resources requested: 2025-26: 7.5 positions and $1,732,000; 2026-27: 9.5 positions and $2,284,000; 2027-28: 9.5 positions and $2,251,000; 2028-29 and ongoing: 9 positions and $2,233,000.

Program Funding Request Summary (DHCS)		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$1,348,000	$1,785,000
0890 – Federal Trust Fund	$1,348,000	$1,785,000
Total Funding Request:	**$2,696,000**	**$3,570,000**
Total Requested Positions:	**11.0**	**11.0**

***** Additional fiscal year resources requested: 2025-26: $1,035,000; 2026-27 and ongoing: $1,575,000. Positions ongoing after 2024-25.

Background. SB 923 (Wiener), Chapter 822, Statutes of 2022, was intended to help create a more inclusive and culturally competent healthcare system for transgender, gender diverse, or intersex (TGI) people in California. TGI people regularly face discrimination and lack access to culturally competent care, including misgendering, harassment, and refusal of treatment. SB 923 seeks to address these issues as follows:

- Continuing Medical Education – Adds gender-affirming care services specific requirements to cultural and linguistic competency components of continuing medical education for physicians and surgeons.

- Provider Directories – By March 1, 2025, requires health care service plans, Medi-Cal managed care plans, and health insurers to include and regularly update information in provider directories and available through call centers that identifies in-network providers that affirm they offer and have provided gender-affirming services.
- Cultural Competency Training – By March 1, 2025, requires health care service plans, Medi-Cal managed care plans, and health insurers to require all support staff in direct contact with enrollees in the delivery of care or services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for TGI people.
- Complaint Tracking and Referrals – Requires DMHC, DHCS, or the California Department of Insurance (CDI) to review and publicly report on discrimination complaints, and refer complaints to the Civil Rights Department or Department of Fair Employment and Housing.
- TGI Working Group – By March 1, 2023, requires CalHHS to convene a working group to develop a quality standard for patient experience to measure cultural competency related to the TGI community and recommend a training curriculum to provide trans-inclusive care. The workgroup is required to release the quality standard and curriculum recommendations by March 1, 2024.

Resource Request. CalHHS, DMHC, and DHCS requests a total of 16 positions and expenditure authority of $4.3 million ($1.7 million General Fund, $1.3 million federal funds, and $1.2 million Managed Care Fund) in 2023-24, 18.5 positions and expenditure authority of $5.3 million ($1.8 million General Fund, $1.8 million federal funds, and $1.7 million Managed Care Fund) in 2024-25, 20.5 positions and expenditure authority of $4.4 million ($1 million General Fund, $1 million federal funds, and $2.3 million Managed Care Fund) in 2025-26, 20.5 positions and expenditure authority of $3.8 million ($788,000 General Fund, $787,000 federal funds, and $2.3 million Managed Care Fund) in 2026-27, and 20 positions and expenditure authority of 3.8 million ($788,000 General Fund, $787,000 federal funds, and $2.2 million Managed Care Fund) annually thereafter. If approved, these positions and resources would allow CalHHS, DMHC and DHCS to implement reforms to improve cultural competence for health plan staff and access to care for transgender, gender diverse, or intersex (TGI) health care services, pursuant to the requirements of SB 923. Specifically, the positions and resources requested by agency and department are as follows:

CalHHS

CalHHS requests General Fund expenditure authority of $400,000 in 2023-24. If approved, these resources would support consultant services to plan, organize, and facilitate a TGI working group.

DMHC

DMHC requests five positions and expenditure authority from the Managed Care Fund of $1.2 million in 2023-24, 7.5 positions and expenditure authority from the Managed Care Fund of $1.7 million in 2024-25, 9.5 positions and expenditure authority from the Managed Care Fund of $2.3 million in 2025-26, 9.5 positions and expenditure authority from the Managed Care Fund of $2.3 million in 2026-27, and nine positions and expenditure authority from the Managed Care Fund of $2.2 million annually thereafter. If approved, these positions and resources would support the following staff and consultant contracts:

- **Office of Legal Services** – 0.5 position (limited-term until 2026-27)

- **0.5 Attorney** would assist with promulgation of regulations, coordinate with other DMHC offices as regulations are developed, issue guidance to health plans, and participate in implementation workgroups and other forums.

- **Office of Plan Licensing** – 3.5 positions
  - **One Attorney IV** position would conduct complex legal research, draft all plan letters (APLs) and regulations, conduct stakeholder and interdepartmental meetings, and conduct legal review of complex health plan documents and disclosures.
  - **Two Attorney III** positions would annually review evidence of coverages, provider contracts, plan-to-plan contracts, and other health plan documents to ensure compliance with SB 923 requirements.
  - **0.5 Staff Services Analyst** would track and log plan letters, assist Attorneys with interdepartmental meetings and information gathering, revise compliance filing instructions and forms, assist with preparation of compliance report filings, and review of updated policies and procedures.

- **Help Center** – 0.5 position (beginning in 2024-25)
  - **0.5 Attorney** (beginning in 2024-25) would analyze consumer complaints, health plan response, and plan and medical group documents for compliance with SB 923 requirements, as well as process referrals of complaints to the Civil Rights Department.

- **Office of Plan Monitoring** – Four positions (two beginning in 2024-25 and two beginning in 2025-26) and consultant resources of $27,000 in 2024-25, $166,000 in 2025-26, $149,000 in 2026-27, and $239,000 annually thereafter.
  - **Two Attorney III** positions (one beginning in 2025-26) would draft regulations, assist with development of plan survey activities, review health plan files, revise survey tools, provide legal guidance regarding routine survey activity, and assist in follow-up survey and enforcement referrals.
  - **Two Health Program Specialist (HPS) II** positions (one beginning in 2025-26) would assist in the development of the survey methodology and assessment tools, prepare reports and supporting documents, review health plan amendment filings, oversee corrective action plan submittals, and manage and coordinate documents and data.
  - **Consultant resources** would support clinical consultant and managed care reviewers to review health plan policies and procedures and Quality Assurance documents for compliance with SB 923 requirements.

- **Office of Enforcement** – One position
  - **One Attorney III** position would provide legal support to evaluate enforcement referrals, including drafting and sending investigative discovery, recommending course of action, negotiating settlement and corrective action, and preparing appropriate course of resolution.

DHCS

DHCS requests 11 positions and expenditure authority of $2.7 million ($1.3 million General Fund and $1.3 million federal funds) in 2023-24, $3.6 million ($1.8 million General Fund and $1.8 million federal funds) in 2024-25, $2.1 million ($1 million General Fund and $1 million federal funds) in 2025-26, and

$1.6 million ($788,000 General Fund and $787,000 federal funds) annually thereafter. If approved, these positions and resources would support the following staff and consultant contracts:

- **Health Information Management Division** – Five positions (three limited-term, two permanent) and $500,000 contract
  - **Five Information Technology Specialist (ITS) I** positions (three limited-term, two permanent) would assist expansion of the Post Adjudicated Claims and Encounter System (PACES) to collect additional data elements from Medi-Cal managed care plans, Drug Medi-Cal Organized Delivery System (DMC-ODS) plans, and Programs for All-Inclusive Care for the Elderly (PACE) plans; monitor and analyze data quality; provide training and technical assistance to plans to ensure accurate data collection and reporting; verify plans are implementing data collection in accordance with SB 923 requirements; and assist data submitters in building technical files that feed into automated data collection systems.
  - **Consultant resources** of $500,000 General Fund in 2023-24 and 2024-25 to support contracting resources to develop implementation guides and specifications for data reporting and work with the plans to test and move into production for the submission of data to DHCS. The contractor would also provide training and support for state staff to continue to monitor data reporting after implementation.

- **Integrated Systems of Care Division** – Two positions
  - **One Associate Governmental Program Analyst (AGPA)** would serve as the analytical lead in the PACE Policy Unit, drafting updates to contracts, policy letter, and other guidance; providing technical assistance to PACE organizations; composing analytical reports and presenting recommendations to management; monitoring PACE organization execution of trans-inclusive cultural competency training and refresher courses; tracking and monitoring PACE organization training, posting of training information, and training of providers against whom complaints are filed; and manage and provide oversight of non-compliance, recommending the imposition of sanctions and corrective action plans when deficiencies are identified.
  - **One AGPA** would update PACE audit tools to reflect SB 923 requirements; conduct audits of PACE organizations to verify compliance; issue corrective action plans; monitor and respond to complaints received by DHCS regarding trans-inclusive health care; develop and implement public reporting of complaints regarding trans-inclusive health care; and contribute to semi-annual status reports to the Legislature.

- **Managed Care Quality and Monitoring Division** – Two positions
  - **One AGPA** would draft updates to managed care plan contracts, all plan letters, and other policy guidance; review plan responses for instances of non-compliance; provide technical assistance to plans regarding instances of non-compliance; compose analytical reports and present recommendations to management; monitor plan execution of trans-inclusive cultural competency training and refresher courses; track and monitor plan training, annual posting of training information, and training of providers against whom complaints are filed; and provide oversight of non-compliance and recommend imposition of sanctions and corrective action plans.
  - **One Health Program Specialist (HPS) I** position would assist in development of implementation timelines, roles, and responsibilities, processes and procedures, and other planning activities; work with department staff to provide support in policy development and implementation; review plan policies and procedures for compliance with trans-inclusive cultural competency training; develop

a monitoring and compliance program to oversee plans' execution of training requirements; develop policies and procedures to track and monitor plans' training and public posting of training information; work with plans on training implementation; ensure plan contracts and all plan letters reflect updated policy; monitor efforts to improve plan and provider compliance; and provide technical assistance to plans.

- **Medi-Cal Behavioral Health Division** – Three positions
  - **One HPS I** would assist with updates to county contracts, Behavioral Health Information Notices (BHINs), and other guidance; assist in development of training procedures, templates, and criteria for trans-inclusive training for counties; assist in development of sanction documents and corrective action plans; provide technical assistance to counties; review and contribute to analytical reports and recommendations to management; develop monitoring and tracking tools for counties' implementation of training and refresher courses; and review county policies and procedures to verify county processes are compliant with training requirements.
  - **Two AGPAs** would draft updates to county contracts, BHINs, and other guidance; develop training procedures, templates, and criteria for trans-inclusive training for counties; develop sanction documents and corrective action plans; provide technical assistance to counties; review and analyze county training plans to ensure compliance with SB 923; prepare analytical reports, sanction letters, and corrective action plans; conduct ongoing monitoring of counties' implementation of training and refresher courses; and review county policies and procedures to verify compliance with training requirements.

- **Quality and Population Health Management** – Two positions and $1 million consulting in 2024-25
  - **One Health Education Consultant (HEC) II** position would participate in the CalHHS workgroup; work with plans and the contractor to develop, implement, and update the TGI cultural competency training; lead stakeholder engagement process for vetting evidence-based cultural competency training; assist with drafting policies; assist with policy update communications; maintain and update TGI cultural competency trainings; and review and address TGI related grievance data.
  - **One AGPA** would assist in developing and implementing TGI cultural competency training; assist with stakeholder engagement; develop and promulgate regulations; usher regulations through regulatory process; and assist with drafting policies and communications.
  - **Consultant resources** of $1 million General Fund in 2024-25 would support development and recording of a TGI-facilitated panel discussion to cover the evidence-based cultural competency training requirements of SB 923.

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 CalHHS, DMHC, and DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 8: Equity-Centered Programs – Transfer to Department of Public Health

Budget Change Proposal – Governor's Budget. CalHHS requests transfer of one position and General Fund expenditure authority of $182,000 to the California Department of Public Health (CDPH) to perform a retrospective analysis of the intersection of the COVID-19 pandemic and health disparities and equity.

Program Funding Request Summary (CalHHS)		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	($182,000)	($182,000)
Total Funding Request:	**($182,000)**	**($182,000)**
Total Requested Positions:	**(1.0)**	**(1.0)**

***** Positions and resource changes ongoing after 2024-25.

Program Funding Request Summary (CDPH)		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$182,000	$182,000
Total Funding Request:	**$182,000**	**$182,000**
Total Requested Positions:	**1.0**	**1.0**

***** Positions and resource changes ongoing after 2024-25.

Background. The 2021 Budget Act included one position and General Fund expenditure authority of $1.7 million in 2021-22 and $154,000 annually thereafter for CalHHS to conduct a retrospective analysis of the intersection of the COVID-19 pandemic and health disparities and inequities. The provisional language accompanying the augmentation required CalHHS to provide a preliminary analysis to the Legislature no later than May 1, 2022, and a final report by January 10, 2023. No reports specifically addressing these requirements have been provided to the Legislature to date.

Resource Request. CalHHS requests transfer of one position and General Fund expenditure authority of $182,000 to the California Department of Public Health (CDPH) to perform a retrospective analysis of the intersection of the COVID-19 pandemic and health disparities and equity.

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 CalHHS and CDPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. What is the expected timeline of completion of the COVID-19 retrospective analysis? Why was it not completed by the deadline?

Issue 9: OSI Reorganization Name Change – Trailer Bill Language

Trailer Bill Language – Governor's Budget. CalHHS proposes trailer bill language to rename the Office of Systems Integration the Office of Technology and Solutions Integration.

Background. The Office of Systems Integration (OSI) procures, manages, and delivers technology systems that support the delivery of health and human services to Californians. OSI manages a portfolio of large, complex information technology (IT) projects, providing project management, oversight, procurement, and support services for these projects and coordinating communication, collaboration, and decision-making among project stakeholders and program sponsors. After the procurement phase, OSI oversees the design, development, governance, and implementation of IT systems that support the administration of health and human services programs in California.

CalHHS proposes trailer bill language to rename the Office of Systems Integration the Office of Technology and Solutions Integration. According to CalHHS, this proposal makes no substantive changes to the mission, authority, or other activities of the Office, but aligns the name of the Office more closely with its current activities.

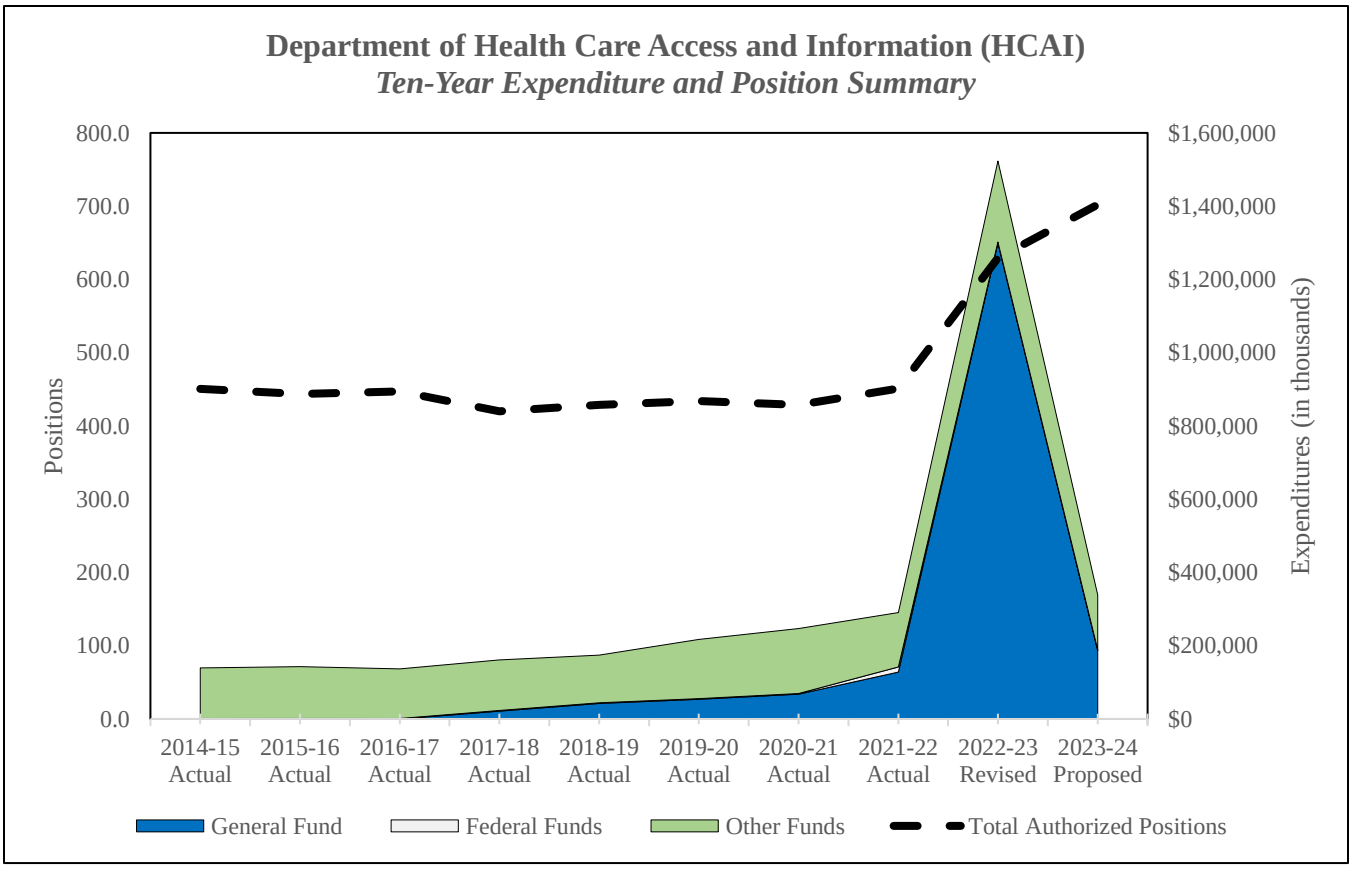
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

Issue 1: Overview



Department of Health Care Access and Information - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2021-22 Actual**	***2022-23 Budget Act***	***2022-23 Revised***	***2023-24 Proposed***
General Fund	$127,767	$716,837	$1,299,266	$185,901
Federal Funds	$13,960	$2,977	$2,977	$3,000
Other Funds	$148,432	$152,866	$221,026	$149,470
Total Department Funding:	**$290,159**	**$872,680**	**$1,523,269**	**$338,371**
Total Authorized Positions:	**451.0**	**624.2**	**629.1**	**702.1**
Other Funds Detail:				
Hospital Building Fund (0121)	*$58,162*	*$70,012*	*$74,661*	*$76,866*
CA Health Data and Planning Fund (0143)	*$37,803*	*$42,022*	*$43,408*	*$42,666*
Registered Nurse Education Fund (0181)	*$2,115*	*$2,158*	*$2,170*	*$2,170*
Health Facility Const. Loan Ins. Fund (0518)	*$13,629*	*$5,350*	*$5,446*	*$5,448*

Health Professions Education Fund (0829)	*$3,764*	*$3,102*	*$3,110*	*$3,106*
Medically Underserved Account/Phys (8034)	*$1,712*	*$4,416*	*$4,416*	*$4,416*
Reimbursements (0995)	*$4,132*	*$8,580*	*$8,580*	*$7,940*
Mental Health Practitioner Ed. Fund (3064)	*$764*	*$762*	*$762*	*$762*
Vocational Nurse Education Fund (3068)	*$198*	*$235*	*$235*	*$235*
Mental Health Services Fund (3085)	*$10,735*	*$12,566*	*$14,993*	*$2,605*
Small and Rural Hosp Relief Fund (3391)	*$0*	*$2,442*	*$2,442*	*$2,171*
CA E-Cig Excise Tax fund (3394)	*$0*	*$1,221*	*$1,221*	*$1,085*
HCBS American Rescue Plan Fund (8507)	*$15,418*	*$0*	*$59,582*	*$0*

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

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

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

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

The Song-Brown program was funded exclusively with state General Fund until the 2004-05 fiscal year. Between 2004-05 and 2008-09, the program received a combination of General Fund and funding from the California Health Data and Planning Fund (Data Fund), which receives fee revenue from licensed health facilities in California. Beginning in 2008-09, the program received no General Fund resources until 2017-18. During that period, the program relied on resources from the Data Fund and a $21 million

grant from the California Endowment for family medicine and family nurse practitioner/physician assistant training.

The 2017 Budget Act authorized $33.3 million annually over three years for augmentation of health care workforce initiatives at HCAI. In the 2020 Budget Act, this allocation was extended permanently. The $33.3 million annual allocation provides up to $18.7 million for existing primary care residency slots, up to $3.3 million for new primary care residency slots at existing residency programs, up to $5.7 million for primary care residency slots at teaching health centers, up to $3.3 million for newly accredited primary care residency programs, up to $333,000 for the State Loan Repayment Program, and up to $2 million for HCAI state operations costs. Unspent funds in each of these categories from prior years are available for expenditure for the subsequent five fiscal years. For example unspent funds from 2017-18 are available until June 30, 2023, and unspent funds from 2018-19 are available until June 30, 2024.

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

WET Program Five-Year Plan 2020-2025. In February 2019, HCAI released the third five year WET plan covering the period from 2020-2025. After engaging with stakeholders, the report is meant to guide efforts to improve and expand the public mental health system (PMHS) workforce throughout California. The plan sets out the following goals and objectives:

Goals

1. Increase the number of diverse, competent licensed and non-licensed professionals in the PMHS to address the needs of persons with serious mental illness.
2. Expand the capacity of California's current public mental health workforce to meet California's diverse and dynamic needs.
3. Facilitate a robust statewide, regional, and local infrastructure to develop the public mental health workforce.
4. Offer greater access to care at a lower level of intensity that enables consumers to maintain and maximize their overall well-being.
5. Support delivery of PMHS services for consumers within an integrated health system that encompasses physical health and substance use services.

Objectives

1. Expand awareness and outreach efforts to effectively recruit racially, ethnically, and culturally diverse individuals into the PMHS workforce.
2. Identify and enhance curricula to train students at all levels in competencies that align with the full spectrum of California's diverse and dynamic PMHS needs.
3. Develop career pathways for individuals entering and advancing across new and existing PMHS professions.
4. Expand the capacity of postsecondary education to meet the identified PMHS workforce needs.
5. Expand financial incentive programs for the PMHS workforce to equitably meet identified PMHS needs in underrepresented, underserved, unserved, and inappropriately served communities.
6. Expand education and training programs for the current PMHS workforce in competencies that align with the full spectrum of PMHS needs.
7. Increase the retention of PMHS workforce identified as high priority.
8. Evaluate methods to expand and enhance the quality of existing PMHS delivery systems to meet California's PMHS needs.
9. Develop and sustain new and existing collaborations and partnerships to strengthen recruitment, training, education, and retention of the PMHS workforce.
10. Explore stakeholder-identified policies that aim to further California's efforts to meet its PMHS needs.
11. Provide flexibility to allow local jurisdictions to meet their unique needs.
12. Standardize PMHS workforce education and training programs across the state.
13. Promote care that reduces demand for high-intensity PMHS services and workforce.

The 2019 Budget Act included a one-time allocation of $60 million ($35 million General Fund and $25 million Mental Health Services Fund) to support implementation of the WET Program Five-Year Plan 2020-2025.

State Loan Repayment Program. The State Loan Repayment Program (SLRP) is a federally funded, state-run program that provides student loan repayment funding to healthcare professionals who commit to practicing in Health Professional Shortage Areas (HPSAs) in California. Professionals eligible for awards under SLRP include physicians (M.D. and D.O.), psychiatric nurse specialists, dentists, mental health counselors, registered dental hygienists, health service psychologists, nurse practitioners (primary care), licensed clinical social workers, physician assistants (primary care), licensed professional counselors, certified nurse midwives, marriage and family therapists, and pharmacists. Recipients must also, among other requirements, commit to a two-year (four-year, if half-time) initial service obligation at a SLRP Certified Eligible Site (CES) in one of the areas designated as an HPSA.

Facilities Development Division – Hospital Seismic Safety. In 1971, the Sylmar earthquake struck the northeast San Fernando Valley, killing 64 people and causing significant damage to structures. In particular, the San Fernando Veterans Administration Hospital in Sylmar, constructed in 1926 with unreinforced concrete, collapsed, resulting in the deaths of 44 individuals trapped inside the building. In addition, a more recently constructed psychiatric ward at Sylmar's Olive View Community Hospital collapsed during the quake, resulting in three deaths and the evacuation of more than 1,000 patients. In response to these tragic events, the Legislature approved the Alfred E. Alquist Hospital Facilities Seismic Safety Act (Alquist Act), which required hospitals to meet stringent construction standards to ensure they

are reasonably capable of providing services to the public after a disaster. In 1983, the act was amended to transfer all hospital construction plan review responsibility from local governments to HCAI, creating the state's largest building department, the Facilities Development Division.

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

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

Cal-Mortgage Loan Insurance Division. HCAI's Cal-Mortgage Loan Insurance Division administers the California Health Facility Construction Loan Insurance Program. Cal-Mortgage provides credit enhancement for eligible health care facilities when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of California, which permits borrowers to obtain lower interest rates. Eligible health facilities must be owned and operated by private, nonprofit public benefit corporations or political subdivisions such as cities, counties, healthcare districts or joint powers authorities. Health facilities eligible for Cal-Mortgage include hospitals, skilled nursing facilities, intermediate care facilities, public health centers, clinics, outpatient facilities, multi-level facilities, laboratories, community mental health centers, facilities for the treatment of chemical dependency, child day care facilities (in conjunction with a health facility), adult day health centers, group homes, facilities for individuals with developmental disabilities, and office or central service facilities (in conjunction with a health facility). As of September 30, 2022, Cal-Mortgage insures 64 loans with a total value of approximately $1.5 billion.

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

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

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

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

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

Office of Health Care Affordability. The 2022 Budget Act established within HCAI the Office of Health Care Affordability (OHCA) to analyze and help constrain the growth of the cost of health care in California. The Office is governed by an eight-member Health Care Affordability Board, with four members appointed by the Governor and confirmed by the Senate, one member each appointed by the Senate Committee on Rules and the Speaker of the Assembly, the Secretary of Health and Human Services, and the Chief Health Director of the California Public Employment Retirement System (CalPERS). OHCA's primary responsibilities are to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, create a state strategy for controlling the cost of health care, ensure affordability for consumers and purchasers, and enforce cost targets. The first cost target will be developed for the 2025 calendar year, for reporting purposes only. The 2026 cost target will be the first in which enforcement action will be taken against providers that fail to meet the target. Enforcement actions will be progressive, beginning with technical assistance or corrective action plans, and could result in financial penalties.

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: Skilled Nursing Facilities: Backup Power Source (AB 2511)

Budget Change Proposal – Governor's Budget. HCAI requests six positions and expenditure authority from the Hospital Building Fund of $1.5 million annually. If approved, these positions and resources would oversee implementation of requirements that skilled nursing facilities maintain alternative power sources in the event of a power outage, pursuant to AB 2511 (Irwin), Chapter 788, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0121 – Hospital Building Fund	$1,452,000	$1,452,000
Total Funding Request:	**$1,452,000**	**$1,452,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2024-25.

Background. AB 2511 (Irwin), Chapter 788, Statutes of 2022, requires skilled nursing facilities to have an alternative power source to protect resident health and safety for at least 96 hours during a power outage. Previously, skilled nursing facilities were only required to maintain emergency power for six hours or 96 hours in certain seismic zones. AB 2511 requires facility compliance by January 1, 2024. According to HCAI, compliance would likely require a facility to upgrade its emergency generator or install an alternative source of power that will have sufficient storage and generation capacity to maintain operation for no fewer than 96 hours. HCAI indicates it will need to develop a work plan in an expedited timeframe to ensure guidance, including development of a Policy Intent Notice, is provided to skilled nursing facilities and other stakeholders prior to January 1, 2024.

Staffing and Resource Request. HCAI requests six positions and expenditure authority from the Hospital Building Fund of $1.5 million annually. If approved, these positions and resources would oversee implementation of requirements that skilled nursing facilities maintain alternative power sources in the event of a power outage, pursuant to AB 2511 (Irwin), Chapter 788, Statutes of 2022. Specifically, HCAI requests the following positions and resources in the Facilities Development Division:

- **Two Senior Architects** would develop, maintain, adopt, and implement administrative and building code regulations by applying essential architectural, engineering, and rulemaking technical expertise, managing plan review, and performing architectural review of each project.
- **One Senior Mechanical Engineer** position would manage plan review and perform mechanical review of each project.
- **One Senior Electrical Engineer** would manage plan review and perform electrical review of each project.
- **One Fire/Life Safety Officer** would manage plan review and perform review of healthcare facility construction requirements for fire and life safety systems, as well as conducting field observations of each project.
- **One Compliance Officer** would provide construction support on site to verify projects are built according to approved plans and specifications of each project.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Hospitals: Seismic Safety (SB 1882)

Budget Change Proposal – Governor's Budget. HCAI requests one position and expenditure authority from the Hospital Building Fund of $120,000 annually. If approved, this position and resources would allow HCAI to identify on its website hospital buildings that may not be repairable or functional following an earthquake, pursuant to the requirements of AB 1882 (Rivas), Chapter 584, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0121 – Hospital Building Fund	$120,000	$120,000
Total Funding Request:	**$120,000**	**$120,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2024-25.

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

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

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

AB 1182 requires HCAI to identify on its website hospital buildings that, based on seismic safety standards, do not significantly jeopardize life, but may not be repairable or functional following an earthquake. HCAI may also identify on its website buildings determined "earthquake resilient" based on seismic safety standards. Until compliance is met, hospital owners must provide annual status updates to HCAI, the Office of Emergency Services, local government entities and other interested parties regarding compliance with the Alquist Act. HCAI must also develop notices that hospitals must post publicly in buildings that are non-compliant with the 2030 Alquist Act seismic safety standards.

Staffing and Resource Request. HCAI requests one position and expenditure authority from the Hospital Building Fund of $120,000 annually. If approved, this position and resources would allow HCAI to identify on its website hospital buildings that may not be repairable or functional following an earthquake, pursuant to the requirements of AB 1882 (Rivas), Chapter 584, Statutes of 2022. Specifically, HCAI request **one Compliance Officer** to assist in the implementation and administration of these new program services within the Seismic Compliance Unit in the Facilities Development Division.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: Support for Health Workforce Education and Training Council

Budget Change Proposal – Governor's Budget. HCAI requests two positions annually, supported by previously approved state operations resources. If approved, these positions would support administration of the Health Workforce Education and Training Council.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0001 – General Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**2.0**	**2.0**

* Positions ongoing after 2024-25.

Background. The 2021 Budget Act, as part of the recast of the former Office of Statewide Health Planning and Development into HCAI, transitioned the former California Health Care Workforce Policy Commission and the Health Professions Education Foundation (HPEF) programs into the California Health Workforce Education and Training Council. The council consists of 17 members, with six appointed by the Governor, three each by the Assembly and Senate, and representatives of DHCS, HCAI, the University of California, the California State University system, and the California Community College system. The council provides guidance on statewide education and health workforce training needs and advises on increasing the supply and diversity of physician and non-physician providers, as well as the placement of providers in medically underserved areas. The council supports the programs previously covered by the commission, such as the Song-Brown Program, as well as those previously covered by HPEF. According to HCAI, the council met for the first time in March 2022 and voted to establish an initial set of priority topic areas, which include:

- Behavioral Health Workforce
- Nursing Workforce
- Graduate Medical Education
- Allied Health Workforce
- Oral Health Workforce
- Health Workforce Data
- Health Career Pathways

The 2022 Budget Act included permanent positions to support the significant increase in volume and complexity of health workforce programs supported by HCAI, including two permanent positions to support the council. Funding for these two positions was dependent on adoption of the Administration's Workforce for a Healthy California for All proposal, which was not approved in the final Budget Act.

Position Request. HCAI requests two positions annually, supported by previously approved state operations resources, to support administration of the Health Workforce Education and Training Council. Specifically, HCAI request the following two positions:

- **One Health Program Specialist I** position would provide health workforce policy support to the council, including components related to allied health, oral health, and Health Career Pathways.

- **One Associate Governmental Program Analyst** would provide coordination and logistical support for the council's public meetings and act as support liaison for all council members.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 5: Abortion Practical Support Fund (SB 1142)

Budget Change Proposal – Governor's Budget. HCAI requests General Fund expenditure authority of $100,000 annually until 2027-28. If approved, these resources would allow HCAI to contract with an external organization to conduct annual evaluations of the Abortion Practical Support Fund, pursuant to the requirements of SB 1142 (Caballero), Chapter 566, Statutes of 2022.

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

* Resources ongoing until 2027-28.

Background. The 2022 Budget Act included General Fund expenditure authority of $20 million, available until June 30, 2028, and the Legislature approved trailer bill language to support practical support grants to nonprofit organizations in California that specialize in assisting pregnant people who are low income, or who face other financial barriers, to increase access to abortion. After the Supreme Court ruling in *Dobbs v. Jackson Women's Health Organization*, California reproductive health providers that perform abortions are expecting individuals in need of abortion care in other states to travel to California for their healthcare needs. The Abortion Practical Support Fund will provide grants to nonprofit organizations that specialize in assisting pregnant people who are low income, or who face other financial barriers, with direct practical support services to access and obtain an abortion, or that provide abortion services. The grants may be used for the following:

- Practical support services, including financial or in-kind assistance to help a person access and obtain an abortion
- Abortion navigators, patient navigators, and community health workers services
- Case management support for patients seeking abortion
- Costs associated with training volunteers and staff in the provision of practical support services to abortion patients
- Costs associated with enabling grantees that meet eligibility requirements to assist pregnant people with practical support services, including staffing and administrative costs
- Costs associated with coordinating practical support services, abortion providers, and other support services.

SB 1142 (Caballero), Chapter 566, Statutes of 2022, requires HCAI to conduct an evaluation of the Abortion Practical Support Fund grant program and report its findings to the Legislature no later than January 1, 2025, and on January 1 annually thereafter. The first annual report is required to cover the period before July 1, 2024, with each subsequent report to cover the previous fiscal year.

Resource Request. HCAI requests General Fund expenditure authority of $100,000 annually until 2027-28. If approved, these resources would allow HCAI to contract with an external organization to conduct annual evaluations of the Abortion Practical Support Fund, pursuant to the requirements of SB 1142 (Caballero), Chapter 566, Statutes of 2022. Specifically, HCAI requests the following resources:

- **Consultant resources** of $100,000 annually for five years to contract with an external organization to conduct the evaluations of the Abortion Practical Support Fund grant program. The evaluation would include mixed methods to understand the impact of the program. HCAI would use qualitative and quantitative methods to collect data from providers and partner organizations to measure the overall access to services, demographics of communities and individuals served, and any remaining barriers to access.

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 HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: Budget Solution: Healthcare Workforce Delays

Trailer Bill Language and Budget Solution – Governor's Budget. HCAI requests to delay expenditure authority approved in the 2022 Budget Act for several health care workforce development programs. The programs that would be delayed are as follows:

- *Comprehensive Nursing Initiative.* $15 million from 2022-23 and $55 million from 2023-24 would be delayed until 2024-25 and 2025-26.
- *Community Health Workers.* $130 million from 2023-24 would be delayed until 2024-25 and 2025-26.
- *Social Work Initiative.* $3.5 million from 2022-23 and $48.4 million from 2023-24 would be delayed until 2024-25 and 2025-26.
- *Addiction Psychiatry and Addiction Medicine Fellowships.* $23.5 million from 2022-23 and $25 million from 2023-24 would be delayed until 2024-25 and 2025-26.
- *University and College Training Grants for Behavioral Health Professionals.* $26 million from 2022-23 and $26 million from 2023-24 would be delayed until 2024-25 and 2025-26.
- *Expand Masters in Social Work Slots at Public Schools of Social Work.* $30 million from 2023-24 would be delayed until 2024-25 and 2025-26.
- *Nursing in Song-Brown.* $15 million from 2023-24 would be delayed until 2024-25 and 2025-26.

HCAI proposes trailer bill language to revert expenditure authority approved in the 2022 Budget Act to the General Fund and express the intent of the Legislature to appropriate these amounts to HCAI in the 2024 Budget Act and 2025 Budget Act.

Health Care Workforce Investments Delays and Repayments			
Comprehensive Nursing Initiative			
2022-23	**2023-24**	**2024-25**	**2025-26**
$ (15,000,000)	**$ (55,000,000)**	**$ 35,000,000**	**$ 35,000,000**
Community Health Workers			
2022-23	**2023-24**	**2024-25**	**2025-26**
$ -	**$ (130,000,000)**	**$ 65,000,000**	**$ 65,000,000**
Social Work Initiative			
2022-23	**2023-24**	**2024-25**	**2025-26**
$ (3,500,000)	**$ (48,400,000)**	**$ 25,950,000**	**$ 25,950,000**
Addiction Psychiatry and Addiction Medicine Fellowships			
2022-23	**2023-24**	**2024-25**	**2025-26**
$ (23,500,000)	**$ (25,000,000)**	**$ 24,250,000**	**$ 24,250,000**
University and College Training Grants for Behavioral Health Professionals			
2022-23	**2023-24**	**2024-25**	**2025-26**
$ (26,000,000)	**$ (25,000,000)**	**$ 26,000,000**	**$ 26,000,000**
Expand Masters in Social Work Slots at Public Schools of Social Work			
2022-23	**2023-24**	**2024-25**	**2025-26**

$ -	**$ (30,000,000)**	**$ 15,000,000**	**$ 15,000,000**
Nursing in Song-Brown			
2022-23	**2023-24**	**2024-25**	**2025-26**
$ -	**$ (15,000,000)**	**$ 7,500,000**	**$ 7,500,000**

Background. The 2022 Budget Act included expenditure authority of $195.1 million ($185.1 million General Fund and $10 million Mental Health Services Fund) in 2022-23, and General Fund expenditure authority of $134.1 million in 2023-24, $34.1 million in 2024-25, and $3.2 million in 2025-26 for investments in workforce development for providers of services in the fields of behavioral health, primary care, and public health. These investments include the following:

Behavioral Health

- *Addiction Psychiatry and Addiction Medicine Fellowship Programs* - $25 million annually for two years to support additional slots for Addiction Psychiatry and Addiction Medicine Fellowship programs.
- *University and College Training Grants for Behavioral Health Professionals* - $26 million annually for two years to support 4,350 licensed behavioral health professionals through grants to existing university and college training programs, including partnerships with the public sector.
- *Expand Masters in Social Work (MSW) Slots at Public Schools of Social Work* - $30 million annually for two years to support grants to public schools of social work to immediately expand the number of MSW students. $27 million would support the 18 California State University programs and $3 million would support the two University of California programs.
- *Graduate Medical Education and Loan Repayment for Psychiatrists* - $19 million annually for two years to support two training programs for psychiatrists: 1) $5 million annually for two years for graduate medical education slots for psychiatrists, 2) $7 million annually for two years to support loan repayment for psychiatrists that agree to a five year service commitment at the Department of State Hospitals, and 3) $7 million annually for two years to support loan repayment for psychiatrists that agree to a five-year service commitment to provide psychiatric services in a local public behavioral health system with an emphasis on prevention and early intervention services for individuals with serious mental illness likely to become justice-involved or are, or at risk of, experiencing homelessness.

Primary Care

- *Additional Primary Care Residency Slots in Song-Brown* - $10 million annually for three years to support additional primary care residency slots in the Song-Brown Primary Care Residency Program.
- *Clinical Dental Rotations* - $10 million one-time to support new and enhanced community based clinical education rotations for dental students to improve the oral health of underserved populations.
- *Health Information Technology (IT) Workforce* - $15 million one-time to support health IT workforce recruitment and training for health clinics and other providers in underserved communities.

- *California Reproductive Health Service Corps* - $20 million one-time to support targeted recruitment and retention resources, and training programs to ensure a range of clinicians and other health workers can receive abortion training.
- *Certified Nurse Midwives Training* - $1 million one-time to allow certified nurse-midwives to participate in the Song-Brown program, consistent with the Midwifery Workforce Training Act authorized by SB 65 (Skinner), Chapter 449, Statutes of 2021.
- *Nurse Practitioner Postgraduate Training* - $4 million one-time to support Nurse Practitioner postgraduate training slots in primary care within underserved communities through the Song-Brown Healthcare Workforce Training Program.
- *Physician Assistant Postgraduate Training* - $1 million one-time to support Physician Assistant postgraduate training slots in primary care within underserved communities through the Song-Brown Healthcare Workforce Training Program.
- *Golden State Social Opportunities Program* - $10 million Mental Health Services Fund one-time to support postgraduate grants for behavioral health professionals that commit to working in a nonprofit eligible setting for two years, with priority given to individuals that are current or former foster youth and homeless youth.

Public Health

- *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.

The 2022 Budget Act also included General Fund expenditure authority of $677.4 million over three years to support the following care economy workforce development investments:

- *Community Health Workers* - $281.4 million over three years to recruit, train and certify 25,000 new community health workers by 2025, with specialized training to work with varying populations, such

as justice-involved, people who are unhoused, older adults, or people with disabilities. The Legislature also approved trailer bill language to require HCAI to develop requirements for community health worker certificate programs, and establish other requirements for community health worker certification and renewal.

- *Comprehensive Nursing Initiative* - $220 million over three years to increase the number of registered nurses, licensed vocational nurses, certified nursing assistants, certified nurse midwives, certified medical assistants, family nurse practitioners, and other health professions.
- *Social Work Initiative* - $126 million over three years to increase the number of social workers trained in the state by supporting social work training programs and providing stipends and scholarships for working people to create a new pipeline for diverse social workers who cannot otherwise afford the financial or time investment required to complete full-time training programs.
- *Nursing in Song-Brown* - $50 million over three years to support nurse training slots in the Song-Brown Healthcare Workforce Training Program.

Budget Solution – Healthcare Workforce Delays. HCAI requests to delay expenditure authority approved in the 2022 Budget Act for several health care workforce development programs. HCAI also proposes trailer bill language to revert expenditure authority approved in the 2022 Budget Act to the General Fund and express the intent of the Legislature to appropriate these amounts to HCAI in the 2024 Budget Act and 2025 Budget Act.

Separately, under the CDPH budget, the Administration is proposing to eliminate all of the public health workforce development programs authorized in the 2022 Budget Act, except 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.

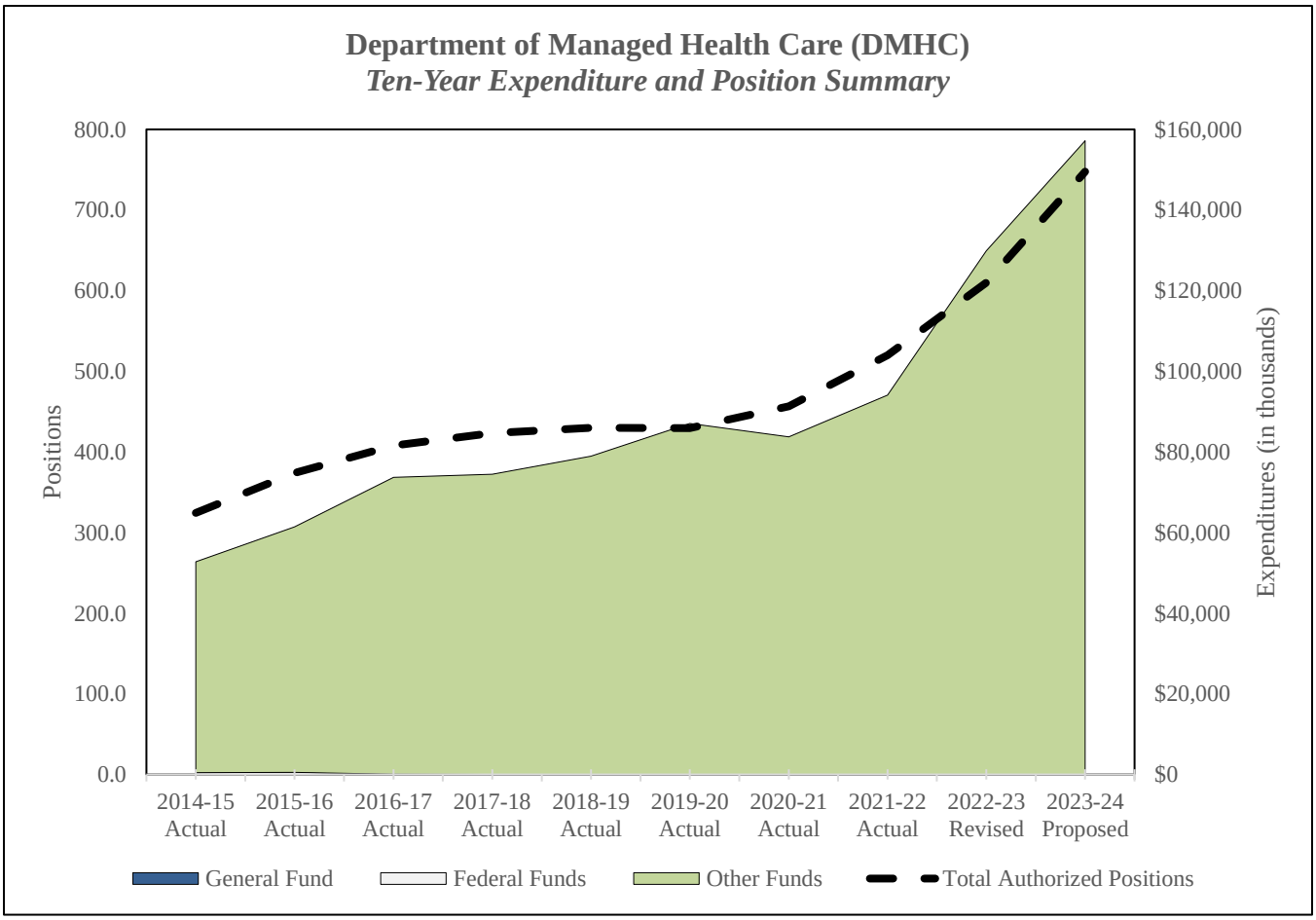
Questions. The subcommittee has requested HCAI to respond to the following:

1. Please provide a brief overview of this proposal.

2. The proposed trailer bill reverts previously approved amounts for healthcare workforce programs to the General Fund, but only expresses intent language that these funds will return to their originally intended purpose in 2024-25 and 2025-26. How can the Legislature ensure these funds will return to support these programs without statutory or other budget authority?

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview



Department of Managed Health Care - *Department Funding Summary* *(dollars in thousands)*				
Fund Source	**2021-22 Actual**	***2022-23 Budget Act***	***2022-23 Revised***	***2023-24 Proposed***
General Fund	$0	$0	$0	$0
Federal Funds	$0	$0	$0	$0
Other Funds	$94,116	$125,762	$129,901	$157,177
Total Department Funding:	**$94,116**	**$125,762**	**$129,901**	**$157,177**
Total Authorized Positions:	**519.9**	**610.0**	**610**	**747.6**
Other Funds Detail:				
Managed Care Fund (0933)	*$94,116*	*$125,762*	*$129,901*	*$157,177*

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 132 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 27.7 million Californians. Established in 2000, DMHC enforces the Knox-Keene Health Care Service Plan Act of 1975, which implemented California's robust oversight regime of the managed care system. In fulfilling its regulatory responsibilities under the Act, DMHC conducts medical surveys and financial examinations to ensure health plan compliance and financial stability, provides a 24-hour call center to help consumers resolve health plan complaints, and administers Independent Medical Reviews of services denied by health plans.

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

DMHC is composed of the following offices and other units:

Help Center. The Help Center educates consumers about their health care rights, resolves consumer complaints against health plans, helps consumers navigate and understand their coverage, and assists consumers in getting timely access to appropriate health care services. The Help Center provides direct assistance in all languages to health care consumers through the department's website (www.HealthHelp.ca.gov) and a toll free number (1-888-466-2219). DMHC collects data on calls received by the Help Center to identify common challenges experienced by consumers to inform potential changes to health plan oversight, regulation, or statutory authority. Common complaints include cancellation of coverage, billing issues, quality of services, coverage disputes, and access complaints. The Help Center often addresses consumer issues through a three-way call between its staff, the consumer, and the health plan. Complaints involving serious or urgent medical issues are routed to nurses who provide immediate assistance 24 hours a day, seven days a week.

The Help Center also oversees the independent medical review (IMR) program. IMR is available to consumers if a health plan denies, modifies, or delays a request for a service as not medically necessary or as experimental or investigational. Independent physicians review these issues and make a determination about whether the service should be provided. If an IMR determines the consumer should receive the service, health plans must provide it promptly.

The Help Center also provides assistance to health care providers to ensure they receive timely and accurate payments from health plans. This assistance includes managing individual provider complaints, complaints with multiple claims, emergency service complaints, and non-emergency service complaints.

The Help Center also manages the Independent Dispute Resolution Process (IDRP) for emergency and non-emergency billing disputes, in which an external reviewer adjudicates between payers and providers to determine the appropriate payment rate.

Office of Plan Licensing. The Office of Plan Licensing (OPL) reviews all aspects of a health plan's operations, including benefits and coverage, template contracts with doctors and hospitals, provider networks, mental health parity and complaint and grievance systems. After a health plan is licensed, OPL monitors the plan and any changes made to plan operations, including changes in service areas, contracts, benefits, or systems. OPL also periodically identifies specific licensing issues for non-routine focused examination or investigation.

Office of Plan Monitoring. The Office of Plan Monitoring (OPM) monitors health plan networks and delivery systems. OPM conducts routine surveys every three years, and conducts non-routine surveys when a specific issue or problem requires a focused review of a health plan's operations. OPM also monitors health plan provider networks and the accessibility of services to enrollees by reviewing the geographic standards, provider-to-patient ratios, and timely access to care. Additionally, OPM reviews health plan block transfer filings when a contract terminates between a health plan and a hospital or provider group.

Office of Financial Review. The Office of Financial Review monitors health plan financial statements and filings, and analyzes health plan reserves, financial management systems and administrative arrangements. The Office conducts routine financial examinations of each health plan every three to five years and initiates non-routine financial examinations as needed. The Office also administers the department's premium rate review program, which holds health plans accountable through transparency and ensures consumers get value for their premium dollar. When the Office finds a proposed rate change to be unreasonable, the health plan must notify impacted members of the unreasonable finding.

Office of Enforcement. The Office of Enforcement represents the department in actions to enforce managed health care laws. The primary purpose of an enforcement action is to change plan behavior to comply with the law, and may include issuing cease and desist orders, imposing administrative penalties, freezing enrollment, and requiring corrective actions. When necessary, the Office pursues legal action to ensure health plans follow the law.

Office of Legal Services. The Office of Legal Services provides legal, legislative, and policy analysis and advice to the department, and develops necessary and appropriate regulations to administer the Knox-Keene Health Care Service Plan Act of 1975.

Office of Administrative Services. The Office of Administrative Services provides a variety of administrative support services to the department, including accounting, budgets, business management services, and human resources.

Office of Technology and Innovation. The Office of Technology and Innovation provides technology support to the department including hardware, software, and information security services.

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: Information Security Resources

Budget Change Proposal – Governor's Budget. DMHC requests five positions and expenditure authority from the Managed Care Fund of $3.5 million in 2023-24, $3.4 million in 2024-25, $3.5 million in 2025-26, $3.5 million in 2026-27, and $3.6 million annually thereafter. If approved, these positions and resources would allow DMHC address critical information technology (IT) gaps, develop a roadmap for implementing and maintaining required IT security, remediate recent audit findings, assist with security monitoring and enhancement, and achieve alignment with statewide security planning efforts.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0933 – Managed Care Fund	$3,459,000	$3,432,000
Total Funding Request:	**$3,459,000**	**$3,432,000**
Total Requested Positions:	**5.0**	**5.0**

* Additional fiscal year resources requested: 2025-26: $3,467,000; 2026-27: $3,482,000; 2027-28 and ongoing: $3,608,000.

Background. AB 670 (Irwin), Chapter 518, Statutes of 2015, authorizes the California Department of Technology (CDT) to conduct independent security assessments of state departments and agencies, requiring no fewer than 35 assessments be conducted annually. AB 670 requires CDT to prioritize for assessment state departments or agencies that are at higher risk due to handling of personally identifiable information or health information protected by law, handling of confidential financial data, or levels of compliance with certain information security and management practices. Independent security assessments are conducted by the Cyber Network Defense (CND) Team at the California Military Department. In June 2019, the CND Team conducted a vulnerability assessment of DMHC's services and assets, resulting in identification of widespread vulnerabilities in software, technical configuration, and maintenance of the department's technical systems.

State Administrative Manual Section 5300 requires each state entity to be responsible for establishing an information security program to effectively manage risk, provide protection of information assets and prevent illegal activity, fraud, waste, and abuse. The 2017 Budget Act included two positions and consultant resources to implement a forward-looking IT roadmap, reduce use and continued investments in its legacy applications, and accelerate migration of its systems to the CDT's Office of Technology Services Cloud, consistent with the CDT Technology Letter 14-04, which details the state's "Cloud First" policy. The consulting resources in the 2017 Budget Act request allowed DMHC to contract with Business Advantage Consulting to review the department's business processes and perform a security assessment of its infrastructure, cybersecurity technologies, tools in place, and the current maturity. The assessment concluded DMHC had no cybersecurity technologies in place for 41 percent of the categories assessed and that 12 percent of the existing technologies required additional configuration.

In addition to these assessments, DMHC participated in the National Cybersecurity Review offered by the Center for Information Security in fall 2018. The review is a self-assessment designed to measure gaps and capabilities of state, local, tribal, and territorial governments' cybersecurity programs. DMHC scored below the recommended minimum maturity level and below the average in comparison to other state and federal departments.

The 2020 Budget Act included two positions and expenditure authority from the Managed Care Fund of $384,000 in 2020-21, $368,000 in 2021-22 and 2022-23, and $328,000 annually thereafter to support implementation of new applications and systems to address vulnerabilities and other issues identified by the three cybersecurity assessments and address the increase in security-related IT tickets.

In June 2021, the CND completed an assessment that found DMHC lacks adequate information security resources to capture data, perform critical daily security practices, and document security procedures. The audit revealed nine high-risk and 21 medium risk findings and determined DMHC must adopt 38 new information security policies, 12 information security and privacy plans, and at least 87 procedures must be created and maintained. The audit also found DMHC had not implemented role-based training in accordance with the State Administrative Manual and does not maintain a software platform and application inventory listing of all programs and information systems that are collecting, using, maintaining, or sharing state-entity information.

Staffing and Resource Request. DMHC requests five positions and expenditure authority from the Managed Care Fund of $3.5 million in 2023-24, $3.4 million in 2024-25, $3.5 million in 2025-26, $3.5 million in 2026-27, and $3.6 million annually thereafter. If approved, these positions and resources would allow DMHC address critical information technology (IT) gaps, develop a roadmap for implementing and maintaining required IT security, remediate recent audit findings, assist with security monitoring and enhancement, and achieve alignment with statewide security planning efforts. Specifically, DMHC requests the following staff and consultant resources:

- **One Information Technology Manager II** position and **three Information Technology Specialist II** positions in the Office of Technology and Innovation would address increased workload and critical IT gaps, in
- **One Attorney III** position in the Office of Legal Services would conduct legal research, draft legal analyses, make policy and operational recommendations, and lead rulemaking activities
- **Consultant resources** as follows:
  - $100,000 annually until 2025-26 to support a consultant to assist DMHC with development of IT policies, plans, and procedures.
  - $75,000 annually until 2024-25 to support gap analysis consultants.
  - $90,000 in 2023-24 to support an identity lifecycle consultant.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Office of Legal Services – Department of Justice (DOJ) Legal Fees

Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $400,000 annually. If approved, these resources would support legal representation by the California Attorney General's Office in litigation to which DMHC is a party or in which DMHC is called as a witness.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0933 – Managed Care Fund	$400,000	$400,000
Total Funding Request:	**$400,000**	**$400,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2024-25.

Background. The California Attorney General's Office (AGO) provides legal services to state departments and agencies when they are party to, or called as a witness during litigation or other legal proceedings. According to DMHC, the number, complexity, and significance of legal cases to which DMHC is a party or called as a witness has increased significantly in recent years. For example, litigation has challenged DMHC's work on developing the "benchmark" plan to determine "essential health benefits" for compliance with the federal Affordable Care Act, as well as implementation of SB 510 (Pan), Chapter 729, Statutes of 2020, which requires health plan coverage of COVID-19 testing and vaccine administration. In addition, AB 595 (Wood), Chapter 292, Statutes of 2018, provides DMHC greater authority to review potentially anti-competitive mergers or purchases in the health plan market. These reviews have been the subject of increased legal challenges, as well.

Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $400,000 annually. If approved, these resources would support legal representation by the California Department of Justice in litigation to which DMHC is a party or in which DMHC is called as a witness.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Office of Financial Review Workload

Budget Change Proposal – Governor's Budget. DMHC requests 14.5 positions and expenditure authority from the Managed Care Fund of $2.7 million in 2023-24 and $2.6 million annually thereafter. If approved, these positions and resources would allow DMHC to conduct more frequent financial examinations of health plans and risk-bearing organizations and to address additional workload related to an increase in licensed health plans.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0933 – Managed Care Fund	$2,676,000	$2,553,000
Total Funding Request:	**$2,676,000**	**$2,553,000**
Total Requested Positions:	**14.5**	**14.5**

* Positions and resources ongoing after 2024-25.

Background. DMHC's Office of Financial Review (OFR) works to ensure stability in California's health care delivery system by actively monitoring the financial status of health plans and provider groups so they can meet their financial obligations to consumers, providers, and other purchasers. OFR reviews health plan financial statements and filings, and analyzes health plan reserves, financial management systems, and administrative arrangements. OFR also conducts routine financial examinations of each health plan every three to five years, and initiates non-routine financial examinations when necessary.

According to DMHC, the number of licensed health plans regulated by DMHC has increased steadily from 121 plans and 25 million covered lives in 2015 to 140 plans and 28 million covered lives in 2021. As a result, the workload associated with financial examinations, as well as the workload associated with financial solvency and statutory compliance issues identified during examinations, has increased significantly.

Staffing and Resource Request. DMHC requests 14.5 positions and expenditure authority from the Managed Care Fund of $2.7 million in 2023-24 and $2.6 million annually thereafter. If approved, these positions and resources would allow DMHC to conduct more frequent financial examinations of health plans and risk-bearing organizations and to address additional workload related to an increase in licensed health plans. Specifically, DMHC requests positions and resources in the following Offices:

Office of Financial Review, Provider Solvency Unit – Five positions

- **One Corporation Examiner IV, Supervisor** position and **four Corporation Examiners** would expand capacity in the OFR Provider Solvency Unit, which reviews financial statements and filings, and conducts routine examination that focus on compliance with administrative requirements, including review of claims payment practices and provider dispute resolution processes.

Office of Financial Review, Exam Unit – 7.5 positions

- **1.5 Corporation Examiner IV, Supervisor** positions and **six Corporation Examiners** would expand capacity in the OFR Exam Unit, which conducts routine and non-routine financial examinations of all

DMHC licensed health plans. The unit currently conducts 40 examinations per year and these additional staffing and resources would allow the unit to conduct financial examinations of each plan every three years, rather than three to five years.

Office of Administrative Services – One position

- **One Associate Governmental Program Analyst** would support additional administrative workload related to the additional staff requested in this proposal. This workload would include hiring activities, and processing of employee-related transactions, such as personnel transactions, travel expense claims and trainings, and contracts and procurement activities.

Office of Technology and Innovation – One position

- **One Information Technology (IT) Specialist I** position would support additional information technology workload related to the additional staff requested in this proposal. This workload would include application/system development and support, procurement and management of IT assets, data security, and support for staff IT needs.

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Health Care Coverage: Abortion Services Cost Sharing (SB 245)

Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $499,000 in 2023-24 and $483,000 in 2024-25 through 2027-28. If approved, these resources would allow DMHC to develop legal memoranda and regulations related to the prohibition on cost-sharing or utilization management for abortion and abortion-related services pursuant to SB 245 (Gonzalez), Chapter 11, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0933 – Managed Care Fund	$499,000	$483,000
Total Funding Request:	**$499,000**	**$483,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2025-26 through 2027-28: $483,000.

Background. SB 245 (Gonzalez), Chapter 11, Statutes of 2022, prohibits health care service plans, Medi-Cal managed care plans, and certain health insurers from imposing cost-sharing requirements or utilization management on abortion or abortion-related services. The types of cost-sharing prohibited by SB 245 include deductibles, coinsurance, copayments, or any other cost-sharing requirement. The types of utilization management prohibited by SB 245 include prior authorization, and annual or lifetime limits on coverage.

SB 245 allows DMHC, in consultation with DHCS and the Department of Insurance (CDI), to interpret and implement the provisions of the bill through plan letters or other similar guidance. However, DMHC is required to adopt regulations implementing these requirements by January 1, 2026. As part of its review of health plan compliance with SB 245, DMHC must also review health plan documents, including evidence of coverage and disclosure forms, utilization management data, and health plan survey data.

Staffing and Resource Request. DMHC requests expenditure authority from the Managed Care Fund of $499,000 in 2023-24 and $483,000 in 2024-25 through 2027-28, to develop legal memoranda and regulations related to the prohibition on cost-sharing or utilization management for abortion and abortion-related services pursuant to SB 245 (Gonzalez), Chapter 11, Statutes of 2022. Specifically, DMHC requests the following resources:

Office of Legal Services –Resources equivalent to two positions

- Resources equivalent to **one Attorney IV** position would oversee development of the regulation, conduct legal research to understand and appropriately implement SB 245, and serve as a subject matter expert for legal advice.
- Resources equivalent to **one Attorney III** position would assist in development of the regulation, conduct legal research to understand and appropriately implement SB 245, and assist in serving as a subject matter expert for legal advice.

DMHC also expects additional workload in its Office of Plan Licensing to review health plan documents for compliance with SB 245. However, DMHC expects this workload can be absorbed within existing resources.

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

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

1. Please provide a brief overview of this proposal.

Issue 6: Health Care Coverage: Mental Health and Substance Use Disorders (AB 2581)

Budget Change Proposal – Governor's Budget. DMHC requests 0.5 position and expenditure authority from the Managed Care Fund of $27,000 in 2023-24, $186,000 in 2024-25, and $177,000 annually thereafter. If approved, these positions and resources would allow DMHC to ensure health plan compliance with mental health and substance use disorder provider credentialing requirements, pursuant to AB 2581 (Salas), Chapter 533, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0933 – Managed Care Fund	$27,000	$186,000
Total Funding Request:	**$27,000**	**$186,000**
Total Requested Positions:	**0.5**	**0.5**

*Additional fiscal year resources requested – 2025-26 and ongoing: $177,000.

Background. AB 2581 (Salas), Chapter 533, Statutes of 2022, requires health plans and insurers that provide coverage for mental health and substance use disorder services and that credential providers of those services to assess and verify the qualifications of those providers within 60 days of receiving a completed credentialing application. Previously, there was no deadline for completing a credentialing application with some applicants waiting up to six months or longer. AB 2581 requires DMHC, as part of its oversight of health plans, to review health plan documents to ensure compliance with the provisions of the bill, modify existing plan survey methodologies and tools, and revise policies and procedures to ensure compliance with AB 2581.

Staffing and Resource Request. DMHC requests 0.5 position and expenditure authority from the Managed Care Fund of $27,000 in 2023-24, $186,000 in 2024-25, and $177,000 annually thereafter to ensure health plan compliance with mental health and substance use disorder provider credentialing requirements, pursuant to AB 2581 (Salas), Chapter 533, Statutes of 2022. Specifically, DMHC requests the following positions and consultant resources:

Office of Plan Monitoring –Consultant resources

- **Consultant resources** of $27,000 in 2023-24 and $47,000 annually thereafter would support a clinical consultant to assist in reviewing e-file and routine survey activities related to AB 2581 requirements.

Office of Enforcement – 0.5 position (beginning in 2024-25)

- **0.5 Attorney III** position would evaluate cases, draft responses, send investigative discoveries during referrals, and recommend a course of enforcement action.

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

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

1. Please provide a brief overview of this proposal.

Issue 7: Health Care Coverage: Prescription Drugs (AB 2352)

Budget Change Proposal – Governor's Budget. DMHC requests two positions and expenditure authority from the Managed Care Fund of $343,000 in 2023-24, 323,000 in 2024-25, and $333,000 annually thereafter. If approved, these positions and resources would allow DMHC to ensure health plan compliance with requirements to provide information to enrollees about prescription drug benefits, pursuant to AB 2352 (Nazarian), Chapter 590, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0933 – Managed Care Fund	$343,000	$323,000
Total Funding Request:	**$343,000**	**$323,000**
Total Requested Positions:	**2.0**	**2.0**

* Additional fiscal year resources requested – 2025-26 and ongoing: $333,000.

Background. AB 2532 (Nazarian), Chapter 590, Statutes of 2022, requires health plans and health insurers to provide information regarding prescription drug coverage upon request to an enrollee or insured. The required information includes eligibility for the prescription drug, the most current formulary, cost sharing information for the drug and any alternatives, and any applicable utilization management requirements. AB 2352 also requires plans to respond in real time to requests through a standard application programming interface (API), ensure information is updated no later than one business day after a change is made, and allow the use of integrated technologies or services necessary to provide the information to enrollees.

DMHC would be required to annually review health plan documents to ensure compliance, modify existing plan survey methodologies and tools, including technical assistance guides, and revise policies and procedures.

Staffing and Resource Request. DMHC requests two positions and expenditure authority from the Managed Care Fund of $343,000 in 2023-24, 323,000 in 2024-25, and $333,000 annually thereafter to ensure health plan compliance with requirements to provide information to enrollees about prescription drug benefits, pursuant to AB 2352 (Nazarian), Chapter 590, Statutes of 2022. Specifically, DMHC requests positions and resources as follows:

Help Center – One position

- **One Staff Services Analyst** would address the increased number of consumer and provider calls, reference resources and procedures, and provide call resolutions to appropriately implement AB 2532.

Office of Plan Monitoring –Consultant resources

- **Consultant resources** of $17,000 in 2023-24, $15,000 in 2024-25, and $25,000 annually thereafter to support a clinical consultant to assist the Office of Plan Monitoring in reviewing health plan filings to ensure compliance with AB 2352.

Office of Enforcement – One position

- **One Attorney** would evaluate cases, draft responses, send investigative discoveries during referrals, and recommend courses of action based upon evidence.

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

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

1. Please provide a brief overview of this proposal.

Issue 8: Health Information (SB 1419)

Budget Change Proposal – Governor's Budget. DMHC requests three positions and expenditure authority from the Managed Care Fund of $572,000 in 2023-24 and $547,000 annually thereafter. If approved, these positions and resources would allow DMHC to ensure health plan compliance with health information application programming interface (API) requirements, pursuant to SB 1419 (Becker), Chapter 888, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0933 – Managed Care Fund	$572,000	$547,000
Total Funding Request:	**$572,000**	**$547,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2024-25.

Background. SB 1419 (Becker), Chapter 888, Statutes of 2022 requires health plans and health insurers, commencing January 1, 2024, to facilitate patient and provider access to health information through application programming interfaces (APIs) for the benefits of enrollees and insured individuals. Health plans and health insurers would be required to implement the following APIs: 1) a patient access API; 2) a provider directory API; 3) a payer-to-payer exchange API; 4) a provider access API; and 5) a prior authorization support API. The provider access and prior authorization support APIs would only be required when final rules are published by the federal government.

DMHC would be required to annually review health plan documents, modify existing plan survey methodologies and tools, and revise policies and procedures to ensure plan compliance with the provisions of SB 1419.

Staffing and Resource Request. DMHC requests three positions and expenditure authority from the Managed Care Fund of $572,000 in 2023-24 and $547,000 annually thereafter to ensure health plan compliance with provider directory application programming interface (API) requirements, pursuant to SB 1419 (Becker), Chapter 888, Statutes of 2022. Specifically, DMHC requests positions and resources as follows:

Office of Financial Review – One position

- **One Corporation Examiner** would review claims, conduct examinations of health plans, prepare preliminary and final reports, and monitor corrective action plans.

Office of Plan Licensing – Two positions

- **One Attorney III** position would review plan documents for legal compliance, including preparing summaries of filing or briefing memorandum, preparing memos, including preparing responsive comments for plan filings and subsequent filing amendments.

- **One Associate Governmental Program Analyst** would assist with developing compliance implementation plans and with ongoing review of plan documents, including evidence of coverage, disclosure forms, formularies, policies and procedures.

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

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

1. Please provide a brief overview of this proposal.

Issue 9: Health Care Service Plans: Discipline: Civil Penalties (SB 858)

Budget Change Proposal – Governor's Budget. DMHC requests 40.5 positions and expenditure authority from the Managed Care Fund of $12.6 million in 2023-24, $9.5 million in 2024-25, $9.6 million in 2026-27, $9.7 million in 2027-28, and $9.7 million annually thereafter. If approved, these positions and resources would allow DMHC to implement revision of administrative and civil penalty provisions of the Knox-Keene Act, pursuant to the provisions of SB 858 (Wiener), Chapter 985, Statutes of 2022.

Program Funding Request Summary		
Fund Source	**2023-24**	**2024-25***
0933 – Managed Care Fund	$12,570,000	$9,510,000
Total Funding Request:	**$12,570,000**	**$9,510,000**
Total Requested Positions:	**40.5**	**40.5**

* Additional fiscal year resources requested – 2025-26: $9,562,000; 2026-27: $9,618,000; 2027-28: $9,678,000; 2028-29 and ongoing: $9,715,000

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

DMHC's Office of Enforcement represents the department in actions to enforce managed health care laws. The primary purpose of an enforcement action is to change plan behavior to comply with the law, and may include issuing cease and desist orders, imposing administrative penalties, freezing enrollment, and requiring corrective actions. When necessary, the Office pursues legal action to ensure health plans follow the law.

SB 858 increases fines on deficient health plans, including civil penalties of not more than $25,000 for each day a violation continues, per enrollee harmed. Many penalties imposed under the Knox-Keene Act have not been adjusted since it was enacted in 1975, even for inflation. Cumulative administrative penalties would escalate as follows: 1) not less than $5,000 for a first violation; 2) not less than $10,000 nor more than $20,000 for a second violation; 3) not less than $30,000 and not more than $200,000 for each subsequent violation. SB 858 requires the DMHC director to take account of the following factors when assessing administrative penalties: 1) the nature, scope, and gravity of the violation; 2) the good or bad faith of the plan; 3) the plan's history of violations; 4) the willfulness of the violation; 5) the nature and extent to which the plan cooperated with the investigation; 6) the nature and extent to which the plan aggravated or mitigated any injury or damage cause by the violation; 7) the nature and extent to which the plan has taken corrective action to ensure the violation will not recur; 8) the financial status of the plan.

Staffing and Resource Request. DMHC requests 40.5 positions and expenditure authority from the Managed Care Fund of $12.6 million in 2023-24, $9.5 million in 2024-25, $9.6 million in 2026-27, $9.7 million in 2027-28, and $9.7 million annually thereafter. If approved, these positions and resources would allow DMHC to implement revision of administrative and civil penalty provisions of the Knox-Keene Act, pursuant to the provisions of SB 858 (Wiener), Chapter 985, Statutes of 2022. Specifically, DMHC requests the following position and resources:

Office of Financial Review – 3.5 positions

- **2.5 Corporation Examiner IV Specialist** positions would conduct the financial examinations of health plans, including analyzing financial statements, assessing and monitoring corrective action plans, and assessing the financial impact of the increased penalties to the viability of health plans.
- **One Associate Governmental Program Analyst (AGPA)** would receive and track activities related to examination documents and referrals, assist with reporting, compliance, and adequacy issues, as well as the financial monitoring of health plans.

Office of Plan Monitoring – 3.5 positions and consultant resources

- **2.5 Attorney IV** positions would be responsible for corrective action plan design, monitoring and enforcement coordination, legal research, collaboration with the enforcement team, review of documents and plan communications pertaining to the timely compliance of imposed corrective action plans.
- **One AGPA** would provide administrative support for enforcement referrals, eFiling and assist in the enforcement coordination to support corrective action plan compliance.
- **Consultant resources** of $447,000 annually for a clinical consultant to assist the Office of Plan Monitoring in reviewing health plan filings and data to ensure compliance with SB 858.

Office of Enforcement – 22.5 positions and consultant resources

- **One Assistant Deputy Director,** at the Career Executive Assignment Level A, would provide day-to-day operational oversight of the administrative and legal support functions of the new compliance team within the Office of Enforcement and serve as an advisor to the office's Deputy Director.
- **1.5 Assistant Chief Counsel** positions would serve as lead counsel for conducting the initial review of documents, including the preliminary report, plan response, final report and follow-up reports. These positions would also review details of referrals, oversee all aspects of investigation and prosecution, and supervise lower-level attorneys and administrative staff involved in corrective action plan referrals.
- **2.5 Attorney IV** positions would be responsible for providing legal support to investigate corrective action plan referral cases, including the case evaluation and drafting discovery and recommended course of actions. These positions would also serve as lead attorneys in all aspects of pre-trial preparation, trail and hearing, and post-trial briefing and motions.
- **Six Attorney III** positions would provide legal support to investigate highly complex referral cases, perform complex legal review, analysis of the findings reports, conduct legal research of statutes, respond to complex legal questions during investigations, develop strategies to respond to difficult and sensitive matters, and serve as lead counsel during pre-trial, trial/hearing, and post-trial.

- **Four Attorneys** would evaluate corrective action plan referral cases, including the survey audit, deficiencies, and subcases resulting from the deficiencies, evaluate and prepare recommended course of action, resolution and motion for prosecution and defense, and coordinate and consult with expert witness consultants for purposes of evaluation and trial/hearing preparation.
- **One Special Investigator** would conduct investigations for case subjects associated with corrective action plan cases, conduct forensic review of case documents, interview witnesses, and prepare reports for final determination or trial.
- **One Staff Services Manager II** position would oversee all aspects of planning, organizing, managing, and direct processing of the Office of Enforcement's administrative workload.
- **1.5 Staff Services Manager I** positions would direct and coordinate the completion of all tasks assigned to the legal analyst and legal assistant staff associated with corrective action plan cases, including answering staff questions and providing direction on court filings.
- **One Legal Analyst** would assist attorneys with planning investigations and conducting legal research, review and analyze discovery initiated by a health plan and summarize and discuss a health plan's responsive documents with the attorney.
- **Three Legal Assistants** would assist attorneys with referral cases, including finalizing documents, following up on plan responses, managing the case management system, coordinating case documents, and making trial-related arrangements.
- **Two AGPAs** would prepare and maintain an attorney log and provide supporting administrative functions, including managing all enforcement action settlement documents, input of settlement-related data into the case management database and prepare a monthly resolution summary report.
- **One Staff Services Analyst** would create and maintain corrective action plan referrals in the enforcement case management system, trouble-shoot and resolve issues with ProLaw cases, reports and data input and manage program timesheets for the new positions in this proposal.
- **Consultant resources** of $135,000 annually to support three expert witness consultants each fiscal year as a matter goes to trial.

Office of Administrative Services – Three positions

- **Three AGPAs** would support administrative services for the new employees in this proposal, including accounting, budgeting, human resources, training, and organizational effectiveness and business management.

Office of Technology and Innovation – Five positions and consultant resources

- **One Information Technology Supervisor II** position would organize and direct the work of system admins, system engineers, and cloud infrastructure engineers to ensure high system availability, security, and operability required to support a high-volume of litigation and ensure compliance with SB 858.
- **One Information Technology Specialist II** position would serve as the System Engineer and be responsible for formulating and executing various system queries in response to information request from DMHC offices.
- **Three Information Technology Specialist I** positions would expand workload capacity in the Office of Technology and Innovation, including application/system development and support, procurement and management of IT assets, data security, and supporting staff IT needs.

- **Consultant resources** of $2.8 million in 2023-24 would support a consultant to implement enhancements to the corrective action plan system and develop a department-wide tracking system to allow addition of new corrective action plan types and associated workflows.

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

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

1. Please provide a brief overview of this proposal.

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

Issue 1: Overview and Open Enrollment Update

Background. The federal Patient Protection and Affordable Care Act (ACA) implemented significant improvements to health care coverage offered in the individual health insurance market. Beginning in September 2010, ACA individual market reforms:

1. Eliminated lifetime limits on coverage.
2. Prohibited post-claims underwriting and rescission of policies.
3. Required health plans to offer coverage to dependent children up to age 26.
4. Eliminated pre-existing condition exclusions for children.
5. Eliminated copays and other cost sharing provisions for 45 preventive services.
6. Required health plans to spend at least 85 percent of premium dollars on health expenditures or provide rebates to customers (effective January 2012).

According to federal data, by 2013, more than eight million Californians received access to no-cost preventive services and 1.4 million residents with private insurance coverage received $65.7 million in insurance company rebates.

Beginning in January 2014, the ACA implemented additional market reforms and required establishment of health benefit exchanges, which provide federally subsidized health care coverage to individuals with incomes between 138 and 400 percent of the federal poverty level (FPL). California established its own health benefit exchange, Covered California, funded by assessments on health plan premiums. Covered California offers several options for individual health care coverage negotiated for cost and quality with health plans. Enrollment occurs during an annual open enrollment period that begins November 1 and ends January 31. The ACA requires all health insurance products, with some exceptions, to cover certain essential health benefits to be considered minimum essential coverage. These benefits include:

- Ambulatory patient services
- Prescription drugs
- Emergency services
- Rehabilitative and habilitative services and devices
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Preventive and wellness services and chronic disease management
- Mental health and substance use disorder services, including behavioral health treatment
- Pediatric services, including oral and vision care

Metal Tiers for Health Insurance Products in Covered California. Consumers purchasing coverage in the Covered California health benefit exchange may choose from different "metal tiers" that determine the level of coverage and cost-sharing amounts provided by the product. According to Covered California, the metal tiers provide coverage as follows:

- **Bronze:** On average, Bronze health plans pay 60 percent of medical expenses, and consumers pay 40 percent.

- **Silver:** On average, Silver health plans pay 70 percent of medical expenses, and consumers pay 30 percent. Certain income-eligible individuals may qualify for an Enhanced Silver plan, which provides coverage with lower cost-sharing. Individuals in these savings categories get the benefits of a Gold or Platinum plan for the price of a Silver plan. The three categories of Enhanced Silver plans pay 94, 87 or 73 percent of medical expenses.

- **Gold:** On average, Gold health plans pay 80 percent of medical expenses, and consumers pay 20 percent.

- **Platinum:** On average, Platinum health plans pay 90 percent of medical expenses, and consumers pay 10 percent.

Figure 1. Metal Tiers of Coverage in Covered California Health Benefit Exchange
Source: *Covered California website: "Coverage Levels/Metal Tiers" https://www.coveredca.com/individuals-and-families/getting-covered/coverage-basics/coverage-levels/*

Advance Premium Tax Credit Subsidies. The ACA subsidizes health care coverage purchased in health benefit exchanges, such as Covered California, for individuals between 138 and 400 percent of the FPL. The subsidies are provided in the form of advance premium tax credits (APTC), which reduce the amount of premium paid by income-eligible consumers purchasing coverage on the exchange. The amount of the APTC is linked to the cost of the second-lowest cost Silver plan in a consumer's coverage region. The APTC is meant to ensure that consumers are required to spend no more than two percent to 9.6 percent of their income for Silver plan premiums. Consumers may use the APTC subsidy amount to purchase other metal tiers of coverage that may be less expensive (e.g. Bronze) or more expensive (e.g. Gold or Platinum).

Individual Mandate Penalty and Cost-Sharing Reductions. In addition to individual market reforms and new coverage options, the ACA eliminated pre-existing condition exclusions for adults beginning in 2014, and imposed a requirement that individuals enroll in health plans that offer minimum essential coverage or pay a penalty, known as the individual mandate penalty. The individual mandate penalty was designed to stabilize premiums by encouraging healthy individuals to enroll in health coverage and reduce the overall acuity of health insurance risk pools. Because health plans cannot deny coverage based on a pre-existing condition, in the absence of a mandate penalty, individuals may delay enrolling in coverage until they are diagnosed with a high-cost health condition, resulting in higher overall plan expenditures, which lead to higher premiums. The ACA also limited the amount of cost-sharing that could be required of plan beneficiaries with incomes under 250 percent of the FPL. These cost-sharing reductions result in

savings to beneficiaries on deductibles, copayments, coinsurance, and maximum out-of-pocket costs. Until 2017, the federal government provided cost-sharing reduction subsidies to health plans to help mitigate the costs of limiting cost-sharing amounts for these beneficiaries. These subsidies were designed to maintain those cost-sharing limits while reducing higher premium costs that would otherwise be required.

Elimination of Cost Sharing Reduction Subsidies and Repeal of Individual Mandate. In October 2017, the federal Administration eliminated cost-sharing reduction subsidies that prevented premium growth due to ACA requirements that limited cost-sharing for health plan beneficiaries with incomes under 250 percent of the FPL. According to Covered California, the loss of these subsidies resulted in an annual reduction of approximately $750 million of federal funds available to reduce premiums. According to the Kaiser Family Foundation, health plans imposed resulting cost-sharing reduction surcharges ranging from seven to 38 percent on premiums beginning in 2018. In addition, recently enacted federal tax legislation included a reduction to zero of the individual mandate penalty for failing to purchase health care coverage. The reduction took effect for coverage in the 2019 calendar year.

State Subsidy Program and State Individual Mandate Penalty. The 2019 Budget Act included General Fund expenditure authority of $428.6 million in 2019-20, $479.8 million in 2020-21, and $547.2 million in 2021-22 to provide state premium subsidies for individuals up to 600 percent of the FPL purchasing health care coverage in Covered California. Approximately 17 percent of the funds supplemented federal APTC subsidies for individuals with incomes between 200 and 400 percent of the FPL (between $51,500 and $103,000 for a family of four) and approximately 83 percent for individuals with incomes between 400 and 600 percent of the FPL (between $103,000 and $154,500 for a family of four). The funding also covered full premium costs for individuals below 138 percent of the FPL ($35,500 for a family of four). In addition, the 2019 Budget Act included trailer bill language to implement a penalty on individuals that fail to maintain minimum essential coverage during a coverage year, to encourage enrollment in the absence of the federal individual mandate penalty. The minimum penalty is $695 for adults in a household and $347.50 for each child. The revenue from the penalty was intended to offset General Fund expenditures for the state subsidy program. According to Covered California, as of June 2020, approximately 598,000 individuals received state subsidies, with 546,000 under 400 percent of the FPL receiving an average of $14 per month and 42,000 between 400 and 500 percent of the FPL receiving an average of $301 per month.

The Federal American Rescue Plan and Inflation Reduction Act Offer More Generous Subsidies. In March 2021, President Biden signed the American Rescue Plan (ARP), which makes a significant investment in advance premium tax credits (APTC) to improve affordability for consumers seeking health care coverage in health benefit exchanges, including Covered California. For the 2021 and 2022 plan years, the ARP removes the income eligibility cap on APTC premium subsidies, which previously limited subsidies to individuals at or below 400 percent of the FPL. The ARP provides subsidies so that no individual at any income level will have to pay more than 8.5 percent of their income for a silver plan in an ACA marketplace, such as Covered California. In addition, no individual with income below 150 percent of the FPL, or any individual that receives unemployment insurance payments at any point in 2021, will pay any premiums at all for silver level coverage.

As a result of the more generous subsidies provided by the ARP, the three-year state premium subsidy program implemented by the 2019 Budget Act was subsumed by the new federal subsidies. The state

subsidy program was designed to limit individuals between 400 and 600 percent of the FPL to spending between 9.68 percent and 18 percent of income on premiums. Because the ARP caps premiums at 8.5 percent for all income levels, no state premium subsidy is necessary to reach the required contribution levels included in the state premium subsidy design. As a result, the 2021 Budget Act reverted General Fund expenditure authority of $405.6 million in 2021-22 to reflect savings in the state subsidy program resulting from the more generous federal premium subsidies. On August 16, 2022, President Biden signed the Inflation Reduction Act, which extended the ARP subsidies through the 2025 plan year.

Health Care Affordability Reserve Fund and Marketplace Affordability Report. The 2021 Budget Act also included trailer bill language to establish the Health Care Affordability Reserve Fund, as well as a transfer of General Fund resources of $333.4 million, which is the revenue the Administration estimated the state would receive from the individual mandate penalty. The reserve fund was meant to provide available resources to support state subsidies if the more generous federal subsidies are not extended beyond the 2022 coverage year, or if the state implements future health care affordability measures.

In addition to establishing the fund, the trailer bill language required Covered California to prepare a report by January 1, 2022, with options for utilizing the Health Care Affordability Reserve Fund to further improve affordability or cost-sharing requirements, including timelines and system requirements for implementation.

2023 Open Enrollment Update. The 2023 Open Enrollment period began on November 1st, 2022, and closed on Monday, January 31st, 2023, for the 2023 coverage year. The 2023 Open Enrollment continued to benefit from implementation of more generous federal subsidies from the American Rescue Plan, extended by the Inflation Reduction Act, as well as implementation of a one-dollar state subsidy program to allow for zero-dollar premiums for income-eligible individuals.

According to Covered California, as of January 29, 2023, with two days remaining of the open enrollment period, nearly 1.8 million Californians enrolled in coverage through the Covered California health benefits exchange, including more than 1.5 million Californians renewing coverage and 240,000 newly enrolled. According to Covered California, Inflation Reduction Act subsidies have allowed two-thirds of Covered California enrollees to be eligible for coverage that costs $10 or less per month.

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

Questions. The subcommittee has requested Covered California to respond to the following:

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

2. Please provide an update on enrollment in Covered California during the most recent open enrollment period.

Issue 2: Budget Solution - California Premium Subsidy Program Reversion to General Fund

Trailer Bill Language and Budget Solution – Governor's Budget. The Administration proposes trailer bill language to transfer $333.4 million from the Health Care Affordability Reserve Fund to the General Fund, while stating the intent of the Legislature to restore funding when federal subsidies expire in the 2025-26 fiscal year.

Inflation Reduction Act Continues ARP Subsidies and Implements Other Programs. The Inflation Reduction Act, signed by President Biden in August 2022, extends the generous federal premium subsidies implemented by the American Rescue Plan (ARP) for three years, until the 2025 plan year. Extension of the federal subsidies continues to subsume the state's previously enacted state subsidy program, which should allow those resources to be devoted to additional support to make coverage more affordable such as yet more generous premium subsidies, or subsidies to reduce or eliminate deductibles, co-pays, or other cost-sharing. If the federal subsidies are not extended after the 2025 plan year, the state would likely need to consider implementation of a replacement subsidy program to prevent a drastic increase in premiums year-over-year and a concomitant reduction in take-up of coverage in the exchange. Covered California estimates failure to extend the federal subsidies would result in a loss of approximately $1.6 billion annually in premium support to California consumers.

Health Care Affordability Reserve Fund and Marketplace Affordability Report. The 2021 Budget Act included trailer bill language to establish the Health Care Affordability Reserve Fund, as well as a transfer of General Fund resources of $333.4 million, which is the revenue the Administration estimates the state received from the individual mandate penalty that year. The reserve fund was meant to provide available resources to support state subsidies if the more generous federal subsidies were not extended beyond the 2022 coverage year, or if the state implement future health care affordability measures.

In addition to establishing the fund, the trailer bill language required Covered California to prepare a report by January 1, 2022, with options for utilizing the Health Care Affordability Reserve Fund to further improve affordability or cost-sharing requirements, including timelines and system requirements for implementation.

Bringing Care Within Reach. In January 2022, Covered California released its report, titled "Bringing Care Within Reach – Promoting California Marketplace Affordability and Improving Access to Care in 2023 and Beyond". The report included options for use by policy makers under three potential scenarios:

1) **American Rescue Plan premium subsidies expire after 2022** – In this scenario, the state would have needed to evaluate options to backfill the loss in federal premium support to avoid drastic increases in consumer premium costs.
2) **American Rescue Plan premium subsidies are extended with federal cost-sharing support** – In this scenario, the state would continue to benefit from generous ARP subsidies and significant additional federal resources would be available to support cost-sharing reduction subsidies for three years.
3) **American Rescue Plan premium subsidies are extended without federal cost-sharing support** – In this scenario, the state would need to consider utilizing its own funds to implement a cost-sharing reduction subsidy program.

In addition to its evaluation of options for subsidies, the report also evaluated operational or other technical challenges to implementing any of the subsidy options. This evaluation includes information about the work that Covered California staff would have to perform to design and implement a new subsidy program.

Focus on Cost-Sharing Reduction Subsidy Options. In general, the report focuses on scenarios 2) and 3) in which the ARP premium subsidies are extended with or without federal cost-sharing support, respectively. The Inflation Reduction Act extended ARP premium subsidies without federal cost-sharing support, consistent with scenario 2).

The report provides various options for cost-sharing reduction subsidies and estimates three levels of cost estimates for each option based on the level of plan switching that occurs due to changes in cost-sharing provisions. The report provides an illustration of seven options, four of which could have been supported by the $333.4 million in the Health Care Affordability Reserve Fund, and three of which could be supported with additional federally-funded cost-sharing reduction subsidies, such as those that were contained in the federal Build Back Better Act. The options presented in the report are as follows:

- **Option 1: Actuarial Value (AV) 95/90/85/80 with no deductibles ($475 million to $626 million).** In this option, cost-sharing reduction support would be expanded to all enrollees up to 600 percent of the federal poverty level (FPL). Coverage generosity would be increased with new cost-sharing reduction (CSR) plan actuarial values set to 95, 90, 85 and 80. All individuals above 150 percent of FPL would be upgraded from their existing plans. As modeled, all deductibles would be eliminated under this option. This is the only modeled option that incorporates CSR enhancements above 400 percent of FPL.

- **Option 2: AV 95/90/85 with no deductibles ($463 million to $604 million).** In this option, CSR support would be expanded to all enrollees up to 400 percent of the FPL. Coverage generosity would be increased with new CSR plan actuarial values set to 95, 90 and 85. All individuals above 150 percent of FPL would be upgraded from their existing plans. As modeled, all deductibles would be eliminated under this option.

- **Option 3: Affordable Care Act cost-sharing reduction plan upgrade with no deductibles and Gold AV for individuals between 300 and 400 percent of the FPL ($386 million to $489 million).** In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to a Silver 94 plan with no deductibles, and individuals between 200 and 300 percent of the FPL would be upgraded from a Silver 73 to a Silver 87 plan with no deductibles. Individuals between 300 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

- **Option 4: Affordable Care Act cost-sharing reduction plan upgrade with no deductibles and Gold AV for individuals between 250 and 400 percent of the FPL ($362 million to $452 million).** In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan, and individuals between 200 and 250 percent of the FPL would be upgraded

from a Silver 73 to an existing Silver 87 plan. Individuals between 250 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

- **Option 5: Affordable Care Act cost-sharing reduction plan upgrade for individuals between 150 and 250 percent of the FPL ($278 million to $322 million).** In this option, eligibility for CSR plans would remain at 250 percent of the FPL, but individuals between 150 and 200 percent of the FPL would be upgraded from a Silver 87 to an existing Silver 94 plan, and individuals between 200 and 250 percent of the FPL would be upgraded from a Silver 73 to an existing Silver 87 plan. Deductibles would not be eliminated in this option, which would potentially prevent the need for benefit-design changes in 2023.

- **Option 6: Affordable Care Act cost-sharing reduction plans with no deductibles and Gold AV for individuals between 200 and 400 percent of the FPL ($128 million to $189 million).** In this option, CSR support would be expanded to all enrollees up to 400 percent of the FPL. Individuals between 200 and 400 percent of the FPL would receive a new Silver 80 plan. As modeled, all deductibles would be eliminated under this option.

- **Option 7: Affordable Care Act cost-sharing reduction plans with no deductibles ($37 million to–$55 million).** In this option, cost-sharing reduction support would be expanded to all enrollees up to 400 percent of the FPL. State funding would be used to eliminate all deductibles in existing CSR plans and upgrade the Silver base plan to a Silver 73 for individuals between 250 and 400 percent of the FPL.

Operational Assessment. In addition to presenting options for cost-sharing reduction subsidies, the report also provides an operational assessment for implementing a state-administered cost-sharing reduction program for benefit year 2023. According to Covered California, the major operational work streams for implementing a cost-sharing reduction program include: 1) development of the benefit design; 2) development of a payment methodology; 3) enrollment forecasting and budgeting; 4) system changes for the eligibility determination process; 5) development and implementation of enrollment processes; 6) planning for education and outreach to consumers and stakeholders; 7) process for cost-sharing reduction payments to carriers; 8) consideration of state risk-adjustment provisions; and 9) renaming of plans to match the new value with cost-sharing reduction subsidies.

2022 Budget Act Authorized Cost-Sharing Reduction Subsidies for 2023. The 2022 Budget Act included expenditure authority of $304 million for Covered California subsidies for the 2023 plan year. Provisional language provided two options: 1) if ARP subsidies were not extended, the funding would be used to reinstate the previous state premium subsidy program implemented prior to ARP; or 2) if ARP subsidies were extended the funds would be available to provide an alternative program of financial assistance pursuant to the program design adopted by Covered California.

In June 2022, the Covered California Board adopted a contingent program design that would have implemented a significant cost-sharing reduction subsidy in the event the ARP subsidies were extended. The program design, based on Option 5 in the "Bringing Care Within Reach" report, would have eliminated deductibles of up to $4,750 and reduced copayments by between 20 and 40 percent for Covered California consumers. However, the Department of Finance did not approve the program design adopted by the Covered California Board, resulting in no additional support for California healthcare consumers.

According to Covered California, the program design would have provided the following benefits:

1) Eliminated deductibles for individuals with income at or below 200 percent of the federal poverty level (FPL) as compared to Covered California's standard Silver 94 and Silver 87 products.

2) Provided an enhanced cost-sharing reduction benefit for individual between 200 and 600 percent FPL. Under the Affordable Care Act, federal funding to lower out-of-pocket costs is only available for individuals with income at or below 250 percent FPL. Under the state enhanced design, a new plan would have been offered with "Gold" level benefits at a lower "Silver" level premium price. The benefit would have had lower copays relative to the standard Silver plan (e.g., $30 office visit compared to $45 office visit and $10 generic drugs compared to $16) without a deductible.

Covered California reports, based on estimates for the most recent Open Enrollment period, that had the enhanced cost sharing reduction program been implemented:

- Approximately 540,000 Covered California consumers would have had their deductibles eliminated.
- Approximately 375,000 Covered California consumers with incomes between 200 and 600 percent FPL would have been able to upgrade from a Silver plan to a Gold plan with no deductibles and lower copayments and cost-sharing.

Administration Proposes to Revert Penalty Revenue Back to the General Fund. The Administration proposes trailer bill language to transfer $333.4 million from the Health Care Affordability Reserve Fund to the General Fund, while stating the intent of the Legislature to restore funding when federal subsidies expire in the 2025-26 fiscal year. The Administration proposes this measure as a budget solution to address the General Fund shortfall in the 2023-24 fiscal year.

As previously discussed, this amount is the estimate of what the state would have received from the individual mandate penalty in the 2021 calendar year. Individual mandate penalty revenue is deposited in the General Fund when received by taxpayers during tax filing. The 2019-20 fiscal year was the only year Covered California offered a state-based premium subsidy program. However, beginning in the 2020-21 plan year, the state implemented a $20 million program to cover the $1 per member per month premium required under the Affordable Care Act for abortion services.

Based on Department of Finance revenue statements, the total revenue received from the individual mandate penalty since its implementation, and use of General Fund for Covered California subsidies is as follows:

Fiscal Year	Mandate Penalty Revenue	Covered CA State Subsidies
2019-20	$0	$252,204,000
2020-21	$417,610,000	$83,000,000
2021-22	$334,035,000	$20,000,000
2022-23 (estimated)	$334,035,000	$20,000,000
2023-24 (estimated)	$357,072,000	$20,000,000
TOTAL	$1,442,752,000	$395,204,000

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

Questions. The subcommittee has requested Covered California to respond to the following:

1. Please provide an overview this proposal.

2. The 2022 Budget Act implemented a multitude of significant expenditure increases. Why did the Administration prioritize reducing Covered California's capacity to lower healthcare costs for low- and middle-income consumers, particularly given the ongoing revenue the state receives from the individual mandate penalty?

3. Does the Administration believe individual mandate penalty revenue should continue to flow into the General Fund indefinitely, or should this tax on Californians that cannot afford health coverage be used to help those same Californians better afford health coverage?