Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Susan Talamantes Eggman, Ph.D., Chair
Senator Melissa Melendez
Senator Richard Pan, M.D.

Monday, May 24, 2021
9:00 a.m.
State Capitol - Room 3191

Consultant: Scott Ogus

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PUBLIC COMMENT

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

4150 Department of Managed Health Care

Issue 1: Children and Youth Behavioral Health Initiative

Trailer Bill Language– May Revision. DMHC is requesting trailer bill language to require Knox-Keene licensed health care service plans to reimburse behavioral health services provided in school settings for plan members, regardless of whether the provider is part of the plan's contracted provider network. The Department of Health Care Services would establish a statewide reimbursement schedule that would govern payment for behavioral health services by health care service plans in the school setting, unless the provider was under contract with the plan.

Background. The California Health and Human Services Agency (CHHSA), the Office of the Surgeon General (OSG), the Office of Statewide Health Planning and Development (OSHPD), the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), and the Department of Public Health (DPH) are requesting positions, expenditure authority, and statutory changes to implement the California Children and Youth Behavioral Health Initiative. According to the Administration, this initiative would transform California's behavioral health system into an innovative ecosystem where all children and youth age 25 and younger, regardless of payer, would be screened, supported, and served for emerging and existing behavioral health needs. The components of the proposal are as follows:

- California Health and Human Services Agency (CHHSA) – CHHSA requests expenditure authority from the CFRF of $10 million in 2021-22, $20 million in 2022-23, and General Fund expenditure authority of $10 million annually beginning in 2024-25 to provide cross-department coordination, convene and engage with stakeholders, draft and run procurement for services including subject matter experts, and commission an initiative-wide independent evaluator for all program components.
- Office of the Surgeon General (OSG) - The Office of the Surgeon General within CHHSA requests one position and expenditure authority from the CFRF of $25.1 million in 2021-22, $100,000 in 2022-23, and General Fund expenditure authority of $100,000 annually thereafter to support a public awareness campaign to address adverse childhood experiences (ACEs) and toxic stress, as well as to provide trauma-informed training for educators.
- Office of Statewide Health Planning and Development (OSHPD) – OSHPD requests expenditure authority from the CFRF of $700 million in 2021-22, and General Fund expenditure authority of $125 million in 2022-23 and $75 million in 2023-24 to support workforce, education, and training efforts. Specifically, these funds would support: 1) expanding training capacity for psychiatry and social workers, 2) creating a school behavioral health coach and counselor workforce, 3) developing the substance use disorder workforce, 4) building the behavioral health workforce pipeline, 5) establishing "earn and learn" apprenticeship models, 6) enhancing training to serve justice- and system-involved youth, 7) expanding behavioral health training for primary care providers, 8) expanding peer personnel training and placement programs, and 9) augmenting existing OSHPD workforce programs for behavioral health disciplines.
- Department of Managed Health Care (DMHC) – DMHC is requesting trailer bill language to require Knox-Keene licensed health care service plans to reimburse behavioral health services provided in school settings for plan members, regardless of whether the provider is part of the plan's contracted provider network. The Department of Health Care Services would establish a statewide

reimbursement schedule that would govern payment for behavioral health services by health care service plans in the school setting, unless the provider was under contract with the plan.

- Department of Health Care Services (DHCS) – DHCS requests 78 positions and expenditure authority from the CFRF of $22 million in 2021-22, $24 million in 2022-23, and expenditure authority of $12 million ($6 million General Fund and $6 million federal funds) annually beginning in 2024-25 to implement a Behavioral Health Service Virtual Platform, school-linked behavioral health services, plan offered behavioral health services, and to expand the continuum of behavioral health treatment resources.
- Department of Public Health (DPH) – DPH requests ten positions and expenditure authority from the CFRF of $5 million in 2021-22, General Fund expenditure authority of $50 million in 2022-23, $40 million in 2024-25, and $5 million annually thereafter to implement and build an effective public education and change campaign around behavioral health to: 1) promote general public acceptance and awareness, 2) partner with community leaders for culturally specific campaigns, and 3) empower youth to co-design the campaign.

Department of Managed Health Care – Health Plan Reimbursement for School-Based Behavioral Health Services. DMHC is requesting trailer bill language to require Knox-Keene licensed health care service plans to, beginning January 1, 2024, reimburse medically necessary behavioral health services provided in school settings for plan members, regardless of whether the provider is part of the plan's contracted provider network. The Department of Health Care Services would establish a statewide reimbursement schedule that would govern payment for behavioral health services by health care service plans in the school setting, unless the provider was under contract with the plan. The trailer bill would also impose these reimbursement requirements on County Organized Health Systems in Medi-Cal, and insurance carriers regulated by the California Department of Insurance.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Restoration of Dental Fee-for-Service in Sacramento and Los Angeles Counties

Local Assistance and Trailer Bill Language – May Revision. DHCS requests a reduction in expenditure authority of $22 million ($8.7 million General Fund and $13.3 million federal funds) and trailer bill language to eliminate dental managed care and restore fee-for-service delivery for dental benefits in Sacramento and Los Angeles County, effective January 1, 2022.

Program Funding Request Summary – COVID-19 Direct Response Expenditures		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	($8,694,000)	($17,388,000)
0890 – Federal Trust Fund	($13,265,000)	($26,530,000)
Total Combined Funding Request:	**($21,960,000)**	**($43,918,000)**

* Savings ongoing after 2022-23.

Background. DHCS contracts with six dental managed care plans that provide dental care to approximately 832,000 Medi-Cal beneficiaries in Sacramento and Los Angeles counties. These plans are regulated by the Department of Managed Health Care and licensed under the Knox-Keene Act. The department contracts with Access Health Plan, Health Net and Liberty Health Plan to provide dental benefits in both Sacramento and Los Angeles. In Sacramento, approximately 431,000 beneficiaries are mandatorily enrolled in one of three geographic managed care plans, while in Los Angeles approximately 369,000 beneficiaries voluntarily enroll in one of three prepaid health plans.

DHCS requests a reduction in expenditure authority of $22 million ($8.7 million General Fund and $13.3 million federal funds) and trailer bill language to eliminate dental managed care and restore fee-for-service delivery for dental benefits in Sacramento and Los Angeles County. According to DHCS, this transition would allow for more effective and uniform provider and beneficiary outreach on a statewide basis. In addition, DHCS reports the rates of dental utilization for dental managed care, particularly among children, are lower than for the fee-for-service delivery system.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please describe the department's transition plan for beneficiaries moving from a dental managed care plan to fee-for-service.

3. What protections would be provided for beneficiaries to maintain continuity of care as they transition?

4. Has the department identified the challenges that led to lower utilization rates for beneficiaries in dental managed care? How would a change in delivery system improve utilization?

Issue 2: California Community Transitions Expansion (SB 214) Clean-up

Trailer Bill Language – May Revision. DHCS requests trailer bill language to clarify the provisions of SB 214 (Dodd), Chapter 300, Statutes of 2020, and reduce the required stay in an inpatient facility from 90 days to 60 days.

Background. To alleviate the impact of COVID-19 on facilities, residents, and staff, SB 214 establishes a state-only program to provide CCT services to individuals residing in facilities for less than 90 days. DHCS expects the program would transition 300 eligible individuals in 2021 and 420 in 2022 from facilities to home- and community-based settings of their choice. According to DHCS, these transitions would also result in long-term savings to the Medi-Cal program by providing lower-cost home- and community-based care to eligible individuals, rather than more costly long-term care in a facility. The state-only CCT program would sunset on January 1, 2023.

DHCS requests trailer bill language to clarify the provisions of SB 214 (Dodd), Chapter 300, Statutes of 2020, and reduce the required stay in an inpatient facility from 90 days to 60 days.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Estimate and Adjustments

ADAP Local Assistance Estimate May Revision Update. The May 2021 ADAP Local Assistance Estimate reflects revised 2020-21 expenditures of $455.5 million, which is a decrease of $11.9 million or 2.5 percent compared to the Governor's January budget. According to DPH, this decrease is primarily due to reduced medication expenditures for medication-only clients. For 2021-22, DPH estimates ADAP expenditures of $489.5 million, a decrease of $13.9 million or 2.8 percent, compared to the Governor's January Budget, and an increase of $34 million or 7.5 percent, compared to the revised 2020-21 estimate. DPH also reports this decrease is primarily due to reduced medication expenditures for medication-only clients.

ADAP Local Assistance Funding 2020-21 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$105,350,000	$109,140,000
3080 – AIDS Drug Assistance Program Rebate Fund	$361,985,000	$346,321,000
Total ADAP Local Assistance Funding – All Funds	**$467,334,000**	**$455,461,000**

ADAP Local Assistance Funding 2021-22 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$105,350,000	$105,350,000
3080 – AIDS Drug Assistance Program Rebate Fund	$398,116,000	$384,189,000
Total ADAP Local Assistance Funding – All Funds	**$503,466,000**	**$489,538,000**

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

Caseload by Client Group	2020-21	2021-22
Medication-Only	12,283	12,452
Medi-Cal Share of Cost	114	114
Private Insurance	10,254	10,265
Medicare Part D	7,421	7,555
Pre-Exposure Prophylaxis (PrEP) Assistance Program	4,090	4,768

Expenditures by Client Group	2020-21	2021-22
Medication-Only	$326,697,586	$339,619,898

Medi-Cal Share of Cost	$1,348,709	$1,511,813
Private Insurance	$92,016,900	$110,326,385
Medicare Part D	$23,048,543	$24,542,320
PrEP Assistance Program	$4,584,656	$5,518,013

Enrollment and Case Management Reimbursement Update. In addition to expenditures for services to clients, the ADAP Local Assistance Estimate also includes funds for a variety of enrollment, case management, and quality improvement efforts to support the program. Previously, enrollment sites received a fixed reimbursement for these activities. Beginning in 2017-18, a new reimbursement methodology includes a payment floor and total payment dependent on the volume of certain enrollment and other services provided. According to DPH, enrollment sites will receive $7.8 million in 2020-21 and $8 million in 2021-22.

Trailer Bill Language - Expansion of PrEP-AP Program. The 2018 Budget Act included expenditure authority from the ADAP Rebate Fund of $2 million annually to expand eligibility for the PrEP-AP program including: 1) allowing PrEP medication for insured clients without requiring use of a manufacturer's assistance program, 2) payment for post-exposure prophylaxis (PEP) costs, 3) payment for PrEP and PEP starter packs, regardless of whether PrEP-AP eligibility requirements are met, 4) PrEP-AP access for individuals 12 years of age and older, 5) the ability to consider insured individuals as uninsured for confidentiality or safety reasons, 6) provision of up to 28 days of PEP medication for victims of sexual assault regardless of whether eligibility requirements are met, and 7) payment of insurance premiums for PrEP-AP clients if it would result in cost-savings to the state. The 2020 Budget Act included trailer bill language to allow provision of up to 30 days of PrEP and PEP for all clients, due to the minimum supply provided by the manufacturer. In the May Revision, DPH is requesting trailer bill language to allow individuals to be eligible for PrEP-AP if these medications have been prescribed, dispensed or otherwise furnished.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the changes to caseload and expenditures in the ADAP May Revision Estimate.

2. Please provide a brief overview of the proposed trailer bill language for the PrEP-AP program expansion.

Issue 2: Rescind Rh Disease Reporting Requirement – Trailer Bill Language Proposal

Trailer Bill Language Proposal. DPH requests trailer bill language to rescind the requirement for health care providers to report diagnoses of rhesus (Rh) isoimmunization hemolytic disease in newborns to the department.

Background. The rhesus factor, or Rh factor, is a class of proteins found on the surface of red blood cells that can elicit an immune response from individuals who do not possess the gene for a particular Rh factor. Rh hemolytic disease of the newborn is a condition that occurs during pregnancy when a woman with an Rh-negative blood type is exposed to Rh-positive blood cells from her baby, leading to the development of antibodies against the Rh factor in a process known as isoimmunization. These antibodies launch an immune system response against the baby, which is viewed as a foreign object.

Since 1970, California has required health care providers to report cases of Rh isoimmunization hemolytic disease in newborns to DPH. As testing for Rh factors has become common practice and California is one of the only states that still requires this reporting, DPH requests trailer bill language to rescind the reporting requirement.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposed statutory changes, including the clinical rationale for rescinding the reporting requirement.

Issue 3: Genetic Disease Screening Program – May Revision Estimate and Adjustments

Genetic Disease Screening Program Estimate - May Revision Update. The May 2021 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $140.5 million ($32.9 million state operations and $107.6 million local assistance) in 2020-21, a decrease of $263,000 or 0.2 percent compared to the January budget. According to DPH, the decreased costs are primarily attributable to reduced estimates of live births in California. The estimate also includes $145.7 million ($33.3 million state operations and $112.3 million local assistance) in 2021-22, an increase of $394,000 or 0.3 percent compared to the January budget, and an increase of $5.2 million or 3.7 percent compared to the revised 2020-21 estimate. According to DPH, the increase in costs is due to higher newborn screening contract rates associated with a laboratory information system upgrade and new reagent kits necessary for more efficient lab instrument validation.

Genetic Disease Screening Program 2020-21 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0203 – Genetic Disease Testing Fund		
State Operations:	$32,873,000	$32,873,000
Local Assistance:	$107,885,000	$107,622,000
Total GDSP Funding	**$140,758,000**	**$140,495,000**

Genetic Disease Screening Program 2021-22 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0203 – Genetic Disease Testing Fund		
State Operations:	$33,322,000	$33,322,000
Local Assistance:	$111,939,000	$112,333,000
Total GDSP Funding	**$145,261,000**	**$145,655,000**

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

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

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

Newborn Screening (NBS) Program. Newborn screening, recognized nationally as an essential preventive health measure, began in California in 1966 with the testing of infants for phenylketonuria (PKU). In 1980, the program was expanded to include galactosemia, primary congenital hypothyroidism, and included a more comprehensive follow-up system. In 1990, screening for sickle cell disease was added to the screening program, which allows for identification of related non-sickling hemoglobin disorders, including beta-thalassemia major, and Hb E/beta thalassemia. In 1999, the program implemented screening for hemoglobin H and hemoglobin H - Constant Spring disease. In 2005 the screening panel was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

According to DPH, disorders screened for by the program have varying degrees of severity and, if identified early, many can be treated before they cause serious health problems. Between 1980 and 2017, 18,920,529 babies were screened resulting in early identification of 18,015 cases for the following disorders:

Disorder	Cases
Phenylketonuria (PKU) and hyperphenylalaninemia	1,264
Primary congenital hypothyroidism	7,857
Galactosemia	1,018
Sickle cell disease and other clinically significant hemoglobinopathies[1/]	5,006
Biotinidase deficiency (BD)	209
Cystic fibrosis (CF)	636
Congenital adrenal hyperplasia (CAH)	376
Metabolic fatty acid oxidation disorders	741
Metabolic amino acid disorders other than PKU	203
Metabolic organic acid disorders	518
Other metabolic disorders	62
Severe combined immunodeficiencies	75
X-linked adrenoleukodystrophy (ALD) and other peroxisomal disorders	50
TOTAL	**18,015**

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

Caseload Estimate: The budget estimates NBS program caseload of 434,178 in 2020-21, a decrease of 10,056 or 2.3 percent, compared to the January budget estimate. The budget estimates NBS program caseload of 440,910 in 2021-22, a decrease of 4,930 or 1.1 percent compared to the January budget estimate, and an increase of 6,732 or 1.6 percent compared to the revised 2020-21 estimate. These estimates are based on state projections of a decrease in live births. DPH assumes 100 percent of births will participate in the NBS program annually.

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

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

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

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

In the January budget, the PNS program proposed to replace the current conventional screenings with cell-free DNA (cfDNA), a less-invasive methodology with demonstrated improved performance for prenatal screening. cfDNA screening also has a significantly lower false positive rate than conventional screenings, which could lead to a lower referral rate for invasive follow-up diagnostic procedures, such chorionic villus sampling and amniocentesis. The program would contract with a private laboratory to conduct the screening beginning July 2022, resulting in expected annual savings to the Genetic Disease Testing Fund of $6 million annually due to decreases in case coordination and prenatal diagnosis referrals that would reduce chromosomal abnormality follow-up services by 91 percent. The fee for testing would remain at $221.60, but PNS would require a separate $75 fee for NTD screening in the second trimester.

Caseload Estimate: The budget estimates PNS program caseload of 307,180 in 2020-21, a decrease of 7,658 or 2.4 percent, compared to the January budget estimate. The budget estimates PNS program caseload of 311,510 in 2021-22, a decrease of 4,210 or 1.3 percent compared to the January budget estimate, and an increase of 4,330 or 1.4 percent compared to the revised 2020-21 estimate. These estimates are based on state projections of a decrease in live births.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

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

Issue 4: Women, Infants, and Children Program – May Revision Estimate

Women, Infants, and Children Program Estimate – May Revision Update. The May 2021 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($944.9 million federal funds and $203.9 million WIC manufacturer rebate funds) in 2020-21, an increase of $11.6 million ($4.4 million federal funds and $7.2 million WIC manufacturer rebate funds) compared to the Governor's January budget. The May 2021 WIC Program Estimate includes $1.3 billion ($1.1 billion federal funds and $189.9 million WIC manufacturer rebate funds) in 2021-22, an increase of $68.4 million ($52.9 million federal funds and $15.5 million WIC manufacturer rebate funds) compared to the Governor's January budget, and an increase of $104.2 million ($118.2 million federal funds offset by a decrease of $14 million WIC manufacturer rebate funds) compared to the revised 2020-21 estimate. The federal fund amounts include state operations costs of $59.2 million in 2020-21 and 2021-22.

WIC Funding Summary 2020-21 May Revision Comparison to January Budget			
	2020-21		**Jan to May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$59,210,000	$59,210,000	$-
Local Assistance:	$881,274,000	$885,706,000	$4,432,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$196,784,000	$203,936,000	$7,152,000
Total WIC Expenditures	**$1,137,268,000**	**$1,148,852,000**	**$11,584,000**

WIC Funding Summary 2021-22 May Revision Comparison to January Budget			
	2021-22		**Jan to May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$59,210,000	$59,210,000	$-
Local Assistance:	$950,951,000	$1,003,897,000	$52,946,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$174,414,000	$189,911,000	$15,497,000
Total WIC Expenditures	**$1,184,575,000**	**$1,253,018,000**	**$68,443,000**

The May Revision assumes a monthly average of 953,347 WIC participants in 2020-21, a decrease of 1,592 or 0.2 percent compared to the Governor's January budget. The May Revision assumes a monthly average of 978,209 WIC participants in 2021-22, a decrease of 1,774 or 0.2 percent compared to the Governor's January budget, and an increase of 24,862 or 2.6 compared to the revised 2020-21 caseload estimate.

Food Expenditures Estimate. The May Revision includes $785.4 million ($581.5 million federal funds and $203.9 million WIC manufacturer rebate funds) in 2020-21 for WIC program food expenditures, an increase of $11.6 million ($4.4 million federal funds and $7.2 million WIC

manufacturer rebate funds) or 1.5 percent, compared to the January budget. The May Revision includes $879.6 million ($689.7 million federal funds and $189.9 million WIC manufacturer rebate funds) in 2021-22 for WIC program food expenditures, an increase of $58.4 million ($42.9 million federal funds and $15.5 million WIC manufacturer rebate funds) or 7.1 percent compared to the January budget, and an increase of $94.2 million ($108.2 million federal funds offset by a decrease of $14 million WIC manufacturer rebate funds) or 12 percent compared to the revised 2020-21 food expenditures estimate. According to DPH, the increase between 2020-21 and 2021-22 is primarily due to increased caseload, the increased cash value benefit amount for fruits and vegetables, and an increase in food inflation.

Nutrition Services and Administration (NSA) Estimate. The May Revision includes $304.2 million for other local assistance expenditures for the NSA budget in 2020-21, unchanged compared to the January budget. The May Revision includes $314.2 million for the NSA budget in 2021-22, an increase of $10 million or 3.3 percent compared to the January budget, and an increase of $10 million or 3.3 percent compared to the revised estimate for 2020-21. According to DPH, the increase in 2021-22 NSA funding is due to higher local agency contract funding to account for increased administrative costs and participation levels.

State Operations Estimate. The May Revision includes state operations expenditures of $59.2 million in 2020-21, unchanged compared to the January budget. The May Revision includes state operations expenditures of $59.2 million in 2021-22, unchanged compared to the January budget, and unchanged compared to the revised estimate for 2020-21.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the major changes to caseload and expenditure in the WIC May Revision Estimate.

Issue 6: COVID-19 Pandemic Response

Budget Change Proposal - May Revision Adjustment. DPH requests General Fund expenditure authority of $259.4 million in 2021-22. If approved, these resources would adjust and augment the department's January budget proposal for COVID-19 pandemic expenditures, including laboratory costs for testing, contact tracing, and hospital and medical surge activities.

DPH also requests General Fund expenditure authority of $6 million in 2021-22 to address external challenges related to the COVID-19 pandemic response.

Program Funding Request Summary – COVID-19 Direct Response Expenditures		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$259,382,000	$-
Total Combined Funding Request:	**$259,382,000**	**$-**

Program Funding Request Summary – COVID-19 Pandemic Response External Challenges		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$6,000,000	$-
Total Combined Funding Request:	**$6,000,000**	**$-**

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

The Administration is requesting total General Fund expenditure authority of $1.8 billion to continue its response and mitigation of the impacts of the COVID-19 pandemic. In the January budget, $1.4 billion of this request was proposed to be allocated specifically to several departments, with the remaining $400 million allocated through the Disaster Response-Emergency Operations Account (DREOA), pursuant to proposed budget control section language.

In the May Revision, the Administration proposes to allocate $1.7 billion specifically to departments, an increase of $325.8 million compared to the January budget, with the remaining $73.5 million allocated through DREOA. In the updated May Revision request, the specified allocations for each department or entity are as follows:

- **Department of Public Health (DPH)** – DPH requests General Fund expenditure authority of $1.1 billion, an increase of $259.4 million compared to the January budget, for statewide testing efforts at the Valencia Branch testing laboratory, testing specimen collection through OptumServe, and other miscellaneous services and procurements related to testing, contact tracing, and vaccine distribution. The May Revision increase in expenditures is primarily due to costs related to vaccine distribution and administration, hospital and medical surge, and statewide response operations, offset by lower than expected expenditures for the Valencia laboratory and OptumServe specimen collection.

- **Department of General Services (DGS)** – DGS requests General Fund expenditure authority of $32 million, a decrease of $52.4 million compared to the January budget, for three key pandemic-

related programs: 1) Hotels for Healthcare Workers, which provides hotel rooms to healthcare workers providing critical care to COVID-19 patients to help them avoid bringing the virus home; 2) Housing for the Harvest, which provides hotel rooms for agricultural workers to isolate safely if they are exposed to, or test positive for COVID-19; and 3) Project Hope, which provides hotel rooms to individuals released from prison that need to quarantine safely. This request also includes DGS' contract with FedEx for testing specimen transportation costs, which would be shifted to the DPH budget. The May Revision reduction in expenditures is due to reduced estimates of the number of people requiring non-congregate sheltering in the Hotels for Healthcare Workers and Housing for the Harvest programs.

- **Department of Corrections and Rehabilitation (CDCR)** – CDCR requests General Fund expenditure authority of $408 million, an increase of $126.7 million compared to the January budget, to support the California Correctional Health Care Services' (CCHCS) efforts to treat COVID-19 and minimize exposure to inmates and staff through testing, vaccinations, medical surge capacity, and personal protective equipment (PPE), as well as to reimburse counties for costs associated with the temporary suspension of prison intake.

- **WITHDRAWN: Department of Veterans Affairs** – In the January budget, the Department of Veterans Affairs requested General Fund expenditure authority of $5.3 million in 2021-22 to continue efforts to mitigate impacts of the pandemic in veterans' homes, including enhanced cleaning protocols, testing of staff and residents, procurement of PPE and cleaning products, and procurement of thermometers and medical devices. In the May Revision, the department is withdrawing this request due to the receipt of federal funds to cover these expenditures.

- **WITHDRAWN: Department of Social Services (DSS)** – In the January budget, DSS requested General Fund expenditure authority of $5 million in 2021-22 for its Rapid Response Program to support entities that provide assistance and services to immigrants during emergent situations when federal funding is not available. In the May Revision, DSS is withdrawing this request as this need is being funded by an alternative effort in the current year within DPH.

- **Board of State and Community Corrections (BSCC)** – BSCC requests General Fund expenditure authority of $12.1 million in 2021-22 to support county probation departments with increased number of individuals released from state prison on Post-Release Community Supervision to reduce institutional populations in response to the pandemic. The May Revision makes no changes to this request.

- **Emergency Medical Services Authority (EMSA) –** In the May Revision, EMSA requests General Fund expenditure authority of $17 million in 2021-22 to continue its support for medical staffing, ambulance transportation services, and related support costs.

- **Department of Developmental Services (DDS)** – DDS requests General Fund expenditure authority of $15 million in 2021-22, a decrease of $21.7 million compared to the January budget, for development of surge sites to serve consumers diagnosed with, exposed to, or at high risk of COVID-19. The funding would support an average of 20 beds each at the Fairview Developmental Center and 10 beds at the Porterville Developmental Center for six months. The May Revision reduction in expenditures is due to updated projections regarding the need for surge sites.

- **Department of State Hospitals (DSH)** – DSH requests General Fund expenditure authority of $69.2 million in 2021-22, an increase of $17.2 million compared to the January budget, to support staff costs for cleaning, staffing coverage, environmental projects, custody tasks, screening and isolation. The request also covers commodity purchases, such as PPE, sanitation supplies, changes in food service, as well as equipment for heating and air, filtration, and information technology solutions. In addition, though most testing costs would be shifting to DPH, DSH expects some costs from a contractor hired to work onsite to collect, process, and report staff testing results. The May Revision increase in expenditures is primarily due to updated estimates of personnel services, overtime, and testing costs.

- **Government Operations Agency (GovOps)** – In the May Revision, GovOps requests General Fund expenditure authority of $90.8 million to manage contracts associated with statewide COVID-19 vaccine distribution efforts, coordination with stakeholders, and direct support to vaccine providers and local health jurisdictions.

- **Governor's Office of Emergency Services (CalOES)** – In the January budget, CalOES requested General Fund expenditure authority of $119.7 million in 2021-22 to reimburse local governments for eligible costs associated with emergency activities undertaken in response to the COVID-19 pandemic. In the May Revision, CalOES is withdrawing this request and is requesting General Fund expenditure authority of $18.9 million for state response operations costs at the State Operations Center and funding of subject matter experts for various response activities.

According to the Administration, the remaining $73.5 million would be allocated through the DREOA process for unanticipated costs related to the COVID-19 pandemic. The Administration indicates it would release the departmental allocations for these funds once additional information is available.

Department of Public Health – Resource Request. DPH requests total General Fund expenditure authority of $1.1 billion in 2021-22, an increase of $259.4 million compared to the January budget, to support response activities to the COVID-19 pandemic, primarily for testing facilities, vaccine distribution, supplies, and logistics. In particular, this funding would support the following:

- Valencia Laboratory – DPH requests General Fund expenditure authority of $440.8 million in 2021-22, a decrease of $42.4 million compared to the January budget, to support testing efforts at its Valencia Laboratory. Beginning operation in October 2020, the Valencia Laboratory has expanded the state's COVID-19 testing capacity by 150,000 tests per day and reduced testing turnaround time. DPH contracts with PerkinElmer to operate the lab. Because DPH expects the need for COVID-19 testing capacity will begin to decline in August 2021, this request assumes a small residual cost to maintain the facility in a "warm" shutdown after the end of 2021.

- Logistics Health, Inc. (OptumServe) – DPH requests General Fund expenditure authority of $107.8 million in 2021-22, a decrease of $208.9 million compared to the January budget, to support a new specimen collection contract with OptumServe. DPH also expects costs to decline beginning in August 2021 until the end of the calendar year.

- Vaccine Distribution and Administration – In the May Revision, DPH requests General Fund expenditure authority of $295.2 million in 2021-22 to support vaccine distribution and administration efforts. In particular, these resources would support the state's contract with Blue Shield as the state's third party administrator for vaccine distribution, as well as other efforts to support disproportionately-impacted communities and vulnerable populations.

- Hospital and Medical Surge and Other State Response Costs – In the May Revision, DPH requests General Fund expenditure authority of $66.1 million for costs related to hospital and medical surge ($60.9 million), contact tracing and tracking ($2.4 million), and procurement ($2.8 million).

- REALLOCATED: Miscellaneous COVID-19 Testing and Other Costs – In the January budget, DPH requested General Fund expenditure authority of $20.7 million in 2021-22 for service contracts, other operating costs, commodity purchases and other procurements, and a contract to provide revenue collection and banking services for the Valencia Laboratory. The cost for these services are now reallocated to the other cost categories.

DPH also requests General Fund expenditure authority of $6 million in 2021-22 to address external challenges related to the COVID-19 pandemic response.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the DPH-related components of this proposal.

Issue 7: Federal Grant Authority

Federal Grant Authority. DPH requests provisional language to allow the department to accept federal grants for epidemiology and laboratory capacity (ELC), as well as grants provided under the federal American Rescue Plan. The requested language would be added, as follows:

Epidemiology and Laboratory Capacity

Item 4265-001-0001

Provisions:
11. The Department of Finance may augment this item to reflect $508,927,000 in an Epidemiology and Laboratory Capacity grant award from the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (P.L. 116-260). Augmentations pursuant to this provision shall not be approved sooner than 30 days after notification in writing is provided to the chairpersons of the committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee, or no sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may in each instance determine.

American Rescue Plan

Item 4265-001-0890

Provisions:
4. The Department of Finance may augment this item by up to $68,400,000 to support genomic sequencing and surveillance allocated from the American Rescue Plan Act (ARPA) of 2021 (P.L. 117-7). The Department of Finance may adjust this amount if actual grant awards differ from public information available at the time of the development of the May Revision. The Department of Finance may adjust any item within the Department of Public Health budget to reflect additional grant awards for this purpose provided to the state under ARPA. Augmentations pursuant to this provision shall not be approved sooner than 30 days after notification in writing is provided to the chairpersons of the committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee, or no sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may in each instance determine.

5. The Department of Finance may augment this item by up to $887,716,000 to support COVID-19 testing in schools allocated from the American Rescue Plan Act (ARPA) of 2021 (P.L. 117-7). The Department of Finance may adjust this amount if actual grant awards differ from public information available at the time of the development of the May Revision. The Department of Finance may adjust any item in Section 2.00 to reflect additional grant awards for this purpose provided to the state under ARPA. Augmentations pursuant to this provision shall not be approved sooner than 30 days after notification in writing is provided to the chairpersons of the committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee, or no sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may in each instance determine.

6. The Department of Finance may augment this item by up to $357,027,000 to support COVID-19 vaccine distribution and monitoring allocated from the American Rescue Plan Act (ARPA) of 2021 (P.L. 117-7). The Department of Finance may adjust this amount if actual grant awards differ from public information available at the time of the development of the May Revision. The Department of Finance may adjust any item in Section 2.00 to reflect additional grant awards for this purpose provided to the state under ARPA. Augmentations pursuant to this provision shall not be approved sooner than 30 days after notification in writing is provided to the chairpersons of the committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee, or no sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may in each instance determine.

7. The Department of Finance may augment this item to reflect grant awards from the American Rescue Plan Act of 2021 (P.L. 117-7) for which the state is eligible. Attachment 4 (Page 2 of 2) Augmentations pursuant to this provision shall not be approved sooner than 10 days after notification in writing is provided to the chairpersons of the committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee, or no sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may in each instance determine.

Item 4265-111-0890

Provisions:
4. The Department of Finance may augment this item to reflect grant awards from the American Rescue Plan Act of 2021 (P.L. 117-7) for which the state is eligible. Augmentations pursuant to this provision shall not be approved sooner than 30 days after notification in writing is provided to the chairpersons of the committees in each house of the Legislature that consider appropriations and the Chairperson of the Joint Legislative Budget Committee, or no sooner than whatever lesser time the chairperson of the joint committee, or the chairperson's designee, may in each instance determine.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposed provisional changes.

Issue 8: Pandemic Response Review

Budget Change Proposal and Budget Bill Language – May Revision. DPH requests General Fund expenditure authority of $3 million in 2021-22. If approved, these resources would allow DPH to conduct a review of essential public health infrastructure needs that would assess the state's pandemic response and the root causes of the disparities and inequities experienced by those disproportionately impacted by COVID-19, as well as assess lessons learned and identify programmatic gaps to inform and develop a proposal for the 2022-23 budget.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$3,000,000	$-
Total Funding Request:	**$3,000,000**	**$-**
Total Positions Requested:	**0.0**	**0.0**

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

Local health departments have been particularly challenged in responding to the pandemic due to chronic underfunding of the state's public health system and categorical funding streams that limit the ability to redirect program staff to pandemic or other emergency response, or to provide mutual aid to other jurisdictions. In addition, the chronic underfunding of local health departments has contributed to the state's failure to address persistent health inequities, which were exacerbated during the pandemic and led to disproportionately high morbidity and mortality in socially vulnerable communities. According to DPH data, Latinos were particularly impacted by the pandemic, comprising 55.9 percent of COVID-19 cases and 46.5 percent of COVID-19 fatalities, despite only comprising 38.9 percent of the state's population.

Resource Request. DPH requests General Fund expenditure authority of $3 million in 2021-22 to conduct a review of essential public health infrastructure needs that would assess the state's pandemic response and the root causes of the disparities and inequities experienced by those disproportionately impacted by COVID-19, as well as assess lessons learned and identify programmatic gaps to inform and develop a proposal for the 2022-23 budget.

According to DPH, the review would occur within the next few months and would identify existing infrastructure gaps and resource needs throughout the state. The review would evaluate lessons learned and begin to build a vision for the future public health system that is able to monitor and detect new and emerging infectious and communicable diseases; to quickly respond and mitigate impacts on

individuals, communities and the economy; and to integrate with the healthcare delivery system to create a seamless continuum that includes surveillance, prevention and treatment.

May Revision Includes No Public Health Infrastructure Investments. The May Revision includes no additional ongoing General Fund expenditure authority to support state or local health departments for COVID-19 response activities or to redress the chronic underfunding challenges that left many departments unprepared for responding to the pandemic and allowed health disparities to persist.

In its justification for the current proposal to conduct a pandemic response review, DPH indicates the following:

- "[A] severe public health workforce shortage, as well as bare minimum state staffing patterns for required programs, has greatly strained the capacity of CDPH during the COVID-19 response, with numerous staff from throughout CDPH redirected to assist in response efforts, including in some instances up to 100 percent of a program's staff."
- "[T]he personal, programmatic, and public health implications due to staff redirections has had dire consequences, including overburdened staff working long hours responding 24/7 on the front lines and overburdened staff assuming additional duties covering for those on the front lines."
- "It's not a matter of if, but when the next major disaster or pandemic will occur. In order to reduce harm and improve the resiliency and health of Californians, it is necessary to strengthen California's public health infrastructure. This requires time and additional state resources to invest in a resilient system rather than one dependent on intermittent short-term funding for various public health emergencies."
- "To stand on its own, California's public health infrastructure requires significant, long-term investment. With a sufficiently resourced public health infrastructure, public health threats can be more rapidly and strongly mitigated, allowing for economic recovery to occur."

However, despite its own view of the overwhelming and pressing need for long-term investment in the state's public health system, the May Revision relies on one-time federal funding and makes no long-term investments in improving public health at the state or local level.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please provide a justification for the lack of ongoing investment in public health infrastructure in the May Revision.

Issue 9: Children and Youth Behavioral Health Initiative

Budget Change Proposal – May Revision. DPH requests ten positions expenditure authority from the Coronavirus Fiscal Recovery Fund of $5 million in 2021-22, and General Fund expenditure authority of $50 million in 2022-23 and $40 million in 2024-25 and 2025-26. If approved, these positions and resources would allow DPH to implement a public education and change campaign that would take a strategic and effective public health approach to behavioral health.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$-	$50,000,000
8506 – Coronavirus Fiscal Recovery Fund	$5,000,000	$-
Total Funding Request:	**$5,000,000**	**$50,000,000**
Total Positions Requested:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2024-25: $40,000,000; 2025-26: $40,000,000.

Background. The California Health and Human Services Agency (CHHSA), the Office of the Surgeon General (OSG), the Office of Statewide Health Planning and Development (OSHPD), the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), and the Department of Public Health (DPH) are requesting positions, expenditure authority, and statutory changes to implement the California Children and Youth Behavioral Health Initiative. According to the Administration, this initiative would transform California's behavioral health system into an innovative ecosystem where all children and youth age 25 and younger, regardless of payer, would be screened, supported, and served for emerging and existing behavioral health needs. The components of the proposal are as follows:

- California Health and Human Services Agency (CHHSA) – CHHSA requests expenditure authority from the CFRF of $10 million in 2021-22, $20 million in 2022-23, and General Fund expenditure authority of $10 million annually beginning in 2024-25 to provide cross-department coordination, convene and engage with stakeholders, draft and run procurement for services including subject matter experts, and commission an initiative-wide independent evaluator for all program components.
- Office of the Surgeon General (OSG) - The Office of the Surgeon General within CHHSA requests one position and expenditure authority from the CFRF of $25.1 million in 2021-22, $100,000 in 2022-23, and General Fund expenditure authority of $100,000 annually thereafter to support a public awareness campaign to address adverse childhood experiences (ACEs) and toxic stress, as well as to provide trauma-informed training for educators.
- Office of Statewide Health Planning and Development (OSHPD) – OSHPD requests expenditure authority from the CFRF of $700 million in 2021-22, and General Fund expenditure authority of $125 million in 2022-23 and $75 million in 2023-24 to support workforce, education, and training efforts. Specifically, these funds would support: 1) expanding training capacity for psychiatry and social workers, 2) creating a school behavioral health coach and counselor workforce, 3) developing the substance use disorder workforce, 4) building the behavioral health workforce pipeline, 5) establishing "earn and learn" apprenticeship models, 6) enhancing training to serve justice- and system-involved youth, 7) expanding behavioral health training for primary care providers, 8)

expanding peer personnel training and placement programs, and 9) augmenting existing OSHPD workforce programs for behavioral health disciplines.

- Department of Managed Health Care (DMHC) – DMHC is requesting trailer bill language to require Knox-Keene licensed health care service plans to reimburse behavioral health services provided in school settings for plan members, regardless of whether the provider is part of the plan's contracted provider network. The Department of Health Care Services would establish a statewide reimbursement schedule that would govern payment for behavioral health services by health care service plans in the school setting, unless the provider was under contract with the plan.
- Department of Health Care Services (DHCS) – DHCS requests 78 positions and expenditure authority from the CFRF of $22 million in 2021-22, $24 million in 2022-23, and expenditure authority of $12 million ($6 million General Fund and $6 million federal funds) annually beginning in 2024-25 to implement a Behavioral Health Service Virtual Platform, school-linked behavioral health services, plan offered behavioral health services, and to expand the continuum of behavioral health treatment resources.
- Department of Public Health (DPH) – DPH requests ten positions and expenditure authority from the CFRF of $5 million in 2021-22, General Fund expenditure authority of $50 million in 2022-23, $40 million in 2024-25, and $5 million annually thereafter to implement and build an effective public education and change campaign around behavioral health to: 1) promote general public acceptance and awareness, 2) partner with community leaders for culturally specific campaigns, and 3) empower youth to co-design the campaign.

Department of Public Health – Public Education and Awareness Campaign. DPH requests ten positions expenditure authority from the Coronavirus Fiscal Recovery Fund of $5 million in 2021-22, and General Fund expenditure authority of $50 million in 2022-23 and $40 million in 2024-25 and 2025-26. If approved, these positions and resources would allow DPH to implement a public education and change campaign that would take a strategic and effective public health approach to behavioral health. According to DPH, the campaign would have three components:

- General Public Acceptance and Awareness – This component of the campaign would work through social media, education channels, and youth organizations to raise behavioral health literacy and awareness, and normalize help-seeking behavior. This component would also raise behavioral health literacy, guide individuals in need towards support, promote engagement with organizations to focus on mental health, and create a movement to lower barriers to mental health access. This component would be implemented in partnership with the department's proposed Office of Suicide Prevention.
- Culturally Specific Campaigns – This component would, in partnership with community leaders, build on existing or promising local efforts on developing or enhancing culturally specific campaigns focused on reducing disparities and addressing inequities.
- Youth Empowerment – This component would empower youth to assist in designing the awareness campaign by partnering and consulting with the youth advisory board proposed to be established by CHHSA, and building and expanding the capacity of existing educational efforts to increase awareness of mental health issues among school-age youth, provide culturally and linguistically appropriate training for adults who interact with school-age youth to detect and respond to mental health issues, and ensure children, youth, and families have access to appropriate treatment services.

Of the ten requested positions, nine would support the Mental Health Prevention and Equity Branch within the Office of Health Equity, and one would support the department's Administration Division.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the DPH proposals as part of the California Children and Youth Behavioral Health Initiative.

Issue 10: Support for Alzheimer's Disease Awareness, Research, and Training – Adjustment

Budget Change Proposal – May Revision Adjustment. DPH requests General Fund expenditure authority of $7.5 million in 2021-22. If approved, these resources would allow DPH to augment its January budget proposal to support an equitable and coordinated approach to Alzheimer's disease and related dementias, including research grants, a public awareness campaign, caregiver training and certification, community challenge grants, and statewide standards for dementia care. The combined General Fund expenditure authority for the January budget and May Revision proposals would be $24.5 million.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$7,500,000	$-
Total Funding Request:	**$7,500,000**	**$-**
Total Positions Requested:	**0.0**	**0.0**

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

1) A senior advisor on Alzheimer's, appointed by the Governor, to lead on implementing recommendations of the task force.
2) Support Alzheimer's research with increased funding, including a focus on historically underrepresented communities, such as women, communities of color and the LGBTQ+ community.
3) Create a multilingual, multicultural, and intergenerational Alzheimer's Disease Public Awareness campaign to shift public perceptions and reduce social stigma.
4) Build a "California Cares" digital portal to serve as a one-stop shop for information and services related to screening and diagnosis of Alzheimer's.
5) Establish voluntary savings accounts for long-term care to address affordability and access.
6) Invest in career incentives for an Alzheimer's health care workforce.
7) Establish a caregiver training and certification program.
8) Establish a California Blue Zone City Challenge to support cities in certifying certain locations and establishments as "Blue Zones" once they adopt a minimum threshold of best practices that address the needs and challenges of people with dementia, Alzheimer's or other age related diseases.
9) Establish a Californians for All Care Corps, to provide opportunities for people of all ages and life stages to contribute meaningful public service.
10) Establish an evidence-based, statewide standard of care for Alzheimer's detection diagnosis, treatment, and care planning.

Resource Request – Augmentation of January Budget Proposal. DPH requests General Fund expenditure authority of $7.5 million in 2021-22 to augment its January budget proposal to support an

equitable and coordinated approach to Alzheimer's disease and related dementias, including research grants, a public awareness campaign, caregiver training and certification, community challenge grants, and statewide standards for dementia care. The combined General Fund expenditure authority for the January budget and May Revision proposals would be $24.5 million, and the added amounts at May Revision would augment funding for a public awareness campaign and development of a statewide standard for dementia care. These resources would reflect five of the task force recommendations described above, including:

1) Alzheimer's Research Grant Funding (Recommendation 2) – DPH requests General Fund expenditure authority of $4 million, unchanged from the January budget, to support research grants that would continue to focus on the greater prevalence of dementia in women and communities of color, but also focus on historically underrepresented populations, such as the LGBTQ+ community. Of this request, $3.4 million would be allocated for research grants and $600,000 would support the state operations costs of administering the grant program.

2) Public Awareness Campaign (Recommendation 3) – DPH requests General Fund expenditure authority of $10 million, an increase of $5 million compared to the January budget, to create a public awareness campaign focused on educating the public on the signs and symptoms of Alzheimer's Disease and related dementias. The campaign would target at-risk and disproportionately impacted populations, incorporate a culturally competent and equity-targeted messaging strategy, provide critical information about Alzheimer's and other aging-related conditions, and drive the public to linguistically and culturally competent dementia care resources delivered through multiple modalities.

3) Caregiver Training and Certification Program (Recommendation 7) – DPH requests General Fund expenditure authority of $4 million, unchanged from the January budget, to design and, if funding is available, develop a caregiver training and certification program. The program would provide access to evidence-based dementia related education and training for both paid and unpaid caregivers, as well as those providing In-Home Supportive Services. Of this request, $3.4 million would support the training and certification programs, while $600,000 would support the state operations costs of administering the program.

4) California Blue Zone Challenge (Recommendation 8) – DPH requests General Fund expenditure authority of $2 million, unchanged from the January budget, to allocate grants to California cities or local health jurisdictions to establish a California Blue Zone program which would, in collaboration with local public and private sector stakeholders, certify certain establishments (e.g. schools, restaurants, grocery stores, workplaces, religious institutions, etc.) as "Blue Zones" if they adopt a minimum threshold of best practices. These best practices would address the unique needs and challenges of people with Alzheimer's disease and related dementias, and other age-related diseases.

5) Statewide Standard of Dementia Care (Recommendation 10) – DPH requests General Fund expenditure authority of $4.5 million, an increase of $2.5 million compared to the January budget, to design a statewide standard of care for dementia. This effort would include ensuring primary care physicians have access to a set of evidence-derived cognitive screening questions for identification of Alzheimer's disease and related dementias, developing a hub and spoke model to leverage resources of the ten California Alzheimer's Disease Centers, and incorporating family caregivers into the diagnostic and care planning process.

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the May Revision augmentations to this proposal.

Issue 11: Miscellaneous Technical Adjustments

Technical Adjustments – May Revision. DPH requests the following technical adjustments and language changes to special fund expenditure authority requested in the January budget:

- Proposition 99 Expenditure Adjustments – DPH requests the following adjustments to its funding allocations supported by Proposition 99 tobacco tax revenue:
    - 4265-001-0231 (Health Education Account) – Increased expenditure authority of $16.2 million
    - 4265-111-0231 (Health Education Account) – Increased expenditure authority of $1.8 million
    - 4265-001-0234 (Research Account) – Increased expenditure authority of $767,000
    - 4265-001-0236 (Unallocated Account) – Increased expenditure authority of $651,000

- Adjustment to Reflect Available Resources in the Breast Cancer Research Fund – Increased expenditure authority in 4265-001-0007 of $1.2 million.

- Adjustment to Reflect Available Resources in the Vectorborne Disease Account – Decreased expenditure authority in 4265-001-0478 of $60,000.

- Adjustment to Reflect Available Resources in the Medical Marijuana Program Fund – Decreased expenditure authority in 4265-001-3074 of $15,000.

- Adjustment to Reflect Available Resources in the Registered Environmental Health Specialist Fund – Decreased expenditure authority in 4265-001-0335 of $70,000.

- Adjustment to Reflect Available Resources in the Occupational Lead Poisoning Prevention Account – Increased expenditure authority in 4265-001-0070 of $41,000.

- Adjustment to Reflect Redistributed Resources – Decreased expenditure authority in Schedule (1) of 4265-001-3098 of $138,000 and increased expenditure authority in Schedule (2) of 4265-001-3098 of $138,000.

- Adjustment to Reflect Available Resources in the Breast Cancer Research Fund – Increased expenditure authority in 4265-001-0007 of $1.2 million.

- Adjustment to Reflect Available Resources in the Breast Cancer Research Fund – Increased expenditure authority in 4265-001-0007 of $1.2 million.

- Adjustment to Reflect Available Resources in the Breast Cancer Research Fund – Increased expenditure authority in 4265-001-0007 of $1.2 million.

- Budget Bill Language: Emergency Item Reimbursement – Provisional language to allow reimbursement authority in 4265-001-0001 for the Emergency Preparedness Office to receive Federal Emergency Management Agency grants related to wildfires. The requested provisional language is as follows:

Item 4265-001-0001

Provisions:
9. Notwithstanding any other law, and upon approval of the Director Finance, the amount appropriated in Schedule (1) shall be increased to adjust for federal reimbursement from FEMA for wildfires and related emergencies. The Department of Finance shall notify the Legislature within 10 days of authorizing an augmentation pursuant to this provision. The 10-day notification to the Legislature shall describe the reason for the augmentation.

- Budget Bill Language: Substance Use Disorder Response Navigators Technical Adjustment – Provisional language to allow transfer of $1.8 million from 4265-001-0001 to 4265-111-0001 in 2020-21 to bolster local hear reduction resources. The requested provisional language is as follows:

  Item 4265-001-0001

  Provisions:
  10. Notwithstanding any other law, the Department of Public Health may authorize the transfer of expenditure authority from this item to Item 4265-111-0001 to support Substance Use Disorder Response Navigator-related activities by the State Department of Public Health.

- Trailer Bill Language: Public Contract Code Exemption for LBTQ Women's Health Equity Initiative – Trailer bill language provide an exemption to the Public Contract Code for the Lesbian, Bisexual, Transgender, and Queer (LBTQ) Women's Health Equity Initiative, to allow smaller community-based organizations to successfully compete for grants and contracts.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposed technical adjustments.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: 2021-22 Program Updates – May Revision Adjustments

Background. DSH oversees five state hospitals which comprise the largest inpatient forensic mental health hospital system in the nation. In addition to forensic admissions, which comprise 91 percent of its population, the five state hospitals admit individuals civilly committed under the Lanterman-Petris-Short (LPS) Act because they require physically secure 24-hour care and meet legal criteria that they represent a danger to themselves or others.

The five state hospitals operated by DSH are:

- **Atascadero State Hospital –** Located on the Central Coast in San Luis Obispo County, Atascadero is a self-contained psychiatric hospital with an all-male population primarily composed of OMD, *Coleman*, IST, and NGI patients. Atascadero has a licensed bed capacity of 1,275 beds.

- **Coalinga State Hospital** – Located in the Central Valley in Fresno County, Coalinga is a self-contained psychiatric hospital with an all-male population primarily composed of OMD, *Coleman*, and SVP patients. Coalinga has a licensed bed capacity of 1,500 beds.

- **Metropolitan State Hospital** – Located in Norwalk in Los Angeles County, Metropolitan is an "open" style campus within a security perimeter. Due to community concerns, a formal agreement with the City of Norwalk and the county sheriff prohibits Metropolitan from accepting patients charged with murder or a sex crime, or at high risk for escape. Metropolitan primarily serves LPS, IST, OMD, and NGI patients and has a licensed bed capacity of 1,106 beds.

- **Napa State Hospital** – Located in Napa County, Napa has an "open" style campus within a security perimeter. Napa primarily treats IST, NGI and LPS patients and has a licensed bed capacity of 1,418 beds.

- **Patton State Hospital** – Located in the town of Highland in San Bernardino County, Patton is an "open" style campus within a security perimeter operated by correctional officers from CDCR due to concerns from the surrounding community. Patton primarily serves LPS, IST, OMD, and NGI patients and has a licensed bed capacity of 1,287 beds.

The categories of individuals admitted to state hospitals for treatment are:

- **Incompetent to Stand Trial (IST)** – IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings. Most IST patients are charged with felonies, with some misdemeanors.

- **Not Guilty by Reason of Insanity (NGI)** – NGI patients are individuals found guilty of an offense, but are admitted to DSH if a court determines the individual was "insane" at the time the crime was committed. NGI patients are committed for a term equal to the maximum sentence which could have

been imposed, though may be recommitted for an additional two years if the individual represents a substantial danger of physical harm.

- **Mentally Disordered Offenders (MDO)** – MDO patients are parolees who meet the following six criteria for MDO classification: (1) presence of a severe mental disorder, (2) the mental disorder is not in remission or requires treatment to be kept in remission, (3) the mental disorder was a factor in the commitment offense, (4) the prisoner has been in treatment at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury, (6) the prisoner continues to be dangerous due to the severe mental disorder. MDO commitments under Section 2962 of the Penal Code span the length of the parole term, but may be extended for up to one year if the patient represents a danger of physical harm to others.

- **Sexually Violent Predators (SVP)** – SVP commitments are civil commitments of prisoners released from prison who meet certain criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses and diagnosed with a mental disorder that increases the likelihood of engaging in sexually violent criminal behavior. SVP patients undergo an annual review process to evaluate the patient's suitability for release into the community, either conditionally or without supervision.

- **Lanterman-Petris-Short (LPS)** – LPS patients are individuals that require physically secure 24-hour care and are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship.

- ***Coleman* Class Patients (Mentally Ill Prisoners)** – *Coleman* patients are referred by the California Department of Corrections and Rehabilitation (CDCR) when they are found to be mentally ill while in prison. *Coleman* patients return to CDCR custody when they have received the maximum benefit from treatment. If these individuals are still mentally ill at the end of their prison term, they may be committed to DSH as MDO.

- **Conditional Release Program (CONREP)** – CONREP provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

	2020-21	**2021-22**
Population by Hospital		
Atascadero	1,040	1,066
Coalinga	1,365	1,365
Metropolitan	797	937
Napa	1,090	1,090
Patton	1,445	1,455
Population Total	**5,737**	**5,913**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,029	1,430
Not Guilty by Reason of Insanity (NGI)	1,410	1,419

Offenders with a Mental Disorder (OMD)	1,301	1,316
Sexually Violent Predator (SVP)	942	942
Lanterman-Petris-Short Civil Commitments (LPS)	775	523
Coleman Referrals	280	280
Jail-Based Competency Treatment (JBCT) and Contracted Programs		
Kern Admission, Evaluation, and Stabilization (AES) Center	60	90
Regional JBCT	237	257
Single County JBCT	138	260
Small County Model JBCT: Mariposa[1]	N/A	N/A
Los Angeles Community Based Restoration (CBR)	415	515
Other Counties CBR	0	54
Total JBCT Programs	**850**	**1,176**
TOTAL POPULATION	**6,587**	**7,089**

[1] Mariposa JBCT does not have a set number of beds and instead focuses on the number of patients served.

Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs
Source: *2021-22 May Revision Estimates, Department of State Hospitals,May 2021*

Withdrawn Proposal – Community Care Demonstration Project for Felony IST. In the January budget, DSH requested four positions and General Fund expenditure authority of $233.2 million in 2021-22 and $136.4 million annually thereafter to establish the Community Care Demonstration Project for Felony Incompetent to Stand Trial (IST), which would contract with counties to provide a continuum of services to felony ISTs in the county instead of the State Hospitals. After consulting with various stakeholders, DSH requests to withdraw this proposal in the May Revision.

Program Update – Metropolitan: Increased Secure Bed Capacity. In the January budget, DSH estimated a reduction of 120.6 positions and General Fund savings of $18.6 million in 2020-21 due to delays in the activation of newly secured units at Metropolitan State Hospital to provide increased capacity for the treatment of IST patients. In the May Revision, DSH estimates a reduction of 1.2 position and an increase in General Fund expenditure authority of $17,000 due to a technical adjustment of prior year expenditures.

The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings that previously housed civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients currently housed in these units will be transferred to non-secured buildings elsewhere on the Metropolitan campus and allow for additional secured capacity for the treatment of IST patients currently in county jails awaiting state hospital treatment.

According to DSH, of the five units under construction, Unit 1 was activated September 23, 2019 and Unit 2 was activated on January 29, 2020. Units 3 and 4 were scheduled to be activated in November 2020 and Unit 5 in January 2021. Due to COVID-19 and further construction delays, all three units are now scheduled to be activated in July 2021. In the interim, these units are being used for AOUs and isolation units to allow isolation of newly admitted patients and existing patients testing positive for COVID-19.

Program Update – Enhanced Treatment Program (ETP) Staffing. In the January budget, DSH estimated a reduction of 30.1 positions and General Fund savings of $4.7 million in 2020-21 and 11.6 positions and $1.8 million in 2021-22 due to delayed completion of Enhanced Treatment Program (ETP)

units at Atascadero and Patton State Hospitals. In the May Revision, DSH estimates an additional reduction of 23 positions and General Fund savings of $3.7 million in 2020-21, a reduction of 8.2 positions and General Fund expenditure authority of $329,000 in 2021-22, and General Fund expenditure authority of $1.1 million annually thereafter. These changes are due to additional delays at Atascadero.

AB 1340 (Achadjian), Chapter 718, Statutes of 2014, authorized DSH to establish an ETP pilot project to expand the range of clinical treatment options for patients determined to be at the highest risk of dangerous behavior or violence against other patients or hospital staff and cannot be safely treated in a standard treatment environment. According to DSH, the risk of violence against other patients or hospital staff imposes both a threat to health and safety, as well as a barrier to the effective treatment of other patients who may fear for their physical safety in a standard treatment environment with a potentially violent patient. The pilot project period extends approximately five years from the first patient admitted to the ETP and imposes certain requirements on admission and treatment within an ETP.

Patients are evaluated for admission to an ETP based on requirements contained in AB 1340. A patient referred to an ETP by state hospital clinical staff is assessed by a dedicated forensic psychologist within three business days to make an initial determination regarding the appropriateness of the referral. If the referral is appropriate, the patient is further assessed by a panel comprised of a state hospital medical director, psychiatrist, and psychologist to certify admission to the ETP within seven days of the original referral. Upon admission, a forensic needs assessment team psychologist conducts a violence risk assessment and develops a treatment plan in writing and, if possible, with the collaboration of the patient. The treatment plan, which must be reviewed and updated every ten days, must include information about the patient's mental health status and diagnoses, prescribed medications, goals of treatment, planned interventions and methods, documentation of success in meeting objectives, evaluation of the factors contributing to or detracting from the patient's progress, an activity plan, plans for other services needed by the patient, discharge criteria, goals for an aftercare plan in a standard treatment environment upon discharge, and a plan for post-discharge follow up.

In addition to the admission and treatment criteria, each ETP has specified staff-to-patient ratios, housing and facility requirements, and accessibility requirements. Each ETP is also required to maintain an independent patients' rights advocate to provide advocacy services to patients admitted to an ETP.

According to DSH, various code issues and COVID-19 cases led to delayed completion of Atascadero Unit 29 until December 2020. Construction on Atascadero Units 33 and 34 was suspended temporarily due to COVID-19, with an expected resumption date of July 2021 and an expected completion date of February 2022. Construction of Patton Unit U-06 was also suspended due to COVID-19. DSH expects to resume fire sprinkler installation on Patton Unit U-06, which was in progress when construction was suspended, in July 2021. The remaining construction would resume January 2022 with expected completion in May 2022. The expected construction timelines are as follows:

Units/Hospital	Construction Initiated (Scheduled)	Construction Completion (Scheduled)
DSH-Atascadero Unit 29	September 24, 2018	December 2020
DSH-Atascadero Unit 33	July 2021	February 2022
DSH-Atascadero Unit 34	July 2021	February 2022

DSH-Patton Unit U-06	July 2021	May 2022

Program Update – Vocational Services and Patient Minimum Wage Caseload. In the January budget, DSH estimated General Fund savings of $100,000 in 2020-21 due to lower than expected referrals to its Vocational Rehabilitation Program. In the May Revision, DSH estimates an additional General Fund savings of $625,000 as this program continues to be impacted.

The Vocational Rehabilitation Program serves as a therapeutic program to provide a range of vocational skills and therapeutic interventions for patients, including the development of social, occupational, life, and career skills, and confidence. Patients are paid an hourly wage for the work performed in the following jobs: custodial, kitchen worker, product assembler, laundry attendant, landscaper, painter, plumbing, barber, horticulture, multimedia production, peer mentor, office clerk, and repair technician. The 2019 Budget Act included $3.2 million annually to implement a uniform wage structure for the DSH Vocational Rehabilitation Program, paying participants at the federal minimum wage. DSH estimates of General Fund savings in 2020-21 are due to the reduction in referrals to the program, as well as restrictions on patient work due to COVID-19.

Program Update – Mission Based Review: Direct Care Nursing. In the January budget, DSH reported no change in positions or General Fund expenditures compared to the 2020 Budget Act for staffing changes to implement methodologies to provide appropriate 24-hour nursing care, administration of medication, and an afterhours nursing supervisory structure. In the May Revision, DSH estimates a reduction of 39.1 positions and General Fund savings of $4.4 million in 2020-21 and General Fund expenditure authority of $434,000 annually thereafter, due to delays in recruitment and staffing due to the COVID-19 pandemic.

The 2019 Budget Act included a total of 379.5 positions and General Fund expenditure authority of $46 million, phased in over three years, to implement the direct care nursing staffing methodology changes. Due to the pandemic-induced recession, and resulting General Fund deficit, the 2020 Budget Act shifted these resources to be phased in across a longer time frame. DSH reports the following updates to the phase in of positions:

- Medication Pass Psychiatric Technicians – The 2019 Budget Act included 335 positions for medication pass staffing. The 2020 Budget Act adjusted the positions to be phased-in over five years. As of November 2020, 51.5 positions have been established and 51.5 positions have been filled.
- Afterhours Supervising Registered Nurses – The 2019 Budget Act included 44.5 positions for afterhours nursing supervision. The 2020 Budget Act adjusted these positions to be phased-in over two years. As of November 2020, nine positions have been established and nine positions have been filled, with an additional four positions administratively established to be made permanent under the phased in position authority in the 2021-22 fiscal year.

In addition to phasing in positions, the 2019 Budget Act reallocated position authority between hospitals to provide the appropriate level of staffing needs for each hospital. As of November 2020, the status of hospital position shifts are as follows:

- Atascadero – 112.0 positions have shifted of 132.0 proposed

- Coalinga – 55.0 positions shifted out of 76.1 proposed
- Patton – 27.4 positions shifted out of 27.4 proposed
- Metropolitan – Gain of 142.5 positions once proposed shifts are complete
- Napa – Gain of 93.0 positions once proposed shifts are complete

The 2019 Budget Act also authorized temporary help position authority equivalent to 254.0 positions to support intermittent staffing needs. DSH reports the combination of permanent positions, temporary help, and overtime will allow all hospitals to meet 100 percent of their staffing needs.

Program Update – Workforce Development for Psychiatric Residency Programs and Psychiatric Technicians. In the January budget, DSH estimated General Fund savings of $425,000 in 2020-21 related to delays in workforce development programs for psychiatry residents, nursing staff, and psychiatric technicians. In the May Revision, DSH estimates a reduction of 1.2 position and General Fund savings of $203,000 in 2020-21 and $40,000 annually thereafter due to additional hiring delays.

The 2019 Budget Act included eight positions and General Fund expenditure authority of $1.8 million in 2019-20, $2.2 million in 2020-21, $2.4 million in 2021-22 and 2022-23, and $2.6 million annually thereafter to implement a Psychiatric Residency Program and expand resources for nursing recruitment. DSH expected four residents would have been recruited in July 2020. However, the implementation of the program has been delayed until July 2021.

Program Update – Mission-Based Review: Court Evaluations and Reports. In the January budget, DSH estimated General Fund savings of $314,000 in 2020-21 related to delays in filling positions to support court evaluation and report workload. In the May Revision, DSH estimates a reduction of 13.7 positions and General Fund savings of $2.7 million in 2020-21, and General Fund expenditure authority of $222,000 annually thereafter due to a pause in recruitment efforts due to the COVID-19 pandemic.

The 2019 Budget Act included 94.6 positions and General Fund expenditure authority of $40.2 million over three years to support forensic services workload associated with court-directed patient treatment. Due to the COVID-19 pandemic, the 2020 Budget Act shifted some of these resources and positions to be phased in across a four-year period.

Program Update – Mission Based Review: Treatment Team and Primary Care. In the January budget, DSH requested ten positions in 2021-22 to support its Clinical Operations Advisory Council (COAC). In the May Revision, DSH estimates reduction of 13.4 positions and General Fund savings of $4.4 million in 2020-21, an additional 44.3 positions and General Fund expenditure authority of $22.8 million in 2021-22, and General Fund expenditure authority of $28 million annually thereafter. These changes are due to changes in the phasing in of positions over five years.

In 2020-21, DSH proposed changes to its staffing methodologies for its treatment and primary care teams, including a total of 250.2 positions and General Fund expenditure authority of $64.2 million over a five year period. However, due to the pandemic induced recession and resulting General Fund shortfall, the 2020 Budget Act only included 12.5 positions and General Fund expenditure authority of $5 million in 2020-21 and 30 positions and General Fund expenditure authority of $10 million annually thereafter to support implementation of these staffing changes.

Program Update – Mission Based Review: Protective Services. In the January budget, DSH requested 12 positions annually to support hospital police officers to provide protective services in the State Hospitals. In the May Revision, DSH requests 35.8 positions and General Fund expenditure authority of $6.5 million in 2021-22, $11.4 million in 2022-23, and $10.4 million annually thereafter. These augmentations represent the positions and resources that were not funded in the 2020 Budget Act.

In 2020-21, DSH proposed a new staffing standard to support protective services functions including 46.3 positions and General Fund expenditure authority of $7.9 million in 2020-21, and 47.8 positions and General Fund expenditure authority of $13.4 million annually thereafter. However, due to the pandemic induced recession and resulting General Fund shortfall, the 2020 Budget Act included no positions or expenditure authority for this purpose.

Program Update – Telepsychiatry Resources. In the January budget, DSH estimated a reduction of 6.5 positions and General Fund savings of $911,000 in 2020-21 due to delays in filling positions authorized to support telepsychiatry services for patients. In the May Revision, DSH estimates a reduction of 4.7 positions and General Fund savings of $635,000 in 2020-21 due to unfilled positions.

The 2019 Budget Act included eleven positions and General Fund expenditure authority of $2.2 million in 2019-20 and 21 positions and General Fund expenditure authority of $3.7 million annually thereafter for the telepsychiatry expansion.

Caseload Update: Forensic Conditional Release Program (CONREP) – General/Non-Sexually Violent Predator (Non-SVP) Program. The Forensic Conditional Release Program (CONREP) was established in 1986 and provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. The CONREP population includes patients committed to state hospitals as Not Guilty by Reason of Insanity (NGI), Offenders with a Mental Health Disorder (OMD), and felony Incompetent to Stand Trial (IST). After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

According to DSH, when a patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if the patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional Residential Program (STRP), a resource used by CONREP to provide patients the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hour supervision.

In the January budget, DSH requested General Fund expenditure authority of $1.2 million in 2021-22 and annually thereafter to fund its contracted CONREP caseload of 810 clients. DSH reports its county CONREP providers have negotiated salary increases for staff through collective bargaining contracts, resulting in increased costs for operation of the program. These resources would allow DSH to support its CONREP population.

In the May Revision, DSH estimates no changes to the January budget for this population.

Caseload Update – Forensic CONREP: Sexually Violent Predator (SVP) Program. Beginning in 1996, Sexually Violent Predators (SVP) were added to the CONREP population and are conditionally

released to their county of domicile by court order with sufficient funding to provide treatment and supervision services. According to DSH, the CONREP-SVP program offers patients direct access to an array of mental health services with a forensic focus, as well as regularly scheduled sex offender risk assessments, polygraph testing, and review of Global Position System (GPS) data and surveillance. DSH estimates a total caseload of 29 SVPs will be conditionally released into the community by June 30, 2022. Currently, there are 18 current participants in the CONREP-SVP program and 11 individuals with court-approved petitions for release into the program who are awaiting placement.

In the January budget, DSH did not request additional resources or positions for its CONREP-SVP program.

In the May Revision, DSH requests General Fund expenditure authority of $1.8 million in 2021-22 and annually thereafter due to an increase in expected CONREP-SVP caseload.

Program Update – Forensic CONREP Continuum of Care: Step-Down Transitional Program. In the January budget, DSH requested 0.3 positions and estimated General Fund savings of $6.6 million in 2020-21 and 0.5 positions and expenditure authority of $7.3 million annually thereafter. In the May Revision, DSH estimates General Fund savings of $2.7 million in 2020-21 and $2.7 million annually thereafter. If approved, these positions and resources would support expansion of the CONREP Continuum of Care step-down program.

Program Update – Jail-Based Competency Treatment (JBCT) Programs and Admission, Evaluation, and Stabilization (AES) Center. In the January budget, DSH reports net General Fund savings of $3.2 million in 2020-21 composed of one-time cost savings of $2.2 million for COVID-19 pandemic related delays in activation of additional beds at the Kern Admission, Evaluation, and Stabilization (AES) Center, and $960,000 for delayed activation of a jail-based competency treatment (JBCT) program in Calaveras County. DSH also requested General Fund expenditure authority of $62,000 in 2021-22 and annually thereafter to support travel reimbursement for a contracted mobile psychologist who will travel to multiple JBCT locations to deliver services.

In the May Revision, DSH requests seven positions and $6.5 million in 2021-22 and $8.7 million annually thereafter.

DSH contracts with county jail facilities to provide restoration of competency services in JBCT programs, treating IST patients with lower acuity and that are likely to be quickly restored to competency. DSH expects these programs to increase bed capacity by 427 in 2020-21 and 483 in 2021-22.

In the January budget, DSH also requested General Fund expenditure authority of $785,000 in 2020-21 and $6.3 million in 2021-22 and annually thereafter to support the proposed activation of new JBCT programs.

In the May Revision, DSH requests General Fund expenditure authority of $6.8 million in 2021-22 and $13.8 million annually thereafter to support additional new program activations.

Program Update – Sex Offender Commitment Program and Offender with a Mental Health Disorder (SOCP/OMD) Pre-Commitment Program. In the May Revision, DSH estimates General

Fund savings of $520,000 in 2020-21 in the Sex Offender Commitment Program and Offender With a Mental Health Disorder (SOCP/OMD) Pre-Commitment Program. This reduction is due to shifts in workload resulting in reduction of the use of contracted staff.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of each of the program updates referenced in this item.

Issue 2: COVID-19 Workers Compensation Claims (SB 1129)

Budget Change Proposal – May Revision. DSH requests General Fund expenditure authority of $16.5 million in 2021-22, $14.4 million in 2022-23, $14.7 million in 2023-24, and $16 million in 2024-25. If approved, these resources would support processing and payment of workers' compensation claims related to the COVID-19 pandemic, pursuant to the requirements of SB 1159 (Hill), Chapter 85, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$16,489,000	$14,684,000
Total Funding Request:	**$16,489,000**	**$14,366,000**

* Additional fiscal year resources requested – 2023-24: $14,684,000, 2024-25: $15,979,000.

Background. SB 1159 (Hill), Chapter 85, Statutes of 2020, creates a rebuttable presumption, until January 1, 2023, that an employee's illness or death resulting from COVID-19 arose out of and in the course of employment and is compensable under workers' compensation if the employee is a specified front-line employee, or if the place of employment experiences an outbreak of COVID-19. The bill also makes a claim relating to a COVID-19 presumptively compensable after 30 or 45 days, rather than 90 days, resulting in the presumption the claim is work-related unless evidence is presented to the contrary within that time period.

According to DSH, as of February 16, 2021, the department has reported 1,531 COVID-19 worker's compensation claims to the State Compensation Insurance Fund (SCIF), approximately 255 claims for each state hospital and the Sacramento headquarters, and approximately 139 claims per month system-wide. SB 1159 requires DSH to report to SCIF relevant data on whether a COVID-19 outbreak occurred in a particular DSH location.

Resource Request. DSH requests General Fund expenditure authority of $16.5 million in 2021-22, $14.4 million in 2022-23, $14.7 million in 2023-24, and $16 million in 2024-25 to support processing and payment of workers' compensation claims related to the COVID-19 pandemic, pursuant to the requirements of SB 1159. Specifically, DSH requests the equivalent of seven positions designated as a strike team in the Sacramento headquarters, including **one Staff Services Manager III** and **six Associate Governmental Program Analysts**, which would deploy to field locations with active needs to support workload related to workers' compensation claims. In addition, this request includes support for anticipated medical and state fund costs, claims costs, and death benefits costs totaling $15.5 million in 2021-22, $13.4 million in 2022-23, $13.8 million in 2023-24, and $15 million in 2024-25.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: CONREP – Mobile FACT Team

Program Estimate – May Revision Adjustment. In the January budget DSH requested two positions and General Fund expenditure authority of $5.6 million in 2021-22 and $8 million annually thereafter to implement a mobile treatment team for CONREP services based on the forensic assertive community treatment (FACT) model of care.

In the May Revision, DSH requests additional General Fund expenditure authority of $4.1 million in 2021-22 and $6.2 million annually thereafter for an additional 80 beds in the CONREP FACT program.

Program Funding Request Summary – Local Assistance Funding Adjustment		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$4,090,000	$6,280,000
Total Funding Request:	**$4,090,000**	**$6,280,000**

* Resources ongoing after 2022-23.

Background. The Forensic Conditional Release Program (CONREP) was established in 1986 and provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. The CONREP population includes patients committed to state hospitals as Not Guilty by Reason of Insanity (NGI), Offenders with a Mental Health Disorder (OMD), and felony Incompetent to Stand Trial (IST). After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

According to DSH, when a patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if the patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional Residential Program (STRP), a resource used by CONREP to provide patients the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hour supervision.

Assertive community treatment was developed to help persons with severe mental illness who are at risk of homelessness and hospitalization to become integrated into their communities. High-risk individuals are engaged in care by using mobile services available 24 hours a day and by performing active outreach. The forensic assertive community treatment (FACT) model of care builds upon this treatment model by addressing criminogenic risks in addition to behavioral health needs for individuals involved in the criminal justice system.

Resource Request. In the January budget, DSH requested two positions and General Fund expenditure authority of $5.6 million in 2021-22 and $8 million annually to implement a mobile treatment team for CONREP services based on the FACT model of care. According to DSH, implementing a FACT model of care within CONREP would allow providers to seek housing in a broader radius. Under the current CONREP program, clients are placed near to a centralized outpatient clinic that supports treatment services. CONREP clients must seek transportation or walk to access services. With a mobile treatment model, CONREP clients may be placed in housing further from the central clinic and may still receive services. This provides a larger inventory of housing options for placement of CONREP clients.

To implement the FACT model of care, DSH would augment existing contracts with current CONREP providers and partner with new contract providers to provide: 1) clinical treatment and client support staff; 2) staff travel costs; 3) administrative support and other operational expenses; 4) client life support costs, such as clothing, food, incentives, and toiletries; and 5) client housing costs, such as rent and utilities.

In the January budget, DSH assumed the annual cost per client would be $75,000 and expects to serve 100 clients annually. In the May Revision, DSH assumes a total of 180 clients annually.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 4: Community Based Restoration Program Expansion

Program Estimate – May Revision Adjustment. In the January budget, DSH requested General Fund expenditure authority of $9.8 million in 2020-21, one position and General Fund expenditure authority of $4.5 million in 2021-22 and $5 million annually thereafter to expand the Los Angeles Community-Based Restoration Program in both Los Angeles and in other counties.

In the May Revision, DSH estimates a reduction in requested General Fund expenditure authority of $4.9 million and requests 4.5 positions and General Fund expenditure authority of $28.3 million in 2021-22 and $54.9 million in 2022-23. If approved, these positions and resources would augment the January budget proposal to expand the Community-Based Restoration Program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$28,330,000	$54,855,000
Total Funding Request:	**$28,330,000**	**$54,855,000**
Total Positions Requested:	**4.5**	**4.5**

* Positions and resources ongoing after 2022-23.

Background. The 2018 Budget Act included General Fund expenditure authority of $15.6 million annually to support a partnership with Los Angeles County to establish community mental health treatment programs for individuals determined incompetent to stand trial (IST). According to DSH, the Los Angeles community-based restoration (CBR) program has expanded IST treatment options with a continuum of care comprised of 150 beds in three different types of placements: residential facilities with clinical and supportive services, locked Institutes for Mental Disease (IMD) or mental health rehabilitation centers, or locked acute psychiatric hospitals. The average length of stay for a patient in a CBR program is approximately 12 months.

The Los Angeles CBR program includes a clinical navigation team to stabilize patients on medications and prepare them for community placement. The team provides support in obtaining social and other services, such as Supplemental Security Income, substance use disorder services, primary care, care management, and specialty mental health services. According to DSH, the availability of programs like the Los Angeles CBR program helps alleviate the wait list of individuals determined IST pending placement into a State Hospital or jail-based competency treatment program. DSH reports the IST wait list was 1,306 patients as of November 30, 2020.

Augmentation to Staffing and Local Assistance Request. In the January budget, DSH requested General Fund expenditure authority of $9.8 million in 2020-21, one position and General Fund expenditure authority of $4.5 million in 2021-22 and $5 million annually thereafter to expand the Los Angeles CBR Program, both within Los Angeles and to other counties. The proposed local assistance resources in the January budget would expand capacity by up to 200 beds in Los Angeles County in 2020-21 and up to 50 beds in additional counties in 2021-22. Due to its withdrawal of the Community Care Demonstration Project for ISTs (CCDP-IST), DSH proposes to increase the capacity by 100 beds for a total of 300 beds in Los Angeles County, and to increase the capacity by 202 beds to a total of 252 beds in other counties.

In addition to the local assistance resources, in the January budget DSH requested **one Staff Services Manager II** position to support implementation and ongoing management of the new and existing CBR programs, $20,000 for travel expenses and $40,000 for a contract with experts to provide technical assistance and training to counties implementing a CBR program.

In the May Revision, DSH requests **one Career Executive Assignment** position, **one Consulting Psychologist**, **one Health Program Specialist I** position, **one Research Data Analyst II** position, and **0.5 Associate Governmental Program Analyst**. These positions would support the additional program administration and data collection workload, as well as technical assistance, as a result of the augmentation of the program.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 5: Discontinue Lanterman-Petris-Short Patient Contracts with Counties

Program Estimate and Trailer Bill Language – May Revision. DSH requests three positions and General Fund expenditure authority of $17.1 million in 2021-22 and $88.5 million annually thereafter. In addition, DSH requests reduction in reimbursement authority of $24.7 million in 2021-22, $96.2 million in 2022-23, and $145.5 million annually thereafter. If approved, these positions and resources would allow DSH to discontinue admissions of patients civilly committed under the Lanterman-Petris-Short Act and increase its commitments of individuals determined to be incompetent to stand trial.

DSH also requests trailer bill language to update the statutes governing LPS patients to remove DSH as a treatment placement option and maintain treatment for LPS only at the county level.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$17,082,000	$88,540,000
0995 – Reimbursements	($24,704,000)	($96,162,000)
Total Funding Request:	**($7,622,000)**	**($7,622,000)**
Total Positions Requested:	**3.0**	**3.0**

* Additional fiscal year resources requested – 2023-24 and ongoing: $145,526,220

Background. The Lanterman-Petris-Short (LPS) Act regulates the involuntary civil commitment of individuals to a mental health institution, including a state hospital, in California. LPS patients are individuals that require physically secure 24 hour care and are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability. LPS patients are discharged from a state hospital when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship.

According to DSH, the LPS Act specifies DSH as only one of many treatment options for LPS patients. Alternative options could include a medical, psychiatric, nursing, or other state-licensed facility, or a county hospital, hospital operated by the Regents of the University of California, a United States government hospital, another nonmedical facility approved by the Department of Health Care Services (DHCS), or an agency accredited by DHCS. DSH indicates LPS patients reflect 15 percent of the state hospitals' average daily census and in recent years has experienced growth in this populations in addition to the growth in its population of patients determined incompetent to stand trial (IST).

Program Estimate Adjustment and Trailer Bill Language Request. DSH requests three positions and General Fund expenditure authority of $17.1 million in 2021-22 and $88.5 million annually thereafter. In addition, DSH requests reduction in reimbursement authority of $24.7 million in 2021-22 and $96.2 million annually thereafter. If approved, these positions and resources would allow DSH to discontinue admissions of patients civilly committed under the Lanterman-Petris-Short Act and increase its commitments of individuals determined to be incompetent to stand trial.

DSH also requests trailer bill language to update the statutes governing LPS patients to remove DSH as a treatment placement option and maintain treatment for LPS only at the county level. DSH would halt admissions of new LPS patients as of July 1, 2021, would identify LPS patient reduction targets over the next three fiscal years until all current LPS patients are placed in the community, and would implement

a 150 percent charge of the daily bed rate for counties exceeding the LPS bed usage above specified reduction amounts. DSH indicates, beginning July 1, 2021, it would engage county partners on the development of a transition plan, with reductions of the existing LPS population to begin January 1, 2022. DSH would propose to achieve a 33 percent reduction in LPS patients by June 30, 2022, a 66 percent reduction by June 30, 2023, and a 100 percent reduction by June 30, 2024. As the LPS population is reduced, DSH proposes to admit additional IST patients to reduce the backlog of this population awaiting placement.

DSH also requests **one Staff Services Analyst**, **one Attorney III** position, and **one Staff Services Manager I (Specialist)** position, as well as General Fund expenditure authority of $480,000 in 2021-22, 2022-23, and 2023-24 to support the equivalent of three positions, to oversee, manage and evaluate efforts towards implementation of this transition.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What is the department's assessment of county capacity to effectively treat the LPS population in the community?

Issue 6: Incompetent to Stand Trial Diversion Program Augmentation and Reappropriation

Trailer Bill Language and Budget Bill Language – May Revision. In the January budget, DSH requested three positions and General Fund expenditure authority of $47.6 million in 2021-22 and $1.2 million in 2022-23 to expand its community-based diversion program for individuals with potential to be determined incompetent to stand trial on felony charges. DSH also requested reappropriation of up to $8 million of General Fund expenditure authority previously authorized in the 2018 Budget Act, to provide additional funding to county diversion programs until June 30, 2020, and to liquidate all funding to counties through June 30, 2024.

In the May Revision, DSH requests trailer bill language to require counties expanding a diversion program to exclusively divert IST patient defendants and eliminate the county matching requirement under the original program contract. DSH also requests to increase its reappropriation amount by $6.6 million to reflect the carryover and reappropriation of the unencumbered balance of funding until June 30, 2022.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposals.

Issue 7: COVID-19 Direct Response Expenditures – May Revision Adjustment

Program Estimate – May Revision. DSH requests General Fund expenditure authority of $17.2 million in 2021-22. If approved, these resources would augment the January budget request to support response activities to the COVID-19 pandemic, primarily for staffing, supplies, testing, and logistics.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$17,226,000	$-
Total Funding Request:	**$17,226,000**	**$-**
Total Positions Requested:	**0.0**	**0.0**

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

The Administration is requesting total General Fund expenditure authority of $1.8 billion to continue its response and mitigation of the impacts of the COVID-19 pandemic. In the January budget, $1.4 billion of this request was proposed to be allocated specifically to several departments, with the remaining $400 million allocated through the Disaster Response-Emergency Operations Account (DREOA), pursuant to proposed budget control section language.

In the May Revision, the Administration proposes to allocate $1.7 billion specifically to departments, an increase of $325.8 million compared to the January budget, with the remaining $73.5 million allocated through DREOA. In the updated May Revision request, the specified allocations for each department or entity are as follows:

- **Department of Public Health (DPH)** – DPH requests General Fund expenditure authority of $1.1 billion, an increase of $259.4 million compared to the January budget, for statewide testing efforts at the Valencia Branch testing laboratory, testing specimen collection through OptumServe, and other miscellaneous services and procurements related to testing, contact tracing, and vaccine distribution. The May Revision increase in expenditures is primarily due to costs related to vaccine distribution and administration, hospital and medical surge, and statewide response operations, offset by lower than expected expenditures for the Valencia laboratory and OptumServe specimen collection.

- **Department of General Services (DGS)** – DGS requests General Fund expenditure authority of $32 million, a decrease of $52.4 million compared to the January budget, for three key pandemic-related programs: 1) Hotels for Healthcare Workers, which provides hotel rooms to healthcare workers providing critical care to COVID-19 patients to help them avoid bringing the virus home; 2) Housing for the Harvest, which provides hotel rooms for agricultural workers to isolate safely if they are exposed to, or test positive for COVID-19; and 3) Project Hope, which provides hotel rooms to individuals released from prison that need to quarantine safely. This request also includes DGS' contract with FedEx for testing specimen transportation costs, which would be shifted to the DPH budget. The May Revision reduction in expenditures is due to reduced estimates of the number of people requiring non-congregate sheltering in the Hotels for Healthcare Workers and Housing for the Harvest programs.

- **Department of Corrections and Rehabilitation (CDCR)** – CDCR requests General Fund expenditure authority of $408 million, an increase of $126.7 million compared to the January budget, to support the California Correctional Health Care Services' (CCHCS) efforts to treat COVID-19 and minimize exposure to inmates and staff through testing, vaccinations, medical surge capacity, and personal protective equipment (PPE), as well as to reimburse counties for costs associated with the temporary suspension of prison intake.

- **WITHDRAWN: Department of Veterans Affairs** – In the January budget, the Department of Veterans Affairs requested General Fund expenditure authority of $5.3 million in 2021-22 to continue efforts to mitigate impacts of the pandemic in veterans' homes, including enhanced cleaning protocols, testing of staff and residents, procurement of PPE and cleaning products, and procurement of thermometers and medical devices. In the May Revision, the department is withdrawing this request due to the receipt of federal funds to cover these expenditures.

- **WITHDRAWN: Department of Social Services (DSS)** – In the January budget, DSS requested General Fund expenditure authority of $5 million in 2021-22 for its Rapid Response Program to support entities that provide assistance and services to immigrants during emergent situations when federal funding is not available. In the May Revision, DSS is withdrawing this request as this need is being funded by an alternative effort in the current year within DPH.

- **Board of State and Community Corrections (BSCC)** – BSCC requests General Fund expenditure authority of $12.1 million in 2021-22 to support county probation departments with increased number of individuals released from state prison on Post-Release Community Supervision to reduce institutional populations in response to the pandemic. The May Revision makes no changes to this requests.

- **Emergency Medical Services Authority (EMSA) –** In the May Revision, EMSA requests General Fund expenditure authority of $17 million in 2021-22 to continue its support for medical staffing, ambulance transportation services, and related support costs.

- **Department of Developmental Services (DDS)** – DDS requests General Fund expenditure authority of $15 million in 2021-22, a decrease of $21.7 million compared to the January budget, for development of surge sites to serve consumers diagnosed with, exposed to, or at high risk of COVID-19. The funding would support an average of 20 beds each at the Fairview Developmental Center and 10 beds at the Porterville Developmental Center for six months. The May Revision reduction in expenditures is due to updated projections regarding the need for surge sites.

- **Department of State Hospitals (DSH)** – DSH requests General Fund expenditure authority of $69.2 million in 2021-22, an increase of $17.2 million compared to the January budget, to support staff costs for cleaning, staffing coverage, environmental projects, custody tasks, screening and isolation. The request also covers commodity purchases, such as PPE, sanitation supplies, changes in food service, as well as equipment for heating and air, filtration, and information technology solutions. In addition, though most testing costs would be shifting to DPH, DSH expects some costs from a contractor hired to work onsite to collect, process, and report staff testing results. The May

Revision increase in expenditures is primarily due to updated estimates of personnel services, overtime, and testing costs.

- **Government Operations Agency (GovOps)** – In the May Revision, GovOps requests General Fund expenditure authority of $90.8 million to manage contracts associated with statewide COVID-19 vaccine distribution efforts, coordination with stakeholders, and direct support to vaccine providers and local health jurisdictions.

- **Governor's Office of Emergency Services (CalOES)** – In the January budget, CalOES requested General Fund expenditure authority of $119.7 million in 2021-22 to reimburse local governments for eligible costs associated with emergency activities undertaken in response to the COVID-19 pandemic. In the May Revision, CalOES is withdrawing this request and is requesting General Fund expenditure authority of $18.9 million for state response operations costs at the State Operations Center and funding of subject matter experts for various response activities.

According to the Administration, the remaining $73.5 million would be allocated through the DREOA process for unanticipated costs related to the COVID-19 pandemic. The Administration indicates it would release the departmental allocations for these funds once additional information is available.

Department of State Hospitals Resource Request. In the January budget, DSH requested General Fund expenditure authority of $52 million in 2021-22 to support response activities to the COVID-19 pandemic, primarily for staffing, supplies, testing, and logistics. In the May Revision, DSH requests additional General Fund expenditure authority of $17.2 million in 2021-22 to augment its January budget request due to updated cost estimates. Specifically, DSH requests resources in the following three categories:

- Personal Services – DSH requests General Fund expenditure authority of $30.5 million in 2021-22, an increase of $20.4 million compared to the January budget request, for staff time directly related to COVID-19 including cleaning, sanitization, staffing coverages, environmental projects, performing custody tasks, screening staff, and isolation staff. Of this amount, $19 million would support regular time for staff, while $11.6 million would support overtime. The request assumes half-year costs consistent with a December 31, 2021, end date for the public health emergency.
- Operating Expense and Equipment (OE&E) – DSH requests General Fund expenditure authority of $24.3 million in 2021-22, a decrease of $10.9 million compared to the January budget request, for commodity purchases of consumable and non-consumable items. Consumable items include personal protective equipment, sanitation supplies, food, and food supplies to support safer meal provision. Non-consumable items are related to modifications of existing space, new temporary space to support COVID-19 response activities, equipment, heating and air filters, and information technology solutions. Of this amount, $12.9 million would support commodity purchases, $8.1 million would support service contracts, and $2.3 million would support other operating costs. The request assumes half-year costs consistent with a December 31, 2021, end date for the public health emergency.
- Testing – DSH requests General Fund expenditure authority of $14.4 million, an increase of $7.8 million compared to the January budget request, for testing of patients and employees. According to DSH, although most testing would be shifting to the Department of Public Health's Valencia Branch Laboratory, some testing costs would continue to be borne by the State Hospitals. A contractor

works onsite at all State Hospitals to collect, process, and report staff testing results. Patient testing is conducted by DSH staff and processed at contracted laboratories. Of this amount, $10.8 million would support testing of staff, while $3.5 million would support testing of patients. The request assumes half-year costs consistent with a December 31, 2021, end date for the public health emergency.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 8: Reevaluation Services for Felony Incompetent to Stand Trial Patients

Program Estimate – May Revision. DSH requests 15.5 positions and General Fund expenditure authority of $12.7 million in 2021-22, $11 million in 2022-23, and $9.2 million annually thereafter. If approved, these positions and resources would allow DSH to partner with local county jails to re-evaluate individuals deemed incompetent to stand trial on a felony charge and pending placement to a DSH treatment program for 60 days of more.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$12,729,000	$11,000,000
Total Funding Request:	**$12,729,000**	**$11,000,000**
Total Positions Requested:	**15.5**	**15.5**

* Additional fiscal year resources requested – 2023-24 and ongoing: $9,176,000.

Background - Incompetent to Stand Trial Referrals. Under California law "[a] person cannot be tried or adjudged to punishment or have his or her probation, mandatory supervision, post-release community supervision, or parole revoked while that person is mentally incompetent." IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings. If a defendant's attorney raises concerns about his or her competency to stand trial, the judge in the case may order a mental health evaluation by a psychiatrist or clinical psychologist. If the evaluation finds substantial evidence the defendant is incompetent, a competency hearing is scheduled with additional expert testimony and an opportunity for the defendant to respond to or refute the findings of the evaluation. If the court finds a defendant incompetent to stand trial, the local community health director determines whether the defendant is best treated in a local facility, an outpatient facility, or at a state hospital. Misdemeanants are typically treated in an outpatient setting or released, while felonies are typically referred for treatment at a state hospital. If a bed is not available in a state hospital, the defendant remains in the custody of the county until a bed becomes available. Capacity constraints in the state hospital system have resulted in ongoing backlogs of defendants deemed IST in county jails for extended periods awaiting treatment.

Long-Standing Issues with IST Backlog. Since the 2007-08 fiscal year, the backlog of IST referrals awaiting treatment in state hospitals has grown from between 200 and 300 to 1,306 as of November 2020. In 1972, the United States Supreme Court found in *Jackson v. Indiana* that a person committed on account of his or her incapacity to proceed to trial cannot be held for longer than the reasonable period of time necessary to determine whether the individual is likely to attain capacity. California law requires state hospital or outpatient facility staff to report to the court within 90 days on the status of the defendant's restoration to competency. Based on this 90 day requirement, several court rulings have recommended that a "reasonable" time to transfer IST patients for treatment is no more than 30 to 35 days. Many IST patients remain in county custody for longer, which may violate these patients' due process rights. In addition, the housing of IST patients in county jails while they await availability of treatment beds in state hospitals places stress on county jail systems.

Program Estimate – May Revision. DSH requests 15.5 positions and General Fund expenditure authority of $12.7 million in 2021-22, $11 million in 2022-23, and $9.2 million annually thereafter to partner with local county jails to re-evaluate individuals deemed incompetent to stand trial on a felony charge and pending placement to a DSH treatment program for 60 days of more. DSH intends to employ a panel of independent contracted forensic evaluators consistent with how it manages its responsibility for pre-commitment evaluations under the Offenders with Mental Health Disorder and Sexually Violent Predator statutes. The forensic evaluator would: 1) assess if the individual has been restored, is malingering, or is non-restorable; 2) file a report to the court on the status of the patient; and 3) assess whether the individual would be a good candidate for diversion or other outpatient treatment program. DSH would prioritize IST defendants waiting in jail for more than 60 days to perform an initial re-evaluation. According to DSH, it expects to pay a flat rate to the contracted forensic evaluator of $1,800 per IST re-evaluation, and expects to conduct 3,343 re-evaluations in 2021-22, 3,172 in 2022-23, and 2,380 in 2023-24 and 2024-25.

In addition, DSH would require 15.5 positions to serve as administrative and operational staff to develop and manage the contractual agreements with each of the counties, process payments, track and manage patient movement, gather updated records for evaluators, schedule re-evaluations, submit and track reports to the courts, and provide IT support. Specifically, DSH requests **two Senior Psychiatrists, one Senior Psychologist, two Consulting Psychologists, one Research Data Specialist I, 0.5 Accounting Officer Specialist, six Associate Governmental Program Analysts, one IT Associate, one Attorney III,** and **one Legal Analyst.**

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

1. Please provide a brief overview of this proposal.

Issue 9: Statewide Integrated Health Care Provider Network

Budget Change Proposal – May Revision. DSH requests six positions and General Fund expenditure authority of $6.3 million in 2021-22 and $1.5 million in 2022-23 and 2023-24. If approved, these positions and resources would allow DSH to contract for a Statewide Integrated Health Care Provider Network, including prior authorization and third party administration services to support continuity of care and provide stable and timely access to specialty, quality medical services for patients.

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

* Resources ongoing after 2022-23.

Background. DSH is responsible for caring for the mental health, medical, dental and safety needs of its patient population. Meeting those needs in a timely and appropriate manner can be challenging, particularly arranging for specialty medical care. The state hospitals access outside medical service providers when the needs of a DSH patient goes beyond the scope of the internal medical staff or facility resources. Outside medical providers are non-civil service providers who perform medical services, both on and off DSH grounds. Some of these outside medical services include but are not limited to: cardiologists, radiologists, urologists, anesthesiologists, endocrinologists, gastroenterologists, neurologists and oncologists as well as emergency services, dialysis, and surgical procedures.

Currently, each hospital identifies providers, negotiates and executes contracts, oversees those contracts, processes invoices and schedules payments. DSH staff is also responsible for maintaining positive relationships with providers, resolving service quality issues, and overseeing the services provided to patients. According to DSH, these manual processes vary by hospital and position type, are time intensive and are not standardized across hospitals. DSH also reports challenges contracting with outside medical providers in rural locations such as Coalinga and Atascadero, which face even greater challenges because outside medical providers are not easily accessible.

Staffing and Resource Request. DSH requests six positions and General Fund expenditure authority of $6.3 million in 2021-22 and $1.5 million in 2022-23 and 2023-24 to contract for a Statewide Integrated Health Care Provider Network, including prior authorization and third party administration services to support continuity of care and provide stable and timely access to specialty, quality medical services for patients. The contractor would provide the following specific services:

- Medical Provider Network – Increases access to a network of outside medical providers, and locates providers willing to serve the DSH patient population via negotiated contracts.
- Prior Authorization – Provides an electronic and standardized guide to treatment protocols for patient referrals to outside medical services, and mitigates the manual process of confirming services provided for the adjudication of invoices.
- Third-Party Administrator – Validates and adjudicates medical invoicing, mitigates and controls inaccurate and duplicative billing, and verifies the invoicing matches the terms of the contract and creates a payment file to be transmitted to DSH for payment.

DSH is also requesting six positions that would be responsible for oversight of the healthcare payment process, including for services provided through telemedicine and on-site mobile services. Specifically, DSH is requesting **one Staff Services Manager II**, **one Staff Services Manager I**, **one Health program Specialist I**, and **three Associate Governmental Program Analysts**.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 10: One-Time Deferred Maintenance Allocation - Adjustment

Budget Change Proposal – May Revision Adjustment. In the January budget, DSH requested General Fund expenditure authority of $15 million in 2021-22, available for encumbrance or expenditure until June 30, 2024, to address critical deferred maintenance, special repairs and replacements, and regulatory compliance projects at the five State Hospitals.

In the May Revision, DSH requests an additional $85 million for these projects.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$85,000,000	$-
Total Funding Request:	**$85,000,000**	**$-**
Total Positions Requested:	**0.0**	**0.0**

Background. DSH reports it entered into an Architecture and Engineering Retainer contract to develop a comprehensive plan to address and prioritize deferred maintenance projects at the State Hospitals. DSH conducted a current needs identification and prioritization analysis of deferred maintenance projects required to address major building repairs and site-wide infrastructure needs. In the January budget, this analysis resulted in identification of 19 critical infrastructure projects that form the basis of this request for General Fund expenditure authority of $15 million. In the May Revision, DSH requests additional General Fund expenditure authority of $85 million to support the following additional projects:

Atascadero - $30 million would support completion of previous projects at Atascadero State Hospital to replace roof membranes and air handling units. DSH reports the scope was underestimated due to unanticipated electrical, structural, and mechanical omissions when the project was approved in the 2016 Budget Act.

Coalinga - $4.2 million would support road repairs and road resurfacing for emergency vehicle access and staff safety at Coalinga State Hospital.

Metropolitan - $12.1 million would support demolition and replacement of a 750,000 gallon fire water storage tank with a 1 million gallon tank ($5.6 million) and replacement of chillers, installation of a cooling tower, and removal of a cooling tower and storage tank ($6.5 million) at Metropolitan State Hospital.

Napa - $15 million would support replacement of an existing roof in the Receiving and Treatment building at Napa State Hospital with a new roof, insulation, HVAC curbing, and fall protection.

Patton - $23.7 million would support replacing a damaged roof ($14 million), repair security perimeter roads ($4.2 million), and replace or repair various modular buildings that have surpassed their lifespan ($5.5 million) at Patton State Hospital.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 11: Non-Restorable Incompetent to Stand Trial Patients

Trailer Bill Language – May Revision. DSH requests trailer bill language to require individuals deemed incompetent to stand trial on felony charges that are determined to be not restorable to mental competency be returned to county custody within 10 days and remain in the county. The trailer bill language would also authorize DSH to charge a county a daily bed rate for patients that remain in a state hospital beyond 10 days.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.