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.

Tuesday, May 4, 2021
2:30 p.m.
State Capitol - Room 3191

Consultant: Scott Ogus

PUBLIC COMMENT

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4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Reappropriations and Other Technical Adjustments

Budget Bill Language – April Finance Letter. OSHPD requests several technical adjustments to budget bill language, including: 1) reappropriation of federal funds for state loan repayments, 2) extension of the encumbrance liquidation period for Peer Personnel Program funding, 3) correcting a program numbering error, 4) correcting a program reference, and 5) correcting an error in reimbursement amounts.

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

OSHPD requests budget bill language to reappropriate up to $31,000 of federal funds, originally authorized in the 2018 Budget Act, until June 30, 2022. According to OSHPD, SLRP has received federal authority to encumber these funds in 2021-22.

Extension of Encumbrance and Liquidation Period for Peer Personnel Program Funding. In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directs the majority of revenues to county mental health programs for community services and supports, prevention and early intervention, innovative programs, workforce education and training (WET), and capital facilities and technological needs. For WET programs, Proposition 63 allocated $210 million to counties and $234.5 million to the state over a ten-year period beginning in 2008. The state's WET programs were originally administered by the Department of Mental Health (DMH), which developed the first five-year plan for the program. After dissolution of DMH in 2012, program responsibility was transferred to OSHPD, which developed the second five-year plan for 2014-2019 in coordination with the California Mental Health Planning Council. In February 2019, OSHPD released the third five year WET plan covering the period from 2020-2025. After engaging with stakeholders, the report is meant to guide efforts to improve and expand the public mental health system (PMHS) workforce throughout California.

The 2018 Budget Act included expenditure authority from the Mental Health Services Fund State Administration Account of $10 million in 2018-19 to allow existing WET programs to continue while OSHPD and stakeholders worked together on options for funding and implementing a new five-year plan for the WET program. The 2019 Budget Act included expenditure authority of $60 million ($35 million General Fund and $25 million Mental Health Services Fund) to implement the 2020-25 Five-Year WET Plan. According to OSHPD, recipients of WET funding for the Peer Personnel Program require additional

time to fulfill the terms of their service grant agreements. As a result, OSHPD is requesting budget bill language to extend the encumbrance liquidation period of the 2018 Budget Act appropriation until June 30, 2022.

Other Technical Adjustments. OSHPD also requests the following technical adjustments to budget bill language:

1. Correct Program Number – OSHPD requests budget bill language to correct the program number in Schedule (3) of Item 4140-001-0001. The program number currently reads 3835, but OSHPD would like to correct it to read 3855, which reflects the correct program.
2. Amend Program Name – OSHPD requests budget bill language to change the reference to its investment in geriatric care workforce programs. The current language refers to the "Alzheimer's Health Care Workforce Program". OSHPD requests to amend the language to instead refer to the "Geriatric Care Workforce Program".
3. Annual Reimbursement Adjustment – OSHPD requests budget bill language to accurately reflect reimbursement amounts in Item 4140-101-0143. The requested language would increase reimbursements in the item by $400,000.

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

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

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

Issue 2: Department of Health Care Access and Information

Budget Change Proposal and Trailer Bill Language – May Revision (Early Release). OSHPD requests nine positions and total expenditure authority from various fund sources of $6.3 million in 2021-22 and 13 positions and $3.9 million annually thereafter to recast and reorganize the Office into the Department of Health Care Access and Information (HCAI). The reorganization includes transferring the Office of Rural Health and the J-1 Visa Waiver Program from DHCS to the new department. OSHPD also proposes trailer bill language to implement these changes.

Program Funding Request Summary – OSHPD/HCAI		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$574,000	$486,000
0121 – Hospital Building Fund	$1,208,000	$325,000
0143 – CA Health Data and Planning Fund	$1,631,000	$1,950,000
0181 – Registered Nurse Education Fund	$34,000	($45,000)
0518 – Health Facility Construction Loan Insurance Fund	$70,000	$26,000
0829 – Health Professions Education Fund	$29,000	($24,000)
0890 – Federal Trust Fund (State Operations)	$998,000	$781,000
0890 – Federal Trust Fund (Local Assistance)	$1,747,000	$498,000
3064 – Mental Health Practitioner Education Fund	$9,000	($70,000)
3068 – Vocational Nurse Education Fund	$13,000	($68,000)
3085 – Mental Health Services Fund	$13,000	($68,000)
8034 – Medically Underserved Account for Physicians	$18,000	$12,000
Total Funding Request:	**$6,337,000**	**$3,877,000**
Total Requested Positions:	**9.0**	**13.0**

* Additional fiscal year resources requested: 2023-24 and ongoing: $3,870,000

Program Funding Request Summary – DHCS		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	($690,000)	($690,000)
0890 – Federal Trust Fund	($1,174,000)	($1,174,000)
Total Funding Request:	**($1,864,000)**	**($1,864,000)**
Total Requested Positions:	**(4.0)**	**(4.0)**

* Reduced positions and resources ongoing after 2022-23.

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

According to OSHPD, California's health care system has changed dramatically since the office's creation in 1978. Recent changes to OSHPD's responsibilities, including management of the Health Care Payments Data (HPD) Program, as well as the proposed Office of Health Care Affordability (OHCA),

require a recasting of OSHPD's role. OSHPD believes the Department of Health Care Access and Information (HCAI) would be a more descriptive name for its new responsibilities and focus.

OSHPD proposes trailer bill language to recast the office as HCAI, including the following components:

- Amends Statutory References – Renames the Office of Statewide Health Planning and Development to the Department of Health Care Access and Information, and amends references to the "office" to the "department".

- Licensing Board Demographic and Other Data Collection – Amends the Business and Professions Code to require healing arts licensing boards to collect certain demographic and other data from its licensees. This language is similar to that contained in AB 1236 (Ting), pending in the current legislative session.

- Access to Vital Records – Allows the new department to request access to certain vital records from the Department of Public Health for the purpose of public reporting and research on health care quality and outcomes.

- Updates SB 17 Prescription Drug Reporting – SB 17 (Hernandez), Chapter 603, Statutes of 2017, requires manufacturers of prescription drugs to submit specific cost transparency information to OSHPD on drugs for which prices increase by more than 16 percent. The proposed trailer bill language would: 1) add data submission requirements to help identify the therapeutic type of drug, factors describing the reason for a price increase, and the basis for withholding or limiting any information otherwise required to be submitted; 2) clarify definitions and requirements for reporting; 3) add information to support comparisons between brand name and generic drugs; and 4) clarify imposition of civil penalties on manufacturers that fail to provide required information.

- Transition Health Care Workforce Clearinghouse to California Health Workforce Research and Data Center – The Health Care Workforce Clearinghouse was established in 2007 by SB 139 (Scott), Chapter 522, Statutes of 2007. The clearinghouse collects, analyzes, and publishes information on educational and employment trends for healthcare occupations in the state. The proposed trailer bill language would transition the clearinghouse into the California Health Workforce Research and Data Center. The Data Center would be the recipient of the demographic and other data collected by healing arts licensing boards and, in addition to continuing the analysis and reporting previously conducted by the clearinghouse, would also report on the outcomes and effectiveness of health care workforce programs.

- Transition California Healthcare Workforce Policy Commission to California Health Workforce Education and Training Council – The California Health Care Workforce Policy Commission consists of 15 members, nine appointed by the Governor, and three each appointed by the Assembly and Senate. The Commission recommends funding awards for programs that demonstrate the ability to place graduates in medically underserved areas, attract and admit members of minority groups, and locate programs in medically underserved areas. The proposed trailer bill language would transition the commission to the California Health Workforce Education and Training Council. The council would also consist of 15 members, with six appointed by the Governor, three each by the Assembly and Senate, and representatives of the

Department of Health Care Services, HCAI, and the University of California. According to OSHPD, the council would provide guidance on statewide education and health workforce training needs across key areas, including general physician education, primary care and behavioral health, and would advise on increasing the supply and diversity of physician and non-physician providers, as well as the placement of providers in medically underserved areas. The council would support the programs currently covered by the commission, such as the Song-Brown Program, as well as those currently covered by the Health Professions Education Foundation (HPEF), which is proposed to transition its programs to HCAI. HCAI would consider the council's policy recommendations as part of its administration of all of its workforce programs, including funding and award selection.

- Absorb Health Professions Education Foundation Programs – OSHPD administers the Health Professions Education Foundation (HPEF), a 501(c)(3) non-profit public benefit corporation established in 1987 through legislation. The HPEF offers scholarships and loan repayments for students and graduates willing to practice in underserved areas. The HPEF manages the following scholarship and loan repayment programs: 1) Allied Healthcare Scholarship and Loan Repayment Programs; 2) Vocational Nurse Scholarship and Licensed Vocational Nurse (LVN) Loan Repayment Programs; 3) LVN to Associate Degree Nursing Scholarship Program; 4) Associate Degree Nursing Scholarship Program; 5) Bachelor of Science in Nursing Scholarship and Loan Repayment Programs; 6) Advanced Practice Healthcare Scholarship and Loan Repayment Programs; 7) Licensed Mental Health Services Provider Education Program; 8) Mental Health Loan Assumption Program; and 9) Steven M. Thompson Physician Corp Loan Repayment Program. The proposed trailer bill language would dissolve the 501(c)(3) structure as of January 1, 2022, and absorb its programs within the new department. The California Healthcare Workforce Education and Training Council would support these programs and make recommendations on funding and awards.

- Expansion of Coronary Artery Bypass Graft Outcomes Reporting – OSHPD reports outcomes data for coronary artery bypass graft (CABG) surgeries in its CABG Outcomes Reporting Program. The reports and visualizations provide quality ratings for the state-licensed hospitals and surgeons that perform CABG surgery. The proposed trailer bill language would expand reporting to new and emerging cardiac procedures, such as transcatheter aortic valve replacement.

In addition to the organizational changes proposed in the trailer bill language, OSHPD also proposes to transition the following two programs from the Department of Health Care Services to the HCAI Primary Care Office:

- Office of Rural Health – The California State Office of Rural health links rural communities with state and federal resources and collaborates with statewide rural health associations and other public and private agencies to promote rural health services.

- J-1 Visa Waiver Program – Federal law requires foreign physicians seeking to pursue graduate education or training in the United States to obtain a J-1 Exchange Visitor Visa. The J-1 Visa Waiver Program makes recommendations to the United State Department of State regarding which visa applications should be granted. The program gives priority to applications from primary care physicians who will work in federally designated underserved areas.

Staffing and Resource Request. OSHPD requests nine positions and total expenditure authority from various fund sources of $6.3 million in 2021-22 and 13 positions and $3.9 million annually thereafter to recast and reorganize the office into the Department of Health Care Access and Information (HCAI). These positions and resources would be allocated as follows:

Department Name Change – OSHPD requests expenditure authority of $1 million ($782,000 Hospital Building Fund, $171,000 Health Data and Planning Fund, $39,000 Health Facility Construction Loan Insurance Fund, and $8,000 Mental Health Services Fund) in 2021-22 to support one-time consulting services to, in collaboration with technology consultants: 1) plan, build new domain name, server environment, and authentication services; 2) migrate existing data; 3) validate data migration; 4) ensure appropriate security controls and interoperability with other systems; and 5) decommission the old domain name.

Health Workforce Research and Data Center – OSHPD requests expenditure authority of $770,000 from various special funds in 2021-22 and four positions and $1 million in 2022-23 to support consulting and software resources to establish and operate the Workforce Research and Data Center, which will replace the Healthcare Workforce Clearinghouse. Specifically, the four requested positions, in addition to one requested reclassification of an existing position, are as follows:

Healthcare Workforce Development Division (HWDD)

- **One Research Data Manager** position would be reclassified from the Executive Director position at HPEF and would be responsible for management of the Research and Data Center, planning long-term vision and strategies, and communicating to executive management and external stakeholders.
- **Two Research Data Specialist I** positions would be responsible for health workforce data management, data analysis, and grant program evaluation.

Information Services Division

- **One Information Technology Associate** would be responsible for data management activities to maintain the existing enterprise data warehouse, data management environment, and data analytics toolsets.
- **One Information Technology Specialist I** position would be responsible for the most complex data management activities to maintain the existing enterprise data warehouse, data management environment, and data analytics toolsets.

The requested consulting resources for the Research and Data Center are as follows:

- $500,000 annually for workforce evaluation and research contracts to support the center in data collection and public reporting, including expertise on graduate medical education and training programs. Workload may include survey development and administration, data collection from healthcare facilities, educational institutions, or health workforce training programs. Public reporting may include grant program evaluation reports and analysis regarding the supply, demand, or educational capacity of the health workforce in the state.
- $150,000 annually for information technology (IT) consulting to support data dashboard design, development, and ongoing support, using existing toolsets.
- $4,000 annually for software licensing of existing toolsets for three data analysis staff.

- $86,000 in 2021-22 for system enhancements for the Department of Consumer Affairs (DCA) to collect required workforce data from healing arts board licensees.
- $30,000 annually for annual transmission of required workforce data from DCA.

State Office of Rural Health and J-1 Visa Waiver Program – OSHPD requests four positions and expenditure authority of $3.4 million ($2.7 million federal funds and $690,000 Health Data and Planning Fund) in 2021-22 and $1.9 million ($1.2 million federal funds and $690,000 Health Data and Planning Fund) in 2022-23 for administration and grant awards of the J-1 Visa Waiver Program administered by the Office of Rural Health. Specifically, the four requested positions are as follows:

Healthcare Workforce Development Division (HWDD)

- **One Health Program Manager I** position would be responsible for program supervision and evaluation of the Small Rural Hospital Improvement Program (SHIP) within the Office of Rural Health, and integration of the office's workforce priorities into HWDD programs.
- **One Health Program Specialist II** position would be responsible for administration, planning, and implementation of the Medicare Rural Hospital Flexibility Program within the Office of Rural Health.
- **One Health Program Specialist I** position would be responsible for coordination, monitoring, and evaluation of the Office of Rural Health grant activities and the J-1 Visa Waiver Program.
- **One Associate Governmental Program Analyst (AGPA)** would administer SHIP and provide supportive services to the Office of Rural Health and J-1 Visa Waiver Program.

As a result of the transfer of responsibilities from DHCS to HCAI, DHCS requests a corresponding decrease of four positions and expenditure authority of $1.9 million ($690,000 General Fund and $1.2 million federal funds) annually.

Dissolution of Health Professions Education Foundation (HPEF) – OSHPD requests reclassification of one Marketing and Outreach Director to **one Staff Services Manager II** position to oversee increased staffing of the Grants Management section. No change in expenditure authority is requested for this purpose.

Shared Services – OSHPD requests three positions and expenditure authority of $576,000 ($329,000 Hospital Building Fund, $217,000 Health Data and Planning Fund, $26,000 Health Facility Construction Loan Insurance Fund, and $4,000 Mental Health Services Fund) annually for administrative, IT, legal, and other shared services resources to support the additional workload and staff included in this request. Specifically, the three requested positions are as follows:

- **One Associate Budget Analyst** in the Administrative Services Division responsible for technical analytical work related to the preparation and maintenance of the budget.
- **One IT Associate** position in the Information Services Division's help desk, responsible for IT services and support, triaging support requests, providing training on enterprise tools, and researching and troubleshooting issues.
- **One Attorney IV** position in the Legal Division to support IT contracting, advise and assist HCAI in privacy law and navigation of intersecting state and federal regulations in operation of the Data Center, advise and support in the implementation and operation of the council activities, policies, and procedures, and support and advise the Office of Rural Health.

Business Application and Design – OSHPD requests two positions and expenditure authority of $341,000 ($171,000 General Fund, $124,000 Health Data and Planning Fund, $12,000 federal funds, $11,000 Health Professions Education Fund, $12,000 Registered Nurse Education Fund, $3,000 Mental Health Practitioner Education Fund, $6,000 Medically Underserved Account of Physicians Health Professions Education Fund, and $2,000 Vocational Education Fund) annually to support maintenance of the electronic application for workforce grant applicants. Specifically, the two requested positions are as follows:

- **One IT Associate** position would be responsible for business application engineering and maintenance activities for continuous operations of existing toolsets.
- **One IT Specialist I** position would be responsible for the most complex business application engineering and maintenance activities for continuous operations of existing toolsets.

Organizational Change Management Support – OSHPD requests expenditure authority of $250,000 from various funds in 2021-22 to support consulting services for organizational change management associated with the transition from OSHPD to HCAI. The consulting support would help facilitate organizational design, organizational process improvements, and creation of business interaction models. Additional responsibilities would include leadership development, team dynamics, employee training, coaching, and robust virtual and digital communication campaigns.

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

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

1. Please provide a brief overview of this proposal.

2. Please explain the rationale for this reorganization and recasting. What is the benefit to the state from making these significant changes?

3. Please describe how the Data Center would utilize data received from healing arts licensing boards and vital records from the Department of Public Health. How would this data be managed to protect confidential patient or provider information?

4. What is the rationale for dissolution of the Health Professions Education Foundation? How would these programs change, if at all, when they are absorbed into the new HCAI?

5. How would the transition from the California Healthcare Workforce Policy Commission to the California Health Workforce Education and Training Council affect funding decisions for the state's healthcare workforce programs? How would the composition of the council be different from the composition of the commission as currently defined by statute?

Issue 3: Office of Health Care Affordability

Budget Change Proposal and Trailer Bill Language – Governor's Budget. OSHPD requests 58 positions and expenditure authority from the California Health Data and Planning Fund of $11.2 million in 2021-22, 106 positions and $24.5 million in 2022-23, 123 positions and $27.3 million in 2023-24, and 123 positions and $27.3 million annually thereafter. If approved, these positions and resources would allow OSHPD to establish an Office of Health Care Affordability to increase health care price and quality transparency, develop strategies and cost targets for different sectors of the health care industry, impose financial consequences for entities that fail to meet these targets, and promote health care workforce stability and training needs. OSHPD is also proposing trailer bill language to establish the Office.

Trailer Bill Language Proposal – Update. This issue was heard at the subcommittee's hearing on February 5th, 2021. OSHPD has since revised its trailer bill language, consistent with amendments made to AB 1130 (Wood), pending in the current legislative session.

Panel Discussion. The subcommittee has requested the following panelists to provide testimony regarding the impacts of this proposal:

- **Bill Kramer** – Executive Director for Health Policy, Purchaser Business Group on Health
- **Ryan Witz** – Vice President – Health Care Financing Initiatives, California Hospital Association
- **Lauren Noland-Hajik** – Senior Manager of Governmental Affairs, Blue Shield of California
- **Janice Rocco** – Vice President – Health Care Access and Coverage, California Medical Association
- **Janice O'Malley** – Legislative Advocate, California Labor Federation
- **Yasmin Peled** – Policy and Legislative Advocate, Health Access California

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0143 – CA Health Data and Planning Fund	$11,194,000	$24,528,000
Total Funding Request:	**$11,194,000**	**$24,528,000**
Total Requested Positions:	**58.0**	**106.0**

* Additional fiscal year resources requested: 2023-24: 123 pos and $27,296,000, 2024-25 & ongoing: 123 pos and $27,262,000.

Background. California has made significant gains in reducing the number of uninsured individuals in the state through expansion of the Medi-Cal program and the establishment of Covered California, the state's health benefit exchange, which provides state and federal premium affordability subsidies to improve access to health care coverage. Despite these gains in coverage, Californians remain concerned about the cost of paying for health care. A 2018 statewide survey by the Kaiser Foundation and the California Health Care Foundation found approximately one in five Californians reported problems paying medical bills, nearly half of Californians experienced some type of cost-related health care access problem, and more than two in five reported delaying or forgoing care in the previous year due to cost. Californians with lower incomes, those who lack health insurance, and black and Latino residents were more likely than their white or Asian American counterparts to forgo care due to cost.

According to the Centers for Medicare and Medicaid Services, Californians spent $292 billion on health care in 2014. Per-capita health spending in the state has grown steadily over time, with those covered by

private health insurance experiencing the highest growth rates of approximately four percent per year. Prescription drug costs have grown at a particularly high rate, averaging seven percent per year.

Other State Efforts to Control Health Care Costs. Four other states have established regulatory bodies or independent entities aimed at controlling the growth of health expenditures. Each of these states (Maryland, Massachusetts, Oregon, and Rhode Island) approach the problem of controlling health expenditures differently.

1) Massachusetts Health Policy Commission – In 2012, Massachusetts established the Health Policy Commission (HPC) to set statewide targets for reducing health care spending growth. The growth targets are comprehensive and cover both public and private payers, as well as all medical expenses, non-claims-related payments, patient out-of-pocket expenses, and the net cost of private insurance. The HPC imposes mandatory reporting requirements on health care organizations to improve transparency and encourage containment of spending growth. If a provider organization exceeds certain growth targets, the HPC may require a performance improvement plan. Health care organizations must also testify at an annual two day hearing regarding efforts to contain costs. During the commission's first five years, Massachusetts' annual cost growth averaged 3.44 percent, which was lower than the target rate of 3.6 percent.

2) Maryland Health Services Cost Review Commission – In 1972, Maryland established the Health Services Cost Review Commission (HSCRC), focused on setting payment rates for hospital services. In 2019, Maryland expanded the model of the HSCRC to include all care for Maryland's Medicare enrollees, adopting a total cost of care model that encourages value-based health care redesign and provides tools and resources for primary care providers to better meet the needs of patients with complex health care needs and achieve better health for all Maryland residents. The HSCRC sets a hospital per capita cost growth limit of 3.58 percent per year, sets and enforces the quality of care and population health goals, and provides incentive programs to reward population health and encourage value-based care.

3) Rhode Island Office of the Health Insurance Commissioner – In 2004, Rhode Island established the Office of the Health Insurance Commissioner (OHIC) to conduct rate reviews for health insurance plans. In 2009, the state expanded the focus of OHIC to mandate insurers spend one percent more in total spending on primary care for five years, expand a statewide multi-payer medical home program to better manage patients with chronic conditions, expand the use of electronic medical records, and reform payment systems to incentivize quality. Beginning in 2018, the state established a Working Group on Healthcare Innovation to develop recommendations for establishing a global health spending cap, linking payments to quality, developing standardized health information technology systems, and establishing performance frameworks to achieve population health and wellness goals.

4) Oregon Health Policy Board – In 2009, Oregon created the Oregon Health Policy Board (OHPB) which works to establish a baseline for sustainable health expenditures. In 2019, Oregon established the Sustainable Health Care Cost Target program and mandated development of a statewide spending growth target and recommendations for instituting a benchmark to contain the growth of health spending.

Office of Health Care Affordability and Health Care Payments Data Program. The Governor, in his 2020 January budget, proposed the establishment of an Office of Health Care Affordability to increase price and quality transparency, develop specific strategies and cost targets for different sectors of the health care industry, and financial consequences for entities that fail to meet these targets. The proposal included expansion and recasting of existing health care cost data efforts as the Health Care Payments Data Program at OSHPD, and expected this program to become an integrated part of the data collection efforts to support the efforts of the new Office of Health Care Affordability. Due to the pandemic, the Administration withdrew its proposal to implement the Office of Health Care Affordability, but continued with its proposal to move forward to the next stage of development of the Health Care Payments Data Program.

The 2021 January budget reintroduces the proposal for the Office of Health Care Affordability. According to the Administration, the proposed Office of Health Care Affordability would do the following:

- **Set Health Care Cost Targets by Sector.** The Office would establish a statewide health care cost target with the authority to set specific targets by sector, including by payer, provider, insurance market or line of business.
- **Increase Cost Transparency.** The Office would collect and analyze data from existing and emerging public and private data sources to publicly report total health care spending and factors contributing to health care cost growth. The Office would publish an Annual Report and conduct public hearings about performance against the health care cost targets, trends in health care costs, and recommendations for mitigating cost growth.
- **Enforce Compliance with Cost Targets.** The Office would oversee the state's progress towards meeting health care cost targets by providing technical assistance, requiring public testimony, requiring submission of corrective action plans, monitoring progress of corrective action plans, and assessing escalating civil penalties for noncompliance.
- **Promote and Measure Quality and Health Equity.** The Office would utilize OSHPD and other departmental data to standardize quality measures for evaluating spending of health care service plans, insurers, hospitals, and physician organizations, with consideration for minimizing administrative burden and duplication.
- **Advance and Monitor Adoption of Alternative Payment Models.** The Office would promote a shift from payments based on fee-for-service to payments that reward high quality and cost-efficient care. The Office would measure progress towards the goal and adopt standards for alternative payment models that may be used by providers and payers during contracting.
- **Advance Standards for Health Care Workforce Stability and Training Needs.** The Office would monitor the effects of health care cost targets on workforce stability, high-quality jobs, and training needs of health care workers. The Office would develop standards to assist health care entities in implementing cost-reduction strategies that advance the stability of the health care workforce and avoid exacerbating existing health care workforce shortages.
- **Address Consolidation and Market Power.** The Office would monitor cost trends in the health care market including the impact of consolidation and market power on competition, prices, access, and quality. The Office would partner with the Attorney General, Department of Managed Health Care, and Department of Insurance to examine mergers, acquisitions, or corporate affiliations in the health care sector to promote competitive health care markets.

The Administration also proposes to establish a Health Care Affordability Advisory Board within the Office, composed of 11 members. Seven members would be appointed by the Governor, two would be appointed by the Senate Committee on Rules, and two would be appointed by the Speaker of the Assembly. Each board member would be required to have demonstrated and acknowledged expertise in one of several health care delivery, management, consumer, or workforce areas. The board would advise the Director and the Office on the following:

1) Establishment of health care cost targets
2) Collection, analysis, and public reporting of data
3) Factors that contribute to cost growth in the state's health care system
4) Strategies to improve affordability for individual consumers and purchasers of health care
5) Recommendations for administrative simplification in the health care delivery system
6) Approaches for measuring access, quality, and equity of care
7) Setting statewide goals and measuring progress for adoption of alternative payment models and developing standards for payers and providers to use during contracting
8) Recommendations for updates to statute necessary to promote innovation and enable increased adoption of alternative payment models
9) Healthcare workforce stability and training related to health care costs
10) Addressing market failures, including consolidation and market power

Funding for the Office of Health Care Affordability. OSHPD proposes to support the Office of Health Care Affordability with expenditure authority from the California Health Data and Planning Fund. This fund is supported by annual assessments on licensed health facilities in the state. Section 127280 of the Health and Safety Code authorizes OSHPD to establish a fee structure sufficient to pay for required functions or health-related programs it administers, which would include the Office of Health Care Affordability. Included in its budget request, OSHPD proposes provisional budget bill language to provide for a General Fund cash flow loan to support the Office due to expected delays in collecting assessments for health facilities for this purpose. The General Fund cash flow loan would be repaid when these assessments are received, according to the requirements of Section 16351 of the Government Code.

Staffing and Resource Request. OSHPD requests 58 positions and expenditure authority from the California Health Data and Planning Fund of $11.2 million in 2021-22, 106 positions and $24.5 million in 2022-23, 123 positions and $27.3 million in 2023-24, and 123 positions and $27.3 million annually thereafter to establish the Office of Health Care Affordability. OSHPD is also proposing trailer bill language to establish the Office. OSHPD is modeling its staffing for this effort on the Massachusetts Health Policy Commission, and expects to phase in staff over three years. In 2020-21, the 58 staff needed to establish the program include the following:

- **One Deputy Director (CEA B)**
- **One Chief Medical Officer**
- **One Pharmaceutical Consultant II (Specialist)**
- **Two Branch Chiefs (CEA A)**
- **One Deputy Chief Counsel (CEA B)**
- **One Assistant Chief Counsel**
- **Four Managers**
- **47 Staff-Level Positions**

Within the Office would be the following divisions, branches, and units:

- Health Care Affordability Division – This division would support setting and enforcing cost targets, measuring quality performance through a set of standard measures, promoting health care workforce stability and training needs, setting a statewide goal for the adoption and monitoring of progress towards alternative payment models, developing standards for alternative payment models, and promoting competitive health care markets. The Health Care Affordability Division would oversee the Health Care Cost Trends Branch and the Quality Performance Branch.
    - Health Care Cost Trends Branch – This branch would oversee all data management, research, and analytic activities for the health care cost target program. The branch would manage the production of high quality, objective research and analysis to support the goal of reducing per capita health costs in California. The Health Care Cost Trends Branch would oversee a Data Management Unit and a Research and Analytics Unit.
        - Data Management Unit – This unit would support data collection efforts to enable measurement of total health care expenditures including use of databases and systems to collect expenditure data, implementing reporting schedules for expenditure data, technical specifications and other resources for data submission, and implementation of quality assurance processes for data completeness, timeliness, and accuracy.
        - Research and Analytics Unit – This unit would lead all research and analytic activities for the health care cost target program including analysis of data on health care expenditures, assembling findings and policy recommendations for the annual report and other cost research and study, and provide advice on research or technical projects related to health care costs.
    - Quality Performance Branch – This branch would support identification and adoption of standard measures to assess quality performance of health care service plans, insurers, hospitals, and physician organizations, while reducing administrative burdens and duplication. This branch would also oversee data collection and reporting of quality performance in the annual report and develop recommendations for improving the quality of care. In addition, this branch would oversee monitoring of workforce impacts and manage the setting of statewide goals and standards for adoption of alternative payment models. The Quality Performance Branch would oversee a Quality Analysis Unit and a Payment Reform Unit.
        - Quality Analysis Unit – This unit would oversee research and analysis to evaluate quality performance of health care service plans, insurers, hospitals and physician organizations. This unit would also oversee the development and monitoring of quality performance measures, creation of dashboards, production of data visualizations for the annual report, review of literature on quality improvement efforts, and recommendations for policy actions to improve quality of care.
        - Payment Reform Unit – This unit would lead the setting of statewide goals and standards for the adoption of alternative payment models, creation of dashboards, and production of data visualizations for the annual report.
- Investigations and Enforcement Branch – This branch would manage legal staff to advise the Office on legal matters, and carry out the Office's investigation and enforcement responsibilities including interpreting laws, rules and regulations, representing the Office in administrative

proceedings and litigation, and managing outside counsel. This branch would also establish the regulatory program for enforcement of cost targets and cost and market impact reviews including development of regulations, guidance, and bulletins, as well as the assignment of cost target violations, notices of proposed material changes, and corrective action plans. These responsibilities would also include financial and market impact reviews. The Investigations and Enforcement Branch would be led by a Deputy Chief Counsel that would report directly to OSHPD's Chief Counsel in its Legal Office.

- Information Technology Services Division – This division would provide support for the information technology infrastructure used to collect data from health care entities and other sources for the Office.

In addition to these units, OSHPD reports establishment of the Office would result in staffing and resource needs in the following existing offices and divisions:

- Office of Legislative and Public Affairs – One new staff position would be required to advise OSHPD management regarding impacts of legislation, provide recommendations in the development of analyses, formulate position statements for CHHSA and other state departments, attend and monitor hearings and other legislative business, facilitate and review policy and correspondence, and prepare responses to constituent inquiries.
- Administrative Services Division – New staff would be required to support the additional administrative workload resulting from the addition of a significant number of new staff for the Office.
- Information Services Division – New staff would be required to support additional information technology workload on existing enterprise services and systems resulting from the addition of a significant number of new staff for the Office.

The proposed phase-in of staffing for the various divisions of the Office are shown in the table below:

Office of Health Care Affordability	**2021-22**	**2022-23**	**2023-24 (Ongoing)**
Health Care Affordability Division			
Deputy Director (CEA B)	1	1	1
Chief Medical Officer	1	1	1
Pharmaceutical Consultant II Specialist	1	1	1
Health Program Specialist II (HPS II)	1	1	1
Staff Services Manager I Specialist	1	1	1
Assoc Governmental Program Analyst (AGPA)	1	1	1
Subtotal	**6**	**6**	**6**
Health Care Cost Trends Branch			
Branch Chief (CEA A)	1	1	1
Senior Health Policy Researcher	0	1	1
Office Technician (Typing)	1	1	1
Subtotal	**2**	**3**	**3**

Data Management Unit			
Data Integrity Manager	1	1	1
Senior Data Integrity Specialist	1	2	3
Data Integrity Specialist	1	2	4
Subtotal	**3**	**5**	**8**
Research and Analytics Unit			
Health Policy Research Manager	1	1	1
Senior Health Policy Specialist	1	2	3
Health Policy Specialist	1	2	4
Subtotal	**3**	**5**	**8**
Quality Performance Branch			
Branch Chief (CEA A)	1	1	1
Healthcare Workforce Specialist	0	1	1
Office Technician (Typing)	1	1	1
Subtotal	**2**	**3**	**3**
Quality Analysis Unit			
Unit Manager (Health Program Manager II)	1	1	1
Senior Quality Specialist (HPS II)	2	4	5
Subtotal	**3**	**5**	**6**
Payment Reform Unit			
Unit Manager (Health Program Manager II)	1	1	1
Senior Quality Specialist (HPS II)	2	3	4
Subtotal	**3**	**4**	**5**
Investigations and Enforcement Branch			
Deputy Director (CEA B)	1	1	1
Assistant Chief Counsel	1	2	3
Attorney IV	6	8	8
Attorney III	5	9	16
Office Technician (Typing)	1	1	1
Supervising Corporation Examiner	0	1	1
Corporation Examiner IV (Supervisor)	0	3	3
Corporation Examiner	0	9	9
Auditor I	0	6	6
Staff Services Manager I	0	1	1
AGPA	0	2	2
Staff Services Analyst	0	1	1
Subtotal	**14**	**44**	**52**
Information Technology Services Division			
Data Architect	1	1	1
Prescription Drug Policy Lead (HPS II)	1	1	1
Sr Enterprise Data Warehouse Database Admin	1	1	1
Assoc Enterprise Data Warehouse Admin	1	1	1
Senior Program and Policy Liaison (HPS II)	1	1	1
Assoc Program and Policy Liaison (HPS I)	1	1	1

Prescription Drug Data Lead	1	1	1
Application Developer	0	1	2
Business Analyst	1	1	1
Project Director	1	1	1
Project Manager	1	1	1
Subtotal	**10**	**11**	**12**
Office of Health Care Affordability Subtotal	**45**	**86**	**103**
Shared Resources			
Office of Legislative and Public Affairs			
AGPA	0	1	1
Subtotal	**0**	**1**	**1**
Administrative Services Division			
Associate Administrative Analyst	1	1	1
Contract Analyst (AGPA)	0	1	1
Associate Budget Analyst	1	1	1
Facility Services Analyst (AGPA)	0	1	1
Classification and Pay Analyst	2	2	2
Exams Analyst (AGPA)	1	1	1
Personnel Specialist	1	1	1
Accounting Officer Specialist	1	2	2
Office Technician (Typing)	1	1	1
Subtotal	**8**	**11**	**11**
Information Services Division			
Security Specialist	0	1	1
Infrastructure Engineer	1	2	2
IT Service Desk Technician	1	1	1
Senior Website Developer	1	1	1
Associate Website Developer	1	1	1
IT Acquisitions Specialist	0	1	1
IT Budget and Training Specialist (AGPA)	1	1	1
Subtotal	**5**	**8**	**8**
Shared Resources Subtotal	**13**	**20**	**20**
GRAND TOTAL	**58**	**106**	**123**

Contract Resources. OSHPD also requests expenditure authority from the California Health Data and Planning Fund for the following contract resources:

- $1.3 million in 2021-22, $750,000 in 2022-23, and $500,000 annually thereafter for information technology (IT) consulting for systems development and continuous operation.
- $400,000 annually for IT software, services, and infrastructure.
- $1.3 million in 2021-22, $550,000 in 2022-23, and $50,000 annually thereafter for program planning and management consulting.
- $2.8 million annually, beginning in 2022-23, for enforcement consulting contracts.

Provisional Budget Bill Language. OSHPD also proposes provisional budget bill language to: 1) authorize General Fund cash flow loans due to delays in collecting health care facility assessments, and 2) specify that $1 million of the request for information technology resources would be contingent upon approval of California Department of Technology Project Approval Lifecycle documents.

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

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

1. Please provide an update on the changes made to this proposal since the subcommittee's February 5th hearing.

The subcommittee has also requested the panelists to respond to the following:

1. Purchaser Business Group on Health:
    a. Please describe how the proposed OHCA would impact purchasers of health care services.
    b. How do the various cost commissions in other states impact purchasers and how could OHCA build on those models to be successful in effectively controlling costs?

2. California Hospital Association:
    a. Please describe how the proposed OHCA would impact California hospitals.
    b. Please also describe the changes, if any, your organization is seeking to improve the proposal.
    c. What is the experience of hospitals and hospital systems in states with cost commissions similar to the one proposed by OSHPD?

3. Blue Shield of California:
    a. Please describe how the proposed OHCA would impact California health plans. In particular, please describe how efforts to control costs may impact premiums paid by consumers, or capitation payments paid by public purchasers.
    b. How do the various cost commissions in other states affect health plan rates in those states?
    c. What other impact on health plans do you expect from the proposed OHCA?

4. California Medical Association:
    a. Please describe how the proposed OHCA would impact physician providers in California.
    b. Please also describe the changes, if any, your organization is seeking to improve the proposal.
    c. How are physicians affected in states with cost commissions similar to the one proposed by OSHPD?

5. California Labor Federation:
    a. Please describe how the proposed OHCA would impact workers in California, particularly how the proposal impacts their ability to access affordable health coverage and medical care.

6. Health Access California:
    a. Please describe how the proposed OHCA would impact health care consumers in California.
    b. To what extent do the various cost impacts to other participants in the health care system ultimately get passed on to the consumer?

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Annual Health Care Service Plan Health Equity and Quality Reviews

Budget Change Proposal and Trailer Bill Language– April Finance Letter. DMHC requests two positions and expenditure authority from the Managed Care Fund of $952,000 in 2021-22, $351,000 in 2022-23, 13 additional positions and $3.6 million in 2023-24, 4.5 additional positions and $4.4 million in 2024-25 and 2025-26, five additional positions and $6.3 million in 2026-27, $6 million in 2027-28, and $5.4 million annually thereafter. If approved, these positions and resources would allow DMHC to establish and enforce health equity and quality standards for all DMHC licensed full-service and behavioral health plans. DMHC also requests trailer bill language to implement and enforce these new standards.

DHCS also requests two positions and expenditure authority of $296,000 ($148,000 General Fund and $148,000 federal funds) in 2021-22, and $278,000 ($139,000 General Fund and $139,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to coordinate with DMHC on the establishment and enforcement of health equity and quality standards and to perform related data analysis, particularly for County Organized Health Systems and other Medi-Cal managed care plans.

Program Funding Request Summary - DMHC		
Fund Source	**2021-22**	**2022-23***
0933 – Managed Care Fund	$952,000	$351,000
Total Funding Request:	**$952,000**	**$351,000**
Total Requested Positions:	**2.0**	**2.0**

* Additional fiscal year positions and resources requested – 2023-24: 13 positions and $3,584,000; 2024-25: 4.5 positions and $4,441,000; 2025-26: $4,402,000; 2026-27: five positions and $6,315,000; 2027-28: $5,999,000; 2028-29 and ongoing: $5,434,000.

Program Funding Request Summary - DHCS		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$148,000	$139,000
0890 – Federal Trust Fund	$148,000	$139,000
Total Funding Request:	**$296,000**	**$278,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2022-23.

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 125 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 26.4 million Californians. Established in 2000, DMHC enforces the Knox-Keene Health Care Service Plan Act of 1975, which implemented California's robust oversight regime of the managed care system. In fulfilling its regulatory responsibilities under the Act, DMHC conducts medical surveys and financial examinations to ensure health plan compliance and financial stability, provides a 24-hour call center to help consumers resolve health plan complaints, and administers Independent Medical Reviews of services denied by health plans.

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

Incorporating Health Equity and Quality into the Knox-Keene Act. According to DMHC, the Administration is committed to addressing long-standing health inequities experienced by minorities. The pandemic has further highlighted systemic racism and discrimination that has created social, economic, and health inequities. The proposed trailer bill language and accompanying staffing and resource request would give DMHC and DHCS the authority to establish and enforce health equity and quality standards, consistent with the Administration's goals.

The proposed trailer bill language would add new statutory requirements to the Knox-Keene Act establishing health equity and quality measures and other reporting overseen by DMHC. The new department and health plan responsibilities would be as follows:

- Health Equity and Quality Committee – By March 1, 2022, DMHC would be required to convene a Health Equity and Quality Committee to make recommendations to the department for standard measures and benchmarks for assessing health equity and quality measures in health care delivery. The members of the committee would be appointed with consideration of: 1) diversity of relevant expertise; 2) reflection of the cultural, ethnic, and geographic diversity of the state; and 3) expertise of other state agencies engaged in setting quality and equity goals or standards for health care entities. By September 30, 2022, the committee would be required to provide recommendations to DMHC on quality measures, surveys, or other outcome measures, as well as setting annual health equity and quality benchmarks for the department to consider for implementation of a set of enforceable standard measures and benchmarks for equity and quality in health care delivery.

- Establishment of Equity and Quality Measures – DMHC would be required to establish standard measures and annual benchmarks for equity and quality in health care delivery. Although no date is specified in the proposed trailer bill language, DMHC expects to collect data from health plans to measure performance against these equity and quality benchmarks beginning in measurement year 2023. DMHC would consider the recommendations of the Health Equity and Quality Committee in establishing the standards and benchmarks, which could be periodically updated or revised by the department.

- Health Plan Reporting and Compliance – After DMHC establishes the standard measures and annual benchmarks, health plans would be required to comply with these measures and

benchmarks and demonstrate compliance through annual reporting to the department. The report would include health equity and quality data and information, consistent with the standards and benchmarks, and determined by the department. Health plans would also be required to receive and maintain accreditation by the National Committee for Quality Assurance (NCQA).

- Progressive Enforcement and Penalties for Non-Compliance – DMHC would be authorized to impose progressive enforcement actions on plans that do not comply with the new health equity and quality reporting requirements, or fail to comply with the standard measures and benchmarks. Enforcement could include: 1) required implementation of a corrective action plan to achieve and demonstrate compliance with the standard measures and benchmarks; 2) monitoring of a plan's corrective action plan and improvement efforts; 3) investigation and required supplemental reporting by the plan; or 4) assessment of administrative penalties in an escalating manner for repeated or continuing failure to meet requirements. Enforcement for measurement years 2023 and 2024 would only address deficiencies in data collection, reporting, corrective action plan implementation, or monitoring requirements. Enforcement in measurement year 2025 and annually thereafter would include these elements, as well as compliance with the standard measures and annual benchmarks.

- Annual Health Equity and Quality Compliance Report – Beginning in 2025 and annually thereafter, DMHC would be required to publish a Health Equity and Quality Compliance Report. The proposed trailer bill language does not provide detail on the content of this report. DMHC indicates the first report in 2025 would be for measurement year 2023.

- Regulatory Action Not Required Until 2027 – The proposed trailer bill language authorizes DMHC to implement, interpret, or make specific these new requirements through all-plan letters, methodologies, rules, policies, forms, or similar instructions, without taking regulatory action, until January 1, 2027. After 2027, it is unclear whether DMHC would be required to take regulatory action to annually update its equity and quality standards and benchmarks.

Staffing and Resource Request. DMHC requests two positions and expenditure authority from the Managed Care Fund of $952,000 in 2021-22, $351,000 in 2022-23, 13 additional positions and $3.6 million in 2023-24, 4.5 additional positions and $4.4 million in 2024-25 and 2025-26, five additional positions and $6.3 million in 2026-27, $6 million in 2027-28, and $5.4 million annually thereafter. If approved, these positions and resources would allow DMHC to establish and enforce health equity and quality standards for all DMHC licensed full-service and behavioral health plans. Specifically, DMHC requests the following staff and resources for the following offices and divisions:

Office of Legal Services – The Office of Legal Services requests two positions and expenditure authority from the Managed Care Fund of $367,000 in 2021-22 and $351,000 annually thereafter.

- **One Attorney IV** position would be responsible for overseeing the development of regulations, conducting complex legal research to understand and appropriately implement the goals of the statute, and serving as a subject matter expert for legal advice.
- **One Staff Services Analyst** would provide administrative and analytical support in conducting legal research, issuing legal memoranda, and implementing the requirements of the statute, including assisting in addressing increases in Public Records Act requests.

Office of Plan Monitoring – The Office of Plan Monitoring (OPM) requests ten positions and expenditure authority from the Managed Care Fund of $2.6 million in 2023-24 and annually thereafter. According to OPM, beginning in 2023-24 the office anticipates conducting 44 health equity and quality compliance reviews per year based on its experience conducting routine and non-routine medical surveys and annual network and timely access reviews.

- **One Assistant Chief Counsel** would oversee and direct the work of legal staff working on compliance reviews, review determinations and recommendations of staff, develop legal strategies for guidance to health plans and enforcement referrals, oversee development of implementing or clarifying regulations, and confer with and make recommendations to NCQA about performance measurements.
- **One Attorney IV** position would be responsible for legal review of complex compliance reviews, oversee quality assurance and health equity review issues, communicate with executive management on complex issues and possible solutions, act as lead to other attorneys working on reviews, develop and update health plan reporting methodologies, develop and maintain internal review procedures for complex reports, provide legal review of compliance issues identified in reports, develop guidance to health plans, develop regulations to implement the statute, draft enforcement referrals, and provide legal guidance to the clinical consultant.
- **Two Attorney III** positions would be responsible for legal review and support of complex data submissions and annual compliance reports.
- **Two Attorneys** would be responsible for routine legal review of compliance reviews and annual compliance reports.
- **Two Health Program Specialist II** positions would be responsible for analyzing the data provided in annual compliance reports, assisting with development of standardized methodologies and reporting requirements for health plans, analyzing database reports to perform cross-plan comparisons for each filing, synthesizing report findings to identify trends across the state, assessing findings from preceding years to detect non-compliance issues, evaluating corrective action plans, and preparing compliance finding reports.
- **One Staff Services Manager II** position would oversee and direct the team of analysts, manage the workflow, delegate assignments, monitor work performance, and act as contract manager for the clinical consulting contract.

Included in this request is $539,000 in 2023-24 and annually thereafter for a clinical consultant to assist with maintaining current standards and methodology by interpreting statistical data and determining quality trends and reporting requirements of health plans, and providing consultation on annual submissions and corrective action plans.

Office of Enforcement – The Office of Enforcement (OE) requests 4.5 positions and expenditure authority from the Managed Care Fund of $952,000 in 2024-25, $912,000 in 2025-26, an additional three positions and $2.5 million in 2026-27, $2.2 million in 2027-28, and $1.7 million annually thereafter. When fully implemented, the office would receive a total of 7.5 positions. According to OE, the office expects 22 enforcement referrals annually beginning in 2024-24, based on historical data.

- **One Assistant Chief Counsel** would serve as lead counsel for conducting initial review of OPM documents, review details of referrals, and oversee all aspects of investigation and prosecution. This position would be established in 2024-25.

- **Two Attorney IV** positions would provide legal support to investigate complex referral cases and would serve as lead attorneys in all aspects of pre-trial preparation, trial and hearing, and post-trial briefing and motions. These positions would be established in 2026-27.
- **Two Attorney III** positions would provide legal support to investigate referral cases, perform complex legal review and analysis of findings reports, conduct legal research of statutes, respond to complex legal questions during investigations, develop strategies to respond to difficult and sensitive matters, and serve as lead counsel during pre-trial, trial and hearings, and post-trial. One position would be established in 2024-25 and the second position would be established in 2026-27.
- **0.5 Attorney** would evaluate health equity and quality referral cases, evaluate and prepare recommended courses of action, resolution and motion for prosecution and defense, and coordinate and consult with expert witness consultants for purposes of evaluation and trial or hearing preparation. This position would be established in 2024-25.
- **One Senior Legal Analyst** would provide research and analytical support to the Attorneys, including drafting and filing legal memoranda and assisting with the dissemination of final determinations. This position would be established in 2024-25.
- **One Legal Assistant** would assist the Attorneys and Senior Legal Analyst with referral cases, including finalizing documents prepared by the Attorneys, following up on plan responses, managing the case management system, and coordinating case documents and trial-related arrangements. This position would be established in 2024-25.

In addition to these permanent positions, this request includes resources to support the following temporary help position equivalents:

- Resources equivalent to **one Attorney IV** would assist with three trial cases in 2026-27 and 2027-28, provide legal support to investigate complex referrals, and serve as lead attorney in all aspects of pre-trial preparation, trial and hearing, and post-trial briefings and motions. These resources would be available in 2026-27 and 2027-28.
- Resources equivalent to **1.5 Attorney III** would assist with three trial cases in 2026-27 and 2027-28, provide legal support to investigate referral cases, perform complex legal reviews and analysis of findings reports, conduct legal research of statutes, respond to complex legal questions during investigations, develop strategies to respond to difficult and sensitive matters, and serve as lead counsel during pre-trial, trial or hearing, and post-trial. These resources would be available in 2026-27 and 2027-28.
- Resources equivalent to **0.5 Attorney** would provide temporary legal support to evaluate referral cases. These resources would be available in 2024-25 and 2025-26.

Also included in this request is $387,000 in 2026-27 and $127,000 annually thereafter to support a consultant for expert witness fees and other trial-related costs, statistician expert witnesses to validate statistical data and methodologies, medical expert witnesses, court reporting, transcription services, printing services, and travel expenses.

Office of Administrative Services – The Office of Administrative Services (OAS) requests expenditure authority from the Managed Care Fund of $585,000 in 2021-22, one position and $139,000 in 2023-24, $135,000 in 2024-25 and 2025-26, one additional position and $277,000 in 2026-27, and $269,000

annually thereafter. These positions and resources would support departmental support services for the additional staff and other resources included in this request.

- **Two Associate Governmental Program Analysts (AGPA)** would support hiring and processing of employee-related transactions. One AGPA position would be established beginning in 2023-24 and the second AGPA would be established beginning in 2026-27

Included in this request is $500,000 in 2021-22 to support consultant costs to provide expertise to the department in planning, organizing, and facilitating the Health Equity and Quality Committee, as well as resources equivalent to **0.5 AGPA** for committee-related costs.

Office of Technology and Innovation – The Office of Technology and Innovation (OTI) requests two positions and expenditure authority from the Managed Care Fund of $460,000 in 2023-24, $449,000 in 2024-25, $450,000 in 2025-26, one additional position and $618,000 in 2026-27 and $610,000 annually thereafter. These positions and resources would support IT needs of new staff including employee setup, service requests, change requests, collection of data analytics, security log analysis, and ongoing maintenance of staff devices. In addition, these positions and resources would support data collection efforts for quality and survey data from health plans, as well as data analysis and software needed to produce the annual public Health Equity and Quality Compliance Report.

- **Two IT Specialist I** positions would assist with the IT support of new staff. One IT Specialist I position would be established beginning in 2023-24 and one would be established beginning in 2026-27.
- **One IT Specialist II** position would support data analysis and reporting for the Health Equity and Quality Compliance Report. This position would be established beginning in 2023-24.

Included in this request is $103,000 in 2023-24, $105,000 in 2024-25, and $106,000 annually thereafter for recurring annual software licenses.

In addition to the resource requested by DMHC, DHCS also requests two positions and expenditure authority of $296,000 ($148,000 General Fund and $148,000 federal funds) in 2021-22, and $278,000 ($139,000 General Fund and $139,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to coordinate with DMHC on the establishment and enforcement of health equity and quality standards and to perform related data analysis, particularly for County Organized Health Systems and other Medi-Cal managed care plans. These positions and resources would be allocated as follows:

Managed Care Quality and Monitoring Division – The Managed Care Quality and Monitoring Division (MCQMD) requests two positions and expenditure authority of $296,000 ($148,000 General Fund and $148,000 federal funds) in 2021-22 and $278,000 ($139,000 General Fund and $139,000 federal funds) annually thereafter to support oversight of equity and quality measures for County Organized Health Systems, which provide health care services to Medi-Cal beneficiaries and are not required to obtain a license under the Knox-Keene Act.

- **One Health Program Specialist II** position would take a lead role in all programmatic aspects of performance measurement for health equity standards including, but not limited to, technical

specification design, coordination with internal and external stakeholders, second-level review and quality assurance of program staff work to support metric calculations, and production support for internal and external reports and dashboards. This position would be established beginning in 2021-22.

- **One AGPA** would coordinate communication and efforts between DMHC and DHCS, assist in developing policy letters related to implementation of enhanced standards and processes, research and make recommendations to management on program implementation, monitoring and evaluation methods, and develop these methods as directed by management. This position would be established beginning in 2021-22.

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

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

1. Please provide a brief overview of this proposal.

2. How would DMHC approach ensuring the availability of relevant and diverse expertise on the Health Equity and Quality Committee?

3. Please describe some examples of the types of equity and quality measures and benchmarks that could become new plan responsibilities as a result of this proposal.

4. Please describe some examples of the actions the department would expect of health plans as they seek to comply with the equity and quality measures and benchmarks.

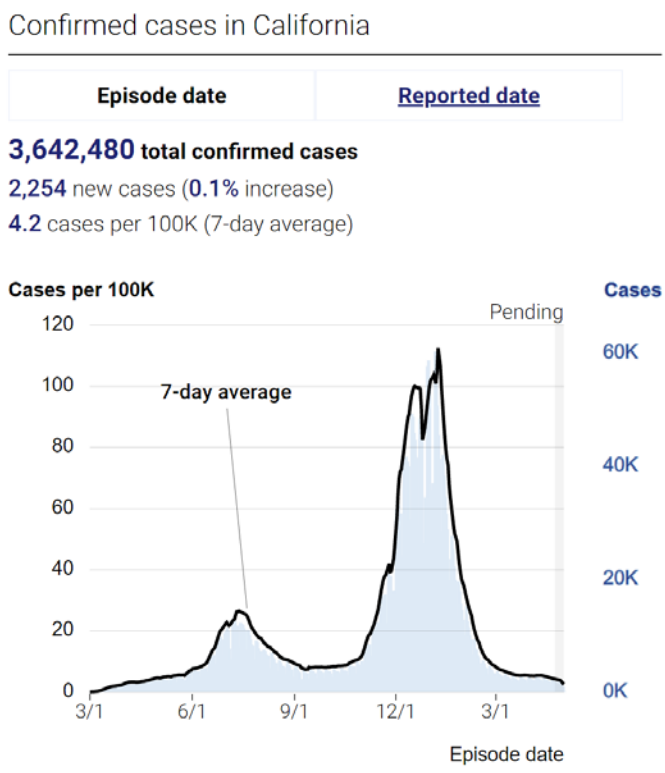
5. After the required promulgation of regulations in 2027, does DMHC expect to have to promulgate new regulations when equity and quality measures and benchmarks are updated periodically?

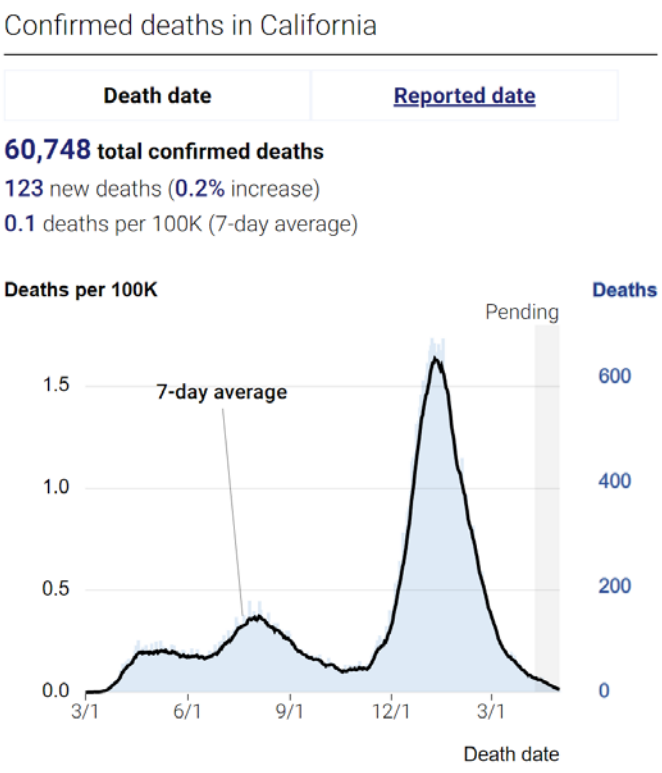
4265 DEPARTMENT OF PUBLIC HEALTH

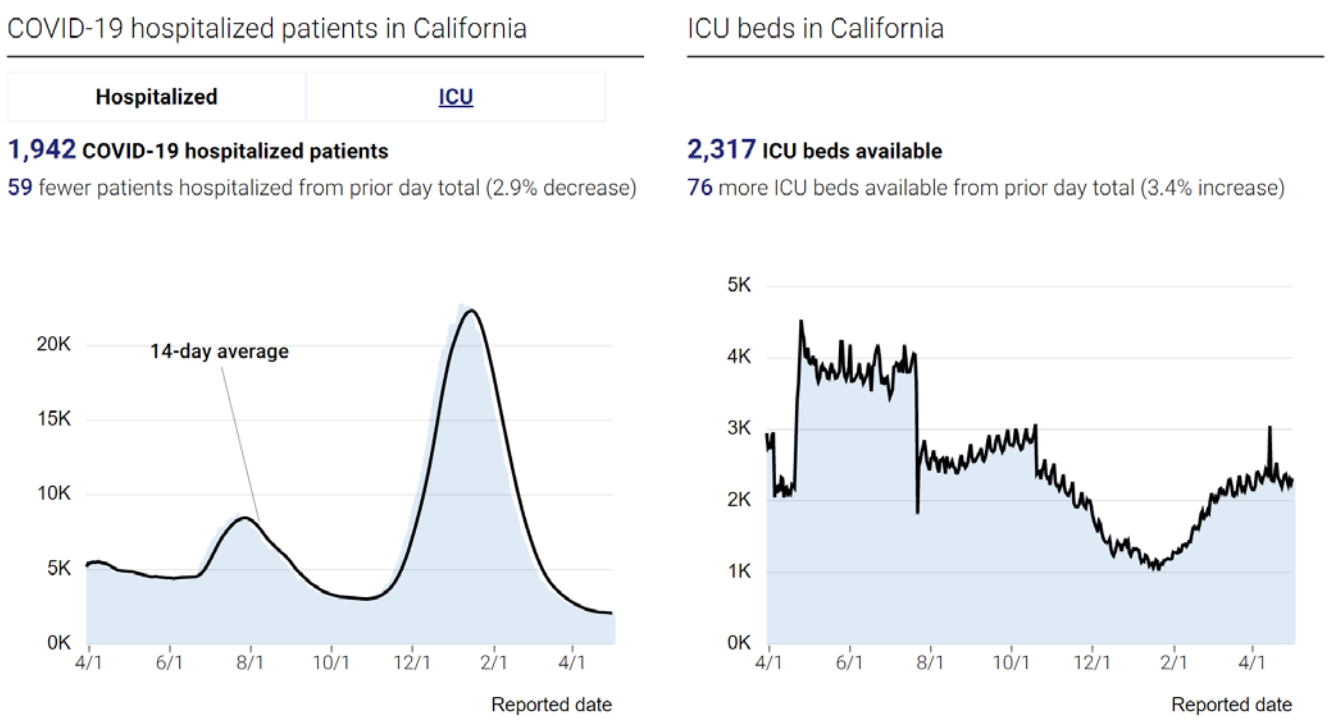
Issue 1: COVID-19 Pandemic Public Health Response Update and Infrastructure Investments

COVID-19 Pandemic Public Health Response. 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.

Current Status of Individuals Affected in California. On March 12th, 2020, this subcommittee held its first hearing on the COVID-19 outbreak. At that time, DPH reported a total of 157 positive cases of COVID-19 in California and 2 deaths. When the subcommittee heard from DPH on February 10th, 2021, there were 8,920 new positive cases and 518 new deaths that day. 11,516 Californians were hospitalized for COVID-19, with 3,127 in the ICU and only 1,394 ICU beds available statewide. As of May 2nd, 2021, there were 2,254 daily cases for a total of 3,642,480 cases confirmed since the beginning of the pandemic. There were 123 daily deaths for a total of 60,748, and 1,942 individuals were hospitalized statewide, with 417 of those individuals in the ICU.





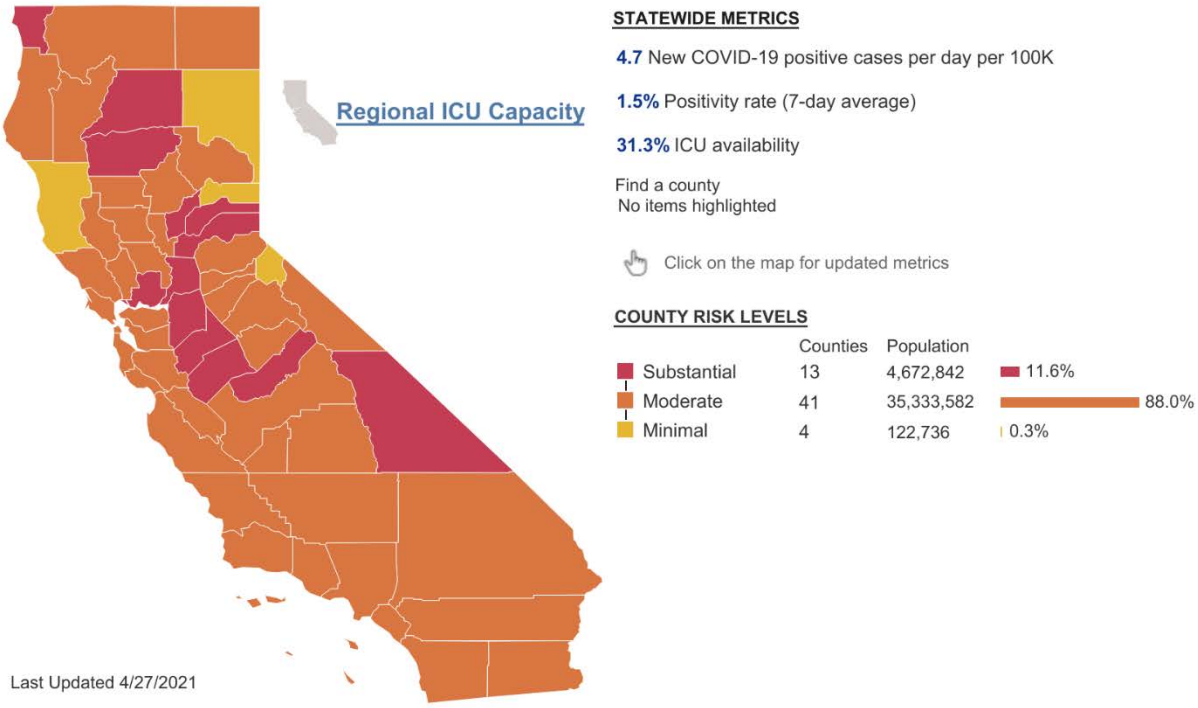


Cumulative, Daily, and 14-Day Average of COVID-19 Case Counts, Deaths, Hospitalized Patients, and ICU Capacity
Source: *California COVID-19 State Dashboard: https://covid19.ca.gov/state-dashboard/. Retrieved May 2nd, 2021.*

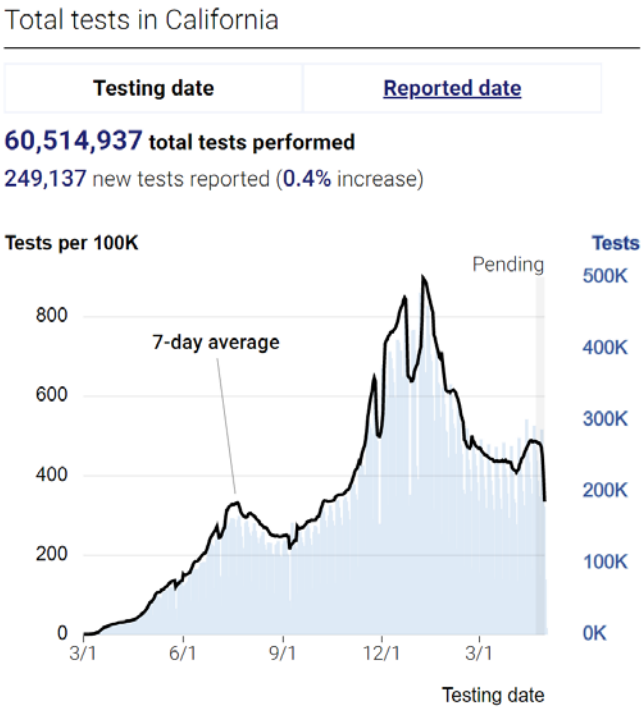
As of May 2nd, 2021, California also has the lowest case rate of any state in the nation, 31.2 weekly cases per 100,000 population, according to data from the federal Centers for Disease Control and Prevention (CDC).

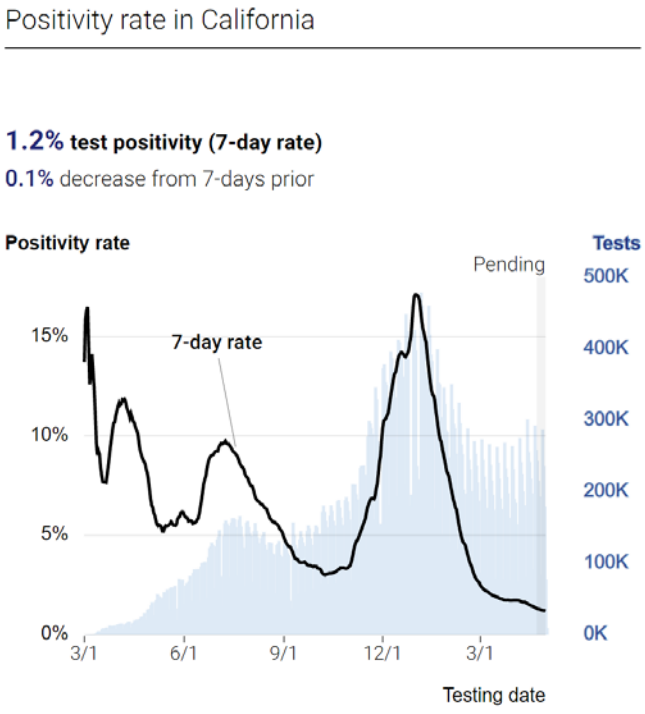
Blueprint for a Safer Economy. On August 28, 2020, DPH unveiled the Blueprint for a Safer Economy, which currently governs public health interventions and allowable activities by county. The Blueprint assigns each county to one of four tiers based on the transmission of COVID-19 in the county. Based on updated tier criteria related to the progress of vaccination in the lowest quartile of the Healthy Places Index, the current tier status of California counties is as follows:

County Tier Status as of April 27th, 2021



Current Testing Status. As of May 2nd, 2021, the state is averaging 249,137 tests over a 7-day period. The 7-day average test positivity rate, one measure of the levels of community transmission, peaked in early 2021 at 14 percent, but has decreased to 1.2 percent.





Distribution and Administration of Approved COVID-19 Vaccines in California. Shortly after approval of the Pfizer and Moderna COVID-19 vaccines, as well as the Johnson and Johnson adenovirus vaccine, doses began to be delivered to California. Because supplies of these vaccines were expected to be in short supply as the companies ramped up production of vaccine doses after FDA approval, California developed a phased prioritization schedule to ensure front-line health care workers and the most vulnerable received vaccines first. In addition, the CDC developed a partnership with CVS and Walgreens to administer vaccine doses in skilled nursing facilities, assisted living facilities, and other congregate care facilities.

The state developed a planning template submitted to the CDC outlining how vaccines would be distributed and administered in California. The plan largely relied on its existing vaccine distribution network, including over 4,000 medical providers enrolled in California's Vaccines for Children program and 500 Federally Qualified Health Centers enrolled in California's Vaccines for Adults program. These programs are supported by funding from the CDC.

The state also adopted CDC-recommended guidelines for a three-phase distribution of the vaccines. Through its Drafting Guidelines Workgroup and Community Vaccine Advisory Committee, the state identified priority groups in the following phases and tiers:

- **Phase 1a –** Health care workforce, and staff and residents of long-term care facilities
- **Phase 1b, Tier 1 –** Persons 65 years of age and older, and workers in the education, childcare, emergency services, and food and agriculture sectors.

On April 15th, 2021, all individuals 16 years of age and over became eligible to receive a vaccine.

According to DPH, as of May 2nd, 2021, the state has administered 30,412,414 doses of the vaccine, and is averaging 305,786 doses daily over the last seven days. 12,806,167 individuals are fully vaccinated and 6,183,564 individuals are partially vaccinated.

Local Health Officers, Health Facilities, Health Care Workers, and Consumers - COVID-19 Response Panel. The subcommittee has requested the following panelists to discuss the state and local public health response to the COVID-19 pandemic, as well as potential investments in public health infrastructure:

- Michelle Gibbons, Executive Director, County Health Executives Association of California
- Julie Vaishampayan, Health Officer, Stanislaus County
- Ronald Coleman, Managing Director of Policy, California Pan-Ethnic Health Network
- Hector Dela Cruz, Chief Environmental Health Specialist, LA County, SEIU Local 721
- Eugene Canson, Policy Analyst, California Black Health Network
- Josefina Alvarado Mena, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of the current case rates, hospitalizations, and mortality statistics for COVID-19 infection in California.

2. Please provide a brief overview of the state's coordinated prevention and response activities for COVID-19.

3. Has the current COVID-19 response highlighted any gaps in readiness that might help the state and DPH to prepare for the next pandemic? What would constitute an adequately resourced preparedness effort?

4. How should state and local governments approach funding for public health infrastructure? What tools are available to help determine whether additional funding of existing programs is required or whether there is a need for new programs to address gaps?

5. What types of investments in our public health infrastructure would be most effective in reducing the health disparities that were exacerbated by the pandemic? What data or other tools are available to help identify existing or emerging disparities in health outcomes?

The subcommittee has also requested local health officers, health care worker, and consumer group panelists to respond to the following:

1. Local Health Departments/Officers
    a. Do local health departments have any current resource needs as they continue to address the COVID-19 pandemic?
    b. Has the response identified any gaps in readiness or resources that should be addressed once the current pandemic is fully under control?
    c. Please describe the local health departments' and local health officers' proposal for ongoing public health infrastructure resources submitted to the committee, including how these investments would enhance preparedness and address health disparities.

2. CPEHN
    a. Please describe the impact of the COVID-19 pandemic on the health status and needs of the state's diverse communities of health care consumers?
    b. In your view, how have pre-existing health inequities been exacerbated by the pandemic?
    c. What is the state doing well to address these inequities and where is it falling short?
    d. What should the Legislature and the Administration be thinking about as we consider how to address these inequities?

3. SEIU
    a. Please describe the impact of the COVID-19 pandemic on public health workers.
    b. How could federal, state, or local resources be better directed to support your work?
    c. What are the most critical investments necessary to address the pandemic and prepare for future public health emergencies?

4. California Black Health Network

a. Please describe the coalition proposal for a Health Equity Fund to support local public health departments and community-based organizations to address health disparities.
b. How would these one-time investments support reducing health disparities on an ongoing basis?

5. REMHDCO
   a. Please describe the proposed investment in the California Reducing Disparities Project.

Issue 2: Books for Low-Income Children - Adjustment

Budget Bill Language – April Finance Letter. DPH requests budget bill language to shift General Fund expenditure authority of $5 million, previously requested to support books for low-income resources, from state operations to local assistance. No other changes are requested to the proposal.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund (State Operations)	($5,000,000)	$-
0001 – General Fund (Local Assistance)	$5,000,000	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. In the January budget, DPH requested General Fund expenditure authority of $5 million in 2021-22 to support an early childhood literacy program for participants in the Women, Infants, and Children (WIC) program. With the requested resources, DPH would develop a competitive grant process available to all 84 local WIC agencies. Local WIC agencies would apply for funds in coordination with their county's First 5 Commission and other local stakeholders to identify a preferred reading program, strategize acceptable adaptations, develop a plan for implementation and oversight, and distribute books and guidance directly to WIC participants and their families. DPH would provide technical assistance and conduct oversight to ensure adherence to the intervention and program expectations.

According to DPH, these resources were inappropriately attributed to a state operations budget item. DPH requests budget bill language to shift the requested General Fund expenditure authority and provisional language for this program from the state operations budget item (4265-001-0001) to the local assistance budget item (4265-111-0001). No other changes are requested to the proposal.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Cosmetic Fragrance and Flavor Ingredient Right to Know Act of 2020 (SB 312)

Budget Change Proposal – April Finance Letter. DPH requests General Fund expenditure authority of $26,000 in 2021-22 and $52,000 annually thereafter. If approved, these resources would allow DPH to support costs associated with changes, maintenance, and operation of an existing database needed to accommodate the requirements of SB 312 (Leyva), Chapter 315, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$26,000	$52,000
Total Funding Request:	**$26,000**	**$52,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2022-23.

Background. SB 484 (Migden), Chapter 729, Statutes of 2005, authorized the California Safe Cosmetics Program (CSCP) in DPH to provide information to consumers and other users of cosmetics regarding the presence of certain toxic ingredients. Under the program, cosmetics manufacturers are required to report to CSCP if they sell products in California and those products contain ingredients that have been identified by authoritative bodies as known or suspected of causing cancer or reproductive or developmental toxicity. The authoritative bodies upon which CSCP relies to determine which ingredients must be reported include:

1) Proposition 65 List of Chemicals Known to Cause Cancer or Reproductive Toxicity.
2) United States Environmental Protection Agency.
3) National Toxicology Program (NTP) - Office of Health Assessment and Translation.
4) National Toxicology Program (NTP) – Report on Carcinogens (RoC).
5) International Agency for Research on Cancer.

Ingredient reporting to the CSCP began in 2009 and, in 2014 the program launched an online searchable database, which provides the public with access to the ingredient information reported by cosmetics manufacturers.

2019 Budget Act Augmentation. The 2019 Budget Act included General Fund expenditure authority of $1.5 million in 2019-20 and $500,000 annually thereafter to increase staffing for enforcement and program improvement activities in the CSCP. Prior to this augmentation, the program was funded with approximately $370,000 annually from the state's General Fund, supporting one Research Scientist III, who serves as the program lead, and one Associate Governmental Program Analyst to support data collection and analysis. According to DPH, the program has no enforcement authority and responds to potential non-compliance by sending reminder letters to companies regarding their responsibility to report under the program. The authorizing statute does not include enforcement penalty authority.

SB 312 Expands Ingredient Reporting to CSCP. SB 312 (Leyva), Chapter 315, Statutes of 2020, creates the Cosmetic Fragrance and Flavor Ingredient Right to Know Act of 2020. Beginning January 1, 2022, SB 312 requires manufacturers of cosmetic products sold in the state to report to CSCP whether any fragrance or flavor ingredient in one of their products is considered hazardous due to its inclusion in one

of 22 designated lists. Manufacturers must also provide a list of fragrance allergens present in their product.

Beginning January 1, 2022, SB 312 also requires CSCP to post a list of those fragrance and flavor ingredients reported by manufacturers, as well as their associated health hazards, on the existing CSCP database of cosmetic product information.

Resource Request. DPH requests General Fund expenditure authority of $26,000 in 2021-22 and $52,000 annually thereafter to support costs associated with changes, maintenance, and operation of an existing database needed to accommodate the mandates of SB 312. According to DPH, the 2019 Budget Act augmentation allowed CSCP to complete a major database upgrade in June 2020, as well as add three positions to the program. DPH expects the increased data collection and reporting workload of SB 312 would be absorbed by these additional staff. This request would support one-time changes and ongoing updates and maintenance to the CSCP database.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Establishing the Office of Suicide Prevention (AB 2112)

Budget Change Proposal – April Finance Letter. DPH requests five positions and General Fund expenditure authority of $780,235 annually. If approved, these positions and resources would allow DPH to establish and administer an Office of Suicide Prevention, pursuant to the requirements of AB 2112 (Ramos), Chapter 142, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$780,235	$780,235
Total Funding Request:	**$780,235**	**$780,235**
Total Requested Positions:	**5.0**	**5.0**

* Positions and resources ongoing after 2022-23.

Background. Suicide, a self-directed form of violence, is a leading cause of premature death and is a major contributor of years of life lost due to its significant impact on young people. Deaths due to suicide leave a tragic loss for decedents' families and society at large. In 2018, 4,490 Californians died by suicide and of those, 544 were youths (ages 10-24). There were 31,712 non-fatal self-harm related emergency department visits among California residents in 2018 and 16,745 of those visits were among California youth (ages 10-24).

Rates of suicide vary greatly across the state with some counties experiencing rates more than twice the statewide level. Suicide rates peak at multiple stages throughout the lifespan and are highest in young adults, middle age, and ages 85 and above. Suicide is the second leading cause of death among adolescents and young adults ages 15-24 in California and suicide rates are highest among White and American Indian/Alaska Native populations.

California Strategic Plan for Suicide Prevention – Striving for Zero. The 2017 Budget Act included expenditure authority of $100,000 from the Mental Health Services Fund (MHSF) for the Mental Health Services Oversight and Accountability Commission (MHSOAC) to develop a suicide prevention plan for California. Public health's role in addressing suicide is emphasized in the new *California Strategic Plan for Suicide Prevention 2020-2025: Striving for Zero*. The Commission's goal was to produce an achievable policy agenda and a foundation for suicide prevention based on best practices. Its overarching objective is to equip and empower California communities with the information they need to minimize risk, improve access to care, and prevent suicidal behavior. Despite the challenges, research demonstrates that effective interventions can save lives, and that public health strategies can prevent loss of life on a broad scale. The Public Health Model involves four repeating steps: 1) defining the problem; 2) identifying the factors that increase or lower risk; 3) developing and evaluating prevention interventions; and 4) implementing interventions and disseminating results to increase the use of effective interventions. The Public Health Model is a key feature of the statewide strategic suicide prevention plan.

The 2020 Budget Act included expenditure authority from the MHSF of $2 million for MHSOAC to begin implementation of some priority objectives outlined in the plan. These initial efforts will aim to help local governments, educators, industry, health care providers, community organizations and everyday

Californians do a better job detecting and responding to suicide risk. Specifically, the Commission plans to procure and oversee contracts to implement the following:

- Promote local strategic planning and coalition building consistent with the new state strategic plan.
- Reduce access to lethal means through outreach and engagement and promotion of strategies to keep homes safe (e.g., safe storage for firearms and medications).
- Build a research agenda that goes beyond data surveillance and tracking.
- Standardize training for educators and health care professionals for screening those at risk.

AB 2112 – Office of Suicide Prevention. AB 2112 (Ramos), Chapter 142, Statutes of 2020 authorized the establishment of an Office of Suicide Prevention within DPH. AB 2112 authorizes the following responsibilities for the office:

- Providing information and technical assistance to statewide and regional partners regarding best practices on suicide prevention policies and programs.
- Conducting state level assessment of regional and statewide suicide prevention policies and practices, including those from other states, and including specific metrics and domains as appropriate.
- Focusing activities on groups with the highest risk, including youth, Native American youth, older adults, veterans, and LGBTQ people.
- Monitoring, tracking, and dissemination of data to inform prevention efforts at the state and local levels.
- Convening experts and stakeholders, including, but not limited to, stakeholders representing populations with high rates of suicide, to encourage collaboration and coordination of resources for suicide prevention.
- Reporting on progress to reduce rates of suicide.
- Sharing and receiving data from other state entities relevant to the responsibilities and objectives of the office.
- Consulting with MHSOAC to implement suicide prevention efforts consistent with the commission's Suicide Prevention Report "Striving for Zero."

Resource Request. DPH requests five positions and General Fund expenditure authority of $780,235 annually to establish and administer the Office of Suicide Prevention. Specifically, the requested positions are as follows:

- **One Health Program Manager II** position would direct, oversee, and supervise project staff, provide direction and oversight to all elements of the office, interface with MHSOAC and other primary stakeholders, oversee contract development and procurement processes, proposal reviews, award and negotiation of contracts, contract and project monitoring, and evaluation processes, be responsible for fiscal management, and advise on program and policy implications.
- **One Health Education Consultant III, Specialist** position would develop performance expectations, assist with development, coordination and dissemination of best practices, educational materials, and evaluation efforts related to suicide prevention practices and policies, monitor contracts, provide highly specialized technical assistance, provide leadership and foster collaboration among state agencies, as well as state and local stakeholders.

- **One Staff Services Analyst** would conduct fiscal analyses to assure appropriate program expenditure authority, prepare and process contract documents, develop contracts and interagency agreements, act as liaison with other departmental divisions, review and process invoices and monitor reimbursements, and compile data and assist in preparation of program progress reports.
- **One Research Scientist III** position would serve as lead Research Scientist for the office and conceive plans, conduct, organize and direct major, highly specialized program-specific surveillance analyses, and complex epidemiologic and statistical analyses using appropriate techniques and complex data sources.
- **One Health Program Specialist I** position would assist with the provision of technical assistance to local entities, conduct ongoing program assessments, meeting planning and facilitation, and report writing.

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

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

1. Please provide a brief overview of this proposal.

2. Please describe how the new office would collaborate with MHSOAC to support its mission and goals.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Relocation to the Clifford L. Allenby Building – Phase 3

Budget Change Proposal – April Finance Letter. CHHSA, DDS, and DSH request General Fund expenditure authority of $9.2 million in 2021-22 and $8.9 million annually thereafter. If approved, these resources would offset increased rental costs of $7.7 million for the three departments as they transition to the new Clifford l. Allenby Building. DSH also requests two positions to provide technology support to CHHSA, and DDS requests resources to address the services and equipment necessary for occupancy in the new building.

Program Funding Request Summary - CHHSA		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$744,000	$744,000
Total Funding Request:	**$744,000**	**$744,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2022-23.

Program Funding Request Summary - DDS		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$5,203,000	$4,831,000
Total Funding Request:	**$5,203,000**	**$4,831,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24 and ongoing: $4,696,000

Program Funding Request Summary - DSH		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$3,295,000	$3,295,000
Total Funding Request:	**$3,295,000**	**$3,295,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2022-23.

Background. A 2015 study of Sacramento state office infrastructure identified serious deficiencies with existing state building including the Bateson Building, occupied by CHHSA, DDS, and DSH. The 2016 Budget Act included a $1.3 billion transfer over two years from the General Fund to a new State Project Infrastructure Fund to be used specifically for the renovation or replacement of state office buildings in the Sacramento area. One of the initial projects that received funding was the construction of a new building at 1215 O Street in Sacramento to replace the vacant Department of Food and Agriculture Annex. Since that time, CHHSA, DDS and DSH were chosen as the new building's future tenants and the building has been named the "Clifford L. Allenby Building (Allenby Building)." Construction of the Allenby Building is currently underway, and all three departments expect to occupy the building beginning in June of 2021.

The 2019 Budget Act included $4.9 million in 2019-20, $1.8 million in 2020-21, and $2.8 million annually thereafter to support Phase 1 of the relocation of CHHSA, DDS, and DSH from its existing location in the

Bateson Building to the Allenby Building. The 2020 Budget Act included $3.3 million in 2020-21 to support Phase 2 of the relocation, which included reevaluating space needs, the use of telework, and restacking opportunities due to the COVID-19 pandemic.

Staffing and Resource Request. CHHSA, DDS, and DSH request General Fund expenditure authority of $9.2 million in 2021-22 and $8.9 million annually thereafter to offset increased rental costs of $7.7 million for the three departments as they transition to the new Clifford l. Allenby Building. DSH also requests two positions to provide technology support to CHHSA, and DDS requests resources to address the services and equipment necessary for occupancy in the new building.

According to the three departments, the current rental budget at the Bateson Building for 2020-21 is $7.7 million. The rental budget for the Allenby Building is expected to be $15.5 million. As a result, the increased rent of $7.7 million would be allocated between the three departments as follows:

- CHHSA - $744,000
- DDS - $3.7 million
- DSH - $3.3 million

In addition to the increased rental budget, DSH requests two positions to provide IT support to CHHSA. The requested positions are as follows:

- **One IT Associate** and **one IT Specialist II** position would support a help desk, infrastructure and application development related duties. According to DSH, these positions would support approximately 75 CHHSA users who will generate 300 requests or incidents per month.

DDS also requests $1.5 million and resources equivalent to one position in 2021-22, $1.1 million and resources equivalent to one position in 2022-23, and $1 million annually thereafter to address decommissioning the Bateson Building, document storage, services and equipment necessary for occupancy in the Allenby Building. Included in this request is $400,000 in 2021-22 for removal and disposition of all furniture items, cubicle partitions, file cabinets, IT and telecommunications wiring in the sub floors, and IT hardware.

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

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

1. Please provide a brief overview of this proposal.

Issue 2: Increased Investigation Workload

Budget Change Proposal – April Finance Letter. DSH requests General Fund expenditure authority of $337,000 in 2021-22 and $266,000 annually thereafter. If approved, these resources would support the reclassification of 20.0 Hospital Police Officer positions to Investigators to better align these positions with current investigative workload.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$337,000	$266,000
Total Funding Request:	**$337,000**	**$266,000**
Total Requested Positions:	**0.0**	**0.0**

* Positions and resources ongoing after 2022-23.

Background. Within DSH, the Office of Protective Services (OPS) encompasses all operations necessary for providing a secure and safe treatment environment for patients and a safe work environment for DSH employees. This service extends to operating a safe facility within the residing communities and ensuring safety to all individuals entering the hospital grounds. As a law enforcement agency, OPS provide 24-hour police services responsible for the safety of all hospital operations, including:

- Ensuring safety and security for the patients and staff during daily living activities and therapeutic treatments.
- Securing all hospital housing and buildings occupied by patients and staff.
- Securely managing and overseeing the inflow and outflow of patients, staff, and visitors.
- Safely transporting forensic patients to medical appointments and procedures and court appearances.
- Providing 24-hour safety and security custodial presence to DSH patients hospitalized in outside medical facilities.
- Securing all hospital grounds both inside and outside the secured treatment areas (STA).

Each hospital within DSH has an allocation of protective services staff operating under the Department of Police Services (DPS). DPS has jurisdiction over all criminal activity and violations of any laws or administrative policies on hospital grounds and are therefore responsible for the investigation of those crimes or allegations of misconduct. Investigative functions at the hospitals are conducted by the Office of Special Investigations (OSI). Investigators operate under the OSI, however as a resolution to increased workloads, urgency of completion and statutory deadlines for completion of investigations DSH implemented the Detective Units. This specialized unit was supported by the county district attorneys to ensure separation of administrative and criminal cases was implemented. The separation of investigative assignments preserves the constitutional right of the individuals, allows DSH to meet the legal requirements of an investigation, and preserves the integrity of the investigation. Meeting the legal requirements and preserving the integrity of the investigation ensures that the criminal or discipline actions needed are not dismissed due to cross contamination and violation of constitutional rights, which is imperative for the safety and security of DSH's patient population.

Staffing and Resource Request. To ensure bifurcation and separation of the investigation processes are consistent across all hospitals, DSH requests reclassification of 20.0 Hospital Police Officers to Investigators. According to DSH, this reclassification would allow for the restructure of the OSI to incorporate the administrative and criminal investigation assignments utilizing the appropriate classification and continuing to ensure bifurcation and separation of criminal and administrative investigations. There are currently two positions at Atascadero, five positions at Coalinga, four positions at Metropolitan, four positions at Napa, and five positions at Patton that would be reclassified.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Statewide Ligature Risk Special Repair Funding

Budget Bill Language – April Finance Letter. DSH requests budget bill language to extend the encumbrance and expenditure authority for ligature risk special repair funding authorized in the 2020 Budget Act.

Background. The 2020 Budget Act included General Fund expenditure authority of $5.3 million in 2020-21 and 2021-22, $8.4 million in 2022-23 and 2023- 24, and $15.4 million in 2024-25, 2025-26, and 2026-27 to mitigate ligature risk within four of its Joint Commission accredited hospitals. The federal Centers for Medicare and Medicaid Services, as well as the Joint Commission have indicated an increased focus on ligature risks, which are defined as anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. According to DSH, the Joint Commission and the federal Centers for Medicare and Medicaid Services (CMS) have required state hospitals, acute psychiatric hospitals, and hospitals with acute psychiatric units to mitigate ligature risks. DSH reports that its state hospitals, like many hospitals nationwide, are experiencing challenges in completing the purchase or fabrication of ligature retrofit materials and labor, as well as hiring issues that necessitate an extended timeline for expenditure of the authorized funding.

DSH requests budget bill language to extend the encumbrance and expenditure authority for ligature risk special repair funding authorized in the 2020 Budget Act until June 30, 2024. The provisional language would be added to Item 4440-011-0001 as follows:

> 4440-011-0001
> Provisions:
> 14. Of the amount appropriated in Schedule (2), $5,257,000 shall be expended for ligature risk special repair projects at Atascadero, Metropolitan, Napa, and Patton state hospitals. The amount allocated shall be available for encumbrance and expenditure until June 30, 2024.

According to DSH, this language would be included in subsequent budget bills to allow extended encumbrance and expenditure periods for the additional fiscal year resources through 2026-27 approved in the 2020 Budget Act.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Adjustments to Budget Change Proposals

Budget Change Proposal – April Finance Letter. DSH requests the following adjustments to proposals included in the January budget:

- DSH requests 5.5 positions be included in its January proposal for Increased Court Appearances and Public Records Act. The original request was heard during the subcommittee's February 26th hearing and included only limited-term resources equivalent to 5.5 positions for two years.
- DSH requests eight positions be included in its January proposal for Protected Health Information. The original request was heard during the subcommittee's February 26th hearing and only included limited-term resources to extend the equivalent of eight positions for two years.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**13.5**	**13.5**

* Positions and resources ongoing after 2022-23.

Background – Increased Court Appearances and Public Records Act. In the January budget, DSH requested General Fund expenditure authority of $777,000 in 2021-22 and 2022-23 to allow DSH to continue to address the increase in workload for attorneys that are required to appear for court hearings and for responding to Public Records Act requests. These resources were a continuation of the limited-term resources approved in the 2019 Budget Act for this purpose. Like the previous requests, the requested resources would support the equivalent of 5.5 positions, including **three Attorney I** positions supported by **one Legal Secretary** to address the legal and court hearings workload, and **one Legal Analyst** and **0.5 Staff Services Analyst** to support the PRA workload.

In its April Finance Letter, DSH requests permanent establishment of these 5.5 positions. As a result, both the positions and the previously requested limited-term General Fund expenditure authority of $777,000 would be an ongoing allocation of positions and resources.

Background – Protected Health Information. In the January budget, DSH requested General Fund expenditure authority of $986,000 in 2021-22 and 2022-23 to continue processing of invoices and payments from external medical providers containing protected health information and consolidating financial operations into a single budget unit. These resources would support the equivalent of eight positions, including **five Accounting Officer Specialists** to continue to address the workload associated with entering invoices with PHI into the DSH accounting systems until implementation of an electronic health record, and **three Associate Accounting Analysts** to support reconciliation activities for transactions for the five State Hospitals and Sacramento Headquarters.

In its April Finance Letter, DSH requests permanent establishment of these eight positions. As a result, both the positions and the previously requested limited-term General Fund expenditure authority of $986,000 would be an ongoing allocation of positions and resources.

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

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

1. Please provide a brief overview of these proposals.

Issue 5: Coalinga - Hydronic Loop Replacement - Adjustment

Capital Outlay Budget Change Proposal – April Finance Letter. DSH requests a reduction in its previously requested General Fund expenditure authority of $23.1 million to reflect reduced costs for the hydronic loop replacement project at Coalinga State Hospital. The revised total request would be $27.5 million, including $539,000 for preliminary plans, $744,000 for working drawings, and $26.2 million for construction.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	($23,069,000)	$-
Total Funding Request:	**($23,069,000)**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. Coalinga State Hospital, which provides acute psychiatric treatment to approximately 1,500 forensic patients, was constructed with a centralized heating and cooling system with a central plant that houses a water boiler and chillers. From the central plant, the hot and chilled water is distributed via underground, direct buried pipelines to the 34 individual buildings on the 320 acre campus. A hydronic loop system is used for distribution of hot water and heating.

According to DSH, the hydronic loop system has experienced numerous catastrophic leaks since the hospital's opening in 2005 due to extensive corrosion of the piping. Since the first leak was discovered in 2007, nine additional leaks were identified. DSH indicates the pipe joints appear to have flanged connections and are not coated or insulated. The deterioration of the system has caused unplanned maintenance and significant repairs requiring extensive excavation and relocation of patients to different buildings for safety and to avoid interruption of patient care. After an extensive geotechnical and engineering evaluation of the system, DSH proposes to replace the hydronic loop with a system both above and below ground and that would resist corrosion.

Revised Cost Estimate for Hydronic Loop Replacement. In the January budget, DSH requested General Fund expenditure authority of $50.5 million for construction costs to replace the hydronic loop system at Coalinga. DSH reports it has, in collaboration with the Department of General Services, evaluated alternative systems and selected a specialized hydronic loop plastic piping for direct build which drastically reduced the construction costs for both labor and materials. As a result, total project costs are estimated to be $27.5 million, including $539,000 for preliminary plans, $744,000 for working drawings, and $26.2 million for construction. The construction amount includes $22.1 million for the construction contract, $1.5 million for contingency, $1.6 million for architectural and engineering services, and $944,000 for other project costs. The schedule estimates preliminary plans would begin in July 2021 and be completed in June 2022. Working drawings would begin in September 2021 and be completed in June 2022. Construction would begin in October 2022 and be completed November 2023.

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

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

1. Please provide a brief overview of this proposal.

Issue 6: Atascadero – Potable Water Booster Pump System Reappropriation

Reappropriation – April Finance Letter. DSH requests reappropriation of General Fund expenditure authority of $229,000, previously approved in the 2020 Budget Act, for the working drawings phase of the Atascadero: Potable Water Booster Pump System project.

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

Background. According to DSH, Atascadero State Hospital's water supply is generated from five underground wells located on the northeast part of the campus. Each well station has a pump that sends water from the wells to an adjacent underground reservoir, from which it is pumped to a one million gallon storage tank on top of a hill. The storage tank then supplies water to the hospital by gravity feed. This gravity line supports the hospital's fire sprinkler system, as well as patient showers, kitchens, and bathrooms.

DSH reports when multiple users draw water, the hospital's main water pressure drops considerably. Water pressure during normal operations averages between 40 and 50 pounds per square inch (psi), which is below the necessary 60 psi required for normal facility operations. According to DSH, the reduced pressure could compromise the hospital's fire sprinkler system in the event of a fire.

The 2019 Budget Act included General Fund expenditure authority of $113,000 in 2019-20 to support preliminary plans for a project to install a potable water booster pump system to serve Atascadero State Hospital's main water system. The 2020 Budget Act included General Fund expenditure authority of $229,000 in 2020-21 for the working drawings phase of the project. According to DSH, the project has experienced delays related to the COVID-19 pandemic. As a result, DSH requests reappropriation of the General Fund expenditure authority of $229,000, previously approved in the 2020 Budget Act, for the working drawings phase of the Atascadero: Potable Water Booster Pump System project. This reappropriation would allow DSH sufficient time to encumber these funds. The requested reappropriation language would read as follows:

> 4440-491—Reappropriation, State Department of State Hospitals. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for in those appropriations and shall be available for encumbrance or expenditure until June 30, 2022:
>
> 0001—General Fund
> (1) Item 4440-301-0001, Budget Act of 2020
> (1) 0005035-Atascadero: Potable Water Booster Pump System
> (a) Working drawings

According to DSH, the total project costs are estimated at $2.2 million, including $133,000 for preliminary plans, $229,000 for working drawings, and $1.7 million for construction. The construction amount

includes $1.5 million for the construction contract, $102,000 for contingency, $129,000 for architectural and engineering services, and $65,000 for other project costs.

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

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

1. Please provide a brief overview of this proposal.

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

Issue 1: Open Enrollment, American Rescue Plan, and State Subsidy Program Updates

Open Enrollment for 2021 Plan Year. Covered California began Open Enrollment for the 2021 Plan Year on November 1st, 2020, reporting a record-low weighted average premium rate increase of 0.5 percent. Covered California also reported all 11 existing health insurance carriers would continue offering products in 2021, with two expanding their coverage areas. Nearly all Californians (99.8 percent) have two or more choices for coverage and 77 percent have four or more choices.

On January 12th, 2021, Covered California reported a record 1.6 million Californians had either renewed coverage or selected a plan during open enrollment, an increase of nearly 200,000 or 14 percent over the same time period in 2020. Over 640,000 were eligible for the state subsidy program, including 44,500 middle-income consumers between 400 and 600 percent of the federal poverty level (FPL).

Impacts of Federal Executive Actions and the American Rescue Plan. On January 28th, 2021, President Biden signed an Executive Order directing HealthCare.gov, the federally facilitated health insurance exchange serving 36 states without their own state-based exchange, to provide a special enrollment period between February 15th and May 15th, 2021, to allow individuals in need of health care coverage during the pandemic the opportunity to sign up. On the same day, Covered California announced that it would also extend its Open Enrollment period, previously scheduled to end on January 31st, 2021, until May 15th, 2021, to match the federal extension.

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

As a result of the more generous subsidies provided by the ARP, the three-year state premium subsidy program implemented by the 2019 Budget Act would be subsumed by the new federal subsidies. The state subsidy program was designed to limit individuals between 400 and 600 percent of the FPL to spending between 9.68 percent and 18 percent of income on premiums. Because the ARP caps premiums at 8.5 percent for all income levels, no state premium subsidy is necessary to reach the required contribution levels included in the state premium subsidy design.

According to Covered California, nearly 2.5 million Californians could benefit from the subsidies in the ARP:

- Currently Insured – Covered California – 1.4 million consumers already enrolled in Covered California plans will benefit from the enhanced subsidies without taking any action. This includes 1.3 million below 400 percent of the FPL and 140,000 above 400 percent of the FPL.

- Currently Insured – Off-Exchange – 270,000 consumers insured in off-exchange products could now benefit from enhanced subsidies by switching to plans in the Covered California exchange. Covered California has been working with carriers to facilitate the transition of consumers from off-exchange plans to exchange plans.
- Currently Uninsured – 810,000 consumers who are currently uninsured could benefit from enhanced subsidies that could lead to more affordable premiums for Covered California plans.

Next Steps for State Subsidy Program. Because the ARP has subsumed the state's General Fund investment in state subsidies for individuals in the Covered California health benefit exchange, the Administration and the Legislature must revisit how best to reallocate these resources to improve affordability of health care coverage for Californians. Health Access California, in coalition with other organizations, has proposed the following options for repurposing the state's General Fund investment:

- Cost-Sharing Affordability Options – Health Access California proposes several options to improve health insurance affordability for consumers for the 2022 plan year by making plans with lower cost-sharing requirements (e.g. deductibles and co-pays) more affordable.

    - "Level-Up" to Next Metal Tier – Under this option, cost-sharing reduction subsidies would be provided to shift consumers into better-value cost-sharing tiers.
        - Individuals between 150 and 200 percent of the FPL would upgrade from a Silver 87 to a Silver 94 plan, resulting in lowering deductibles from $800 to $75, primary care copays from $15 to $5 per visit, and tier I generic drug copays from $5 to $3.
        - Individuals between 200 and 250 percent of the FPL would upgrade from a Silver 73 to a Silver 87 plan, resulting in lowering deductibles from $3,700 to $800, primary care copays from $35 to $15 per visit, and tier I generic drug copays from $15 to $5.
        - Individuals between 250 and 400 percent of the FPL would upgrade into a Gold plan, resulting in lowering deductibles from $6,300 (Bronze) or $4,000 (Silver) to zero, primary care copays from $65 (Bronze) to $35 per visit (no change for Silver) and tier I generic drug copays from $18 (Bronze) to $15 (no change for Silver).

    - Zero Deductibles Upgrade – An alternative proposal would use state subsidy dollars to reduce deductibles to zero for individuals between 150 and 400 percent of the FPL, but with little change to other cost-sharing, such as copays.
        - Individuals between 150 and 200 percent of the FPL would reduce their deductibles from $800 to zero. Copays and other cost-sharing would remain unchanged.
        - Individuals between 200 and 250 percent of the FPL would reduce their deductibles from $3,700 to zero. Copays and other cost-sharing would remain unchanged.
        - Individuals between 250 and 400 percent of the FPL would upgrade into a Gold plan, resulting in lowering deductibles from $6,300 (Bronze) or $4,000 (Silver) to zero, primary care copays from $65 (Bronze) to $35 per visit (no change for Silver) and tier I generic drug copays from $18 (Bronze) to $15 (no change for Silver).

- State Subsidies to Provide Zero Premiums for Covered California Plans – Health Access California also requests annual General Fund expenditure authority of $15 to $19 million and trailer bill language to allow state-level premium subsidies to cover the $1 per member per month premiums for state-only coverage, for all Covered California marketplace enrollees. According to Health Access California, affordability remains a significant barrier to enrollment in the Covered California marketplace. Despite the economic crisis resulting from the pandemic, and record numbers of Californians facing unemployment, Covered California has seen only modest increases in enrollment. Recent research has shown that any premiums, regardless of amount, play a role in deterring enrollment, particularly for those in lower income ranges. Under current law, California is not able to offer true zero premium plans, but instead health plans charge a minimum of $1 per member per month for every enrollee in Covered California. It's been estimated that 2019 enrollment in Covered CA would have increased by about 60,000 enrollments if true zero premium plans had been offered (Health Affairs, Jan. 2020). By changing statute to provide for state subsidy coverage of the $1 per month premiums for state-only coverage, the state could offer true zero premium plans in the Covered California marketplace. This change would potentially increase enrollment for consumers who are deterred by the presence of any premium, regardless of how low, by improving affordability and removing the administrative barrier of the separate $1 premium. In addition, by allowing true zero premium coverage, it would facilitate enrollment of those who are moving from Medi-Cal to Covered California as the minimum wage rises, as well as other approaches to auto-enrollment, such as those subject to the California individual mandate penalty.

Panel Discussion – Options for Reinvestment of State Premium Subsidy Allocations. The subcommittee has requested the following panelists to discuss these and other options for reinvestment of state premium subsidy allocations:

- Diana Douglas, Policy and Legislative Advocate, Health Access California
- Jen Flory, Policy Advocate, Western Center on Law and Poverty
- Mark Herbert, Vice President – Strategic Initiatives, Small Business Majority

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

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

1. Please provide an update on enrollment in Covered California during the most recent open enrollment period, as well as expected impacts of the most recent special enrollment periods.

2. Please describe how the American Rescue Plan has impacted health insurance affordability for Covered California and other consumers. Please also describe how the American Rescue Plan has affected expenditures in the state subsidy program.

The subcommittee has also requested the panelists to respond to the following:

1. Please present the various options for improving affordability of cost-sharing in Covered California.

2. What is the impact of high cost-sharing requirements on the ability and willingness of lower-income Californians to enroll in low-cost health coverage options offered through Covered California? How would reducing cost-sharing requirements impact the rates of coverage?

3. Please describe the proposal for state subsidies to achieve true zero dollar premiums by covering the federally required $1 per member per month premium amount. How would the availability of zero dollar premiums improve enrollment and aid transitions between sources of health care coverage?

Issue 2: Hospital Discharge Data Sharing

Trailer Bill Language – April Finance Letter. Covered California requests trailer bill language to require the Office of Statewide Health Planning and Development (OSHPD) to provide hospital discharge data to Covered California to improve the accuracy of annual premium rate setting.

Background. Health facilities, including hospitals and ambulatory surgery clinics, are required by state law to report to OSHPD specific data on hospital discharges, emergency department encounters, and ambulatory surgical procedures. OSHPD currently provides this data to the Department of Health Care Services and the Department of Public Health, which are required to ensure a patient's rights to confidentiality are not violated in any manner and are required to comply with policies and requirements imposed by the state Committee for the Protection of Human Subjects.

According to Covered California, utilization and risk mix analyses are an essential part of carrier pricing. Due to the short period between the end of open enrollment and the deadline for rate-setting, carriers often operate with limited information to accurately assess risk for pricing. This lack of information may lead to incorrect pricing and additional business risk, as consumers are harmed by inaccurate pricing and carriers may be harmed by federal risk adjustment transfer payments.

In 2014, Covered California entered into a research collaboration with the University of California, San Francisco and DHCS to demonstrate the value of using OSHPD patient discharge data to help carriers understand their risk mix in a way that protects patient privacy and maintains confidentiality of the rate-setting process. According to the UCSF research team's findings[1], providing carriers with a means to assess health risk of their enrollees allowed them to anticipate whether they would receive or contribute payments to a risk-adjustment pool. Removing this uncertainty allowed the carriers to reduce initially proposed rates and saving consumers tens of millions of dollars.

Covered California requests trailer bill language to allow OSHPD to share data directly with the exchange to allow carriers to better assess risk mix and more accurately set premium rates. Although Covered California had access to the data in partnership with DHCS in 2014, as well as in partnership with the California Health and Human Services Agency in 2020, resource limitations and data sharing restrictions have prevented further collaboration. In addition to allowing data sharing between OSHPD and Covered California, the proposed language would require Covered California to report to the Governor and Legislature on or before August 1, 2023, on the impacts of the new data sharing requirements on premium rates and availability of health plan offerings through the exchange.

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

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

1. Please provide a brief overview of this proposal.

[1] Bindman AB, Hulett D, Gilmer T, Bertko J. "Sorting Out the Health Risk in California's State-Based Marketplace". Health Services Research. Feb 2016.