Senate Budget and Fiscal Review

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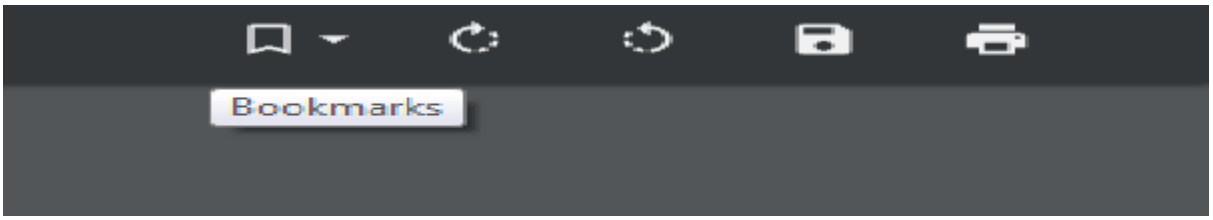

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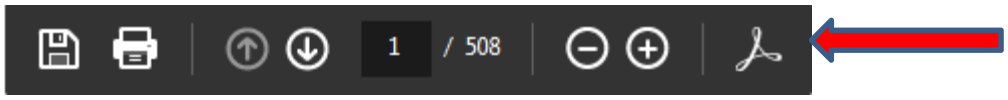

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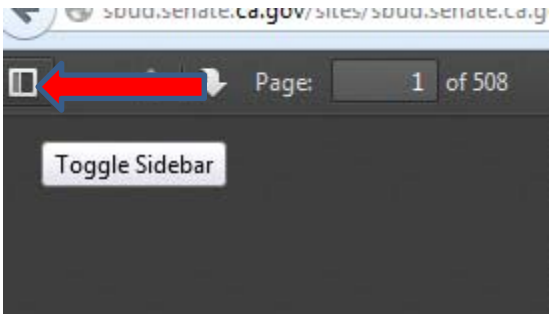

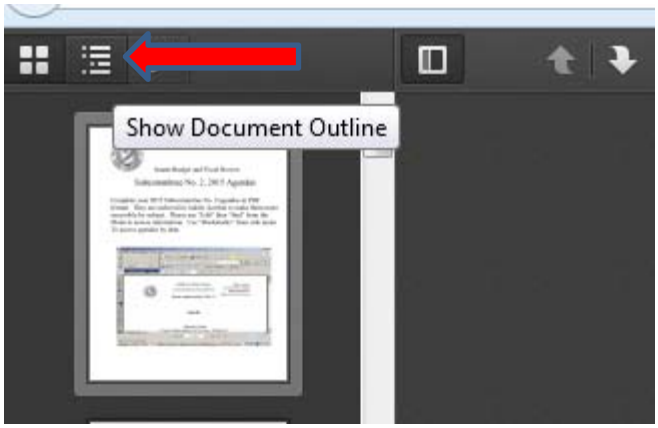

Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Friday, February 12, 2021
9:00 a.m. or upon adjournment of session
State Capitol - Room 3191

Consultant: Scott Ogus

PUBLIC COMMENT

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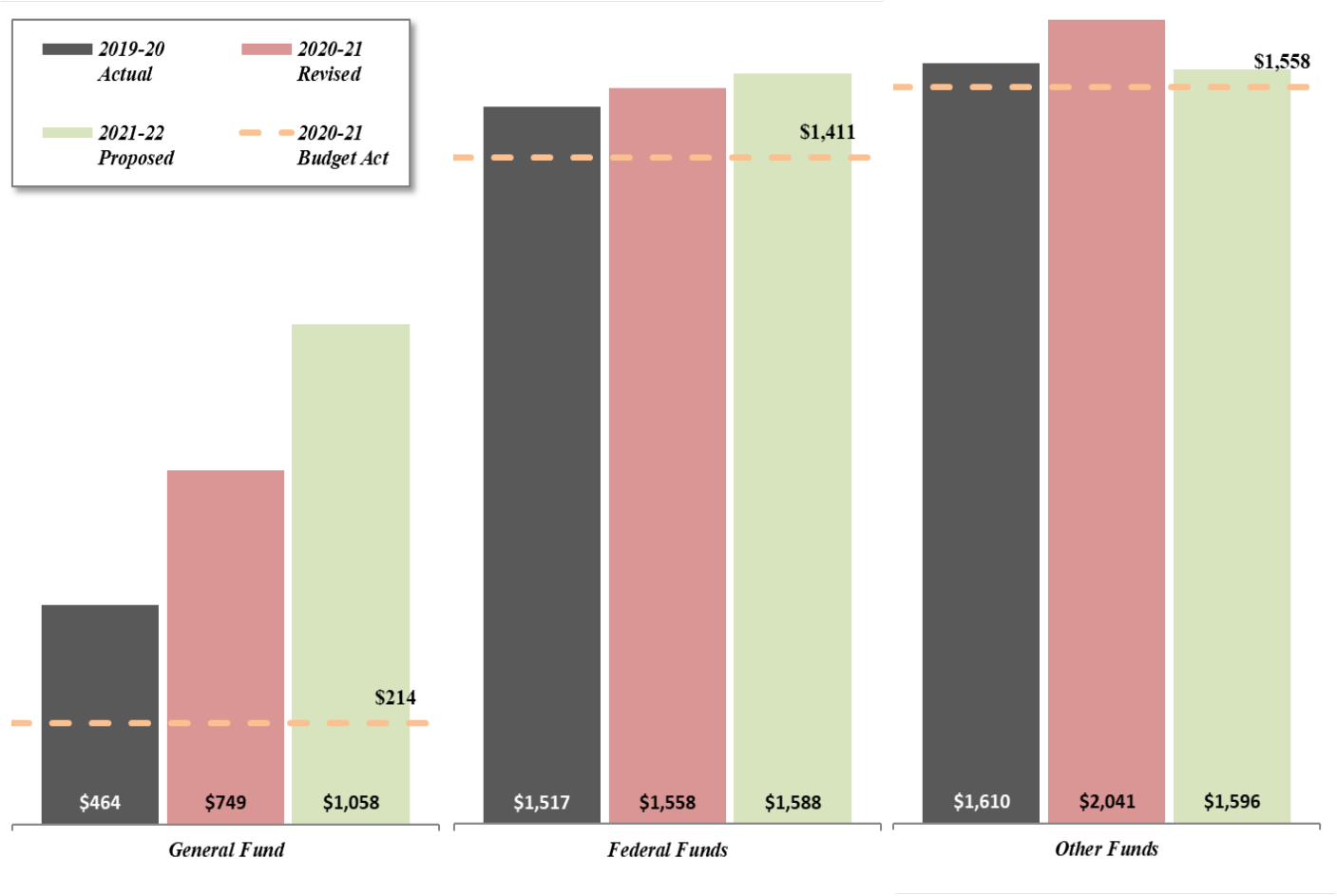
4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Overview

Department of Public Health – *Three-Year Funding Summary*
(dollars in millions)



Department of Public Health - *Department Funding Summary*			
Fund Source	**2019-20 *Actual***	***2020-21 Revised***	***2021-22 Proposed***
General Fund	$463,622,000	$748,987,000	$1,058,070,000
Federal Funds	$1,517,420,000	$1,557,612,000	$1,587,791,000
Other Funds	$1,609,513,000	$2,040,607,000	$1,595,717,000
Total Department Funding:	**$3,590,555,000**	**$4,347,206,000**	**$4,241,578,000**
Total Authorized Positions:	**3611.9**	**3741.4**	**3699.4**
Other Funds Detail:			
Breast Cancer Research Account (0007)	*$1,244,000*	*$791,000*	*$965,000*

Nuclear Planning Assessment Acct (0029)	*$1,003,000*	*$971,000*	*$1,020,000*
Motor Vehicle Acct, Trans. Fund (0044)	*$1,595,000*	*$1,551,000*	*$1,621,000*
Sale of Tobacco to Minors Ctrl Acct (0066)	*$1,180,000*	*$14,000*	*$811,000*
Occup. Lead Poisoning Prev Acct (0070)	*$3,787,000*	*$2,120,000*	*$3,847,000*
Medical Waste Management Fund (0074)	*$2,884,000*	*$2,755,000*	*$2,948,000*
Radiation Control Fund (0075)	*$28,623,000*	*$27,564,000*	*$29,176,000*
Tissue Bank License Fund (0076)	*$665,000*	*$636,000*	*$679,000*
Childhood Lead Poisoning Prev Fund (0080)	*$42,045,000*	*$44,729,000*	*$42,480,000*
Export Document Program Fund (0082)	*$859,000*	*$823,000*	*$590,000*
Clinical Lab. Improvement Fund (0098)	*$13,458,000*	*$12,956,000*	*$13,790,000*
Health Statistics Special Fund (0099)	*$30,246,000*	*$30,374,000*	*$31,587,000*
Dept. of Pesticide Regulation Fund (0106)	*$330,000*	*$314,000*	*$336,000*
Air Pollution Control Fund (0115)	*$305,000*	*$298,000*	*$305,000*
CA Health Data and Planning Fund (0143)	*$240,000*	*$240,000*	*$240,000*
Food Safety Fund (0177)	*$12,237,000*	*$9,650,000*	*$11,348,000*
Genetic Disease Testing Fund (0203)	*$143,229,000*	*$139,453,000*	*$145,885,000*
Health Education Account, Prop 99 (0231)	*$52,576,000*	*$42,015,000*	*$35,852,000*
Research Account, Prop 99 (0234)	*$7,507,000*	*$6,151,000*	*$3,481,000*
Unallocated Account, Prop 99 (0236)	*$4,506,000*	*$3,735,000*	*$1,861,000*
Infant Botulism Treatment/Prev Fund (0272)	*$14,300,000*	*$10,309,000*	*$9,068,000*
Child Health and Safety Fund (0279)	*$551,000*	*$551,000*	*$551,000*
Registered Enviro. Health Spec Fund (0335)	*$467,000*	*$407,000*	*$477,000*
Indian Gaming Spec Dist Fund (0367)	*$8,369,000*	*$8,320,000*	*$8,391,000*
Vectorborne Disease Account (0478)	*$216,000*	*$160,000*	*$195,000*
Toxic Substances Control Acct (0557)	*$543,000*	*$529,000*	*$559,000*
Domestic Violence Training/Ed Fund (0642)	*$636,000*	*$610,000*	*$647,000*
CA Alzheimers Research Fund (0823)	*$657,000*	*$645,000*	*$663,000*
Special Deposit Fund (0942)	*$11,059,000*	*$15,564,000*	*$13,163,000*
Reimbursements (0995)	*$255,602,000*	*$714,233,000*	*$255,156,000*
Drug and Device Safety Fund (3018)	*$6,552,000*	*$4,609,000*	*$7,685,000*
WIC Manufacturer Rebate Fund (3023)	*$210,098,000*	*$196,784,000*	*$174,414,000*
Medical Marijuana Program Fund (3074)	*$163,000*	*$3,000*	*$17,000*
AIDS Drug Assistance Program Fund (3080)	*$307,061,000*	*$373,037,000*	*$409,717,000*
Cannery Inspection Fund (3081)	*$3,145,000*	*$3,040,000*	*$3,227,000*
Mental Health Services Fund (3085)	*$42,483,000*	*$2,393,000*	*$2,468,000*
Licensing and Certification Fund (3098)	*$193,927,000*	*$212,458,000*	*$257,179,000*
Gambling Addiction Program Fund (3110)	*$150,000*	*$150,000*	*$150,000*
Birth Defects Monitoring Prog Fund (3114)	*$2,410,000*	*$2,347,000*	*$2,434,000*
Lead-Related Construction Fund (3155)	*$861,000*	*$1,244,000*	*$1,298,000*
Cost/Impl Acct, Air Poll. Ctrl Fund (3237)	*$379,000*	*$373,000*	*$386,000*

Cannabis Control Fund (3288)	*$13,973,000*	*$28,216,000*	*$908,000*
State Dental Program Acct., Prop 56 (3307)	*$31,339,000*	*$25,541,000*	*$25,054,000*
DPH Tobacco Law Enforc, Prop 56 (3318)	*$12,982,000*	*$4,583,000*	*$4,463,000*
DPH, Tobacco Prev/Ctrl, Prop 56 (3322)	*$143,071,000*	*$106,761,000*	*$88,625,000*
Coronavirus Relief Fund (8505)	*$0*	*$600,000*	*$0*

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

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

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

The department is composed of seven major program areas:

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

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

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

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

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

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

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

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 DPH's programs and budget.

Issue 2: COVID-19 Pandemic - Public Health Response

Oversight – 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 two recently approved COVID-19 vaccines.

Outbreak Origin and Transmission. According to the federal Centers for Disease Control and Prevention (CDC), coronaviruses are a large family of viruses that are common in people and many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with MERS-CoV and SARS-CoV. COVID-19 is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats and sequencing in the early stages of the pandemic suggests a likely single, recent emergence of this virus from an animal reservoir.

COVID-19 was first identified in Wuhan, Hubei Province, China. Early on, many of the patients at the epicenter of the outbreak in Wuhan had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside Hubei and in countries outside China, including in the United States, with nearly every nation reporting cases of COVID-19. Epidemiological studies of COVID-19 estimate infected individuals transmit COVID-19 to an average of 2.5 additional people. For reference, the equivalent transmission rate of influenza A is 1.1 to 1.5.

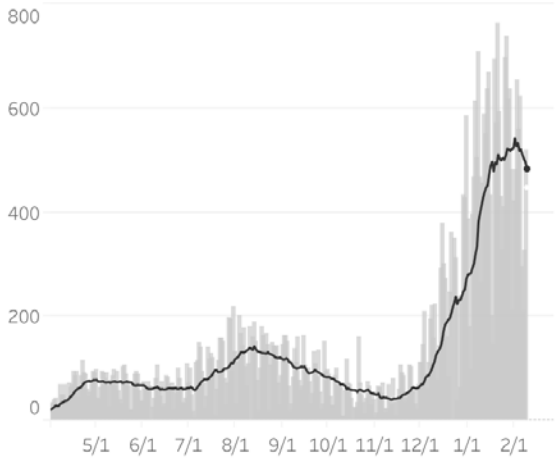
Current Status of Individuals Affected in California. Nearly one year ago, on March 12th, 2020, this subcommittee held one of the first hearings on the COVID-19 outbreak. At that time, DPH reported there were a total of 157 positive cases of COVID-19 in California and 2 deaths. As of February 10th, 2021, there have been 3,362,981 positive cases and 44,995 deaths. 11,516 Californians are hospitalized for COVID-19, with 3,127 in the ICU and only 1,394 ICU beds available statewide. The state is currently in the midst of an alarming surge of COVID-19 cases and deaths that began in mid-November and tested the capacity limits of the state's hospitals and health care systems. During this surge, in multiple regions of the state, particularly in Southern California and the San Joaquin Valley, intensive care needs for COVID-19 patients exceeded the limits of licensed ICU bed capacity and these regions had to resort to surge planning and other modifications to accommodate the increased need for ICU beds. Recent data suggest the rate of new cases may be slowing, and although COVID-19 deaths remain near their pandemic peaks, the expected lag between cases and deaths suggests the rate of deaths may slow in the coming weeks, as well.

Total cases in California

3,362,981 positive cases
8,390 new cases
0.3% increase from prior day total

Total deaths in California

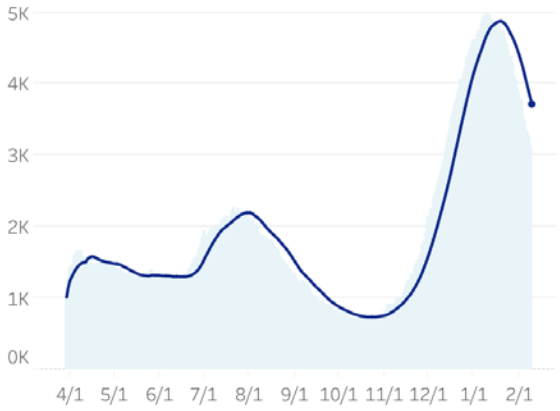
44,995 total deaths
518 new deaths
1.2% increase from prior day total



COVID-19 ICU hospitalized patients in California

Hospitalized | ICU

3,127 COVID-19 ICU hospitalized patients
-137 patients
4.4% decrease from prior day

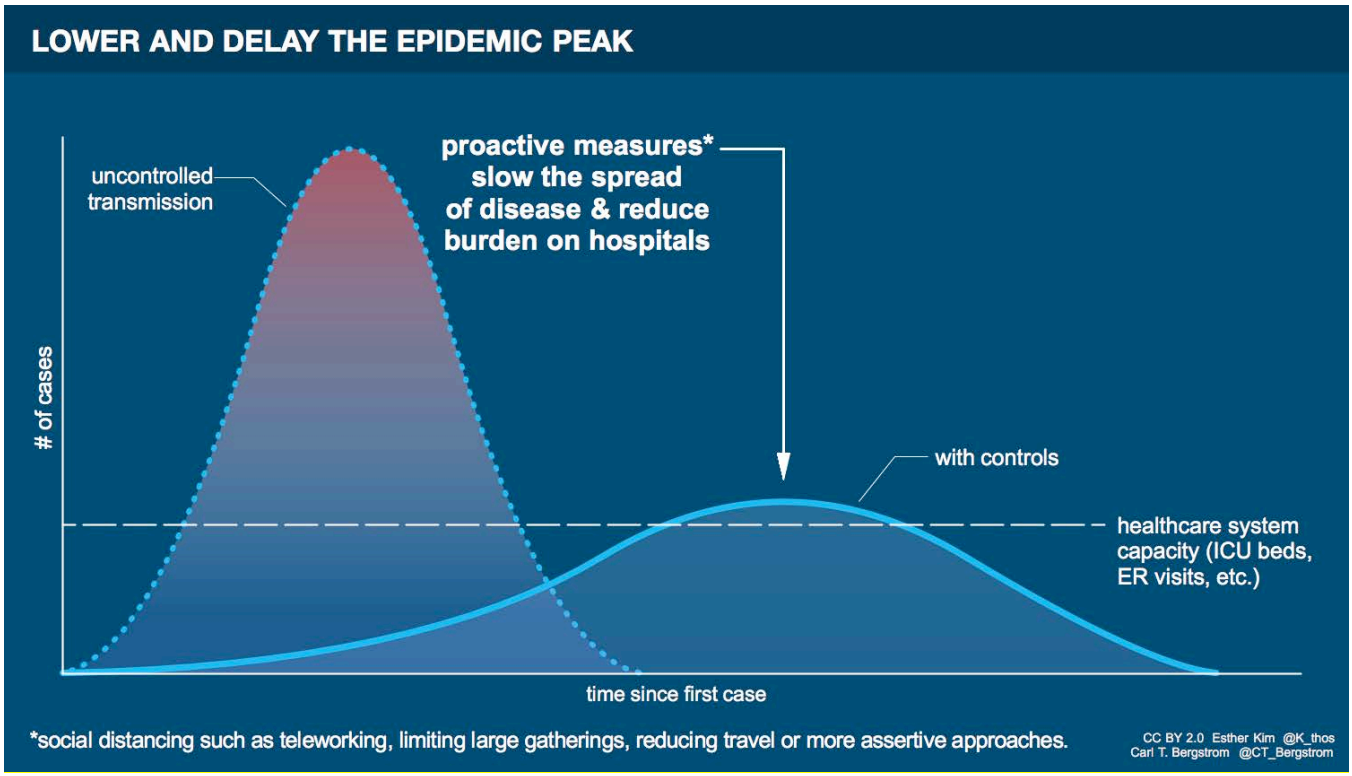


ICU beds in California

1,394 ICU beds available
10 increase from prior day

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 February 10th, 2021.*

Non-Pharmaceutical Interventions to Mitigate COVID-19 Transmission. During the initial phases of the pandemic, much of the response was focused around efforts to "flatten the curve", which refers to mitigation efforts to slow down the spread of COVID-19 and reduce the burden on the health care system. The chart below, many versions of which were circulating during the early stages of the pandemic, demonstrates the relative levels of epidemic peaks with uncontrolled COVID-19 transmission compared with the implementation of mitigation strategies including social distancing, telework, limitations on gatherings, and reducing travel.



The first recommendations for non-pharmaceutical interventions included guidance to Californians to:

- Wash hands with soap and water
- Avoid touching eyes, nose or mouth with unwashed hands
- Avoid close contact with people who are sick
- Stay away from work, school, or other people if you become sick

Initially, the use of masks and face coverings was only recommended for health care settings, but the most updated guidance emphasizes the importance of wearing masks and the overwhelming scientific evidence that masks minimize the spread of respiratory droplets and aerosols that may transmit COVID-19.

Stay-at-Home Orders and Other Public Health Interventions. On March 19th, 2020, DPH issued a statewide stay-at-home order, requiring all individuals in California to stay home or at their place of residence except for workers in 16 federally-identified critical sectors, or to shop for essential needs. Telework was encouraged to the extent feasible for business that could be conducted remotely, but K-12 schools and universities began to close their doors, as well. These interventions were implemented to

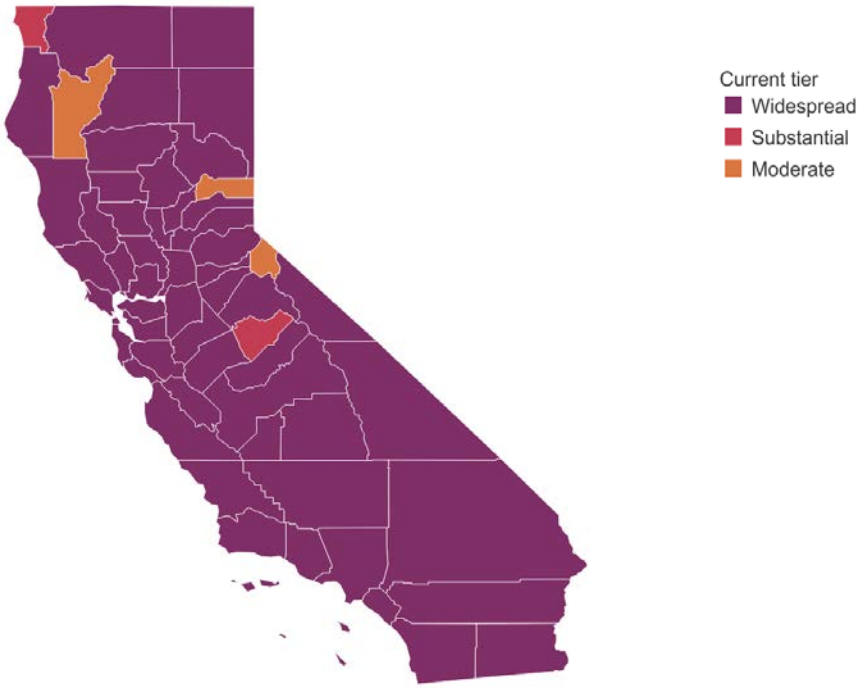
mitigate the rapid transmission of COVID-19 occurring in California to allow time for the health system to prepare for a potential surge of patients. These preparations included efforts to procure sufficient supplies of personal protective equipment (PPE), implementation of health facility surge planning to expand the availability of treatment space and staff, and expand the state's COVID-19 testing and contact tracing infrastructure.

On May 4th, 2020, DPH issued the California Pandemic Roadmap, which identified four stages of reopening safely: 1) safety and preparation, 2) reopening of lower-risk workplaces and other spaces, 3) reopening of higher-risk workplaces and other spaces, and 4) an easing of final restrictions leading to the end of the stay-at-home order. At the same time, DPH allowed all areas of the state to move into stage 2 and reopen lower-risk workplaces, but to practice social distancing, minimize time outside the home, and wash hands frequently. However, by summer of 2020, transmission of COVID-19 and hospitalizations began to rise significantly, and much of the reopening progress was stalled or reversed.

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:

TIER LEVEL	New Cases per 100,000	Test Positivity Rate
Widespread - Tier 1	More than seven	More than eight percent
Substantial - Tier 2	Four to seven	Five to eight percent
Moderate - Tier 3	One to 3.9	Two to 4.9 percent
Minimal - Tier 4	Less than one	Less than 2 percent

County Tier Status as of February 10th, 2021



A county must remain in its current tier for a minimum of three weeks before it may advance to a less restrictive tier. To advance, a county must meet the less restrictive tier's criteria for two consecutive weeks. Counties must also meet the California Health Equity Metric, which ensures the test positivity rate in the most disadvantaged neighborhoods does not significantly lag behind the overall county test positivity rate, and requires counties to have submitted a plan to DPH to make targeted investments to address disproportionately impacted populations. Changes in tier levels are announced every Tuesday. As of February 10th, 2021, 53 counties are in Tier 1 (Widespread), two counties are in Tier 2 (Substantial), and three counties are in Tier 3 (Moderate). No counties are in Tier 4 (Minimal).

The restrictions imposed by Tier are as follows:

Blueprint for a Safer Economy Guidelines				
SECTORS	**Widespread Tier 1**	**Substantial Tier 2**	**Moderate Tier 3**	**Minimal Tier 4**
Critical Infrastructure	Open with modifications	Open with modifications	Open with modifications	Open with modifications
Gatherings	Outdoor only with modifications (3 households)	Indoor allowed (but, discouraged) with modifications (3 households)	Indoor allowed (but, discouraged) with modifications (3 households)	Indoor allowed (but, discouraged) with modifications (3 households)
Limited Services	Open with modifications	Open with modifications	Open with modifications	Open with modifications
Outdoor Playgrounds/Rec. Facilities	Open with modifications	Open with modifications	Open with modifications	Open with modifications
Hair Salons and Barbershops	Open indoors with modifications	Open indoors with modifications	Open indoors with modifications	Open indoors with modifications
All Retail	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 50% capacity	Open indoors with modifications	Open indoors with modifications
Shopping Centers	Open indoors with modifications Max 25% capacity Closed common areas and food courts	Open indoors with modifications Max 50% capacity Closed common areas and reduced capacity at food courts	Open indoors with modifications Closed common areas and reduced capacity at food courts	Open indoors with modifications Reduced capacity at food courts
Personal Care Services	Open indoors with modifications	Open indoors with modifications	Open indoors with modifications	Open indoors with modifications
Museums, Zoos, and Aquariums	Outdoor only with modifications	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 50% capacity	Open indoors with modifications
Places of Worship	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 50% capacity	Open indoors with modifications Max 50% capacity

Movie Theaters	Outdoor only with modifications	Open indoors with modifications Max 25% capacity or 100 people	Open indoors with modifications Max 50% capacity or 200 people	Open indoors with modifications Max 50% capacity
Hotels/Lodging	Open with modifications	Open with modifications Fitness Ctrs (10%)	Open with modifications Fitness Ctrs (25%) Indoor pools	Open with modifications Fitness Ctrs (50%) Spa facilities
Gyms and Fitness Centers	Outdoor only with modifications	Open indoors with modifications Max 10% capacity Climbing walls	Open indoors with modifications Max 25% capacity Indoor pools	Open indoors with modifications Max 50% capacity Saunas Steam rooms
Restaurants	Outdoor only with modifications	Open indoors with modifications Max 25% capacity or 100 people	Open indoors with modifications Max 50% capacity or 200 people	Open indoors with modifications Max 50% capacity
Wineries	Outdoor only with modifications	Outdoor only with modifications	Open indoors with modifications Max 25% capacity or 100 people	Open indoors with modifications Max 50% capacity or 200 people
Bars, Breweries, and Distilleries	CLOSED	CLOSED	Open outdoors with modifications	Open indoors with modifications Max 50% capacity
Family Entertainment Centers (e.g. Kart Racing, Mini Golf, Batting Cages)	Outdoor only with modifications	Outdoor only with modifications	Open indoors for naturally distanced activities with modifications Max 25% capacity Bowling Alleys	Open indoors for activities with increased risk of proximity and mixing with modifications Max 50% capacity Arcade Games Skating Indoor playground
Cardrooms, Satellite Wagering	Outdoor only with modifications	Outdoor only with modifications	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 50% capacity
Offices	Remote	Remote	Open indoors with modifications Encourage telework	Open indoors with modifications Encourage telework
Professional Sports	Open without live audiences with modifications	Open without live audiences with modifications	Open without live audiences with modifications	Open without live audiences with modifications
Live Audience Sports	CLOSED	CLOSED	Outdoors only Max 20% capacity	Outdoors only Max 25% capacity

			Regional visitors (120 miles) Adv reservations Assigned seating In-seat concessions only	Regional visitors (120 miles) Adv reservations Assigned seating In-seat concessions only
Amusement Parks	CLOSED	CLOSED	Small Parks Open Max 25% capacity or 500 people Outdoor attractions only In-county visitors Adv reservations	Large Parks Open Max 25% capacity Adv reservations

Regional Stay-at-Home Order During Fall and Winter Surge. Beginning in November 2020, the state experienced an alarming rise in transmission of COVID-19, followed by a rise in hospitalizations and deaths. On November 19th, 2020, DPH issued a limited stay-at-home order to slow transmission of COVID-19. Over the subsequent two weeks, the daily number of new cases increased by over 112 percent (from 8,743 to 18,588) and the number of new hospital admissions rose from 777 on November 15th, 2020, to 1,651 on December 2nd, 2020.

On December 3rd, 2020, DPH issued a Regional Stay-at-Home Order, subdividing the state into five regions (Northern California, Bay Area, Sacramento, San Joaquin Valley, and Southern California), utilizing the availability of ICU beds as a metric for assessing the level of restrictions in a region. Under the order, if a region's ICU capacity fell below 15 percent, the following restrictions applied:

1) All gatherings with members of other households were prohibited
2) All individuals in the region were required to stay home or at their place of residence except for critical workers or infrastructure sectors, or to shop for essential needs
3) Worship and political expression were permitted outdoors, consistent with DPH guidance
4) Indoor retail was required to operate at no more than 20 percent capacity, and the sale of food, beverages, and alcohol for in-store consumption was prohibited

During the fall and winter surge, the ICU capacity of both the San Joaquin Valley and Southern California regions fell to zero. Four of the five regions fell below the 15 percent ICU capacity threshold and were subject to the stay-at-home order restrictions. During this period, the Administration began forecasting projections for a region's four-week ICU capacity, which allowed certain regions to reopen before ICU capacity returned to the 15 percent threshold.

On January 25th, 2021, the Administration relied on four-week ICU capacity forecasts to rescind the Regional Stay-at-Home Order, returning counties to the Blueprint for a Safer Economy tiered framework for reopening and public health restrictions.

Diagnostic Testing for COVID-19. Shortly after identification of the novel coronavirus as the cause of the respiratory illness spreading throughout the world, scientists had sequenced and published its genome, and developed the nucleotide primers necessary to perform diagnostic polymerase chain reaction (PCR)

testing to identify individuals with COVID-19. PCR testing relies on transcription enzymes to amplify portions of the viral genome specific to COVID-19 to determine the presence of viral RNA and an estimate of the number of copies in a sample. PCR testing has been used for diagnostics for nearly 40 years.

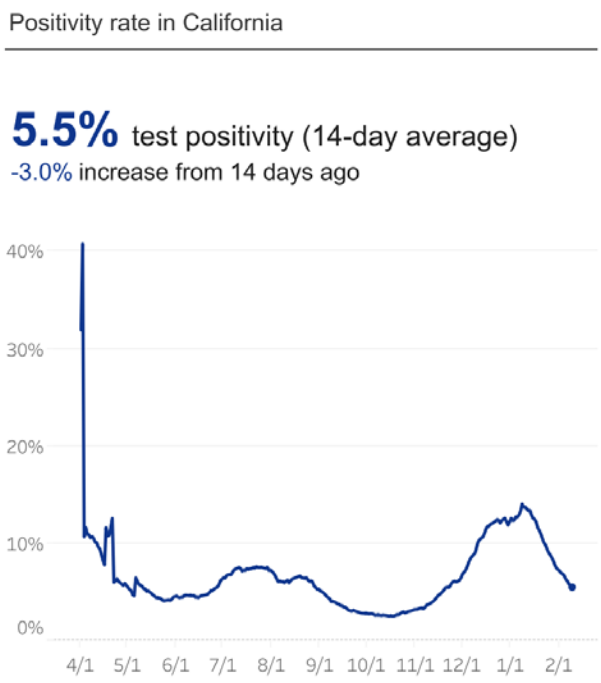
Due to the widespread transmission of COVID-19 during the pandemic, there was limited availability of supplies to conduct the necessary testing to diagnose the significant number of individuals presenting with COVID-19 symptoms. The world experienced shortages of sample collection supplies, transport and other media, and PCR reagents at the same time the need for diagnostic testing for COVID-19 became critical to containment and mitigation strategies. California implemented several initiatives to address the need for COVID-19 testing.

According to DPH, 22 public health laboratories in California began testing for COVID-19 in March 2020, including the DPH State Laboratory in Richmond, and county public health laboratories in Alameda, Contra Costa, Humboldt, Los Angeles, Monterey, Napa-Solano-Yolo-Marin (located in Solano), Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, Santa Clara, Shasta, Sonoma, Tulare and Ventura. California also worked with academic labs at the University of California and Stanford, as well as commercial labs at Quest Diagnostics, LabCorp, and Kaiser to increase testing capacity.

The state also established mass testing sites throughout the state. These included large venues, such as CalExpo in Sacramento, and Dodger Stadium in Los Angeles. The state also partnered with Verily and OptumServe to open additional testing sites, and implemented a web page to allow individuals to find testing resources in their area.

Valencia Laboratory. In August 2020, the Administration announced a partnership with PerkinElmer to open a new, dedicated testing laboratory in Valencia. PerkinElmer would begin processing up to an additional 150,000 PCR tests per day, with a contractual turnaround time of 24 to 48 hours. Beginning operations in October 2020, the Administration indicated it expected the lab to reach the goal of 150,000 tests per day no later than March 1, 2021. According to the Administration, the opening of the Valencia Laboratory required approximately $20 to $25 million to build out, with approximately $100 million per month of contract costs for Perkin Elmer. The total cost of the contract is $1.4 billion and covers multiple fiscal years. DPH is requesting General Fund expenditure authority of $483.2 million in 2021-22 for continued operation of the Valencia Laboratory. (*see Issue 3: COVID-19 Direct Response Expenditures).*

Current Testing Status. As of February 10th, 2021, the state is averaging 251,294 tests over a 14-day period. Testing capacity in the state rose steadily through the spring and early summer of 2020, stabilized at more than 100,000 tests per day through the summer and early fall of 2020, then began to ramp up to reach more than 300,000 tests per day during the fall and winter surge, and currently down to just over 250,000 per day. The 14-day average test positivity rate, one measure of the levels of community transmission, peaked in early 2021 at 14 percent, but has decreased to 5.5 percent.



Contact Tracing, Isolation and Quarantine of Identified COVID-19 Cases. One of the oldest public health tools for managing outbreaks of infectious diseases is contact tracing, isolation, and quarantine. Once a positive case is identified, public health staff interview the individual to determine other individuals who may have been exposed during periods of close contact with the reference case. Public health staff then contact those individuals to notify them of their potential exposure, and to recommend isolation, quarantine, and diagnostic testing to break the onward chain of viral transmission.

Contact tracing activities are typically the responsibility of local health departments. However, during the pandemic, widespread transmission in many local communities overwhelmed the ability of local health departments to keep up with the workload of contact tracing. Decades of state and federal underinvestment in the public health infrastructure that supports contact tracing efforts resulted in a system unprepared for a global pandemic. In addition, there was significant wariness by individuals unaccustomed to being contacted by public health officials to cooperate with contact tracing efforts for COVID-19.

Virtual Training Academy and Contact Tracing Platform. In May 2020, DPH received an augmentation of General Fund expenditure authority of $27.4 million to help expand contact tracing efforts. This funding was used to support development of a virtual training academy, in partnership with the University of California (UC) campuses in San Francisco and Los Angeles, for contact tracing staff. According to DPH, these newly trained contact tracers would be available to augment local public health department staff to aid in the contact tracing workload. The academy is primarily conducted online, including live sessions with instructors, and can be completed in approximately 20 hours over five days. Contact tracers receive training in epidemiology, principles of contact tracing, and infectious disease containment strategies. The training is provided to local public health departments at no cost.

In addition to the academy, the augmentation was used to support development of a data management platform, which can interface with the state's disease surveillance system, to support the contact tracing workforce. DPH contracted with Accenture to launch a contact tracing technology platform, developed by Salesforce, and to operate a contact tracing call center in collaboration with Amazon. This system was modeled on a similar system implemented for the contact tracing program in the state of Massachusetts.

COVID-19 Vaccine Distribution and Administration. Almost as soon as the novel coronavirus was identified as the cause of the respiratory illness spreading throughout the world, dozens of research laboratories and pharmaceutical companies began work developing a vaccine for the new virus. In May 2020, the federal government launched Operation Warp Speed to accelerate development, production and distribution of COVID-19 vaccines, therapeutics, and diagnostics. The current pipeline of COVID-19 vaccines that have been approved by the Food and Drug Administration (FDA) or are currently in clinical development includes the following:

FDA Approval - Emergency Use Authorization (EUA)

mRNA Vaccines

- *Pfizer-BioNTech* – The first COVID-19 vaccine to receive FDA approval, Pfizer-BioNTech's BNT162b2 is an mRNA vaccine that packages the sequence for the COVID-19 spike protein inside lipid nanoparticles. Once injected, the lipid nanoparticles deliver the mRNA sequence into the patient's cells, which produce copies of the spike protein, activating the patient's immune system to produce neutralizing antibodies and confer immunity. Pfizer-BioNTech's vaccine requires two doses, 21 days apart, and requires storage at -60 to -80 degrees Celsius (-76 to -112 degrees Fahrenheit). According to clinical trial data, the Pfizer-BioNTech vaccine is approximately 95 percent effective.
- *Moderna* – Moderna's vaccine, mRNA-1273, the second to receive FDA approval, is also an mRNA vaccine that delivers the sequence for the COVID-19 spike protein with lipid nanoparticles. Moderna's vaccine also requires two doses, 28 days apart, and requires storage at -15 to -25 degrees Celsius (-13 to 5 degrees Fahrenheit). According to clinical trial data, the Moderna vaccine is approximately 95 percent effective.

Other Vaccines in Clinical Development

Adenovirus Vectors

- *Johnson and Johnson* – Currently in Phase 3 trials, Johnson and Johnson's Ad26.COV2.S vaccine utilizes an adenovirus, with its viral replication machinery inactivated, to deliver the COVID-19 spike protein into a patient's cells, which then produce the spike protein and activate the patient's immune system. The Johnson and Johnson vaccine requires only a single dose and can be stored at refrigeration temperatures of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data suggests the Johnson and Johnson vaccine may be up to 72 percent effective.
- *CanSino Biologics* – Currently in Phase 3 trials, CanSino's Ad5-nCoV vaccine also utilizes an adenovirus vector to deliver the COVID-19 spike protein. The CanSino vaccine also requires only a single dose and can be stored at refrigeration temperatures of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data suggests the CanSino vaccine may be up to 66 percent effective.
- *Oxford-AstraZeneca* – Currently in Phase 2/3 trials, Oxford-AstraZeneca's AZD1222 vaccine also utilizes an adenovirus vector to deliver the COVID-19 spike protein. The Oxford-AstraZeneca vaccine requires two doses given 12 weeks apart and can be stored at refrigeration temperatures

of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data suggests the Johnson and Johnson vaccine may be up to 82.4 percent effective.

Recombinant Spike Protein

- *Novavax* – Currently in Phase 2b trials, Novavax's NVX-CoV2373 vaccine utilizes a recombinant version of the COVID-19 spike protein itself to mediate an immune response. The Novavax vaccine requires two doses, 21 days apart, and can be stored at refrigeration temperatures of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data conducted in the United Kingdom suggests the Novavax vaccine may be up to 89.3 percent effective.

In addition to these approved vaccines and vaccine candidates, several others are in development that use adenovirus vectors and inactivated COVID-19 viruses.

Distribution and Administration of Approved COVID-19 Vaccines in California. Shortly after approval of the Pfizer and Moderna COVID-19 vaccines, doses began to be delivered to California. Because supplies of these vaccines were expected to be in short supply as the companies ramp 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 receive 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.

California's COVID-19 Vaccination Plan. Prior to the approval of COVID-19 vaccines, the state developed a planning template submitted to the CDC outlining how vaccines would be distributed and administered in California. The plan largely relies 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 has 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.

The Drafting Guidelines Workgroup and Community Vaccine Advisory Committee have not released final guidelines on the subsequent tiers and affected individuals or sectors likely to be next to receive the vaccines.

According to CDC data, as of February 10th, 2021, the state has administered 4,957,297 doses of the vaccine, including 3,994,969 first doses and 928,615 second doses. More than 10 percent of California's population has received a first dose of vaccine. The federal partnership with CVS and Walgreens has administered 477,862 doses to residents and staff of long-term care facilities in California, with 369,687 receiving a first dose and 106,842 receiving a second dose.

Third-Party Administrator and Other Vaccination Efforts – Blue Shield of California and Kaiser. On January 26, 2021, the Administration announced a new partnership with Blue Shield of California to serve as a third-party administrator for vaccine distribution in California. According to the state's letter of intent, Blue Shield would develop and manage a statewide vaccine administration network by executing contracts with providers that meet state criteria for distribution and administration of vaccines at mobile clinics, vaccine hubs, mega vaccination sites, and to at-risk patients at home. Blue Shield would also assist providers with start-up cost payments and implement incentive payments to encourage vaccine providers to administer vaccines quickly, efficiently, at high volume, and with a focus on communities that have been disproportionately impacted by COVID-19. The Administration also plans to enter into a partnership with Kaiser Foundation Health Plan to assist with the vaccine distribution effort. According to the state's letter of intent, Kaiser would secure, plan, organize, stand up and oversee two or more mass vaccination sites and other efforts to vaccinate hard to reach and disproportionately impacted populations.

2019-20 and 2020-21 Pandemic-Related Emergency Budget Augmentations. During the COVID-19 pandemic, the Administration augmented expenditure authority for DPH through a variety of Executive Orders, provisional language, budget control sections, and transfers from the Disaster Response-Emergency Operations Account (DREOA). In addition, a variety of federal funding streams have supported the pandemic response including reimbursements from the Federal Emergency Management Agency (FEMA) and direct categorical funding from Congressional relief packages.

SB 89 General Fund Allocation for 2019-20. SB 89 (Committee on Budget and Fiscal Review), Chapter 2, Statutes of 2020, appropriated up to $1 billion of General Fund expenditure authority to any item for any purpose related to the Governor's declaration of a state of emergency related to the coronavirus pandemic. SB 89 required the Department of Finance to notify the Joint Legislative Budget Committee (JLBC) 72 hours prior to any expenditures made pursuant to this authority. DPH received the following augmentations under SB 89:

- Hospital Capacity Expansion - $30 million (Item 4265-001-0001) to support lease costs for two hospitals, Seton Medical Center in Daly City and St. Vincent Medical Center in Los Angeles, until June 30, 2020, to expand the state's hospital capacity.
- Testing Capacity at Richmond Laboratory - $1.4 million (Item 4265-001-0001) to expand capacity for diagnostic testing for COVID-19 at DPH's Richmond Laboratory.
- Virtual Training Academy for Contact Tracing - $8.7 million (Item 4265-001-0001) to support development of a virtual training academy to train new staff to augment existing local public health staff to conduct contact tracing of confirmed COVID-19 cases.
- Contact Tracing Technology Platform - $18.7 million (Item 4265-001-0001) to support development of a data management platform to support the contact tracing workforce, developed by Salesforce, and a call center in collaboration with Amazon.

Disaster Response-Emergency Operations Account (DREOA). Government Code Section 8690.6 established the Disaster Response-Emergency Operations Account (DREOA) within the Special Fund for Economic Uncertainties (SFEU). DREOA begins with an unencumbered balance of $1 million at the beginning of each fiscal year, but allows the Director of Finance to transfer sufficient funds from the SFEU to support DREOA expenditures. Section 8690.6 also authorizes DREOA funds, upon allocation by the Director of Finance, to be transferred to state agencies for disaster response operation costs incurred as a result of a proclamation by the Governor of a state of emergency. On March 4th, 2020, the Governor

declared a state of emergency related to the COVID-19 pandemic, which allows transfers for this purpose to state departments, with notification to JLBC and the chairpersons of the fiscal committees in the Senate and Assembly.

On March 25, 2020, the Department of Finance notified JLBC of the transfer of $1.3 billion from the SFEU to DREOA to secure personal protective equipment and critical medical supplies, enhance the surge capacity of hospitals and medical facilities, and procure other items necessary to support the state's efforts to protect public health and safety and reduce the spread of the COVID-19 outbreak. On May 21, 2020, the Department of Finance notified JLBC of the transfer of an additional $1.8 billion to continue emergency response actions, including procurements of personal protective equipment and critical medical supplies, support for over 3,000 hospital and medical surge beds, hotels for healthcare workers and support staff, state response operations, testing, contact tracing and tracking, and other support services.

DPH received a total augmentation of General Fund expenditure authority of $87.7 million from two allocations of funds from DREOA in 2019-20, and $540.3 million from two allocations of funds from DREOA in 2020-21.

Federal Funding for Pandemic Emergency Response. The Federal Emergency Management Agency (FEMA) provides reimbursements for state, local, tribal, and territorial government entities for emergency protective measures taken during the COVID-19 pandemic. FEMA reimburses for eligible expenditures related to the emergency at no less than 75 percent of the cost. During California's pandemic response, the Administration has reported it believes FEMA will reimburse the state for much of its response expenditures at 75 percent. It is unclear how much, if any, of DPH's pandemic-related costs have been reimbursed by FEMA. In addition, the Biden Administration issued an Executive Order on January 21, 2021, authorizing 100 percent FEMA reimbursement for certain pandemic-related response expenditures. Recent federal guidance also suggests the availability of 100 percent FEMA reimbursement would be retroactive to the beginning of the pandemic. It is also unclear how the change in reimbursement would affect funding for DPH's pandemic-related expenditures to date, or in the future.

Section 11.95 – 2020 Budget Act. The 2020 Budget Act included budget control section language in Section 11.95 that authorizes the Department of Finance to adjust any item to account for additional federal funding or additional reimbursements to support testing and contact tracing. The federal Paycheck Protection Program and Health Care Enhancement Act provided $499 million to California through the CDC's Epidemiology and Laboratory Capacity (ELC) grant program to assist local public health departments to reduce transmission of COVID-19. The ELC allocations to DPH in 2020-21 were as follows:

- $286 million (Item 4265-101-0001) was provided to local governments to further six strategies, including: 1) enhance laboratory, surveillance, informatics, and other workforce capacity; 2) strengthen laboratory testing; 3) advance electronic data exchange at public health laboratories; 4) improve public health surveillance and reporting of electronic health data; 5) use laboratory data to enhance investigation, response, and prevention; and 6) coordinate and engage with partners.
- $176.1 million (Item 4265-001-0001) was provided to DPH to, in coordination with local governments, further the same six strategies referenced above.

Other Federal Funding to Support COVID-19 Response. The annual Budget Act includes provisional language in federal fund appropriations for DPH to allow the augmentation of federal fund expenditure authority if funds are made available by the CDC. Using this provisional authority, the Department of Finance approved augmentation of federal fund expenditure authority for DPH to reflect two awards from the CDC: an Immunization Supplemental Grant and an Immunization and Vaccines for Children award. These augmentations will allow DPH to support state and local COVID-19 response efforts. The augmentations were as follows:

Immunization Supplemental Grant

- $11.8 million in Item 4265-001-0890 (DPH State Operations)
- $8.3 million in Item 4265-111-0890 (Local Assistance)

Immunization and Vaccines for Children

- $18.7 million in Item 4265-001-0890 (DPH State Operations)
- $10.6 million in Item 4265-111-0890 (Local Assistance)

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:

- Michelle Gibbons, County Health Executives Association of California
- Kat DeBurgh, Executive Director, Health Officers Association of California
- Andie Martinez Patterson, Vice President of Government Affairs, California Primary Care Association
- BJ Bartleson, Vice President – Nursing and Clinical Services, California Hospital Association
- Kiran Savage-Sangwan, California Pan-Ethnic Health Network (CPEHN)
- Julio Ramirez, SEIU Local 721, Microbiology Supervisor, Los Angeles County Dept. of Public Health
- DeAnn Walters, Director of Clinical Affairs, California Association of Health Facilities

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. Please provide a brief overview of the state's COVID-19 testing capacity, including the prevalence of different testing methodologies and their distribution and deployment throughout the state.

4. Please provide a brief overview of the components of California's systems for vaccine distribution, including the role of local health departments, the federal CVS and Walgreens partnership, and the new third-party administrator.

5. Does the department have any data on the effectiveness of case identification and contact tracing efforts in reducing transmission of COVID-19? What lessons, if any, has the department learned about contact tracing during a pandemic that may inform more effective contact tracing efforts in the future?

6. 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?

7. Please provide a brief accounting of allocations of state or federal funding to DPH for pandemic related expenditures in 2019-20 and 2020-21 from the following sources: SB 89, DREOA, FEMA, the Coronavirus Relief Fund, CDC grant funding, or other federal funding sources.

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

1. Local Health Officers – How are local health officials coordinating with DPH and other state entities to manage the COVID-19 pandemic? Do local health departments have any current resource needs to address the pandemic? Has the response identified any gaps in readiness or resources that should be addressed once the current pandemic is under control?

2. Hospitals - How have your facilities been impacted by the COVID-19 pandemic? What surge procedures do you employ during periods of high hospital utilization? How have you managed staffing needs, particularly for ICU care, during the most recent surge periods?

3. Clinics – How have your clinics been impacted by the COVID-19 pandemic? What role have your clinics played in testing and treatment of COVID-19 patients, as well as the administration of vaccines? How has the delivery of primary care been affected by the pandemic in your clinics?

4. Skilled Nursing Facilities – How have skilled nursing facilities operations been affected by the COVID-19 pandemic? What protective measures have been implemented to protect residents and staff? Please report on the progress of vaccinations in skilled nursing facilities for residents and staff under the federal long-term care partnership? Can you share an estimate of the percentage of skilled nursing facility residents that have received at least one dose of vaccine?

5. CPEHN – 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? In your view, how have pre-existing health inequities been exacerbated by the pandemic? What is the state doing well to address these inequities and where is it falling short? What should the Legislature and the Administration be thinking about as we consider how to address these inequities?

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

Issue 3: COVID-19 Direct Response Expenditures

Budget Change Proposal – Governor's Budget. DPH requests General Fund expenditure authority of $820.5 million in 2021-22. If approved, these resources would support response activities to the COVID-19 pandemic, primarily for testing facilities, supplies, and logistics.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$820,549,000	$-
Total Funding Request:	**$820,549,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

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

The Administration is requesting total General Fund expenditure authority of $1.8 billion to continue its response and mitigation of the impacts of the COVID-19 pandemic. $1.4 billion of this request is allocated specifically to several departments. The remaining $400 million would be allocated through the Disaster Response-Emergency Operations Account (DREOA), pursuant to proposed budget control section language included in this request. The specified allocations for each department or entity are as follows:

- **Department of Public Health (DPH)** – DPH requests General Fund expenditure authority of $820.5 million in 2021-22 for statewide testing efforts at the Valencia Branch testing laboratory, testing specimen collection through OptumServe, and other miscellaneous services and procurements related to testing.
- **Department of General Services (DGS)** – DGS requests General Fund expenditure authority of $84.4 million in 2021-22 for three key pandemic-related programs: 1) Hotels for Healthcare Workers, which provides hotel rooms to healthcare workers providing critical care to COVID-19 patients to help them avoid bringing the virus home; 2) Housing for the Harvest, which provides hotel rooms for agricultural workers to isolate safely if they are exposed to, or test positive for COVID-19; and 3) Project Hope, which provides hotel rooms to individuals released from prison that need to quarantine safely. This request also includes DGS' contract with FedEx for testing specimen transportation costs, which would be shifted to the DPH budget.
- **Department of Corrections and Rehabilitation (CDCR)** – CDCR requests General Fund expenditure authority of $281.3 million in 2021-22 to support the California Correctional Health Care Services' (CCHCS) efforts to treat COVID-19 and minimize exposure to inmates and staff through testing, vaccinations, medical surge capacity, and personal protective equipment (PPE).
- **Department of Veterans Affairs** – The Department of Veterans Affairs requests General Fund expenditure authority of $5.3 million in 2021-22 to continue efforts to mitigate impacts of the pandemic in veterans' homes. These resources would support enhanced cleaning protocols, testing of staff and residents, procurement of PPE and cleaning products, and procurement of thermometers and medical devices.

- **Department of Social Services (DSS)** – DSS requests General Fund expenditure authority of $5 million in 2021-22 for its Rapid Response Program to support entities that provide assistance and services to immigrants during emergent situations when federal funding is not available.
- **Department of State Hospitals (DSH)** – DSH requests General Fund expenditure authority of $52 million in 2021-22 to support staff costs for cleaning, staffing coverage, environmental projects, custody tasks, screening and isolation. The request also covers commodity purchases, such as PPE, sanitation supplies, changes in food service, as well as equipment for heating and air, filtration, and information technology solutions. In addition, though most testing costs would be shifting to DPH, DSH expects some costs from a contractor hired to work onsite to collect, process, and report staff testing results.
- **Board of State and Community Corrections (BSCC)** – BSCC requests General Fund expenditure authority of $12.1 million in 2021-22 to support county probation departments with increased number of individuals released from state prison on Post-Release Community Supervision to reduce institutional populations in response to the pandemic.
- **Department of Developmental Services (DDS)** – DDS requests General Fund expenditure authority of $36.7 million in 2021-22 for development of surge sites to serve consumers diagnosed with, exposed to, or at high risk of COVID-19. The funding would support an average of 25 beds each at Fairview and Porterville Developmental Centers for six months.
- **Governor's Office of Emergency Services (CalOES)** – CalOES requests General Fund expenditure authority of $119.7 million in 2021-22 to reimburse local governments for eligible costs associated with emergency activities undertaken in response to the COVID-19 pandemic.

According to the Administration, the remaining $400 million would be allocated through the DREOA process for statewide hospital and medical surge preparation, contact tracing, and emergency operations costs. The Administration indicates it would release the departmental allocations for these funds once additional information is available.

Department of Public Health – Resource Request. DPH requests total General Fund expenditure authority of $820.5 million in 2021-22 to support response activities to the COVID-19 pandemic, primarily for testing facilities, supplies, and logistics. In particular, this funding would support the following:

- Valencia Laboratory – DPH requests General Fund expenditure authority of $483.2 million in 2021-22 to support testing efforts at its Valencia Laboratory. Beginning operation in October 2020, the Valencia Laboratory will expand the state's COVID-19 testing capacity by an expected 150,000 tests per day by March 2021. DPH contracts with PerkinElmer to operate the lab. Because DPH expects the need for COVID-19 testing capacity will begin to decline in August 2021, this request assumes a small residual cost to maintain the facility in a "warm" shutdown after the end of 2021.
- Logistics Health, Inc. (OptumServe) – DPH requests General Fund expenditure authority of $316.7 million in 2021-22 to support a new specimen collection contract with OptumServe. DPH also expects costs to decline beginning in August 2021 until the end of the calendar year.
- Miscellaneous COVID-19 Testing and Other Costs – DPH requests General Fund expenditure authority of $20.7 million in 2021-22 for service contracts, other operating costs, commodity purchases and other procurements, and a contract to provide revenue collection and banking services for the Valencia Laboratory.

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 the DPH-related components of this proposal, as well as a brief description of the components for other state departments.

2. After the pandemic is over, what are the department's long-term plans for the Valencia Laboratory testing facility? Could this capacity be repurposed for other public health priorities?

Issue 4: Adjustment to Support Infectious Disease Modeling

Budget Change Proposal – Governor's Budget. DPH requests General Fund expenditure authority of $450,000 in 2021-22, available for encumbrance or expenditure until June 30, 2023. If approved, these resources would support infectious disease modeling activities to inform public health emergency decision-making.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$450,000	$-
Total Funding Request:	**$450,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. During the COVID-19 pandemic, determination of the suitability of various public health interventions required modeling of the transmission and public health impacts of the virus within California communities. In February 2020, DPH established the Coronavirus Modeling Team to provide epidemiologic estimates of the potential consequences of COVID-19 and to provide the evidentiary basis of the state's pandemic response. In July 2020, the University of California (UC) Office of the President, with input from DPH, established the California COVID-19 Modeling and Analytics Consortium to consolidate modeling and analytic activities across the UC system to inform state policy. The Consortium includes over 150 investigators from nine UC campuses. According to DPH, as COVID-19 transmission has continued to increase, disproportionately impacting socially vulnerable communities, infectious disease modeling has been highlighted as a central theme in providing transparent data, primarily through the establishment of an open-source, publicly available modeling platform, CalCAT, which disseminates modeling based results produced through collaborations and partnerships with academic and citizen science modeling groups. DPH also reports its infectious disease modeling may be helpful in the state's understanding of the role of new COVID-19 variants in transmission and disease in the state.

Resource Request. DPH requests General Fund expenditure authority of $450,000 in 2021-22, available for encumbrance or expenditure until June 30, 2023, to support its infectious disease modeling activities to inform public health emergency decision-making. DPH reports it has redirected six positions to support its current modeling efforts, including CalCAT, and intends to fund a dedicated staff member to support CalCAT and other infectious disease modeling activities. According to DPH, $300,000 would support the staff salary, benefits, and other operating expenses, and $150,000 would support the modeling and analytics efforts, as well as in-house training for DPH staff.

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. Once the COVID-19 pandemic is under control, how could these modeling resources and efforts be helpful in addressing other infectious diseases?

Issue 5: AIDS Drug Assistance Program (ADAP) Estimate

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

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

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

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

ADAP is funded by federal funds and the ADAP Rebate Fund (Fund 3080). The federal government began funding state programs to assist people living with HIV to purchase antiretroviral medications in 1987. Since 1990 with the passage of the Ryan White Comprehensive AIDS Resources Emergency Act,

now known as the Ryan White Program, the federal Health Resources and Services Administration (HRSA) provides funding to states for ADAP programs. In addition to federal funds, ADAP receives significant funding from mandatory and voluntary manufacturer rebates for ADAP drug expenditures.

ADAP Estimate – Governor's Budget. The November 2020 ADAP Local Assistance Estimate reflects revised 2020-21 expenditures of $467.3 million, an increase of $29 million or 6.6 percent compared to the 2020 Budget Act. According to DPH, this increase is primarily due to higher projected medication expenditures for medication-only clients. For 2021-22, DPH estimates ADAP expenditures of $503.5 million, an increase of $36.1 million or 7.7 percent compared to revised expenditures for 2020-21. According to DPH, this increase is similarly attributable to higher projected medication expenditures for medication-only clients.

ADAP Local Assistance Funding Summary		
Fund Source	**2020-21**	**2021-22**
0890 – Federal Trust Fund	$109,140,000	$105,350,000
3080 – AIDS Drug Assistance Program Rebate Fund	$358,194,000	$398,116,000
Total ADAP Local Assistance Funding	**$467,334,000**	**$503,466,000**

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

Caseload by Client Group	**2019-20**	**2020-21**
Medication-Only	13,105	13,142
Medi-Cal Share of Cost	104	108
Private Insurance	10,479	10,717
Medicare Part D	7,720	7,767
PrEP Assistance Program	3,325	3,430
TOTAL	**34,733**	**35,164**

Expenditures by Client Group	**2019-20**	**2020-21**
Medication-Only	$342,103,793	$356,480,156
Medi-Cal Share of Cost	$1,116,065	$1,158,425
Private Insurance	$88,775,907	$107,608,168
Medicare Part D	$24,421,933	$26,652,684
PrEP Assistance Program	$4,136,501	$4,151,355
TOTAL	**$460,554,199**	**$496,050,788**

In addition, enrollment costs are estimated to be $6.8 million in 2020-21 and $7.4 million in 2021-22. Beginning in 2017-18, ADAP introduced a new reimbursement methodology for enrollment sites which includes a payment floor and variable payments dependent on new client medication enrollment, client

bi-annual self-verification, client annual re-enrollment, client insurance assistance enrollment and re-enrollment, and PrEP client enrollment and re-enrollment.

General Fund Loan – ADAP Rebate Fund. The 2020 Budget Act included provisional language to provide for a loan of up to $100 million from the ADAP Rebate Fund to the General Fund. The provisional language requires the repayment of all or a portion of the loan if the Director of Finance determines that any of the following circumstances exist: (a) the fund or account from which the loan was made has a need for the moneys to maintain a prudent reserve of not less than 40 percent of operating expenses in the previous year for the ADAP Program, (b) the fund or account from which the loan was made has a need for the moneys to maintain a prudent reserve due to a decrease in federal funding, (c) the fund or account from which the loan was made has a need for the moneys to provide drugs and services through the ADAP Program or the HIV prevention program, (d) the fund or account from which the loan was made has a need for the moneys to increase eligibility criteria or add new drugs and services to the ADAP Program or the HIV prevention program, or (e) there is no longer a need for the moneys in the fund or account that received the loan.

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 the major changes to the ADAP Estimate.

Issue 6: Center for Health Care Quality Estimate

Center for Health Care Quality Program Estimate – Governor's Budget. The budget includes expenditure authority for the Center for Health Care Quality of $341.1 million ($4.3 million General Fund, $96.6 million federal funds, and $240.2 million special funds and reimbursements) in 2020-21, a decrease of $9.9 million or 2.8 percent compared to the 2020 Budget Act, and $391.5 million ($4.3 million General Fund, $101.5 million federal funds, and $285.7 million special funds and reimbursements) in 2021-22, an increase of $50.4 million or 14.8 percent compared to the revised 2020-21 budget. According to DPH, the increase in 2021-22 is attributed to increased costs for the third year of the department's contract with Los Angeles County, implementation of a centralized application unit, and legislatively mandated requirements related to personal protective equipment stockpiles for healthcare employers, staffing compliance oversight for skilled nursing facilities, and investigation of complaints against caregivers.

CHCQ Funding Summary, November 2020 Estimate		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$4,296,000	$4,296,000
0890 – Federal Trust Fund	$96,643,000	$101,522,000
0942 – Special Deposit Fund		
Internal Departmental Quality Improvement Account	$3,600,000	$3,600,000
State Health Facilities Citation Penalty Account	$2,144,000	$2,144,000
Federal Health Facilities Citation Penalty Account	$9,873,000	$9,873,000
0995 – Reimbursements	$12,134,000	$12,914,000
3098 – Licensing and Certification Program Fund	$212,458,000	$257,178,000
Total CHCQ Funding	**$291,351,000**	**$311,429,000**
Total CHCQ Positions	**1425.3**	**1456.3**

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

History of Problems with Health Facility Oversight. L&C's regulatory oversight of health care facilities has raised concerns from the federal government, the Legislature, the California State Auditor, stakeholders, and the media for more than fifteen years. In particular, L&C has demonstrated a consistently poor record of completing investigations of health care facility complaints of abuse and neglect of residents in a timely manner. The Legislature has sought to address the ongoing issues with L&C through a variety of budget actions and reporting requirements.

2014 Budget Act – The 2014 Budget Act included trailer bill language requiring L&C to:

- Report metrics quarterly on: (1) investigations of paraprofessional complaints; (2) long-term care health facility complaints, investigations, state relicensing, and federal recertification surveys; and (3) vacancy rates and hiring within L&C.
- Report by October 2016 the above information for all facility types.
- Assess the possibilities of using professional position classifications other than health facility evaluator nurses to perform licensing and certification survey or complaint workload.
- Hold semiannual meetings for all interested stakeholders to provide feedback on improving the L&C program.

2015 Budget Act – The 2015 Budget Act included*:*

- Approval of 237 positions over two years to address the licensing and certification workload.
- $2 million from the Internal Departmental Quality Improvement Account to implement quality improvement projects.
- $14.8 million from the L&C Program Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County.
- $378,000 from the L&C Program Fund and 3 positions to provide on-site oversight and perform workload management, training, and quality improvement activities to improve the efficiency and effectiveness of the Los Angeles County contract licensing and certification activities.
- Trailer bill language to establish timeframes to complete complaint investigations at long-term care facilities, as follows:
    - For immediate jeopardy complaints the department must complete the investigation within 90 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
    - For all other categories of complaints received on or after July 1, 2017, the department must complete the investigation within 90 days of receipt, with an additional extension of 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
    - For all complaints received on or after July 1, 2018, the department must complete the investigation within 60 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
    - Report on an annual basis (in the Licensing and Certification Fee report) data on the department's compliance with these new timelines.

- Beginning with the 2018-19 Licensing and Certification November Program budget estimate, the department must evaluate the feasibility of reducing investigation timelines based on experience implementing the timeframes described above.
- States the intent of the Legislature that the department continues to seek to reduce long-term care complaint investigation timelines to less than 60 days with a goal of meeting a 45-day timeline.

2016 Budget Act – The 2016 Budget Act included*:*

- $2 million from the Internal Departmental Quality Improvement Account to execute two contracts to redesign the Centralized Applications Unit (CAU) information technology systems, and the Health Facilities Consumer Information System (HFCIS).
- $2.5 million in expenditure authority from the L&C Program Fund to convert 18 existing two-year limited-term positions to permanent positions, and fund two additional positions for the Office of Legal Services, for a total of 20 positions to improve the timeliness of investigations of complaints against caregivers.
- One-time $1 million augmentation to the Long-Term Care Ombudsman Program using funds from the State Health Facilities Citation Account.
- $2.1 million from the L&C Program Fund to augment the Los Angeles County contract to account for two, three percent salary increases effective October 2015 and October 2016, an increase to the employee benefit rate from 55.1 to 57.8 percent, and a decrease in the indirect cost rate from 33.2 to 31.4 percent.

2017 Budget Act – The 2017 Budget Act included*:*

- $2 million from the Internal Departmental Quality Improvement Account for IT assessment, performance dashboards, implementation of tablet use, automation of caregiver applications, outcomes and effectiveness evaluation, quality improvement facilitation, onboarding and retention contract for Health Facilities Evaluator Nurses (HFEN), and contracts to continue the redesign of the CAU and HFCIS.
- $1.1 million to augment the Los Angeles County contract to account for salary increases approved by the Los Angeles County Board of Supervisors.
- Implementation of requirements that free-standing skilled nursing facilities have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for certified nurse assistants, beginning July 1, 2018.

2018 Budget Act – The 2018 Budget Act included*:*

- $2.6 million from the Licensing and Certification Program Fund to fund a one-year extension of the Los Angeles County contract for licensing and certification activities and to account for adjustments to the indirect cost rate, employee benefits rate, personnel costs, and lease costs.
- Budget bill language to authorize DPH to increase funding for the Los Angeles County contract as needed based on actual cost information that becomes available during 2018-19.
- Trailer bill language to authorize a supplemental license fee on facilities located in Los Angeles County to offset additional costs necessary to regulate facilities in the county.
- 22 positions and expenditure authority of $2.7 million ($2.4 million Licensing and Certification Program Fund and $294,000 Internal Departmental Quality Improvement Account) annually to allow DPH to improve core operations and effectiveness, foster quality improvement projects, and address workforce needs, particularly in the licensing of certified nurse assistants.

Vacancy Rates: Center for Health Care Quality and HFEN Classification. According to DPH's Vacancy Reports Metrics Dashboard, the Center for Health Care Quality, which oversees the L&C Division, had a 7.1 percent vacancy rate for all positions reported as of June 30, 2020, compared to 6.5 percent as of June 30, 2019. The vacancy rate for the HFEN classification, the primary classification conducting health facility oversight and investigation, was 5.3 percent as of June 30, 2020, compared to 3.9 percent as of June 30, 2019. L&C vacancies, particularly in the HFEN classification, have been a persistent concern for the program, the Legislature, and stakeholders, about the program's ability to manage its licensing and certification and complaint and entity-reported incident investigation workload. However, DPH has been relatively successful in reducing its HFEN vacancy rate, which was 19.5 percent as of June 30, 2016.

DPH indicates its successful reduction in its vacancy rate is due to recent implementation of recruitment and retention strategies. The program hired two contractors to help remedy the high vacancy rates for HFENs in the L&C program: 1) an onboarding and retention contractor assists hiring candidates to navigate the state civil service process and helps improve retention of hired staff, and 2) a recruitment contractor seeks candidates for HFEN positions at job fairs, conducts outreach to registered nurses in California, develops marketing materials and attempts to meet recruitment targets. Funding for these contracts was approved in the 2015 Budget Act from the Internal Departmental Quality Improvement Account.

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 the L&C Program, including regulatory responsibilities, organizational structure, funding, and performance.

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

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

Issue 7: Health Care and Essential Workers: Personal Protective Equipment (SB 275)

Budget Change Proposal – Governor's Budget. DPH requests one position and expenditure authority from the Licensing and Certification Fund of $164,000 annually. If approved, this position and resources would allow DPH to establish regulations for a personal protective equipment (PPE) stockpile by health care employers, pursuant to the requirements of SB 275 (Pan), Chapter 301, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$164,000	$164,000
Total Funding Request:	**$164,000**	**$164,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2022-23.

Background. During the first months of the pandemic emergency, planning for a potential surge in hospital and intensive care unit (ICU) utilization uncovered serious challenges for the state's health systems and health care providers to obtain the personal protective equipment (PPE) necessary to safely treat an influx of COVID-19 patients. In particular, hospital staff across the nation reported shortages of masks, respirators, gowns, gloves, and other equipment, with hospitals often resorting to one or more rationing procedures to ensure availability for hospital staff.

Statewide PPE Stockpile. SB 275 (Pan), Chapter 301, Statutes of 2020, requires DPH and the Governor's Office of Emergency Services (CalOES) to establish a statewide stockpile of PPE by January 1, 2022, upon appropriation and as necessary. The bill requires DPH to establish a PPE Advisory Committee comprised of representatives of various provider associations, labor organizations representing health care and other essential workers, the PPE manufacturing industry, consumers, counties, DPH, CalOES, the Emergency Medical Services Authority, and the Department of Social Services. The Committee will make recommendations to DPH and CalOES to develop guidelines for the procurement, management, and distribution of PPE.

Despite the PPE procurement challenges experienced by health care providers throughout the state during the pandemic, the budget does not include staffing or other resources to establish the statewide stockpile or to support the PPE Advisory Committee. Because the language in SB 275 conditions the establishment of a statewide stockpile on an appropriation in the budget, this omission is allowable. However, it is unclear why the Administration has neglected to include such a vital tool for the stable management of the state's supplies of PPE in its January budget.

Provider-Specific PPE Stockpiles. SB 275 also requires health care employers, including general acute care hospitals, health facilities, certain medical practices, and dialysis clinics, to maintain an inventory of unexpired PPE for use in the event of a pandemic or other emergency. Beginning January 1, 2023, health care employers would be required to maintain an inventory at least sufficient for 45 days of surge consumption, as determined by regulations promulgated by the Department of Industrial Relations (DIR) in coordination with DPH. These regulations would include, but not be limited to, the types and amount of PPE to be maintained based on the type and size of each health care employer and the composition of its workforce. Health care employers that fail to maintain the required stockpile would be subject to civil

penalties. This budget request includes staffing and resources for DPH to assist DIR in promulgating regulations. The budget includes a separate request for DIR to promulgate these regulations and enforce the requirements of SB 275.

Staffing and Resource Request. DPH requests one position and expenditure authority from the Licensing and Certification Fund of $164,000 annually to assist DIR in the establishment of regulations for health care employers' PPE stockpiles. Specifically, DPH requests the following partial positions:

- **0.5 Research Scientist Supervisor I (Epidemiology/Biostatistics)** would conduct research, analysis, and compilation of PPE types, amount of PPE needed, and workforce composition of health care employers, as well as provide expertise in health care associated infections.
- **0.5 Associate Governmental Program Analyst** would assist DIR in writing regulations for health care employers that would be required to maintain stockpiles of PPE.

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 explain why this request does not include resources to establish a statewide stockpile of PPE. Has the Administration determined such a stockpile is not necessary?

Issue 8: Skilled Nursing Facility Staffing Requirements Compliance (AB 81)

Budget Change Proposal – Governor's Budget. DPH requests six positions and expenditure authority from the Licensing and Certification Fund of $939,000 annually. If approved, these positions and resources would allow DPH to enforce skilled nursing facility compliance with staffing requirements, impose penalties, and manage disputes and appeals, pursuant to the requirements of AB 81 (Committee on Budget), Chapter 13, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$939,000	$939,000
Total Funding Request:	**$939,000**	**$939,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2022-23.

Background. AB 1629 (Frommer), Chapter 875, Statutes of 2004, authorized the development of a cost-based, facility-specific reimbursement rate methodology for freestanding skilled nursing facilities serving Medi-Cal beneficiaries and imposed a Quality Assurance Fee (QAF), which supports the nonfederal share of reimbursement rate increases to these facilities. The reimbursement rate methodology and QAF have been reauthorized three times since 2004. Though the basic structure of the reimbursement rate methodology and QAF have remained the same, each reauthorization has provided for the rate of reimbursement rate increases each year and imposes certain other requirements on skilled nursing facilities.

Quality and Accountability Supplemental Payment Program. SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, the first reauthorization of the AB 1629 QAF, also required the Department of Health Care Services to implement a Quality and Accountability Supplemental Payment (QASP) program to enable the reimbursement of skilled nursing facilities to be partially dependent on demonstrated quality of care improvements and adherence to quality standards. Until 2015, the QASP program withheld a portion of the annual rate increase specified in the AB 1629 QAF reauthorization until the required quality of care improvements or adherence to quality standards were demonstrated by a health facility. AB 119 (Committee on Budget), Chapter 17, Statutes of 2015, amended the structure of the QASP withhold, freezing the total reimbursement withheld at 2014-15 levels, or $81 million ($40.5 million QASP funds and $40.5 million federal funds).

Skilled Nursing Facility Minimum Staffing Requirements. SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, requires skilled nursing facilities to have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for certified nursing assistants (CNAs). Previously, the minimum staffing requirement had been 3.2 hours per patient day, with no minimum requirements for CNAs. DPH is responsible for auditing skilled nursing facilities for compliance with these minimum staffing requirements. Failure to comply may result in administrative penalties assessed by DPH, or ineligibility for payments in the QASP program.

Most Recent AB 1629 QAF Reauthorization Includes Enhanced Appeal Rights. AB 81 (Committee on Budget), Chapter 13, Statutes of 2020, the most recent reauthorization of the AB 1629 QAF, extends

the current structure until December 31, 2022, with some changes to the schedule of reimbursement rate increases, changes to the treatment of labor costs and other components of the facility-specific reimbursement rate methodology, exemption of freestanding pediatric subacute facilities from the QAF, and an enhanced right for skilled nursing facilities to appeal determinations or assessments of compliance by DPH. According to DPH, skilled nursing facilities are audited for 24 days of staffing annually to ensure compliance with the minimum requirements for direct care services hours per patient day. If a facility is non-compliant for 2 days or more, it is assessed a penalty and is determined ineligible for QASP payments. Prior to AB 81, only facilities in this category could appeal this determination, because they were assessed a penalty. However, a facility determined non-compliant for only one day is not assessed a penalty and, although it would also be ineligible for QASP payments, it previously could not appeal the determination. AB 81 expanded these appeal rights to allow skilled nursing facilities determined non-compliant for one day to appeal the determination, as well. Based on data trends, DPH expects 106 one-day non-compliant findings to be issued annually and, because this finding results in loss of QASP eligibility, expects all skilled nursing facilities with such findings would appeal. As a result, DPH expects an increase in its auditing and appeals workload.

Staffing and Resource Request. DPH requests six positions and expenditure authority from the Licensing and Certification Fund of $939,000 annually to enforce skilled nursing facility compliance with staffing requirements, impose penalties, and manage disputes and appeals. Specifically, DPH requests the following positions:

Office of Legal Services (OLS) – **Two Attorney III** positions and **one Senior Legal Analyst** would manage the additional 106 appeals of one-day non-compliant findings for skilled nursing facilities, including reviewing arguments, witnesses, and preparing or responding to any supporting documentation.

Staffing Audits Section (SAS) – **Two Associate Governmental Program Analysts** and **one Office Technician** would work as quality assurance auditors conducting on-site staffing audits, quality assurance reviews, reviewing files, and verifying all documentation is included, complete, and correct.

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 9: Timely Investigation of Caregivers

Budget Change Proposal – Governor's Budget. DPH requests seven positions and expenditure authority from the Licensing and Certification Fund of $1 million annually. If approved, these positions and resources would allow DPH to improve the timeliness of investigations of complaints against caregivers.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$1,000,000	$1,000,000
Total Funding Request:	**$1,000,000**	**$1,000,000**
Total Requested Positions:	**7.0**	**7.0**

* Positions and resources ongoing after 2022-23.

Background. DPH's Professional Certification Branch (PCB) is responsible for the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensure of nursing home administrators. It is also responsible for the investigation of allegations involving health care professionals and the enforcement of disciplinary actions. These caregivers provide approximately 80 percent of direct patient care activities for daily living in skilled nursing facilities licensed by DPH, and may also provide direct care in residences through licensed home health agencies.

Federal and state laws require investigation of complaints against caregivers. DPH received 1,310 complaints in 2017-18, 1,372 in 2018-19, and 1,116 in 2019-20. DPH indicates the decrease in complaints received in 2019-20 is due to the significant impact of the COVID-19 pandemic and expects a return to previous levels once pandemic-related restrictions are lifted. Complaints typically involve physical sexual, mental, or verbal abuse or misconduct; misappropriation of property; or other forms of unprofessional conduct. According to DPH, the backlog of pending caregiver investigations has increased from 246 in 2017-18 to 696 in 2019-20, an increase of 183 percent.

Staffing and Resource Request. DPH requests seven positions and expenditure authority from the Licensing and Certification Fund of $1 million annually to improve the timeliness of investigations of complaints against caregivers and mitigate the ongoing investigation backlog. Specifically, DPH requests **one Supervising Special Investigator I** position, who would supervise a team of **six Special Investigators** to manage the increased investigation workload.

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 10: Medical Breach Enforcement Section Expansion

Budget Change Proposal – Governor's Budget. DPH requests 17 positions and expenditure authority from the Licensing and Certification Fund of $2.6 million annually. If approved, these positions and resources would allow DPH to expand its Medical Breach Enforcement Section, which investigates complaints and administers penalties against individuals and health care providers for breaches of medical privacy.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$2,616,000	$2,616,000
Total Funding Request:	**$2,616,000**	**$2,616,000**
Total Requested Positions:	**17.0**	**17.0**

* Positions and resources ongoing after 2022-23.

Background. SB 541 (Alquist), Chapter 605, Statutes of 2008, requires investigation of and assessment of penalties on licensed medical facilities for breaches of patients' confidential medical information. SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014, transferred responsibility for the investigation of medical breaches from the California Health and Human Services Agency to DPH, along with three investigative staff. Since 2009, over 1,600 licensed health facilities have reported nearly 42,000 medical breach incidents.

Pilot Project to Test Use of Non-Clinical Staff for Medical Breach Investigations. In 2016-17, DPH expanded its medical breach investigative staff from three to 17, and included non-clinical classifications such as Special Investigators (SIs) and Associate Governmental Program Analysts (AGPAs) in a Medical Breach Enforcement Section (MBES). Previously, most medical breach investigations were conducted by Health Facility Evaluator Nurses (HFENs), the same classification that conducts investigations of abuse and neglect in skilled nursing facilities. The Center for Health Care Quality's Licensing and Certification Division, which is responsible for complaint investigations in skilled nursing facilities, had a long history of challenges completing investigations of abuse and neglect in a timely manner. In 2016-17, one of the contributing factors to these challenges was a high vacancy rate in the division for the HFEN classification. The transition from HFENs to SIs and AGPAs was intended to free up HFENs to focus on improving the timeliness of abuse and neglect complaint investigations. Since this transition began in 2016-17, DPH reports non-clinical staff from MBES have assumed all medical breach investigation workload in 12 of 19 DPH field offices.

Staffing and Resource Request. DPH requests 17 positions and expenditure authority from the Licensing and Certification Fund of $2.6 million annually to expand MBES staff to the remaining 7 DPH field offices. This expansion would allow HFENs currently performing this workload in these field offices to focus on complaint investigation workload and other duties. Specifically, DPH is requesting **four AGPAs, one Supervising Special Investigator II, one Supervising Special Investigator I, seven Special Investigators,** and **one Program Technician** for the MBES. In addition, DPH is requesting **one Attorney III** in its Legal Office to support medical breach investigations.

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 11: COVID-19 Workplace Outbreak Reporting (AB 685)

Budget Change Proposal – Governor's Budget. DPH requests three positions and General Fund expenditure authority of $677,225 annually. If approved, these positions and resources would allow DPH to create a new program to manage COVID-19 workplace outbreak reporting, pursuant to the requirements of AB 685 (Reyes), Chapter 84, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$677,225	$677,225
Total Funding Request:	**$677,225**	**$677,225**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2022-23.

Background. Due to public health interventions implemented during the COVID-19 pandemic, including stay-at-home orders and prohibitions on the operation of certain types of business and other establishments, many workplaces have transitioned employees to remote work or shut down altogether. However, certain classes of employees are considered "essential workers" and are exempt from stay-at-home orders and other restrictions. As a result, many of these workplaces have experienced outbreaks of COVID-19, as workers continue to occupy indoor spaces with other workers and customers, increasing the risk of transmission. In addition, the pandemic has disproportionately affected certain racial and ethnic groups, particularly Latinos who represent 39 percent of California's population, but 60 percent of its COVID-19 cases. According to DPH, these disparities are likely exacerbated by occupational factors such as the large number of workers from racial and ethnic minorities employed as essential workers. Preliminary data indicates that Latino workers make up 81 percent of COVID-19 fatalities in the construction industry, 79 percent in the restaurant and food service industry, and 93 percent in the crop production industry.

The Occupational Health Branch (OHB) at DPH works to prevent injury and illness on the job by: 1) identifying and evaluating workplace hazards, 2) tracking patterns of work-related injury and illness, 3) developing training and informational materials, 4) providing technical assistance, 5) working with partners to develop safer ways to work, and 6) recommending protective occupational health standards. OHB works closely with the Division of Occupational Safety and Health (Cal/OSHA) at the Department of Industrial Relations (DIR), which enforces workplace safety and health regulations.

AB 685 (Reyes) Chapter 84, Statutes of 2020, mandates employer reporting of COVID-19 outbreaks, which is defined as three or more cases at a worksite within a 14 day period. AB 685 also requires DPH to post information about COVID-19 outbreaks by industry on its website to increase public awareness. According to DPH, this reporting will allow the state to more effectively track and analyze data on workplace outbreaks, identify work-related risk factors for COVID-19 transmission, and inform preventive efforts. DPH reports it has received information about approximately 1,700 workplace outbreaks in January 2020, and plans to implement a dashboard for outbreak information on its website in February 2020. The dashboard would include information by industry, outbreak totals, and workplace settings.

Staffing and Resource Request. DPH requests three positions and General Fund expenditure authority of $677,225 annually to create the new program to manage COVID-19 workplace outbreak reporting. Specifically, DPH requests the following positions:

- **Two Research Scientist II (Epidemiology/Biostatistics)** positions would manage and analyze data on workplace outbreaks reported to the California Reportable Disease Information Exchange (CalREDIE) by local health departments. These positions would ensure data quality and integrity, analyze data to identify industries and occupations with high numbers of cases and rates of COVID-19 transmission, develop user-friendly visual representations of workplace outbreak data, and developing and delivering online training to local health departments on the accurate collection and reporting of data.
- **One Health Program Specialist II** position would conduct outreach to employers and local health departments to disseminate reporting requirements and data findings, develop partnerships and educational materials for local health departments, as well as workers and employers, receive and respond to inquiries regarding reporting requirements, assist the research scientist positions in developing visual representations of data, and update the website weekly.

Included in this request is General Fund expenditure authority of $200,000 annually to support maintenance and operations of system changes and database modifications to facilitate collection and reporting of workplace outbreak data.

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 12: Support for Alzheimer's Disease Awareness, Research, and Training

Budget Change Proposal – Governor's Budget. DPH requests General Fund expenditure authority of $17 million ($6.8 million in state operations and $10.2 million in local assistance) in 2021-22, available for encumbrance or expenditure until June 30, 2024. If approved, these resources would be available to DPH over three years to support an equitable and coordinated approach to Alzheimer's disease and related dementias, including research grants, a public awareness campaign, caregiver training and certification, community challenge grants, and statewide standards for dementia care.

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

Background. According to DPH, Alzheimer's is the seventh most common cause of death for Americans, including COVID-19. Federal Centers for Disease Control and Prevention data indicates California had 15,570 deaths attributable to Alzheimer's disease in 2016, which made it the 4th leading cause of death in the state. Alzheimer's disease disproportionately impacts women, as nearly two-thirds of Americans with Alzheimer's disease or other dementias are women. While the prevailing view has been that the difference is due to the fact that women, on average, live longer than men and older age is the greatest risk factor for Alzheimer's, many researchers question whether the risk of the disease is higher for women at any given age due to biological or genetic variations, or due to differences in life experiences. Alzheimer's disease also disproportionately impacts some communities of color. African-Americans are about two times more likely than older whites to have Alzheimer's and Hispanics are about one and one-half times more likely. Among people ages 65 and older, African Americans have the highest prevalence of Alzheimer's disease and related dementias (13.8 percent), followed by Hispanics (12.2 percent).

AB 2225 (Felando), Chapter 1601, Statutes of 1984, established the Alzheimer's Disease Program (ADP) at DPH, which seeks to reduce the human burden and economic costs associated with Alzheimer's Disease and related dementias. The program, currently funded by individual voluntary contributions by taxpayers on state tax returns, performs two primary functions:

1. *California Alzheimer's Disease Centers.* ADP established and administers a statewide network of ten California Alzheimer's Disease Centers (CADCs) at university medical centers. These Centers provide diagnostic and treatment services; professional training for medical residents, postdoctoral fellows, nurses, interns, and medical students; and community education such as caregiver training and support.
2. *Alzheimer's Disease and Related Disorders Research Fund Grants.* ADP established and administers the Alzheimer's Disease and Related Disorders Research Fund (ADRDF), which awards grants through a competitive process to scientists in California engaged in the study of Alzheimer's disease and related disorders.

Alzheimer's Disease and Related Disorders Research Grants. Since its creation, ADP has provided more than $30 million of funding for more than 130 research projects to contribute to the better

understanding, care, and support of patients and families affected by Alzheimer's Disease and related disorders. Past research grants have contributed to significant breakthroughs including: identifying a novel specific plasma biomarker for Alzheimer's Disease, improving differential diagnosis and training, and providing definitive evidence of how amyloids contribute to the basic pathophysiological abnormalities typical of Alzheimer's and other neurodegenerative diseases.

Before 2018, ADP funded between five and seven research grants with its ADRDF allocations. The 2018 Budget Act included annual General Fund expenditure authority of $3.1 million for Alzheimer's research projects in the following categories:

- *Caregiving*: strengthening caregivers' health and effectiveness
- *Prevention*: reducing risk for cognitive decline and dementia
- *Early Diagnosis and Detection*: expanding early detection and diagnosis
- *Long-Term Services and Support Systems/Health Services:* improving safety and quality of care for people living with dementia
- *Health Disparities:* understanding the prevalence, policies, environmental, and social determinants of health affecting California's diverse population.

The 2019 Budget Act included additional General Fund expenditure authority of $2.7 million annually to support research to understand the greater prevalence of Alzheimer's among women and communities of color.

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

1) A senior advisor on Alzheimer's, appointed by the Governor, to lead on implementing recommendations of the task force.
2) Support Alzheimer's research with increased funding, including a focus on historically underrepresented communities, such as women, communities of color and the LGBTQ+ community.
3) Create a multilingual, multicultural, and intergenerational Alzheimer's Disease Public Awareness campaign to shift public perceptions and reduce social stigma.
4) Build a "California Cares" digital portal to serve as a one-stop shop for information and services related to screening and diagnosis of Alzheimer's.
5) Establish voluntary savings accounts for long-term care to address affordability and access.
6) Invest in career incentives for an Alzheimer's health care workforce.
7) Establish a caregiver training and certification program.
8) Establish a California Blue Zone City Challenge to support cities in certifying certain locations and establishments as "Blue Zones" once they adopt a minimum threshold of best practices that

address the needs and challenges of people with dementia, Alzheimer's or other age related diseases.

9) Establish a Californians for All Care Corps, to provide opportunities for people of all ages and life stages to contribute meaningful public service.
10) Establish an evidence-based, statewide standard of care for Alzheimer's detection diagnosis, treatment, and care planning.

Resource Request. DPH requests General Fund expenditure authority of $17 million ($6.8 million in state operations and $10.2 million in local assistance) in 2021-22, available for encumbrance or expenditure until June 30, 2024. These resources would support an equitable and coordinated approach to Alzheimer's disease and related dementias, and reflect five of the task force recommendations described above, including:

1) Alzheimer's Research Grant Funding (Recommendation 2) – DPH requests General Fund expenditure authority of $4 million to support research grants that would continue to focus on the greater prevalence of dementia in women and communities of color, but also focus on historically underrepresented populations, such as the LGBTQ+ community. Of this request, $3.4 million would be allocated for research grants and $600,000 would support the state operations costs of administering the grant program.
2) Public Awareness Campaign (Recommendation 3) – DPH requests General Fund expenditure authority of $5 million to create a public awareness campaign focused on educating the public on the signs and symptoms of Alzheimer's Disease and related dementias. The campaign would target at-risk and disproportionately impacted populations, incorporate a culturally competent and equity-targeted messaging strategy, provide critical information about Alzheimer's and other aging-related conditions, and drive the public to linguistically and culturally competent dementia care resources delivered through multiple modalities.
3) Caregiver Training and Certification Program (Recommendation 7) – DPH requests General Fund expenditure authority of $4 million to design and, if funding is available, develop a caregiver training and certification program, The program would provide access to evidence-based dementia related education and training for both paid and unpaid caregivers, as well as those providing In-Home Supportive Services. Of this request, $3.4 million would support the training and certification programs, while $600,000 would support the state operations costs of administering the program.
4) California Blue Zone Challenge (Recommendation 8) – DPH requests General Fund expenditure authority of $2 million to allocate grants to California cities or local health jurisdictions to establish a California Blue Zone program which would, in collaboration with local public and private sector stakeholders, certify certain establishments (e.g. schools, restaurants, grocery stores, workplaces, religious institutions, etc.) as "Blue Zones" if they adopt a minimum threshold of best practices. These best practices would address the unique needs and challenges of people with Alzheimer's disease and related dementias, and other age-related diseases.
5) Statewide Standard of Dementia Care (Recommendation 10) – DPH requests General Fund expenditure authority of $2 million to design a statewide standard of care for dementia. This effort would include ensuring primary care physicians have access to a set of evidence-derived cognitive screening questions for identification of Alzheimer's disease and related dementias, developing a hub and spoke model to leverage resources of the ten California Alzheimer's Disease Centers, and incorporating family caregivers into the diagnostic and care planning process.

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

Subcommittee Staff Comment and Recommendation—Hold Open. 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. What is the Administration's plan to address the other five recommendations of the Task Force on Alzheimer's Disease Prevention and Preparedness?

Issue 13: California Parkinson's Disease Registry Program Extension (AB 2821)

Budget Change Proposal and Budget Bill Language – Governor's Budget. DPH requests General Fund expenditure authority of $408,591 in 2021-22. If approved, these resources would allow DPH to continue outreach and surveillance efforts as part of the California Parkinson's Disease Registry, which was extended by AB 2821 (Nazarian), Chapter 103, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$408,591	$-
Total Funding Request:	**$408,591**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The 2017 Budget Act included General Fund expenditure authority of $1.7 million to establish a three-year pilot program to collect data from health providers on the incidence of Parkinson's disease in California. SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, requires healthcare providers diagnosing or providing treatment to Parkinson's disease patients to report each case to DPH. The data is included in the Richard Paul Hemann California Parkinson's Disease Registry (CPDR), a statewide population-based registry utilized to measure the incidence and prevalence of Parkinson's disease.

According to DPH, as of May 31, 2020, CPDR received 272,243 records from over 500 reporting entities for 71,671 total Parkinson's patients in California. The data demonstrate the age-related increase in Parkinson's risk, with only 2,456 patients under the age of 55, just 3.4 percent of all patients. 16,450 patients, or 23 percent, were over age 85.

SB 97 required the registry to begin collecting patient records on July 1, 2018, and included a sunset date for the program of January 1, 2021. AB 2821 (Nazarian), Chapter 103, Statutes of 2020, extended the sunset date until January 1, 2022. However, no additional funding was provided for the additional year.

Resource Request. DPH requests General Fund expenditure authority of $408,591 in 2021-22 to continue outreach and surveillance efforts as part of the CPDR. DPH indicates these resources would support redirection of the following existing positions for one year:

- **One Research Scientist I** position would solicit input from stakeholders on data collection and processing to improve the data warehouse, develop an evaluation plan for CPDR data, and respond to and manage external data requests.
- **One Research Scientist II** position would oversee data collection for CPDR, ensure data quality, develop and implement the CPDR surveillance framework, and conduct analyses using epidemiologic and biostatistical techniques.

In addition to this resource request, DPH is requesting budget bill language that would authorize the Director of the department to enter into contracts, grants or other agreements to conduct the registry, as well as accept grants of public or private non-state funds to support operation of the registry. DPH reports it has received foundation funding in the past for this purpose.

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 14: Women, Infants, and Children (WIC) Program Estimate

WIC Program Estimate – Governor's Budget. The November 2020 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($940.5 million federal funds and $196.8 million WIC manufacturer rebate funds) in 2020-21 and $1.2 billion ($1 billion federal funds and $174.4 million WIC manufacturer rebate funds) in 2021-22. The federal fund amounts include state operations costs of $59.2 million in 2020-21 and 2021-22.

Women, Infants, and Children (WIC) Funding Summary			
	2020-21	**2021-22**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$59,210,000	$59,210,000	$-
Local Assistance:	$881,274,000	$950,951,000	$69,677,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$196,784,000	$174,414,000	($22,370,000)
Total WIC Expenditures	**$1,137,268,000**	**$1,184,575,000**	**$47,307,000**

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

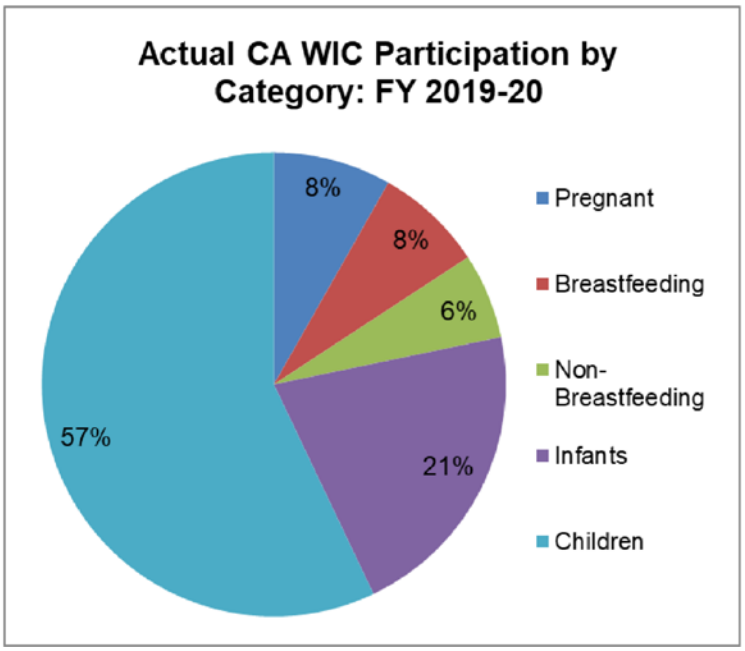
The WIC program's food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant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

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

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

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

According to the WIC program Estimate, WIC participation by category, as of 2019-20, was as follows:



Caseload Estimates. The budget assumes 951,755 average monthly WIC participants in 2020-21, an increase of 133,208 or 16.3 percent from the assumptions in the 2020 Budget Act. The budget assumes 979,983 average monthly WIC participants in 2021-22, an increase of 28,228 or three percent from the revised 2020-21 caseload estimate. According to DPH, the significant increase in participants is due to the economic impacts of the pandemic-induced recession. DPH also reports increases in participation may partially be attributable to the implementation of its electronic benefit transfer (EBT) delivery system and the auto-issuance of WIC benefits during the pandemic, both of which reduce barriers to participation in the program.

Food Expenditures Estimate. The budget includes $773.8 million in 2020-21 for WIC program food expenditures, an increase of $113.7 million or 17.2 percent, compared to the 2020 Budget Act. According to DPH, this increase in costs is due to increased participation related to the pandemic-induced recession, as well as potential impacts of implementation of EBT and auto-issuance of benefits. Of these expenditures, federally funded food expenditures are $577 million, an increase of $105.9 million from the 2020 Budget Act, and WIC Manufacturer Rebate Fund food costs are $196.8 million, an increase of $7.8 million from the 2020 Budget Act.

The budget includes $821.1 million in 2021-22 for WIC program food expenditures, an increase of $47.3 million or 6.1 percent from the revised 2020-21 food expenditures estimate. According to DPH, this increase in costs is also due to increased participation related to the pandemic-induced recession, as well as potential impacts of implementation of EBT and auto-issuance of benefits. Of these expenditures, federally funded food costs are $646.7 million, an increase of $69.7 million from the revised 2020-21 food expenditure estimate, and WIC Manufacturer Rebate Fund food costs are projected to be $174.4 million, a decrease of $22.4 million from the revised 2020-21 food expenditure estimate.

Nutrition Services and Administration (NSA) Estimate. The budget includes $304.2 million for other local assistance expenditures for the NSA budget in 2020-21 and 2021-22, which is unchanged from the level assumed in the 2020 Budget Act. The budget also includes $59.2 million for state operations expenditures in 2020-21 and 2021-22, also unchanged from the level assumed in the 2020 Budget Act.

Implementation of Electronic Benefit Transfer (EBT) System. The federal Healthy, Hunger-Free Kids Act of 2010 requires all state WIC agencies to implement an electronic benefit transfer (EBT) benefits delivery system by October 1, 2020. DPH completed statewide implementation of EBT on July 22, 2020. The California WIC Card replaces the previous paper checks required for accessing WIC benefits. In addition to the WIC Card, DPH implemented the California WIC App, which allows participants to view their food benefit balances, scan food bar codes to determine if the item is in their food benefit balance, view upcoming WIC appointments, and find WIC offices and grocery stores. These improvements have made it easier for participants to access benefits and improved the shopping experience for both participants and grocers. According to DPH, since June 2019, approximately 765,000 cards have been issued, 10 million transactions have been completed, and 100 percent of WIC authorized stores are capable of processing EBT transactions.

WIC Program COVID-19 Response. On March 18, 2020, Congress approved the Families First Coronavirus Response Act (FFCRA), which allocated $500 million to state WIC programs to support the increased need for food benefits and increased costs for providing services. These funds are available until September 30, 2021, but have not been distributed yet. Once these funds are distributed, they may offset expenditures currently supported by rebate funds.

In addition, FFCRA provided administrative flexibility to states to assist the delivery of food benefits to WIC participants. These flexibilities include waiver of in-person enrollment or re-enrollment requirements, auto-issuance of benefits, food substitution if grocer availability of certain foods is limited, and administrative and budgetary flexibilities for local WIC agencies. These flexibilities are scheduled to expire 30 days after the end of the national emergency declaration for the COVID-19 pandemic.

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 the caseload and expenditure changes for the WIC program.

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

3. Please briefly describe the program flexibilities and other actions taken by WIC to respond to the COVID-19 pandemic. Does DPH believe any of these flexibilities would benefit the program after the pandemic state of emergency ends?

Issue 15: Books for Low-Income Children

Budget Change Proposal – Governor's Budget. DPH requests General Fund expenditure authority of $5 million in 2021-22. If approved, these resources would allow DPH to support an early childhood literacy program for participants in the Women, Infants, and Children (WIC) program.

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

Background. Several pilot projects over the last thirty years have demonstrated the effectiveness of coupling WIC sites or pediatric offices with efforts to enhance the development of literacy and school readiness in young children. In pediatric settings, the Reach Out and Read model developed by Boston City Hospital promotes reading aloud as an integral part of routine preventive care, provides a picture book at each provider visit between age 6 months and 6 years, and provides waiting room volunteers to read aloud with children. These pilot projects have demonstrated clinically meaningful increases in preschool vocabulary, parent-reported literacy promoting attitudes and practices, identification of books as a favorite activity, reading aloud thought of as leading to school success, use of books at bedtime, and reading aloud three or more days per week.[1] Parent involvement with early literacy, such as those encouraged by the Reach Out and Read model, has demonstrated significant positive impacts on future reading outcomes.

In February 2020, First 5 California conducted an online survey among 58 county First 5 Commissions to inventory literacy interventions, including key details and program designs. All First 5 Commissions support one or more literacy programs, including many that provide books to children either as the primary goal or bundled along with another effort. These efforts include the Little by Little program in Los Angeles, which provides books to children at WIC offices; the Dolly Parton Imagination Library, which provides free, high-quality books by mail to children at any income level between birth and the beginning of school; and the Kit for New Parents, which provides parenting resources for parents of newborns, and includes a free picture book.

In particular, the Little by Little program in Los Angeles has demonstrated success in improving literacy through its efforts at local WIC agencies. Little by Little was funded by First 5 Los Angeles in 2003 at six WIC centers and includes three components: 1) a brief individual counseling session regarding child development for WIC staff members, 2) a brief handout with information about developmental milestones and appropriate ways to interact with a child to encourage optimal development, and 3) gift of a children's book or developmentally appropriate toy (e.g. black, white, and red chart for newborns or building blocks for 2.5 year old children). The intervention begins in the mother's third trimester of pregnancy and continues until the child's fifth birthday, or the end of WIC eligibility. According to a controlled study

[1] Needlman, R., Toker, K., Dreyer, Benard., Klass, P., Mednelsohn, A., "Effectiveness of a Primary Care Intervention to Support Reading Aloud: A Multicenter Evaluation". Ambulatory Pediatrics. Jul-Aug 2005.

published in the journal *Pediatrics*, the Little by Little intervention demonstrated statistically significant improvements in school readiness, particularly among Spanish-speaking WIC participants.[2]

Resource Request. DPH requests General Fund expenditure authority of $5 million in 2021-22 to support an early childhood literacy program for participants in the 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.

In addition, DPH indicates it would need to temporarily redirect **two Health Program Specialist I** positions to prepare the request for application process for grant funding, manage the competitive award process, and provide technical assistance and oversight for the grant program.

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

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

1. Please provide a brief overview of this proposal.

[2] Whaley, S., Jiang L., Gomez, J., Jenks, E. "Literacy Promotion for Families Participating in the Women, Infants and Children Program". Pediatrics. Feb 2011.

Issue 16: Genetic Disease Screening Program (GDSP) Estimate

Genetic Disease Screening Program Estimate – Governor's Budget. The November 2020 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $140.8 million ($32.9 million state operations and $107.9 million local assistance) in 2020-21, and $145.3 million ($33.3 million state operations and $111.9 million local assistance) in 2021-22.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2020-21	**2021-22**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$32,873,000	$33,322,000	$449,000
Local Assistance:	$107,885,000	$111,939,000	$4,054,000
Total GDSP Expenditures	**$140,758,000**	**$145,261,000**	**$4,503,000**

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

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

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

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

was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

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

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

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

NBS Caseload Estimate: The budget estimates NBS program caseload of 444,234 in 2020-21, a decrease of 6,110 or 1.4 percent, compared to the 2020 Budget Act. The budget estimates NBS program caseload of 445,840 in 2021-22, an increase of 1,606 or 0.4 percent, compared to the revised 2020-21 estimate. These estimates are based on state projections of the number of live births in California. DPH assumes 100 percent of children born in California will participate in the NBS program annually.

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

- Sequential Integrated Screening – This screen combines first and second blood test results with nuchal translucency (NT) ultrasound results, which measure the back of a fetus' neck. This measurement helps screen for Down syndrome (trisomy 21).

- Serum Integrated Screening – This screen combines a first trimester blood test screening result with a second trimester blood test screening result.
- Quad Marker Screening - One blood specimen drawn at 15 weeks - 20 weeks of pregnancy (second trimester test).

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

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

PNS Caseload Estimate: The budget estimates PNS program caseload of 485,230 in 2020-21, a decrease of 10,782 or 2.2 percent, compared to the 2020 Budget Act. The budget estimates PNS program caseload of 477,386 in 2021-22, a decrease of 7,844 or 1.6 percent, compared to the revised 2020-21 estimate. These estimates are based on state projections of the number of live births in California. DPH estimates approximately 71 percent of mothers of children born in California will have participated in the PNS program.

General Fund Loan – Genetic Disease Testing Fund. The 2020 Budget Act included provisional language to provide for a loan of up to $3 million from the Genetic Disease Testing Fund to the General Fund. This fund, which receives fee revenue from NBS and PNS screening activities, supports expenditures in GDSP. The provisional language requires the repayment of all or a portion of the loan if the Director of Finance determines that either of the following circumstances exist: (a) the fund or account from which the loan was made has a need for the moneys, or (b) there is no longer a need for the moneys in the fund or account that received the loan.

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 the caseload and expenditure changes for the Newborn Screening Program.

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

Issue 17: Improving the California Prenatal Screening Program

Budget Change Proposal – Governor's Budget. DPH requests three positions and expenditure authority from the Genetic Disease Testing Fund of $4.3 million ($449,000 for state operations and $3.9 million for local assistance) in 2021-22, and $20.6 million ($449,000 for state operations and $20.2 million for local assistance) annually thereafter. If approved, these positions and resources would allow DPH to meet current standards of care and improve the screening process for the California Prenatal Screening Program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0203 – Genetic Disease Testing Fund	$4,349,000	$20,649,000
Total Funding Request:	**$4,349,000**	**$20,649,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2022-23.

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

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

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

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

New Standard of Care for Prenatal Screening – Cell-Free DNA. A new screening methodology, known as cell-free DNA (cfDNA), has demonstrated improved performance for prenatal screening. cfDNA screens for fetal chromosomal abnormalities through the extraction of fetal DNA that is contained in a maternal blood sample. Recent guidance from the American College of Obstetricians and Gynecologists (ACOG) indicates cfDNA is the most sensitive and specific screening test for detecting common fetal aneuploidies. Fetal aneuploidies are conditions in which a fetus has one or more extra or missing chromosomes, such as trisomy 21 or trisomy 18. The American College of Medical Genetics and

Genomics (ACMGG) indicates that cfDNA has been rapidly integrated into prenatal care and new evidence suggests it can replace conventional screening for chromosomal abnormalities.

Current screening for chromosomal abnormalities in the PNS program relies on analysis of maternal blood samples for levels of two to four pregnancy hormones. The results are used to calculate the risk for two chromosomal abnormalities and neural tube defects. This screening is only available during certain critical periods of pregnancy.

Compared to the current PNS screening methodology, cfDNA has demonstrated superior performance and accuracy, may be performed at any time during a pregnancy, and provides more flexibility in the timing of testing for pregnant women. In addition, because cfDNA screening is diagnostic, rather than a risk-assessment, DPH expects adoption of cfDNA to reduce costs for public and private health care payers, as well as consumers with out-of-pocket costs, due to reduced need for follow-up screenings for chromosomal abnormalities, such as nuchal translucency examinations or amniocentesis. DPH estimates Medi-Cal would experience General Fund savings in the hundreds of thousands of dollars annually compared to current costs, beginning in 2022-23.

Staffing and Resource Request. DPH requests three positions and expenditure authority from the Genetic Disease Testing Fund of $4.3 million ($449,000 for state operations and $3.9 million for local assistance) in 2021-22, and $20.6 million ($449,000 for state operations and $20.2 million for local assistance) annually thereafter to implement cfDNA screening in the California PNS program. According to DPH, cfDNA screening would be offered to all pregnant individuals in California from 10 through 20 weeks of gestation and neural tube defect screening would be offered to all pregnant individuals between 15 and 20 weeks of gestation. DPH indicates it would require **two Health Program Specialist I** positions to support redesign of the current program and for ongoing program maintenance, and **one Health Education Consultant II** position to lead a new and ongoing statewide communication and education effort to reach all prenatal care providers and pregnant individuals. The request includes expenditure authority from the Genetic Disease Testing Fund of $449,000 annually to support these positions.

In addition, the request includes expenditure authority from the Genetic Disease Testing Fund of $3.9 million in the first year, to cover launch preparation costs for the new screening program, and $20.2 million in 2022-23 and annually thereafter to support the new screening program. According to DPH, this estimated local assistance cost assumes annual expected savings of approximately $6 million due to decreases in referrals for follow-up services due to the diagnostic capacity of cfDNA. DPH indicates it intends to contract with private laboratories to conduct the new screening.

In addition, DPH indicates the PNS fee would remain $221.60 for cfDNA, which is its current level. However, DPH would assess a separate fee of $75 for neural tube defect screening for pregnant individuals between 15 and 20 weeks of gestation, which would be established through the program's existing rulemaking process.

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. Why is DPH contracting with a private laboratory for this screening, rather than utilizing its existing laboratory resources?

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, February 9, 2021
1:30 p.m.
State Capitol - Room 3191

Consultant: Renita Polk

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

5180 DEPARTMENT OF SOCIAL SERVICES - CALWORKS

The revised 2020-21 budget includes $6.5 billion in total funds for the CalWORKs program and estimates an average monthly caseload of 405,317. $3.6 billion is for local assistance in 2020-21. The 2021-22 budget includes $7.2 billion in total funds for the program and estimates an average monthly caseload of 482,436 (19 percent increase over the current year caseload). Of that $7.2 billion, $4.4 billion is for local assistance.

Issue 1: CalWORKs COVID-19 Relief

Governor's Proposal. The Governor's budget includes $18.2 million in 2020-21 and $46.1 million in 2021-22 to provide a time-on-aid exemption in the CalWORKs program. Additionally, the Governor's budget includes $1 million ($250,000 General Fund) in 2020-21 to provide clients with broad access to new learning platforms and technologies.

Background. On March 4, 2020, Governor Newsom declared a state of emergency; President Trump declared a national emergency on March 13, 2020. The funding granted from the emergency declarations for DSS programs is to provide for the mass care, food, shelter, and essential services necessary to ensure the safety and protection of vulnerable Californians in this time of crisis. DSS continues to provide funding through the regular budget process, the federal Coronavirus Relief Funds (CRF), and the Disaster Response-Emergency Operations Account.

CalWORKs Time-on-Aid Exemption. The budget includes funding to continue to exempt any month or partial month of CalWORKs aid or services from counting toward the CalWORKs 48-month time limit based on a good-cause exemption due to the COVID-19 pandemic through April 2022, preceding the May 2022 change in the CalWORKs lifetime limit to 60 months. This will apply to all current CalWORKs recipients, unless they have already exceeded the federal time-on-aid limit or have another clock stopper or time-on-aid extender (approximately 800 cases based on Welfare Data Tracking Implementation Project data from October 2020) in place. Examples of other clock stoppers include if an individual is disabled or 60 years or older.

Supporting Success for Remote Clients. The budget also includes funding to provide clients with broad access to new learning platforms and technologies, such as remote lessons on basic literacy, math for daily life, citizenship and civic courses, skills assessments, and certifications as well as loaner laptops and hotspots, to help them on the path to economic independence and wellbeing. Public health guidance related to the pandemic has created barriers to the ways the counties have traditionally served clients and recipients. As a result, the potential for clients to succeed in self-sufficiency efforts has been severely impacted. This funding is expected to serve 4,000 individuals in both the CalWORKs Welfare-to-Work and CalFresh Employment and Training programs over six months beginning in January 2021.

Staff Comment and Recommendation. Hold open.

In its recent publication "The 2021-22 Budget: Analysis of the Governor's CalWORKs Proposals," the Legislative Analyst's Office (LAO) describes a recent and significant drop in CalWORKs

caseload to a new all-time low in November 2020[1]. This drop in caseload is particularly concerning during a time of economic strain as it goes against expected trends. Additionally, the LAO pointed out that a larger share of applications has been denied compared to recent years (60 percent versus 48 percent) and that the exit rate has accelerated in October and November of 2020. Note that November 2020 is the most recent month for which data is available. The department is currently working to better understand these trends. The Subcommittee may wish to follow up on this analysis in a future hearing to ensure that all eligible families are being reached by the program.

Questions.

1. Please detail the budget proposals related to CalWORKs COVID-19 relief.

2. Please detail the recent trends in CalWORKs caseload, application denials, and exit rate.

3. How is the department working to ensure that all eligible families are being served by the CalWORKs program during this time of economic crisis?

[1] https://lao.ca.gov/Publications/Report/4341

Issue 2: CalWORKs Grant Increases

Governor's Proposal. The budget includes a 1.5 percent increase to CalWORKs maximum aid payment levels, effective October 1, 2021. This increase is estimated to cost $50.1 million in 2021-22 and will be funded entirely by the Child Poverty and Family Supplemental Support Subaccount.

Background. The Child Poverty and Family Supplemental Support Subaccount is used to fund CalWORKs assistance grant increases, as well as the repeal of the Maximum Family Grant (MFG) rule, which took effect January 1, 2017. In conjunction with the Governor's Budget in January and the annual May Revision, the Administration provides estimates of the total amount of funding that will be in the subaccount. If that amount is not enough to fully fund the costs of all the CalWORKs assistance grant increases already provided plus the MFG repeal, the state General Fund makes up the difference. If there is more funding in the subaccount than is needed to fund all the CalWORKs assistance grant increases and the MFG repeal, then an additional grant increase is triggered that equals an amount that the available funding is estimated to support. There is estimated to be $513.9 million and $506.3 million in the Child Poverty and Family Supplemental Support Subaccount in fiscal years 2020-21 and 2021-22, respectively. The Administration indicates that there will be enough to fully fund the previous grant increases and MFG repeal in 2020-21.

Previous Budget Actions. The 2018 budget increased the maximum aid payment (MAP) amounts for CalWORKs recipients by 10 percent effective April 1, 2019, and included $90 million in 2018-19 and $360 million annually thereafter. Trailer bill language also stated the intent of the Legislature to provide future grant increases in 2019-20 and 2020-21 to increase grants to no less than 50 percent of the federal poverty level (FPL). The 2019 budget included $331.5 million in 2019-20 and $441.8 million annually thereafter to increase MAP amounts so grants for assistance units (AUs) of one person were at 50 percent of the 2019 FPL. Grants for all other AU sizes were increased to no less than 47 percent of the 2019 FPL.

This proposed grant increase will bring MAP levels to $891 per month for an assistance unit of three residing in a high-cost county. This is part of a multi-year strategy to ensure that all CalWORKs families live above 50 percent of the FPL. The MAP increase set for October 2021 would bring families to 49 percent of the 2020 FPL.

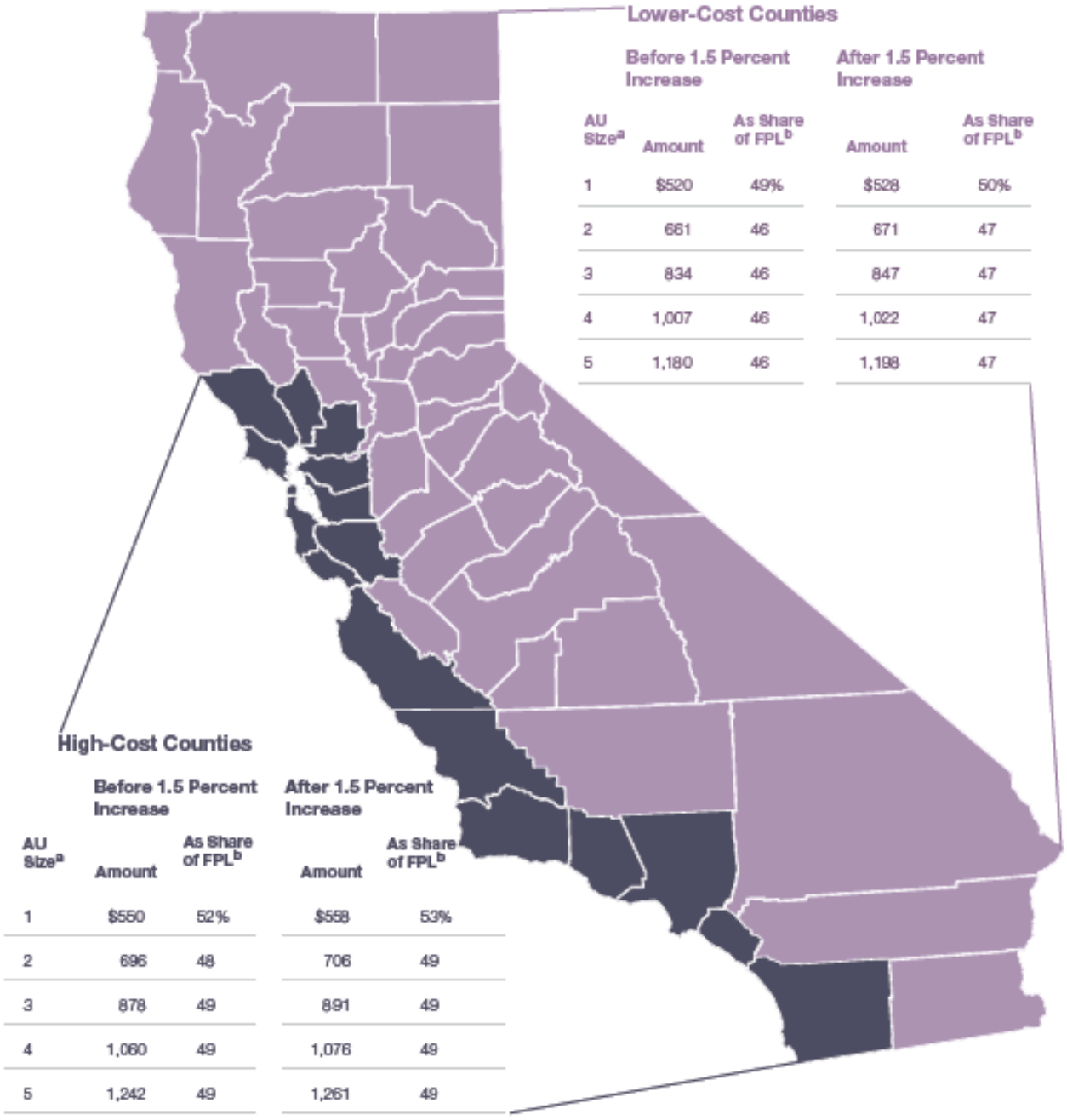
Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of the proposal and the steps remaining to achieve the statutory goal of ensuring no CalWORKs family is living below 50 percent of the federal poverty level.

Governor's Budget Includes 1.5 Percent Increase to CalWORKs Grants

As Shown, for CalWORKs Families With No Other Income



[a] Assistance unit (AU) size is the number of family members who are eligible for CalWORKs.

[b] Share of 2020 FPL guideline for a family size equal to AU size.

FPL = federal poverty level.

LAO

5180 DEPARTMENT OF SOCIAL SERVICES – CALFRESH/FOOD ASSISTANCE PROGRAMS

The revised 2020-21 budget includes $2.1 billion ($730.4 million General Fund) for CalFresh administration. In 2021-22, the proposed budget includes $2.4 billion ($909.3 million General Fund), which represents a projected increase of $355 million ($178.9 million General Fund) from 2020-21. The revised budget estimates a caseload of 2.7 million for 2020-21 and a caseload of 3.2 million for 2021-22.

The budget includes $86.8 million General Fund in 2020-21, an increase of $11.8 million General Fund from the 2020 Budget Act, for the California Food Assistance Program (CFAP). The budget also includes $97.1 million General Fund in 2021-22, a projected increase of $10.3 million General Fund from 2020-21. This funding includes 12 months of Emergency Allotments in 2020-21 and six months of Emergency Allotments in 2021-22.

Issue 3: CalFresh/Food Assistance COVID-19 Relief

Governor's Proposal. The Governor's budget includes $56.4 million total funding for COVID-19 relief in 2021-22 and $195.9 million total funding in 2020-21 for CalFresh and other food assistance programs.

Background. On March 4, 2020, Governor Newsom declared a state of emergency; President Trump declared a national emergency on March 13, 2020. The funding granted from the emergency declarations for DSS programs is to provide for the mass care, food, shelter, and essential services necessary to ensure the safety and protection of vulnerable Californians in this time of crisis. DSS continues to provide funding through the regular budget process, the federal Coronavirus Relief Funds (CRF), and the Disaster Response-Emergency Operations Account.

Increased Federal Support. The federal government has provided additional CalFresh benefits over the past year. The CARES Act increased CalFresh benefits to the maximum amount allowable by household size from March 2020 through the duration of the public health emergency. The most recent federal relief, passed in December 2020, further increased CalFresh benefits by 15 percent from January 2021 to June 2021.

Pandemic Electronic Benefit Transfer (P-EBT) Transaction Cost and Extension. The Governor's budget includes $47.1 million ($34.3 million General Fund) in 2020-21 for the administration of the P-EBT program. The initial P-EBT program provided federal food benefits to children missing school meals from mid-March through mid-June 2020. Applications continued to be processed through August 2020 with benefit payments made in 2020-21, which required $2.9 million ($1.5 million General Fund) in transaction costs to shift from 2019-20 to 2020-21. The P-EBT transaction cost is funded 50 percent federal and 50 percent GF, which is being replaced with federal CRF for the expenditures through December 30, 2020.

An additional 102,000 children were identified as eligible for P-EBT after the September 30, 2020 deadline. The costs related to benefits for these additional children are estimated to be $21 million General Fund with costs related to the issuances at $700,000. Since its inception, the P-EBT program

has issued $2 billion in food benefits to 3.7 million California children. The General Fund associated with P-EBT is partially replaced with federal CRF. The Continuing Appropriations Act (2021) and Other Extensions Act (Public Law 116-159) extends P-EBT through the end of September 2021. That means that P-EBT is now available for the entire 2020-2021 school year. Administrative costs for this extension will be 100 percent federally funded. Implementation of this extension is in progress.

California Food Assistance Program (CFAP). The Governor's budget includes $22.8 million General Fund in 2020-21 and $11.4 million General Fund in 2021-22 for CFAP Emergency Allotments. Emergency Allotments, as authorized by the Families First Coronavirus Response Act, bring all CalFresh households to the maximum allotment for their household size. Issuances related to CFAP must be covered by General Fund, which is being partially replaced with federal Coronavirus Relief Funds. Issuances will continue each month until the Public Health Emergency Declaration ends. The budget reflects anticipated costs through December 2021.

COVID-19 Food Bank Support. The Governor's budget includes $125 million federal CRF in 2020-21 and proposes $30 million General Fund in 2021-22 for COVID-19 Food Bank Support, and $15 million federal CRF in 2020-21 for COVID-19 Food Bank Diaper Support. Note that the $125 million in CRF are not new funds and have been spent.

Supporting Success for Remote Clients. The Governor's budget includes $1 million ($250,000 General Fund) in 2020-21 to provide clients with broad access to new learning platforms and technologies. This proposal is discussed in more detail in the previous agenda issue item.

Staff Comment and Recommendation. Hold open.

The CFAP provides state-funded food benefits for legal noncitizens who meet all CalFresh eligibility criteria except for their immigration status. To be eligible for CalFresh, legal noncitizens must have been in the country for five years, disabled, a member of certain refugee communities, under the age of 18, or over the age of 59. The CFAP serves all other legal noncitizens. However, many other immigrants are unable to access CalFresh or CFAP. The Subcommittee may want to inquire about the feasibility of expanding CFAP to all Californians ineligible for CalFresh solely due to their immigration status. Staff notes that many immigrants not eligible for CFAP or CalFresh are getting food from food banks, increasing demand on them.

Despite the federal and state interventions, the most recent data show that overall food insecurity has spiked to more than 25 percent of California households – that is approximately 10 million people, since COVID[2]. Additional funding for emergency food and food banks in the 2020 budget was $175 million one-time (including state and federal funds). Food banks have reported that funding will last through April 2021, at the latest. Food banks are reporting record demands and estimate they will need to double the volume of food boxes to meet the need across the state. The Governor's 2021 budget proposes a total of $65 million (state and federal funds) for emergency food and food banks, a reduction of $110 million from the 2020 Budget. The Subcommittee may want to discuss options for providing additional support to food banks.

[2] Schanzenbach, Diane, and Natalie Tomeh. Visualizing State Food Insecurity. Northwestern University Institute for Policy Research. https://www.ipr.northwestern.edu/state-food-insecurity.html.

In this time of economic crisis when food insecurity is increasing, the state needs to ensure that all eligible Californians are accessing the CalFresh program. Staff notes the state has one of the lowest CalFresh participation rates in the nation, and that is even more pronounced when looking at seniors and individuals with disabilities The Subcommittee may want to inquire about how the department is ensuring all eligible Californians are enrolled in the program. Additionally, the Subcommittee may want to consider actions that would help eligible Californians enroll in CalFresh. For example, requiring the department to implement a simplified application for older adults.

Due to the timing of the recent Congressional action and Presidential approval, the DSS budget will need to be adjusted to reflect the additional federal support coming to California.

Questions.

1. Please provide a brief overview of budget proposals related to food assistance and COVID-19 relief.

2. Has the Administration determined how the December federal COVID relief legislation will affect the DSS budget? If so, how?

3. Please discuss the impact of COVID on hunger in California, and identify any communities that have been especially impacted. How is the department working to reach out to these communities?

Issue 4: Supplemental Nutrition Benefit (SNB)/Transitional Nutrition Benefit (TNB) Programs

Governor's Proposal. The Governor's budget includes $58.7 million General Fund in 2020-21 and $81.7 million General Fund in 2021-22 to update the SNB and TNB benefit tables. Automation funding of $88,000 is proposed to make the update in the Statewide Automated Welfare System (SAWS).

Background. The SNB and TNB programs are part of the CalFresh expansion to SSI/SSP recipients that went into effect in June 2019. The SNB program provides state-funded nutrition benefits for households that include at least one SSI/SSP recipient and would have had their CalFresh benefits reduced when the SSI/SSP recipient is added to the household. The TNB program provides state-funded nutrition benefits for households that include at least one SSI/SSP recipient and would have become ineligible for CalFresh benefits when the SSI/SSP recipient is added to the household.

The SNB and TNB benefit tables were established based on point-in-time assumptions developed from sample data on CalFresh household characteristics and income levels. Since implementation, actual data suggests the distribution and the net benefit loss experienced by recipients is different from the original estimate. The average monthly benefit will increase from $102.77 to $172.33 for SNB households and $182.98 to $259.40 for TNB households. The new benefits can be issued only after automation is complete which may occur after July 1, 2021, and therefore reduce benefits cost in 2021-22.

Staff Comment and Recommendation. Hold open.

The SNB and TNB programs were designed to "hold harmless" families that may have been adversely affected when CalFresh was opened up to SSI/SSP recipients. Currently, participants in the CalFresh program can receive a replacement of their benefits during a disaster. However, SNB & TNB beneficiaries cannot replace these benefits when they need them most. Staff notes that this creates an inequity between the CalFresh and SNB/TNB programs. The Subcommittee may want to inquire about the feasibility of providing the same replacement for these households. The department has estimated that costs for replacement benefits in these programs, if they had been available from September 2020 to November 2020, would have resulted in roughly $93,698 of benefits. Automation would be required to issue replacement benefits and the timing and costs of automation are unknown at this time.

Recent data from DSS show a decline in TNB enrollment, which under the program design means a potential lifetime loss of this benefit. Note that households may be added back into the program within a 30-day window after missing their recertification deadline, once they complete the recertification process. Since recertifications began in July 2020 close to 4,000 households have left the TNB program, and roughly 1,200 of those families returned to the CalFresh program. The Subcommittee may want to inquire about the feasibility of pausing recertifications during the pandemic or granting other flexibilities for the programs that have been granted for CalFresh during the pandemic.

Questions.

1. Please provide an overview of the budget proposal.

2. What is the feasibility of allowing SNB and TNB recipients to receive replacement benefits?

3. Please detail the recent trends in TNB and SNB enrollment.

Issue 5: BCP – CalFresh Operations Support

Governor's Proposal. The Governor's budget includes $554,000 ($332,000 General Fund) in 2021-22 and $521,000 ($313,000 General Fund) ongoing to add two Staff Service Manager II positions and one Informational Technology Specialist II position. The proposal also includes making permanent the position authority for nineteen existing limited-term positions.

Background. DSS oversees seven federal food programs, including CalFresh, known federally as the Supplemental Nutrition Assistance Program (SNAP), which provides monthly food benefits to low-income individuals and families and economic benefits to communities. CalFresh is the largest food program in California and provides an essential hunger safety net. CalFresh is federally mandated and in California, is state-supervised and county-operated.

CalFresh Operations Bureau. The Operations Bureau currently includes one Technical Assistance (TA) and Evaluation Section and one Quality Control (QC) and Improvement Section and is responsible for examining county welfare departments' CalFresh operations to determine compliance with both state and federal SNAP regulations and supporting client access. Recent events, specifically the 2019 expansion of CalFresh to Supplementary Security Income (SSI) recipients and the coronavirus pandemic, have increased CalFresh caseload and impacted the workload of the CalFresh TA and Evaluation Section. From May 2019 to May 2020, the total number of CalFresh households statewide increased from 1.8 million to nearly 2.6 million, representing over a 38 percent increase. A higher caseload size results in more county reviews being conducted, as the frequency of reviews is based on county CalFresh caseload size.

CalFresh Programs Bureau. The CalFresh Programs Bureau includes the CalFresh Outreach Unit, three Food Distribution Units (FDUs), and the CalFresh Healthy Living Section. The three FDUs primarily manage DSS's emergency food programs via a network of food banks. These emergency programs include the Emergency Food Assistance Program (TEFAP), the Commodity Supplemental Food Program, and other state-funded programs connected to food banks such as the Diaper Bank program.

CalFresh Policy and Employment Bureau. The CalFresh Policy and Employment bureau currently includes the Policy Section and the CalFresh Employment and Training (E&T) Section. The CalFresh E&T program provides CalFresh recipients with opportunities to gain skills, training, and/or experience that will improve their employment prospects and reduce their reliance on CalFresh benefits. California's E&T program currently operates in 37 counties with an annual budget of over $110 million. As part of efforts to support counties and third-party providers in expanding access to E&T services, DSS is leading the development of the "CalFresh Confirm" tool. CalFresh Confirm is a new tool developed by the CalFresh E&T Program that allows authorized users to confirm CalFresh eligibility to seek CalFresh E&T reimbursement for employment and training services provided to CalFresh recipients. CalFresh Confirm will require ongoing management and maintenance to certify appropriate agreements are established with authorized users, only authorized users are accessing the system, and that authorized users are receiving adequate support. Currently, the CalFresh Confirm tool has no dedicated staffing in CDSS' Information Systems Division (ISD).

DSS has made significant changes over the past few years to expand the program's reach. While CalFresh's program access measurement of how many people are served relative to the total number who are eligible has increased from approximately 55 percent to over 70 percent in the last few years, there are still many eligible Californians who need food assistance. Improvements must also be made to retain eligible households and provide benefits without unnecessary interruption. Recently, as a result of the COVID-19 pandemic, the CalFresh program is serving a record number of eligible Californians, reaching over 4.5 million individuals in May 2020. The requested positions in the units identified above will allow the department to support continued access among eligible Californians with improved customer service, while also maintaining compliance with state and federal regulations.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of the proposal.

2. While tremendous progress has been made toward enrolling all eligible Californians, the state still has one of the lowest participation rates in the nation. How will the expansion of the CalFresh branch enable more eligible people to benefit from the program?

5180 DEPARTMENT OF SOCIAL SERVICES – HOUSING AND HOMELESSNESS PROGRAMS

DSS' Housing and Homelessness Branch (HHB) team has effectively designed and stood up pilot programs to support critical needs in local communities through the development of the Housing Support Program (HSP), Bringing Families Home (BFH), Housing and Disability Advocacy Program (HDAP), Home Safe and Project Roomkey. These programs serve a significant portion of the population of Californians experiencing homelessness. In 2019-20, CDSS supported counties and tribes providing critical housing interventions to over 100,000 families and individuals experiencing homelessness or housing instability. The HHB team worked with over 200 local programs to provide intensive technical assistance and oversight to deliver these supports.

Issue 6: Rehabilitation of Adult Residential Facilities/ Residential Care Facilities for the Elderly

Governor's Proposal. The Governor's budget includes $250 million General Fund in 2021-22 for the acquisition and/or rehabilitation of Adult Residential Facilities (ARF) and Residential Care Facilities for the Elderly (RCFE) available to individuals who are homeless or at risk of becoming homeless. These funds will further stabilize ARFs and RCFEs, including physical upgrades and capital improvements. According to the department, there is a significant need for this funding as many facilities are at risk of closing due to the economic recession caused by the COVID-19 pandemic. Grants would be provided to local governments and a portion of the funding will be used for state operations.

Background. Over 200,000 Californians live in ARFs or RCFEs. These are adults who cannot live independently due to physical limitations or behavioral health needs and depend on licensed residential care facilities for housing and assistance with activities of daily living (ADLs). These facilities, commonly referred to as board and care or assisted living facilities, are licensed by the DSS Community Care Licensing Division (CCLD) as Adult Residential Facilities (ARFs) or Residential Care Facilities for the Elderly (RCFEs). ARFs serve adults ages 18 to 59 and RCFEs serve those 60 and older. All facilities serve individuals with differing needs. Those individuals include people with disabilities, cognitive impairments, and mental and behavioral health needs. ARFs and RCFEs do not provide medical services, but rather provide 24-hour, assistance with ADLs, such as meals, help with toileting or bathing, transportation to appointments in the community, and medication management. The average cost of care in an RCFE ranges from a low of around $900 a month for a resident on SSI to over $5,000 a month for residents who pay privately.

How individuals pay for these facilities varies. Some residents pay out of their pocket. Other times facilities are reimbursed through public assistance programs such as SSI/SSP. The state provides a supplement to SSI/SSP grants known as the Non-medical Out of Home Care (NMOHC) rate. This rate is intended to support SSI/SSP recipients who require additional care. As of January 2021, the SSI rate with the NMOHC supplement is $1,217.37 per month for an individual. This amount is meant to cover a resident's room and board and overall care and supervision. Facilities are not permitted to charge individuals receiving SSI above the state-mandated rate. As a result, few facilities are willing to take residents who receive SSI/SSP income.

The Social Security Administration (SSA) reports the number of SSI/SSP recipients who are receiving the NMOHC rate. According to the SSA, the NMOHC rate is distributed to about 45,500 individuals statewide. However, data limitations make it difficult to accurately estimate how many SSI/SSP recipients receiving this rate reside in these facilities. CCL reports that from 2014-15 to 2018-19 the number of licensed ARFs has increased by 132 facilities, while the capacity of these facilities has decreased by 1,572. The number of licensed RCFEs has decreased by 187, but the capacity has increased by 9,159. This suggests newly opening RCFEs have a larger capacity than those that closed, while newly opened ARFs have less capacity than those that closed.

Staff Comment and Recommendation. Hold open.

With the Governor's budget proposal including funding to stabilize ARFs and RCFEs, the Legislature must have an understanding of what services these homes provide, who they serve, and their capacity. As conversations around these types of facilities have increased, in part due to the Governor's proposed budget, questions remain surrounding the scope of the supply and demand of these facilities. Various stakeholders have expressed concerns surrounding reports that board and care facilities are closing at an increased rate and that these closures could be caused, in part, by the low reimbursement rates for facilities that accept SSI/SSP recipients and facilities' generally high operating costs. However, there is limited data detailing the reasons why facilities are closing. This proposal would help sustain facilities with deferred maintenance needs but would not stabilize these facilities in the long-term. The subcommittee should inquire about the reach of the proposed $250 million and how this funding will impact operations of ARFs and RCFEs in the long-term.

The Administration has indicated that budget bill language, and not trailer bill, will accompany this proposal. Staff notes that lack of trailer bill language would significantly limit the Legislature's oversight of the program. The Subcommittee should inquire as to why the Administration chose to not implement this proposal through trailer bill language. Additionally, staff urges the Subcommittee to consider implementing this proposal through trailer bill.

The Administration includes this proposal as part of its homelessness package. Yet there is limited data on how the role ARFs and RCFEs play in addressing homelessness. The Subcommittee may want to consider options to provide accountability and address homelessness. For example, the provision of funds could be granted contingent on facilities providing a certain number of beds for those at risk of homelessness. The concerns listed above, as well as others, are detailed in a recent LAO report[3] entitled "The 2021-22 Budget: Analysis of Housing and Homelessness Proposals."

Note that the Community Care Licensing Division, which oversees the licensing of these facilities will be heard in this Subcommittee on March 2, 2021.

Questions.

1. Please provide detail on how the funding for ARFs and RCFEs will be distributed. Will facilities apply for the funding? Will the funding be in the form of a grant or will it need to be repaid? Will the state require facilities to care for individuals who receive SSI to receive funding?

[3] https://lao.ca.gov/Publications/Detail/4352

2. What is the estimated number of facilities that could benefit from the $250 million for ARF/RCFE upgrades? How does this compare to the overall number of facilities throughout the state? How does this compare to the overall number of facilities in need of an upgrade?

Issue 7: BCPs – CalWORKs Homeless Assistance Program/Housing Support Program Resources

Governor's Proposal. The Governor's budget includes the following proposals for increased resources to support the CalWORKs Homeless Assistance Program (HAP) and the CalWORKs Housing Support Program (HSP).

- $260,000 ($38,000 General Fund) to support one Associate Governmental Program Analyst (AGPA) and one-half (0.5) Staff Services Manager I (SSM I) to provide adequate ongoing county technical assistance and oversight as well as implementing the ongoing and multiple policy changes associated with SB 1065 (Hertzberg), Chapter 152, Statutes of 2020.

- $350,000 ($178,000 General Fund) to support one Staff Services Manager I (SSM I) and one Associate Governmental Program Analyst (AGPA) for the CalWORKs HSP.

SB 1065 Background. The HAP was established to help families in the CalWORKs program meet the costs of securing or maintaining permanent housing or to provide emergency shelter when a family is experiencing homelessness. SB 1065 makes ten distinct changes to the Homeless Assistance Program, which include repealing the $100 asset limit, redefining eligibility criteria, requiring same-day payments, and expanding the availability of benefits for applicants that are fleeing domestic violence. The implementation of the policy changes will be a complex and ongoing workload for the staff at CDSS, beyond the initial implementing guidance. DSS estimates a timely, accurate implementation of SB 1065 will require: 1) a minimum of three initial statewide county letters 2) regulation updates; and 3) revisions to a minimum of three program forms in addition to various automation changes requiring meetings, research, and implementation.

Utilization of the program is also expected to increase as a result of SB 1065. Utilization of the program has increased each year since 2015-16 and DSS anticipates that trend will continue.

Fiscal Year	Families Served	Expenditures
2015 - 2016	34,968	$30,201,101
2016-2017	50,518	$43,323,428
2017-2018	63,890	$54,096,667
2018-2019	64,094	$62,279,210
2019- 2020	65,574	Expenditures not yet final

The requested AGPA will be responsible for, but not limited to, writing ACLs and All County Information Notices (ACINs) to formally advise counties on how to implement changes in the HA program. The requested SSM I will provide program oversight by reviewing the submitted ACLs and ACINs and revising emergency regulations.

CalWORKs HSP Background. The CalWORKs HSP was created via Senate Bill 855 (Committee on Budget and Fiscal Review), Chapter 29, Statutes of 2014 to foster housing stability for families experiencing homelessness in the CalWORKs program. HSP offers financial assistance and housing-related wrap around supportive services. To implement this program, counties require individualized and intensive technical assistance from DSS. DSS provides technical assistance in many forms, including providing statewide written guidance, statewide training opportunities, and webinars as

well as individualized resources directly related to each local community. DSS also convenes ongoing HSP seminars where HSP counties share best practices and outside experts present materials related to housing support.

DSS is requesting one AGPA position and one SSM I to support ongoing increases in technical assistance and policy development for the CalWORKs HSP. The requested AGPA will be involved in, but not limited to, drafting new regulations pertaining to the HSP and circulating them for review by all levels of management, and drafting memorandums and other various documents related to regulations development. The SSM I will be assisting with county inquiries, reviewing legislation, and coordinating department meetings. These positions will support the larger county caseload, as well as the ongoing policy and program guidance needs, critical to combat family homelessness. HSP state operations have remained stagnant over the past six years and this proposal requests resources to support the ongoing workload necessary to successfully administer HSP.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of the proposals and their impact on the state's efforts to reduce homelessness.

2. How does HSP interact with other programs in DSS and other departments to target assistance to homeless individuals?

PROPOSALS FOR INVESTMENT

The Subcommittee has received the following proposals for investment related to the CalWORKs, CalFresh, and Housing and Homelessness Programs within the DSS. Note that proposal sponsors provided all information below, aside from staff comments and recommendations. Staff recommends all proposals be held open.

1. Global Telephonic Signature Solution

Budget Issue. The County Welfare Directors Association (CWDA) of California requests $5 million General Fund in 2021-22 and $1 million ongoing to provide a simple, global telephonic signature solution that could be used by any county human services program that does not otherwise have access to a method of recording and storing telephonic signatures.

Background. The COVID pandemic introduced temporary flexibilities allowing for signatures to be attested to by phone, waiving the usual requirement of recording and storing these telephonic signatures, when that functionality wasn't available. When the pandemic ends, many counties would like to continue to provide customers with the flexibility of using telephonic signatures yet cannot afford the cost of the technology and ongoing storage required to do so. This solution will allow counties who do not have their own telephonic signature solutions to offer applicants/recipients the ability to enroll and recertify in eligibility (e.g. CalFresh, CalWORKs, and Medi-Cal) and services (e.g. IHSS, transitional foster youth) programs over the phone, without having to enter an office, sign and mail back a document or go online. This solution would be managed by the CalSAWS project, leveraging their technical infrastructure, federal approvals to use cloud storage, and contracts to stand up a simple, non-integrated, telephonic signature solution. This will be a standalone solution, and will not integrate with SAWS, CMIPS, CWS/CMS, CWS-CARES, CalHEERS, etc.

Staff Comment and Recommendation. Hold open.

2. "Food for All" – Modernizing the California Food Assistance Program (CFAP)

Budget Issue. Nourish California requests up to $6 million in 2021-22, $12 million in 2022-23, and $51 million in 2023-24 to expand the CFAP to provide state-funded nutrition benefits to anyone ineligible for CalFresh solely due to their immigration status.

Background. The pandemic and resulting economic crisis is exacerbating hardship across the state, particularly among low-wage immigrants and their families. While most low-income Californians have been helped by federal relief programs and/or CalFresh, many immigrants have been left out of relief measures solely due to their immigration status. Undocumented immigrants, DACA recipients, Temporary Protected Status (TPS) holders, and certain visa holders are excluded from federal CalFresh and our state-funded CFAP. This proposal would allow noncitizen immigrants to be eligible for CFAP if they satisfy all other CalFresh eligibility criteria except the immigration status requirement.

Staff Comment and Recommendation. Hold open.

3. Simplified CalFresh Application for Older Adults and People with Disabilities and Ensuring Full Telephonic Access.

Budget Issue. Nourish California requests $1 million General Fund in 2021-22 to design and integrate a user-centered, simplified CalFresh application for seniors and people with disabilities. Nourish California also requests that the 2021-22 budget include language ensuring that all CalFresh clients are able to complete all forms requiring a client signature entirely by phone upon completion of the CalSAWS consortia consolidation project in each county, respectively.

Background. COVID-19 is exacerbating already high levels of hunger and hardship, particularly among older adults and people with disabilities. As a proven positive public health intervention and powerful economic stabilizer, CalFresh has a critical dual role to play in California's immediate COVID-19 response and long-term recovery efforts. Yet, because of a complicated and burdensome application process, only 19 percent of eligible older Californians (age 60 or over) are enrolled in the program. In fact, California ranks last in the nation when it comes to enrolling eligible older adults in CalFresh (or SNAP, as it is known federally). In order to better connect older adults with ongoing federal food assistance, it is critical that every available option is exercised to simplify access to CalFresh.

Staff Comment and Recommendation. Hold open. Note that there is a pending policy bill, SB 107 (Wiener), associated with this request.

4. COVID Food Bank Support (State Emergency Food Boxes)

Budget Issue. The California Association of Food Banks requests $110 million one-time for state emergency food boxes.

Background. Hunger is reaching new, tragic levels. Food insecurity has spiked to more than 25 percent of California households. An estimated 34.9 percent of Latinx households and 38.6 percent of Black households with children are facing harm from hunger. Food banks expect that demand will remain at double pre-pandemic levels for several years. Food banks continue to face extraordinary demand as well as higher than normal costs given the loss of many local agencies and the need to shift to direct, 'drive through' distributions. The requested funds would sustain food banks through the 2021-22 fiscal year. The state's support delivers boxes of staple items that families need and are in short supply because of the drop in donations from retailers, and facilitate safe, contact-free distributions. This program also supports jobs in the hard-hit food service sector, including thousands of Teamster members who are helping create the boxes that food banks distribute.

Staff Comment and Recommendation. Hold open.

5. Decreasing CalWORKs Family Stress during COVID-19 with Evidence-based Online Positive Parenting Programs

Budget Issue. Triple P (Positive Parenting Program) requests $2.4 million one-time to be expended over three years to provide parenting support to CalWORKs families.

Background. Programs provided by Triple P are preventive in nature and may be offered entirely online and at the same strength as in-person services but at a much lower cost. The County of Santa Cruz has launched a small CalWORKs Triple P Online project with unspent local dollars that will work with their general CalWORKs population. Similar to that pilot, this proposal addresses the most at-risk subpopulations that can benefit from statewide leadership/coordination, particularly the Cal-Learn population which is scattered in small numbers across the 58 counties. Triple P fears that these small numbers, especially within rural communities make them more susceptible to falling through the cracks. The requested funds would provide positive parenting support to CalWORKs families experiencing the highest levels of stress and risk, including families in the 16 rural communities without access to the CalWORKs home visiting program and families at high risk for homelessness and child maltreatment.

Staff Comment and Recommendation. Hold open.

6. Pandemic Relief for CalWORKs Families

Budget Issue. The County Welfare Directors Association (CWDA) requests trailer bill language to exempt enhanced unemployment benefits that exceed the regular calculated unemployment benefit level and have been authorized because of a state or federal public health emergency, for purpose of determining eligibility for CalWORKs recipients and applicants. The CWDA also requests that government issued photo identification provided via video conference or other electronic means to meet the identification verification requirement for CalWORKs on an ongoing basis.

Background. During the COVID-19 pandemic, Americans receiving unemployment benefits have been eligible to receive additional (enhanced) weekly payments through the Federal Pandemic Unemployment Compensation Program (PUC). This benefit is currently counted as income for purposes of determining CalWORKs eligibility for applicants, but is excluded from being counted as income for recipients already on the CalWORKs program. This proposal aims to ensure that low-income families can continue to rely on CalWORKs while receiving other forms of pandemic or public health emergency-related relief payments during severe economic crises, while also enabling eligibility workers to meet the demand for CalWORKs benefits, now and in the future.

The pandemic also illustrates the difficulties created by in-person verification requirements for CalWORKs. State law requires that social services departments verify the identity of all adult applicants in the form of photo identification to complete the CalWORKs application and eligibility determination process. An Executive Order issued June of 2020 allowed for ID verification to be done electronically if a county office is closed, however now that many offices are now open, some with reduced hours, it is important that CalWORKs eligibility workers be able to conduct identity verification safely and remotely. This proposal would also allow government issued photo identification to be provided via videoconference or other electronic means that allows for visual interaction to meet the identification verification requirement for CalWORKs on an ongoing basis, regardless of whether a county office is closed.

7. CalWORKs Good Cause Clock Stopper

Budget Issue. The Western Center on Law and Poverty and the California Coalition of Welfare Rights Organizations request trailer bill language to stop the counting of months on aid due to an inability to participate in welfare to work activities.

Background. California provides exemption from welfare to work requirements in WIC 11320.3. Among the items that exempt participation is one related to good cause for not participating, which is normally when the county is unable to provide necessary services for the adult to participate such as child care or transportation. Without this exemption, a family could be subject to a cash grant sanction.

Prior to 2013, if a CalWORKs recipient received a good cause exemption for non-participation they also did not have that month counted towards their state 60-month time limit. After the passage of SB 1041 in 2012, this time clock stopper was removed. As a result, if a person cannot participate due to no fault of their own, they lose a month from their time clock. Last spring Governor Newsom issued executive order N-29-20 that stopped the counting of months on aid due to CalWORKs families inability to participate in welfare to work activities. This provision, however, expired on June 17th even though many families were still not able to participate. This change would ensure that families do not lose months in welfare to work when they do not have the necessary supportive services provided by the county.

Staff Comment and Recommendation. Hold open.

8. Temporary Assistance for Needy Families (TANF) Race Equity Research

Budget Issue. The Western Center on Law and Poverty and the California Coalition of Welfare Rights Organizations requests that the Legislature fund an exhaustive study of CalWORKs and the impacts it has on poor women of color.

Background. Historically, the TANF program has developed a rigorous compliance system that mandated work, time limited assistance, and imposed harsh sanctions on those who failed to comply. In California, adults with drug felony convictions were barred from receiving aid, monthly income reporting was required, and harsh resource limits for applicants and recipients were imposed. In recent years, the state has reversed many of the policies that perpetuated the punishment of poor women of color but the core TANF program exists to this day. Many key elements of TANF restrict state flexibility and result in outcomes for families that need to be changed. The goal of this budget request is to identify policy changes that the California Legislature can make to reduce racial inequities in the CalWORKs program and to establish the need for federal changes to the TANF statutes.

Staff Comment and Recommendation. Hold open. Costs associated with the requested study are unknown at this time.

9. CalWORKs Cal-OAR Policy Realignment Recommendations

Budget Issue. The Western Center on Law and Poverty and the California Coalition of Welfare Rights Organizations request trailer bill langue that would adopt some or all of the department's recommendations for CalWORKs policy changes consistent with the goals of the Cal-OAR program.

Background. The 2019 budget included trailer bill language directing the department to form a stakeholder work group to recommend CalWORKs policy changes that are consistent with the goals of the CalWORKs Outcome and Accountability Review (Cal-OAR) program. The goal of Cal-OAR

is to continuously improve CalWORKs by tracking measurements of county performance and family outcomes and periodically making programmatic adjustments to improve the outcomes. Counties and advocates have both expressed an interest in reviewing the CalWORKs program to remove provisions that impede the success of Cal-OAR. The department held a series of meetings involving stakeholders, including CalWORKs recipients, to develop the recommendations. The department will be forwarding those recommendations shortly to the Legislature and the requestors encourage the committee to reach out to stakeholders and consider adopting all or some of the recommendations.

Staff Comment and Recommendation. Hold open.

10. CalWORKs Grant Increase

Budget Issue. Effective October 1, 2021, the Western Center on Law and Poverty and the California Coalition of Welfare Rights Organizations request $450 million in 2021-22, and $600 million ongoing to bring all CalWORKs grant levels to 55 percent of the federal poverty level.

Background. The 2018 Budget Act included a historic commitment to end deep childhood poverty by bringing all grants levels to 50 percent of the federal poverty level in California. The budget agreement stated the Legislature's intent to provide future grant increases in 2019-20 and 2020-21 and provided a three step process to increase CalWORKs grants. To meet this goal CalWORKs grants were increased by 10 percent effective April 2019, and increased again, effective October 2019, to bring grants up to no less than 50 or 47 percent of the poverty level, depending on assistance unit size.

Staff Comment and Recommendation. Hold open.

11. Redirection of Unallocated TANF/CalWORKs funds

Budget Issue. The Coalition of California Welfare Rights Organizations requests trailer bill language specifying that any unallocated TANF/CalWORKs funds be placed in the Child Poverty and Family Supplemental Support Subaccount and that the funding be used to bring CalWORKs grants up to 100 percent of the federal poverty level.

Staff Comment and Recommendation. Hold open.

12. CalWORKs Sanction Reform to Achieve Program Equity

Budget Issue. The Coalition of California Welfare Rights Organizations (CCWRO) requests trailer bill language that would limit sanctions and penalties within the CalWORKs program only to the extent required by federal law. If required by federal law, CCWRO requests that the sanction or penalty be the minimum allowable by federal law.

Background. According to the sponsors, sanctions and penalties are a source of inequity within the CalWORKs program. They are applied disproportionately against families of color and can cause more harm than good by exacerbating the impact of deep poverty on CalWORKs families.

Staff Comment and Recommendation. Hold open.

13. Reforming CalWORKs Aid to Pregnant Parents

Budget Issue. The Coalition of California Welfare Rights Organizations (CCWRO) requests trailer bill language that allows CalWORKs aid from the date of proof of pregnancy and exempts pregnant parents from welfare to work activities unless the parent volunteers to participate.

Staff Comment and Recommendation. Hold open.

14. Protecting Victims of Domestic Violence

Budget Issue. The Coalition of California Welfare Rights Organizations (CCWRO) requests trailer bill language requiring counties to issue domestic violence waivers to CalWORKs parents when they are deemed eligible for the waiver.

Background. Federal law allows states to issue "domestic violence waivers" to CalWORKs recipients found eligible. State law provides that if a CalWORKs recipient can prove they need a waiver then the county may grant a waiver. The sponsors purport that this is a highly subjective standard, leading to equity concerns. The requested language would require counties to issue a waiver when recipients can prove their need for it.

Staff Comment and Recommendation. Hold open.

15. Repeal the 100 Hour Rule for CalWORKs Two Parent Families

Budget Issue. The Coalition of California Welfare Rights Organizations (CCWRO) requests trailer bill language to repeal the 100-hour rule for two parent families in the CalWORKs programs.

Background. Under current law, families can lose eligibility if the principal wage earner was employed for 100 hours or more a month, even if the family's wages from employment were so low that the family would still be eligible. Economic stress can contribute greatly to family instability. Repealing the 100-hour rule will greatly reduce instability for low income families and inequities.

Staff Comment and Recommendation. Hold open.

16. Align the CalWORKs and CalFresh Rules for Beneficiaries with an Arrest Warrant

Budget Issue. The Coalition of California Welfare Rights Organizations (CCWRO) requests trailer bill language to align CalWORKs and CalFresh rules for beneficiaries with an arrest warrant.

Background. The rules for CalWORKs and CalFresh relative to how persons with an arrest warrant are treated are different, making the programs complicated. Aligning these rules would simplify the program for both beneficiaries and eligibility workers.

Staff Comment and Recommendation. Hold open.

17. Allow CalWORKs Children to Complete High School Until Age 20

Budget Issue. The Coalition of California Welfare Rights Organizations (CCWRO) requests $2.4 million ongoing and trailer bill language to allow children on CalWORKs to complete their high school requirements before they reach the age of 20.

Background. Under current law, children on CalWORKs must complete their high school degree by the age of 19 to continue to receive CalWORKs benefits. This proposal will allow children to attend school as long as they can complete their requirements by age 20. Giving children an additional year will help avoid generational dependence on public benefits.

18. Reforming CalWORKs Homeless Assistance Program (HAP)

Budget Issue. The Coalition of California Welfare Rights Organizations requests trailer bill language to repeal the HAP's limit on receiving assistance once every 12 months.

Background. Under current law, receipt of assistance under HAP is limited to once every 12 months. Eliminating this provision will reduce homelessness of CalWORKs families and children enduring homelessness that can have a lifetime negative impact.

Staff Comment and Recommendation. Hold open.

19. Flexible Funding for County Human Services Department-Administered Housing Programs

Budget Issue. The County Welfare Directors Association (CWDA) requests $100 million one-time to be available through the 2022-23 fiscal year to provide additional, flexible resources for DSS administered housing programs.

Background. Homelessness continues to be one of the most growing and unremitting problems in California and has been exacerbated even further by the COVID-19 pandemic. There is a clear need for more resources, and a shift towards more preventative strategies and flexible uses of funding targeted towards the most vulnerable individuals in the state. The current CDSS-administered housing programs, while very successful, are limited in the services they can provide, and participants often have to already be homeless or about to be evicted in order to receive services. This request would establish a pool of additional one-time funding for housing and homelessness prevention and intervention in order to mitigate the on-going and expected long-term impacts of the COVID-19 pandemic specifically for populations served by the CDSS safety net programs. The fund would be allocated to counties to supplement various CDSS-administered housing programs, allowing counties to direct the funds based on local needs and priorities to meet a broader range of housing needs.

Staff Comment and Recommendation. Hold open.

20. Statutory Flexibilities for the CalWORKs Housing Support Program (HSP) and the Housing and Disability Advocacy Program (HDAP)

Budget Issue. CWDA requests the following statutory flexibilities in the HSP and the HDAP

- For HSP, CWDA proposes to allow for interventions with clients to take place prior to the issuance of an eviction notice from a client's landlord.

- For HDAP, CWDA proposes to move from a grants-based to an allocation-based fund distribution process and to remove the interim assistance reimbursement (IAR).

Background. Counties operate an array of housing programs for those they already serve in larger safety-net programs that are tailored and targeted towards individuals who are homeless or at-risk of homelessness. However, these programs are often constricted in their use of funds, particularly for preventative purposes, or have some statutory limitations that are barriers to clients and counties utilizing the programs. Currently CalWORKs recipients are only eligible for HSP once they have received an eviction notice. Once an eviction notice is issued, families often have mere days to try to rectify the situation. This stress coupled with the trauma of losing one's home can cause negative impacts on families. With the additional flexibility of allowing for HSP services to be utilized as interventions for those at risk of homelessness, counties would have the ability to assist families prior to the deleterious impacts of receiving an eviction notice.

Counties are currently required to submit a lengthy application as well as an updated plan each year to receive HDAP funds, even tough it is a long-established program. The application process leads to funding uncertainty for counties since they do not know from year to year whether their grant will increase or decrease or be approved at all. Other established programs within CDSS utilize an allocation-based distribution, which provides funding amounts to counties without an up-front application. There is still the ability to report on program outcomes and adjust funding levels as appropriate, but an allocation-based process provides for more predictable and timely funding.

The current IAR requirement in HDAP statute means that counties must ask a client if they will agree to reimburse the county once they receive their disability benefits check. Even though this agreement is voluntary (clients can say no and still receive HDAP services), counties have noted that having to ask this question discourages clients from joining the program. Rather than yield program savings as it was originally intended, the requirement has become a barrier to participation and an additional source of workload for county staff that is not directly related to the services these clients need.

Staff Comment and Recommendation. Hold open.

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.

Friday, February 12, 2021
Upon Adjournment of Session
State Capitol - Room 3191

Consultant: Scott Ogus

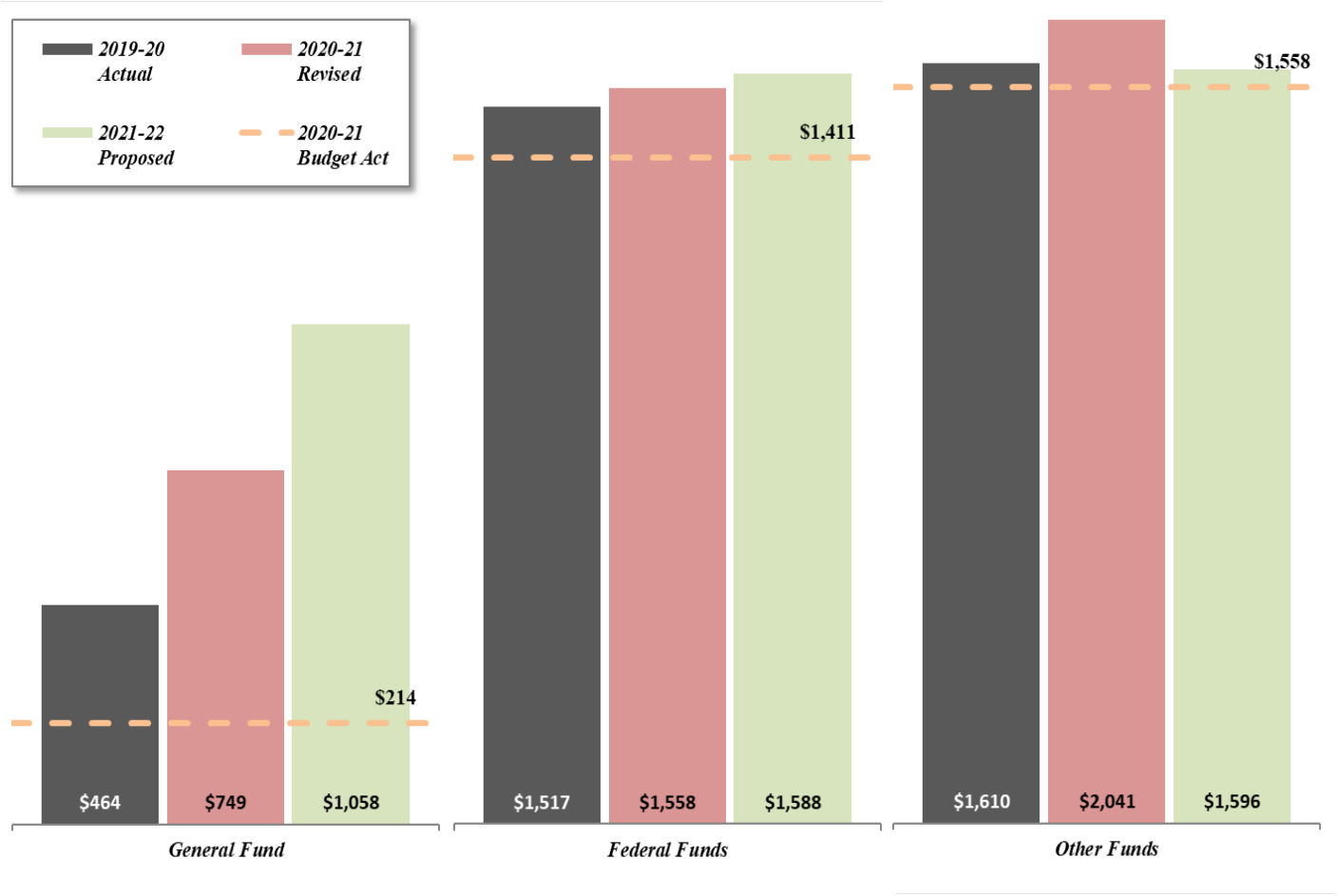
PUBLIC COMMENT

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

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Overview

Department of Public Health – *Three-Year Funding Summary*
(dollars in millions)



Department of Public Health - *Department Funding Summary*			
Fund Source	**2019-20 *Actual***	***2020-21 Revised***	***2021-22 Proposed***
General Fund	$463,622,000	$748,987,000	$1,058,070,000
Federal Funds	$1,517,420,000	$1,557,612,000	$1,587,791,000
Other Funds	$1,609,513,000	$2,040,607,000	$1,595,717,000
Total Department Funding:	**$3,590,555,000**	**$4,347,206,000**	**$4,241,578,000**
Total Authorized Positions:	**3611.9**	**3741.4**	**3699.4**
Other Funds Detail:			
Breast Cancer Research Account (0007)	*$1,244,000*	*$791,000*	*$965,000*

Nuclear Planning Assessment Acct (0029)	*$1,003,000*	*$971,000*	*$1,020,000*
Motor Vehicle Acct, Trans. Fund (0044)	*$1,595,000*	*$1,551,000*	*$1,621,000*
Sale of Tobacco to Minors Ctrl Acct (0066)	*$1,180,000*	*$14,000*	*$811,000*
Occup. Lead Poisoning Prev Acct (0070)	*$3,787,000*	*$2,120,000*	*$3,847,000*
Medical Waste Management Fund (0074)	*$2,884,000*	*$2,755,000*	*$2,948,000*
Radiation Control Fund (0075)	*$28,623,000*	*$27,564,000*	*$29,176,000*
Tissue Bank License Fund (0076)	*$665,000*	*$636,000*	*$679,000*
Childhood Lead Poisoning Prev Fund (0080)	*$42,045,000*	*$44,729,000*	*$42,480,000*
Export Document Program Fund (0082)	*$859,000*	*$823,000*	*$590,000*
Clinical Lab. Improvement Fund (0098)	*$13,458,000*	*$12,956,000*	*$13,790,000*
Health Statistics Special Fund (0099)	*$30,246,000*	*$30,374,000*	*$31,587,000*
Dept. of Pesticide Regulation Fund (0106)	*$330,000*	*$314,000*	*$336,000*
Air Pollution Control Fund (0115)	*$305,000*	*$298,000*	*$305,000*
CA Health Data and Planning Fund (0143)	*$240,000*	*$240,000*	*$240,000*
Food Safety Fund (0177)	*$12,237,000*	*$9,650,000*	*$11,348,000*
Genetic Disease Testing Fund (0203)	*$143,229,000*	*$139,453,000*	*$145,885,000*
Health Education Account, Prop 99 (0231)	*$52,576,000*	*$42,015,000*	*$35,852,000*
Research Account, Prop 99 (0234)	*$7,507,000*	*$6,151,000*	*$3,481,000*
Unallocated Account, Prop 99 (0236)	*$4,506,000*	*$3,735,000*	*$1,861,000*
Infant Botulism Treatment/Prev Fund (0272)	*$14,300,000*	*$10,309,000*	*$9,068,000*
Child Health and Safety Fund (0279)	*$551,000*	*$551,000*	*$551,000*
Registered Enviro. Health Spec Fund (0335)	*$467,000*	*$407,000*	*$477,000*
Indian Gaming Spec Dist Fund (0367)	*$8,369,000*	*$8,320,000*	*$8,391,000*
Vectorborne Disease Account (0478)	*$216,000*	*$160,000*	*$195,000*
Toxic Substances Control Acct (0557)	*$543,000*	*$529,000*	*$559,000*
Domestic Violence Training/Ed Fund (0642)	*$636,000*	*$610,000*	*$647,000*
CA Alzheimers Research Fund (0823)	*$657,000*	*$645,000*	*$663,000*
Special Deposit Fund (0942)	*$11,059,000*	*$15,564,000*	*$13,163,000*
Reimbursements (0995)	*$255,602,000*	*$714,233,000*	*$255,156,000*
Drug and Device Safety Fund (3018)	*$6,552,000*	*$4,609,000*	*$7,685,000*
WIC Manufacturer Rebate Fund (3023)	*$210,098,000*	*$196,784,000*	*$174,414,000*
Medical Marijuana Program Fund (3074)	*$163,000*	*$3,000*	*$17,000*
AIDS Drug Assistance Program Fund (3080)	*$307,061,000*	*$373,037,000*	*$409,717,000*
Cannery Inspection Fund (3081)	*$3,145,000*	*$3,040,000*	*$3,227,000*
Mental Health Services Fund (3085)	*$42,483,000*	*$2,393,000*	*$2,468,000*
Licensing and Certification Fund (3098)	*$193,927,000*	*$212,458,000*	*$257,179,000*
Gambling Addiction Program Fund (3110)	*$150,000*	*$150,000*	*$150,000*
Birth Defects Monitoring Prog Fund (3114)	*$2,410,000*	*$2,347,000*	*$2,434,000*
Lead-Related Construction Fund (3155)	*$861,000*	*$1,244,000*	*$1,298,000*
Cost/Impl Acct, Air Poll. Ctrl Fund (3237)	*$379,000*	*$373,000*	*$386,000*

Cannabis Control Fund (3288)	*$13,973,000*	*$28,216,000*	*$908,000*
State Dental Program Acct., Prop 56 (3307)	*$31,339,000*	*$25,541,000*	*$25,054,000*
DPH Tobacco Law Enforc, Prop 56 (3318)	*$12,982,000*	*$4,583,000*	*$4,463,000*
DPH, Tobacco Prev/Ctrl, Prop 56 (3322)	*$143,071,000*	*$106,761,000*	*$88,625,000*
Coronavirus Relief Fund (8505)	*$0*	*$600,000*	*$0*

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

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

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

The department is composed of seven major program areas:

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

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

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

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

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

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

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

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 DPH's programs and budget.

Issue 2: COVID-19 Pandemic - Public Health Response

Oversight – 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 two recently approved COVID-19 vaccines.

Outbreak Origin and Transmission. According to the federal Centers for Disease Control and Prevention (CDC), coronaviruses are a large family of viruses that are common in people and many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people such as with MERS-CoV and SARS-CoV. COVID-19 is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats and sequencing in the early stages of the pandemic suggests a likely single, recent emergence of this virus from an animal reservoir.

COVID-19 was first identified in Wuhan, Hubei Province, China. Early on, many of the patients at the epicenter of the outbreak in Wuhan had some link to a large seafood and live animal market, suggesting animal-to-person spread. Later, a growing number of patients reportedly did not have exposure to animal markets, indicating person-to-person spread. Person-to-person spread was subsequently reported outside Hubei and in countries outside China, including in the United States, with nearly every nation reporting cases of COVID-19. Epidemiological studies of COVID-19 estimate infected individuals transmit COVID-19 to an average of 2.5 additional people. For reference, the equivalent transmission rate of influenza A is 1.1 to 1.5.

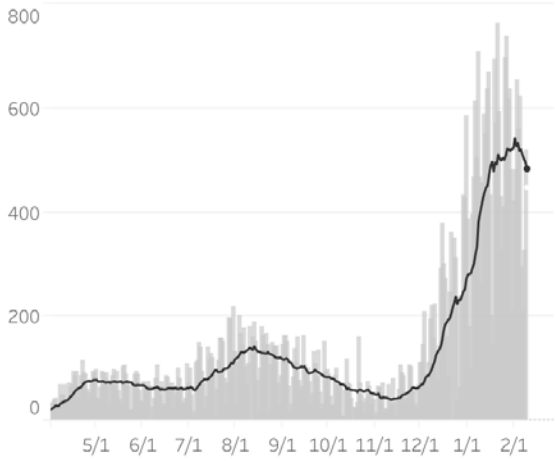
Current Status of Individuals Affected in California. Nearly one year ago, on March 12th, 2020, this subcommittee held one of the first hearings on the COVID-19 outbreak. At that time, DPH reported there were a total of 157 positive cases of COVID-19 in California and 2 deaths. As of February 10th, 2021, there have been 3,362,981 positive cases and 44,995 deaths. 11,516 Californians are hospitalized for COVID-19, with 3,127 in the ICU and only 1,394 ICU beds available statewide. The state is currently in the midst of an alarming surge of COVID-19 cases and deaths that began in mid-November and tested the capacity limits of the state's hospitals and health care systems. During this surge, in multiple regions of the state, particularly in Southern California and the San Joaquin Valley, intensive care needs for COVID-19 patients exceeded the limits of licensed ICU bed capacity and these regions had to resort to surge planning and other modifications to accommodate the increased need for ICU beds. Recent data suggest the rate of new cases may be slowing, and although COVID-19 deaths remain near their pandemic peaks, the expected lag between cases and deaths suggests the rate of deaths may slow in the coming weeks, as well.

Total cases in California

3,362,981 positive cases
8,390 new cases
0.3% increase from prior day total

Total deaths in California

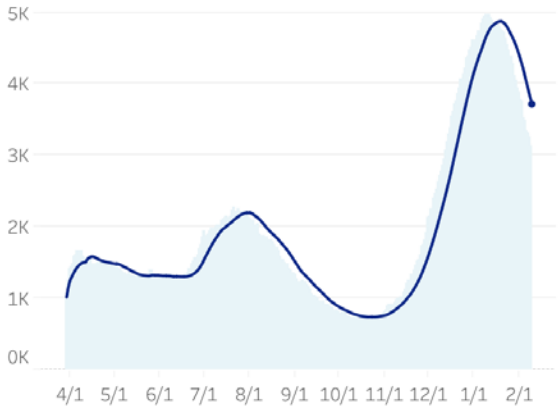
44,995 total deaths
518 new deaths
1.2% increase from prior day total



COVID-19 ICU hospitalized patients in California

Hospitalized | ICU

3,127 COVID-19 ICU hospitalized patients
-137 patients
4.4% decrease from prior day

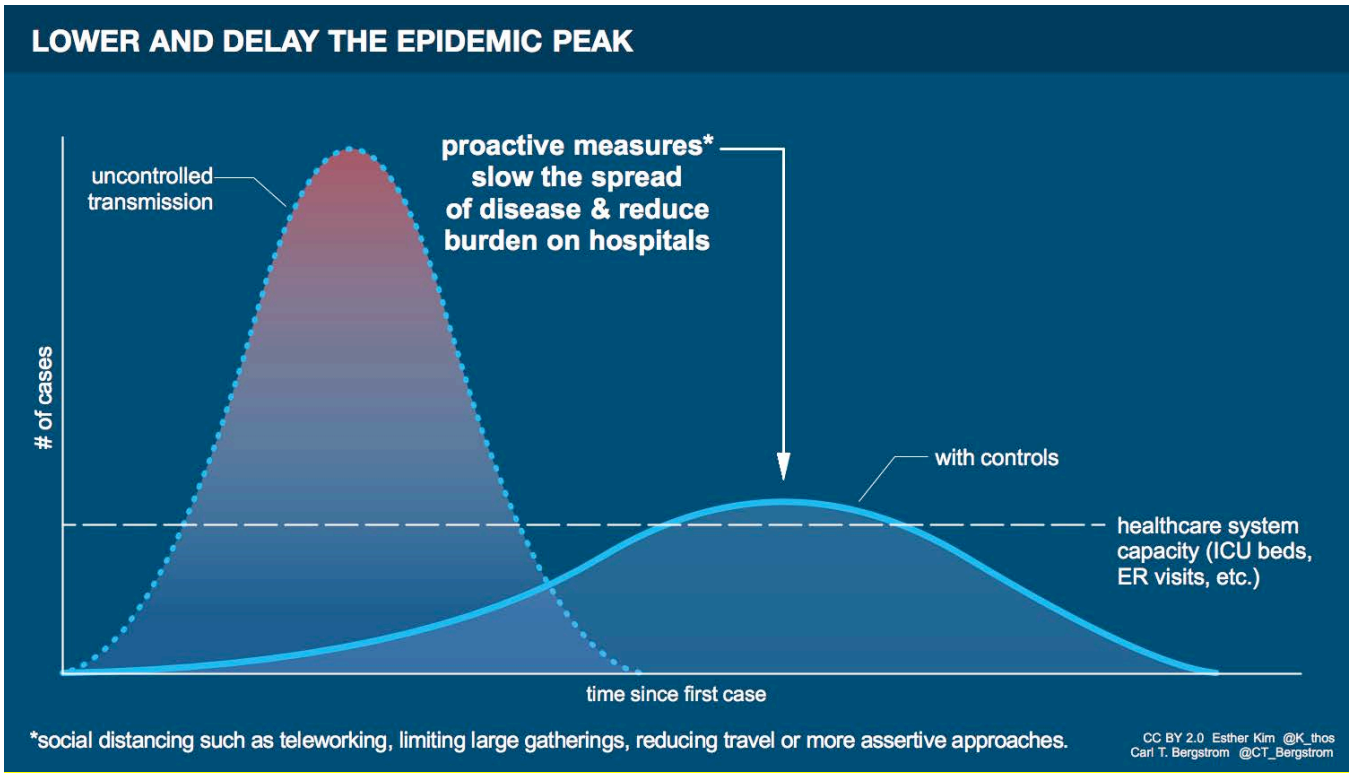


ICU beds in California

1,394 ICU beds available
10 increase from prior day

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 February 10th, 2021.*

Non-Pharmaceutical Interventions to Mitigate COVID-19 Transmission. During the initial phases of the pandemic, much of the response was focused around efforts to "flatten the curve", which refers to mitigation efforts to slow down the spread of COVID-19 and reduce the burden on the health care system. The chart below, many versions of which were circulating during the early stages of the pandemic, demonstrates the relative levels of epidemic peaks with uncontrolled COVID-19 transmission compared with the implementation of mitigation strategies including social distancing, telework, limitations on gatherings, and reducing travel.



The first recommendations for non-pharmaceutical interventions included guidance to Californians to:

- Wash hands with soap and water
- Avoid touching eyes, nose or mouth with unwashed hands
- Avoid close contact with people who are sick
- Stay away from work, school, or other people if you become sick

Initially, the use of masks and face coverings was only recommended for health care settings, but the most updated guidance emphasizes the importance of wearing masks and the overwhelming scientific evidence that masks minimize the spread of respiratory droplets and aerosols that may transmit COVID-19.

Stay-at-Home Orders and Other Public Health Interventions. On March 19th, 2020, DPH issued a statewide stay-at-home order, requiring all individuals in California to stay home or at their place of residence except for workers in 16 federally-identified critical sectors, or to shop for essential needs. Telework was encouraged to the extent feasible for business that could be conducted remotely, but K-12 schools and universities began to close their doors, as well. These interventions were implemented to

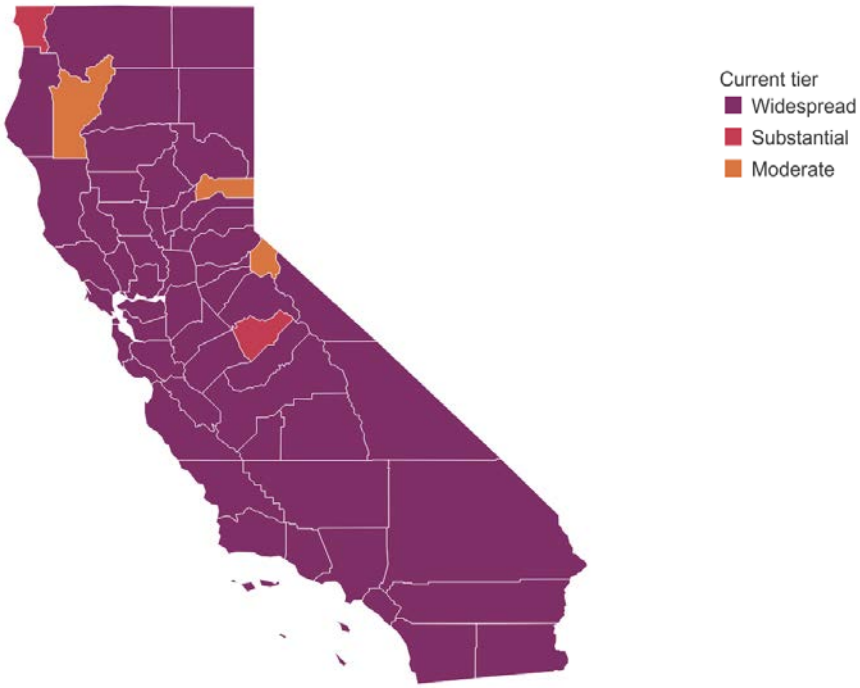
mitigate the rapid transmission of COVID-19 occurring in California to allow time for the health system to prepare for a potential surge of patients. These preparations included efforts to procure sufficient supplies of personal protective equipment (PPE), implementation of health facility surge planning to expand the availability of treatment space and staff, and expand the state's COVID-19 testing and contact tracing infrastructure.

On May 4th, 2020, DPH issued the California Pandemic Roadmap, which identified four stages of reopening safely: 1) safety and preparation, 2) reopening of lower-risk workplaces and other spaces, 3) reopening of higher-risk workplaces and other spaces, and 4) an easing of final restrictions leading to the end of the stay-at-home order. At the same time, DPH allowed all areas of the state to move into stage 2 and reopen lower-risk workplaces, but to practice social distancing, minimize time outside the home, and wash hands frequently. However, by summer of 2020, transmission of COVID-19 and hospitalizations began to rise significantly, and much of the reopening progress was stalled or reversed.

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:

TIER LEVEL	New Cases per 100,000	Test Positivity Rate
Widespread - Tier 1	More than seven	More than eight percent
Substantial - Tier 2	Four to seven	Five to eight percent
Moderate - Tier 3	One to 3.9	Two to 4.9 percent
Minimal - Tier 4	Less than one	Less than 2 percent

County Tier Status as of February 10th, 2021



A county must remain in its current tier for a minimum of three weeks before it may advance to a less restrictive tier. To advance, a county must meet the less restrictive tier's criteria for two consecutive weeks. Counties must also meet the California Health Equity Metric, which ensures the test positivity rate in the most disadvantaged neighborhoods does not significantly lag behind the overall county test positivity rate, and requires counties to have submitted a plan to DPH to make targeted investments to address disproportionately impacted populations. Changes in tier levels are announced every Tuesday. As of February 10th, 2021, 53 counties are in Tier 1 (Widespread), two counties are in Tier 2 (Substantial), and three counties are in Tier 3 (Moderate). No counties are in Tier 4 (Minimal).

The restrictions imposed by Tier are as follows:

Blueprint for a Safer Economy Guidelines				
SECTORS	**Widespread Tier 1**	**Substantial Tier 2**	**Moderate Tier 3**	**Minimal Tier 4**
Critical Infrastructure	Open with modifications	Open with modifications	Open with modifications	Open with modifications
Gatherings	Outdoor only with modifications (3 households)	Indoor allowed (but, discouraged) with modifications (3 households)	Indoor allowed (but, discouraged) with modifications (3 households)	Indoor allowed (but, discouraged) with modifications (3 households)
Limited Services	Open with modifications	Open with modifications	Open with modifications	Open with modifications
Outdoor Playgrounds/Rec. Facilities	Open with modifications	Open with modifications	Open with modifications	Open with modifications
Hair Salons and Barbershops	Open indoors with modifications	Open indoors with modifications	Open indoors with modifications	Open indoors with modifications
All Retail	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 50% capacity	Open indoors with modifications	Open indoors with modifications
Shopping Centers	Open indoors with modifications Max 25% capacity Closed common areas and food courts	Open indoors with modifications Max 50% capacity Closed common areas and reduced capacity at food courts	Open indoors with modifications Closed common areas and reduced capacity at food courts	Open indoors with modifications Reduced capacity at food courts
Personal Care Services	Open indoors with modifications	Open indoors with modifications	Open indoors with modifications	Open indoors with modifications
Museums, Zoos, and Aquariums	Outdoor only with modifications	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 50% capacity	Open indoors with modifications
Places of Worship	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 50% capacity	Open indoors with modifications Max 50% capacity

Movie Theaters	Outdoor only with modifications	Open indoors with modifications Max 25% capacity or 100 people	Open indoors with modifications Max 50% capacity or 200 people	Open indoors with modifications Max 50% capacity
Hotels/Lodging	Open with modifications	Open with modifications Fitness Ctrs (10%)	Open with modifications Fitness Ctrs (25%) Indoor pools	Open with modifications Fitness Ctrs (50%) Spa facilities
Gyms and Fitness Centers	Outdoor only with modifications	Open indoors with modifications Max 10% capacity Climbing walls	Open indoors with modifications Max 25% capacity Indoor pools	Open indoors with modifications Max 50% capacity Saunas Steam rooms
Restaurants	Outdoor only with modifications	Open indoors with modifications Max 25% capacity or 100 people	Open indoors with modifications Max 50% capacity or 200 people	Open indoors with modifications Max 50% capacity
Wineries	Outdoor only with modifications	Outdoor only with modifications	Open indoors with modifications Max 25% capacity or 100 people	Open indoors with modifications Max 50% capacity or 200 people
Bars, Breweries, and Distilleries	CLOSED	CLOSED	Open outdoors with modifications	Open indoors with modifications Max 50% capacity
Family Entertainment Centers (e.g. Kart Racing, Mini Golf, Batting Cages)	Outdoor only with modifications	Outdoor only with modifications	Open indoors for naturally distanced activities with modifications Max 25% capacity Bowling Alleys	Open indoors for activities with increased risk of proximity and mixing with modifications Max 50% capacity Arcade Games Skating Indoor playground
Cardrooms, Satellite Wagering	Outdoor only with modifications	Outdoor only with modifications	Open indoors with modifications Max 25% capacity	Open indoors with modifications Max 50% capacity
Offices	Remote	Remote	Open indoors with modifications Encourage telework	Open indoors with modifications Encourage telework
Professional Sports	Open without live audiences with modifications	Open without live audiences with modifications	Open without live audiences with modifications	Open without live audiences with modifications
Live Audience Sports	CLOSED	CLOSED	Outdoors only Max 20% capacity	Outdoors only Max 25% capacity

			Regional visitors (120 miles) Adv reservations Assigned seating In-seat concessions only	Regional visitors (120 miles) Adv reservations Assigned seating In-seat concessions only
Amusement Parks	CLOSED	CLOSED	Small Parks Open Max 25% capacity or 500 people Outdoor attractions only In-county visitors Adv reservations	Large Parks Open Max 25% capacity Adv reservations

Regional Stay-at-Home Order During Fall and Winter Surge. Beginning in November 2020, the state experienced an alarming rise in transmission of COVID-19, followed by a rise in hospitalizations and deaths. On November 19th, 2020, DPH issued a limited stay-at-home order to slow transmission of COVID-19. Over the subsequent two weeks, the daily number of new cases increased by over 112 percent (from 8,743 to 18,588) and the number of new hospital admissions rose from 777 on November 15th, 2020, to 1,651 on December 2nd, 2020.

On December 3rd, 2020, DPH issued a Regional Stay-at-Home Order, subdividing the state into five regions (Northern California, Bay Area, Sacramento, San Joaquin Valley, and Southern California), utilizing the availability of ICU beds as a metric for assessing the level of restrictions in a region. Under the order, if a region's ICU capacity fell below 15 percent, the following restrictions applied:

1) All gatherings with members of other households were prohibited
2) All individuals in the region were required to stay home or at their place of residence except for critical workers or infrastructure sectors, or to shop for essential needs
3) Worship and political expression were permitted outdoors, consistent with DPH guidance
4) Indoor retail was required to operate at no more than 20 percent capacity, and the sale of food, beverages, and alcohol for in-store consumption was prohibited

During the fall and winter surge, the ICU capacity of both the San Joaquin Valley and Southern California regions fell to zero. Four of the five regions fell below the 15 percent ICU capacity threshold and were subject to the stay-at-home order restrictions. During this period, the Administration began forecasting projections for a region's four-week ICU capacity, which allowed certain regions to reopen before ICU capacity returned to the 15 percent threshold.

On January 25th, 2021, the Administration relied on four-week ICU capacity forecasts to rescind the Regional Stay-at-Home Order, returning counties to the Blueprint for a Safer Economy tiered framework for reopening and public health restrictions.

Diagnostic Testing for COVID-19. Shortly after identification of the novel coronavirus as the cause of the respiratory illness spreading throughout the world, scientists had sequenced and published its genome, and developed the nucleotide primers necessary to perform diagnostic polymerase chain reaction (PCR)

testing to identify individuals with COVID-19. PCR testing relies on transcription enzymes to amplify portions of the viral genome specific to COVID-19 to determine the presence of viral RNA and an estimate of the number of copies in a sample. PCR testing has been used for diagnostics for nearly 40 years.

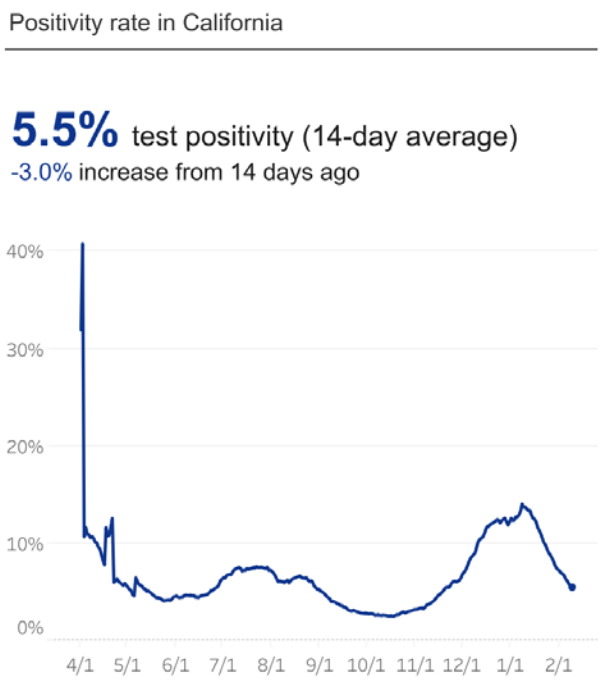
Due to the widespread transmission of COVID-19 during the pandemic, there was limited availability of supplies to conduct the necessary testing to diagnose the significant number of individuals presenting with COVID-19 symptoms. The world experienced shortages of sample collection supplies, transport and other media, and PCR reagents at the same time the need for diagnostic testing for COVID-19 became critical to containment and mitigation strategies. California implemented several initiatives to address the need for COVID-19 testing.

According to DPH, 22 public health laboratories in California began testing for COVID-19 in March 2020, including the DPH State Laboratory in Richmond, and county public health laboratories in Alameda, Contra Costa, Humboldt, Los Angeles, Monterey, Napa-Solano-Yolo-Marin (located in Solano), Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, Santa Clara, Shasta, Sonoma, Tulare and Ventura. California also worked with academic labs at the University of California and Stanford, as well as commercial labs at Quest Diagnostics, LabCorp, and Kaiser to increase testing capacity.

The state also established mass testing sites throughout the state. These included large venues, such as CalExpo in Sacramento, and Dodger Stadium in Los Angeles. The state also partnered with Verily and OptumServe to open additional testing sites, and implemented a web page to allow individuals to find testing resources in their area.

Valencia Laboratory. In August 2020, the Administration announced a partnership with PerkinElmer to open a new, dedicated testing laboratory in Valencia. PerkinElmer would begin processing up to an additional 150,000 PCR tests per day, with a contractual turnaround time of 24 to 48 hours. Beginning operations in October 2020, the Administration indicated it expected the lab to reach the goal of 150,000 tests per day no later than March 1, 2021. According to the Administration, the opening of the Valencia Laboratory required approximately $20 to $25 million to build out, with approximately $100 million per month of contract costs for Perkin Elmer. The total cost of the contract is $1.4 billion and covers multiple fiscal years. DPH is requesting General Fund expenditure authority of $483.2 million in 2021-22 for continued operation of the Valencia Laboratory. (*see Issue 3: COVID-19 Direct Response Expenditures).*

Current Testing Status. As of February 10th, 2021, the state is averaging 251,294 tests over a 14-day period. Testing capacity in the state rose steadily through the spring and early summer of 2020, stabilized at more than 100,000 tests per day through the summer and early fall of 2020, then began to ramp up to reach more than 300,000 tests per day during the fall and winter surge, and currently down to just over 250,000 per day. The 14-day average test positivity rate, one measure of the levels of community transmission, peaked in early 2021 at 14 percent, but has decreased to 5.5 percent.



Contact Tracing, Isolation and Quarantine of Identified COVID-19 Cases. One of the oldest public health tools for managing outbreaks of infectious diseases is contact tracing, isolation, and quarantine. Once a positive case is identified, public health staff interview the individual to determine other individuals who may have been exposed during periods of close contact with the reference case. Public health staff then contact those individuals to notify them of their potential exposure, and to recommend isolation, quarantine, and diagnostic testing to break the onward chain of viral transmission.

Contact tracing activities are typically the responsibility of local health departments. However, during the pandemic, widespread transmission in many local communities overwhelmed the ability of local health departments to keep up with the workload of contact tracing. Decades of state and federal underinvestment in the public health infrastructure that supports contact tracing efforts resulted in a system unprepared for a global pandemic. In addition, there was significant wariness by individuals unaccustomed to being contacted by public health officials to cooperate with contact tracing efforts for COVID-19.

Virtual Training Academy and Contact Tracing Platform. In May 2020, DPH received an augmentation of General Fund expenditure authority of $27.4 million to help expand contact tracing efforts. This funding was used to support development of a virtual training academy, in partnership with the University of California (UC) campuses in San Francisco and Los Angeles, for contact tracing staff. According to DPH, these newly trained contact tracers would be available to augment local public health department staff to aid in the contact tracing workload. The academy is primarily conducted online, including live sessions with instructors, and can be completed in approximately 20 hours over five days. Contact tracers receive training in epidemiology, principles of contact tracing, and infectious disease containment strategies. The training is provided to local public health departments at no cost.

In addition to the academy, the augmentation was used to support development of a data management platform, which can interface with the state's disease surveillance system, to support the contact tracing workforce. DPH contracted with Accenture to launch a contact tracing technology platform, developed by Salesforce, and to operate a contact tracing call center in collaboration with Amazon. This system was modeled on a similar system implemented for the contact tracing program in the state of Massachusetts.

COVID-19 Vaccine Distribution and Administration. Almost as soon as the novel coronavirus was identified as the cause of the respiratory illness spreading throughout the world, dozens of research laboratories and pharmaceutical companies began work developing a vaccine for the new virus. In May 2020, the federal government launched Operation Warp Speed to accelerate development, production and distribution of COVID-19 vaccines, therapeutics, and diagnostics. The current pipeline of COVID-19 vaccines that have been approved by the Food and Drug Administration (FDA) or are currently in clinical development includes the following:

FDA Approval - Emergency Use Authorization (EUA)

mRNA Vaccines

- *Pfizer-BioNTech* – The first COVID-19 vaccine to receive FDA approval, Pfizer-BioNTech's BNT162b2 is an mRNA vaccine that packages the sequence for the COVID-19 spike protein inside lipid nanoparticles. Once injected, the lipid nanoparticles deliver the mRNA sequence into the patient's cells, which produce copies of the spike protein, activating the patient's immune system to produce neutralizing antibodies and confer immunity. Pfizer-BioNTech's vaccine requires two doses, 21 days apart, and requires storage at -60 to -80 degrees Celsius (-76 to -112 degrees Fahrenheit). According to clinical trial data, the Pfizer-BioNTech vaccine is approximately 95 percent effective.
- *Moderna* – Moderna's vaccine, mRNA-1273, the second to receive FDA approval, is also an mRNA vaccine that delivers the sequence for the COVID-19 spike protein with lipid nanoparticles. Moderna's vaccine also requires two doses, 28 days apart, and requires storage at -15 to -25 degrees Celsius (-13 to 5 degrees Fahrenheit). According to clinical trial data, the Moderna vaccine is approximately 95 percent effective.

Other Vaccines in Clinical Development

Adenovirus Vectors

- *Johnson and Johnson* – Currently in Phase 3 trials, Johnson and Johnson's Ad26.COV2.S vaccine utilizes an adenovirus, with its viral replication machinery inactivated, to deliver the COVID-19 spike protein into a patient's cells, which then produce the spike protein and activate the patient's immune system. The Johnson and Johnson vaccine requires only a single dose and can be stored at refrigeration temperatures of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data suggests the Johnson and Johnson vaccine may be up to 72 percent effective.
- *CanSino Biologics* – Currently in Phase 3 trials, CanSino's Ad5-nCoV vaccine also utilizes an adenovirus vector to deliver the COVID-19 spike protein. The CanSino vaccine also requires only a single dose and can be stored at refrigeration temperatures of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data suggests the CanSino vaccine may be up to 66 percent effective.
- *Oxford-AstraZeneca* – Currently in Phase 2/3 trials, Oxford-AstraZeneca's AZD1222 vaccine also utilizes an adenovirus vector to deliver the COVID-19 spike protein. The Oxford-AstraZeneca vaccine requires two doses given 12 weeks apart and can be stored at refrigeration temperatures

of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data suggests the Johnson and Johnson vaccine may be up to 82.4 percent effective.

Recombinant Spike Protein

- *Novavax* – Currently in Phase 2b trials, Novavax's NVX-CoV2373 vaccine utilizes a recombinant version of the COVID-19 spike protein itself to mediate an immune response. The Novavax vaccine requires two doses, 21 days apart, and can be stored at refrigeration temperatures of 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit). Clinical data conducted in the United Kingdom suggests the Novavax vaccine may be up to 89.3 percent effective.

In addition to these approved vaccines and vaccine candidates, several others are in development that use adenovirus vectors and inactivated COVID-19 viruses.

Distribution and Administration of Approved COVID-19 Vaccines in California. Shortly after approval of the Pfizer and Moderna COVID-19 vaccines, doses began to be delivered to California. Because supplies of these vaccines were expected to be in short supply as the companies ramp 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 receive 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.

California's COVID-19 Vaccination Plan. Prior to the approval of COVID-19 vaccines, the state developed a planning template submitted to the CDC outlining how vaccines would be distributed and administered in California. The plan largely relies 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 has 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.

The Drafting Guidelines Workgroup and Community Vaccine Advisory Committee have not released final guidelines on the subsequent tiers and affected individuals or sectors likely to be next to receive the vaccines.

According to CDC data, as of February 10th, 2021, the state has administered 4,957,297 doses of the vaccine, including 3,994,969 first doses and 928,615 second doses. More than 10 percent of California's population has received a first dose of vaccine. The federal partnership with CVS and Walgreens has administered 477,862 doses to residents and staff of long-term care facilities in California, with 369,687 receiving a first dose and 106,842 receiving a second dose.

Third-Party Administrator and Other Vaccination Efforts – Blue Shield of California and Kaiser. On January 26, 2021, the Administration announced a new partnership with Blue Shield of California to serve as a third-party administrator for vaccine distribution in California. According to the state's letter of intent, Blue Shield would develop and manage a statewide vaccine administration network by executing contracts with providers that meet state criteria for distribution and administration of vaccines at mobile clinics, vaccine hubs, mega vaccination sites, and to at-risk patients at home. Blue Shield would also assist providers with start-up cost payments and implement incentive payments to encourage vaccine providers to administer vaccines quickly, efficiently, at high volume, and with a focus on communities that have been disproportionately impacted by COVID-19. The Administration also plans to enter into a partnership with Kaiser Foundation Health Plan to assist with the vaccine distribution effort. According to the state's letter of intent, Kaiser would secure, plan, organize, stand up and oversee two or more mass vaccination sites and other efforts to vaccinate hard to reach and disproportionately impacted populations.

2019-20 and 2020-21 Pandemic-Related Emergency Budget Augmentations. During the COVID-19 pandemic, the Administration augmented expenditure authority for DPH through a variety of Executive Orders, provisional language, budget control sections, and transfers from the Disaster Response-Emergency Operations Account (DREOA). In addition, a variety of federal funding streams have supported the pandemic response including reimbursements from the Federal Emergency Management Agency (FEMA) and direct categorical funding from Congressional relief packages.

SB 89 General Fund Allocation for 2019-20. SB 89 (Committee on Budget and Fiscal Review), Chapter 2, Statutes of 2020, appropriated up to $1 billion of General Fund expenditure authority to any item for any purpose related to the Governor's declaration of a state of emergency related to the coronavirus pandemic. SB 89 required the Department of Finance to notify the Joint Legislative Budget Committee (JLBC) 72 hours prior to any expenditures made pursuant to this authority. DPH received the following augmentations under SB 89:

- Hospital Capacity Expansion - $30 million (Item 4265-001-0001) to support lease costs for two hospitals, Seton Medical Center in Daly City and St. Vincent Medical Center in Los Angeles, until June 30, 2020, to expand the state's hospital capacity.
- Testing Capacity at Richmond Laboratory - $1.4 million (Item 4265-001-0001) to expand capacity for diagnostic testing for COVID-19 at DPH's Richmond Laboratory.
- Virtual Training Academy for Contact Tracing - $8.7 million (Item 4265-001-0001) to support development of a virtual training academy to train new staff to augment existing local public health staff to conduct contact tracing of confirmed COVID-19 cases.
- Contact Tracing Technology Platform - $18.7 million (Item 4265-001-0001) to support development of a data management platform to support the contact tracing workforce, developed by Salesforce, and a call center in collaboration with Amazon.

Disaster Response-Emergency Operations Account (DREOA). Government Code Section 8690.6 established the Disaster Response-Emergency Operations Account (DREOA) within the Special Fund for Economic Uncertainties (SFEU). DREOA begins with an unencumbered balance of $1 million at the beginning of each fiscal year, but allows the Director of Finance to transfer sufficient funds from the SFEU to support DREOA expenditures. Section 8690.6 also authorizes DREOA funds, upon allocation by the Director of Finance, to be transferred to state agencies for disaster response operation costs incurred as a result of a proclamation by the Governor of a state of emergency. On March 4th, 2020, the Governor

declared a state of emergency related to the COVID-19 pandemic, which allows transfers for this purpose to state departments, with notification to JLBC and the chairpersons of the fiscal committees in the Senate and Assembly.

On March 25, 2020, the Department of Finance notified JLBC of the transfer of $1.3 billion from the SFEU to DREOA to secure personal protective equipment and critical medical supplies, enhance the surge capacity of hospitals and medical facilities, and procure other items necessary to support the state's efforts to protect public health and safety and reduce the spread of the COVID-19 outbreak. On May 21, 2020, the Department of Finance notified JLBC of the transfer of an additional $1.8 billion to continue emergency response actions, including procurements of personal protective equipment and critical medical supplies, support for over 3,000 hospital and medical surge beds, hotels for healthcare workers and support staff, state response operations, testing, contact tracing and tracking, and other support services.

DPH received a total augmentation of General Fund expenditure authority of $87.7 million from two allocations of funds from DREOA in 2019-20, and $540.3 million from two allocations of funds from DREOA in 2020-21.

Federal Funding for Pandemic Emergency Response. The Federal Emergency Management Agency (FEMA) provides reimbursements for state, local, tribal, and territorial government entities for emergency protective measures taken during the COVID-19 pandemic. FEMA reimburses for eligible expenditures related to the emergency at no less than 75 percent of the cost. During California's pandemic response, the Administration has reported it believes FEMA will reimburse the state for much of its response expenditures at 75 percent. It is unclear how much, if any, of DPH's pandemic-related costs have been reimbursed by FEMA. In addition, the Biden Administration issued an Executive Order on January 21, 2021, authorizing 100 percent FEMA reimbursement for certain pandemic-related response expenditures. Recent federal guidance also suggests the availability of 100 percent FEMA reimbursement would be retroactive to the beginning of the pandemic. It is also unclear how the change in reimbursement would affect funding for DPH's pandemic-related expenditures to date, or in the future.

Section 11.95 – 2020 Budget Act. The 2020 Budget Act included budget control section language in Section 11.95 that authorizes the Department of Finance to adjust any item to account for additional federal funding or additional reimbursements to support testing and contact tracing. The federal Paycheck Protection Program and Health Care Enhancement Act provided $499 million to California through the CDC's Epidemiology and Laboratory Capacity (ELC) grant program to assist local public health departments to reduce transmission of COVID-19. The ELC allocations to DPH in 2020-21 were as follows:

- $286 million (Item 4265-101-0001) was provided to local governments to further six strategies, including: 1) enhance laboratory, surveillance, informatics, and other workforce capacity; 2) strengthen laboratory testing; 3) advance electronic data exchange at public health laboratories; 4) improve public health surveillance and reporting of electronic health data; 5) use laboratory data to enhance investigation, response, and prevention; and 6) coordinate and engage with partners.
- $176.1 million (Item 4265-001-0001) was provided to DPH to, in coordination with local governments, further the same six strategies referenced above.

Other Federal Funding to Support COVID-19 Response. The annual Budget Act includes provisional language in federal fund appropriations for DPH to allow the augmentation of federal fund expenditure authority if funds are made available by the CDC. Using this provisional authority, the Department of Finance approved augmentation of federal fund expenditure authority for DPH to reflect two awards from the CDC: an Immunization Supplemental Grant and an Immunization and Vaccines for Children award. These augmentations will allow DPH to support state and local COVID-19 response efforts. The augmentations were as follows:

Immunization Supplemental Grant

- $11.8 million in Item 4265-001-0890 (DPH State Operations)
- $8.3 million in Item 4265-111-0890 (Local Assistance)

Immunization and Vaccines for Children

- $18.7 million in Item 4265-001-0890 (DPH State Operations)
- $10.6 million in Item 4265-111-0890 (Local Assistance)

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:

- Michelle Gibbons, County Health Executives Association of California
- Kat DeBurgh, Executive Director, Health Officers Association of California
- Andie Martinez Patterson, Vice President of Government Affairs, California Primary Care Association
- BJ Bartleson, Vice President – Nursing and Clinical Services, California Hospital Association
- Kiran Savage-Sangwan, California Pan-Ethnic Health Network (CPEHN)
- Julio Ramirez, SEIU Local 721, Microbiology Supervisor, Los Angeles County Dept. of Public Health
- DeAnn Walters, Director of Clinical Affairs, California Association of Health Facilities

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. Please provide a brief overview of the state's COVID-19 testing capacity, including the prevalence of different testing methodologies and their distribution and deployment throughout the state.

4. Please provide a brief overview of the components of California's systems for vaccine distribution, including the role of local health departments, the federal CVS and Walgreens partnership, and the new third-party administrator.

5. Does the department have any data on the effectiveness of case identification and contact tracing efforts in reducing transmission of COVID-19? What lessons, if any, has the department learned about contact tracing during a pandemic that may inform more effective contact tracing efforts in the future?

6. 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?

7. Please provide a brief accounting of allocations of state or federal funding to DPH for pandemic related expenditures in 2019-20 and 2020-21 from the following sources: SB 89, DREOA, FEMA, the Coronavirus Relief Fund, CDC grant funding, or other federal funding sources.

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

1. Local Health Officers – How are local health officials coordinating with DPH and other state entities to manage the COVID-19 pandemic? Do local health departments have any current resource needs to address the pandemic? Has the response identified any gaps in readiness or resources that should be addressed once the current pandemic is under control?

2. Hospitals - How have your facilities been impacted by the COVID-19 pandemic? What surge procedures do you employ during periods of high hospital utilization? How have you managed staffing needs, particularly for ICU care, during the most recent surge periods?

3. Clinics – How have your clinics been impacted by the COVID-19 pandemic? What role have your clinics played in testing and treatment of COVID-19 patients, as well as the administration of vaccines? How has the delivery of primary care been affected by the pandemic in your clinics?

4. Skilled Nursing Facilities – How have skilled nursing facilities operations been affected by the COVID-19 pandemic? What protective measures have been implemented to protect residents and staff? Please report on the progress of vaccinations in skilled nursing facilities for residents and staff under the federal long-term care partnership? Can you share an estimate of the percentage of skilled nursing facility residents that have received at least one dose of vaccine?

5. CPEHN – 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? In your view, how have pre-existing health inequities been exacerbated by the pandemic? What is the state doing well to address these inequities and where is it falling short? What should the Legislature and the Administration be thinking about as we consider how to address these inequities?

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

Issue 3: COVID-19 Direct Response Expenditures

Budget Change Proposal – Governor's Budget. DPH requests General Fund expenditure authority of $820.5 million in 2021-22. If approved, these resources would support response activities to the COVID-19 pandemic, primarily for testing facilities, supplies, and logistics.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$820,549,000	$-
Total Funding Request:	**$820,549,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

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

The Administration is requesting total General Fund expenditure authority of $1.8 billion to continue its response and mitigation of the impacts of the COVID-19 pandemic. $1.4 billion of this request is allocated specifically to several departments. The remaining $400 million would be allocated through the Disaster Response-Emergency Operations Account (DREOA), pursuant to proposed budget control section language included in this request. The specified allocations for each department or entity are as follows:

- **Department of Public Health (DPH)** – DPH requests General Fund expenditure authority of $820.5 million in 2021-22 for statewide testing efforts at the Valencia Branch testing laboratory, testing specimen collection through OptumServe, and other miscellaneous services and procurements related to testing.
- **Department of General Services (DGS)** – DGS requests General Fund expenditure authority of $84.4 million in 2021-22 for three key pandemic-related programs: 1) Hotels for Healthcare Workers, which provides hotel rooms to healthcare workers providing critical care to COVID-19 patients to help them avoid bringing the virus home; 2) Housing for the Harvest, which provides hotel rooms for agricultural workers to isolate safely if they are exposed to, or test positive for COVID-19; and 3) Project Hope, which provides hotel rooms to individuals released from prison that need to quarantine safely. This request also includes DGS' contract with FedEx for testing specimen transportation costs, which would be shifted to the DPH budget.
- **Department of Corrections and Rehabilitation (CDCR)** – CDCR requests General Fund expenditure authority of $281.3 million in 2021-22 to support the California Correctional Health Care Services' (CCHCS) efforts to treat COVID-19 and minimize exposure to inmates and staff through testing, vaccinations, medical surge capacity, and personal protective equipment (PPE).
- **Department of Veterans Affairs** – The Department of Veterans Affairs requests General Fund expenditure authority of $5.3 million in 2021-22 to continue efforts to mitigate impacts of the pandemic in veterans' homes. These resources would support enhanced cleaning protocols, testing of staff and residents, procurement of PPE and cleaning products, and procurement of thermometers and medical devices.

- **Department of Social Services (DSS)** – DSS requests General Fund expenditure authority of $5 million in 2021-22 for its Rapid Response Program to support entities that provide assistance and services to immigrants during emergent situations when federal funding is not available.
- **Department of State Hospitals (DSH)** – DSH requests General Fund expenditure authority of $52 million in 2021-22 to support staff costs for cleaning, staffing coverage, environmental projects, custody tasks, screening and isolation. The request also covers commodity purchases, such as PPE, sanitation supplies, changes in food service, as well as equipment for heating and air, filtration, and information technology solutions. In addition, though most testing costs would be shifting to DPH, DSH expects some costs from a contractor hired to work onsite to collect, process, and report staff testing results.
- **Board of State and Community Corrections (BSCC)** – BSCC requests General Fund expenditure authority of $12.1 million in 2021-22 to support county probation departments with increased number of individuals released from state prison on Post-Release Community Supervision to reduce institutional populations in response to the pandemic.
- **Department of Developmental Services (DDS)** – DDS requests General Fund expenditure authority of $36.7 million in 2021-22 for development of surge sites to serve consumers diagnosed with, exposed to, or at high risk of COVID-19. The funding would support an average of 25 beds each at Fairview and Porterville Developmental Centers for six months.
- **Governor's Office of Emergency Services (CalOES)** – CalOES requests General Fund expenditure authority of $119.7 million in 2021-22 to reimburse local governments for eligible costs associated with emergency activities undertaken in response to the COVID-19 pandemic.

According to the Administration, the remaining $400 million would be allocated through the DREOA process for statewide hospital and medical surge preparation, contact tracing, and emergency operations costs. The Administration indicates it would release the departmental allocations for these funds once additional information is available.

Department of Public Health – Resource Request. DPH requests total General Fund expenditure authority of $820.5 million in 2021-22 to support response activities to the COVID-19 pandemic, primarily for testing facilities, supplies, and logistics. In particular, this funding would support the following:

- Valencia Laboratory – DPH requests General Fund expenditure authority of $483.2 million in 2021-22 to support testing efforts at its Valencia Laboratory. Beginning operation in October 2020, the Valencia Laboratory will expand the state's COVID-19 testing capacity by an expected 150,000 tests per day by March 2021. DPH contracts with PerkinElmer to operate the lab. Because DPH expects the need for COVID-19 testing capacity will begin to decline in August 2021, this request assumes a small residual cost to maintain the facility in a "warm" shutdown after the end of 2021.
- Logistics Health, Inc. (OptumServe) – DPH requests General Fund expenditure authority of $316.7 million in 2021-22 to support a new specimen collection contract with OptumServe. DPH also expects costs to decline beginning in August 2021 until the end of the calendar year.
- Miscellaneous COVID-19 Testing and Other Costs – DPH requests General Fund expenditure authority of $20.7 million in 2021-22 for service contracts, other operating costs, commodity purchases and other procurements, and a contract to provide revenue collection and banking services for the Valencia Laboratory.

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 the DPH-related components of this proposal, as well as a brief description of the components for other state departments.

2. After the pandemic is over, what are the department's long-term plans for the Valencia Laboratory testing facility? Could this capacity be repurposed for other public health priorities?

Issue 4: Adjustment to Support Infectious Disease Modeling

Budget Change Proposal – Governor's Budget. DPH requests General Fund expenditure authority of $450,000 in 2021-22, available for encumbrance or expenditure until June 30, 2023. If approved, these resources would support infectious disease modeling activities to inform public health emergency decision-making.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$450,000	$-
Total Funding Request:	**$450,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. During the COVID-19 pandemic, determination of the suitability of various public health interventions required modeling of the transmission and public health impacts of the virus within California communities. In February 2020, DPH established the Coronavirus Modeling Team to provide epidemiologic estimates of the potential consequences of COVID-19 and to provide the evidentiary basis of the state's pandemic response. In July 2020, the University of California (UC) Office of the President, with input from DPH, established the California COVID-19 Modeling and Analytics Consortium to consolidate modeling and analytic activities across the UC system to inform state policy. The Consortium includes over 150 investigators from nine UC campuses. According to DPH, as COVID-19 transmission has continued to increase, disproportionately impacting socially vulnerable communities, infectious disease modeling has been highlighted as a central theme in providing transparent data, primarily through the establishment of an open-source, publicly available modeling platform, CalCAT, which disseminates modeling based results produced through collaborations and partnerships with academic and citizen science modeling groups. DPH also reports its infectious disease modeling may be helpful in the state's understanding of the role of new COVID-19 variants in transmission and disease in the state.

Resource Request. DPH requests General Fund expenditure authority of $450,000 in 2021-22, available for encumbrance or expenditure until June 30, 2023, to support its infectious disease modeling activities to inform public health emergency decision-making. DPH reports it has redirected six positions to support its current modeling efforts, including CalCAT, and intends to fund a dedicated staff member to support CalCAT and other infectious disease modeling activities. According to DPH, $300,000 would support the staff salary, benefits, and other operating expenses, and $150,000 would support the modeling and analytics efforts, as well as in-house training for DPH staff.

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. Once the COVID-19 pandemic is under control, how could these modeling resources and efforts be helpful in addressing other infectious diseases?

Issue 5: AIDS Drug Assistance Program (ADAP) Estimate

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

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

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

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

ADAP is funded by federal funds and the ADAP Rebate Fund (Fund 3080). The federal government began funding state programs to assist people living with HIV to purchase antiretroviral medications in 1987. Since 1990 with the passage of the Ryan White Comprehensive AIDS Resources Emergency Act,

now known as the Ryan White Program, the federal Health Resources and Services Administration (HRSA) provides funding to states for ADAP programs. In addition to federal funds, ADAP receives significant funding from mandatory and voluntary manufacturer rebates for ADAP drug expenditures.

ADAP Estimate – Governor's Budget. The November 2020 ADAP Local Assistance Estimate reflects revised 2020-21 expenditures of $467.3 million, an increase of $29 million or 6.6 percent compared to the 2020 Budget Act. According to DPH, this increase is primarily due to higher projected medication expenditures for medication-only clients. For 2021-22, DPH estimates ADAP expenditures of $503.5 million, an increase of $36.1 million or 7.7 percent compared to revised expenditures for 2020-21. According to DPH, this increase is similarly attributable to higher projected medication expenditures for medication-only clients.

ADAP Local Assistance Funding Summary		
Fund Source	**2020-21**	**2021-22**
0890 – Federal Trust Fund	$109,140,000	$105,350,000
3080 – AIDS Drug Assistance Program Rebate Fund	$358,194,000	$398,116,000
Total ADAP Local Assistance Funding	**$467,334,000**	**$503,466,000**

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

Caseload by Client Group	**2019-20**	**2020-21**
Medication-Only	13,105	13,142
Medi-Cal Share of Cost	104	108
Private Insurance	10,479	10,717
Medicare Part D	7,720	7,767
PrEP Assistance Program	3,325	3,430
TOTAL	**34,733**	**35,164**

Expenditures by Client Group	**2019-20**	**2020-21**
Medication-Only	$342,103,793	$356,480,156
Medi-Cal Share of Cost	$1,116,065	$1,158,425
Private Insurance	$88,775,907	$107,608,168
Medicare Part D	$24,421,933	$26,652,684
PrEP Assistance Program	$4,136,501	$4,151,355
TOTAL	**$460,554,199**	**$496,050,788**

In addition, enrollment costs are estimated to be $6.8 million in 2020-21 and $7.4 million in 2021-22. Beginning in 2017-18, ADAP introduced a new reimbursement methodology for enrollment sites which includes a payment floor and variable payments dependent on new client medication enrollment, client

bi-annual self-verification, client annual re-enrollment, client insurance assistance enrollment and re-enrollment, and PrEP client enrollment and re-enrollment.

General Fund Loan – ADAP Rebate Fund. The 2020 Budget Act included provisional language to provide for a loan of up to $100 million from the ADAP Rebate Fund to the General Fund. The provisional language requires the repayment of all or a portion of the loan if the Director of Finance determines that any of the following circumstances exist: (a) the fund or account from which the loan was made has a need for the moneys to maintain a prudent reserve of not less than 40 percent of operating expenses in the previous year for the ADAP Program, (b) the fund or account from which the loan was made has a need for the moneys to maintain a prudent reserve due to a decrease in federal funding, (c) the fund or account from which the loan was made has a need for the moneys to provide drugs and services through the ADAP Program or the HIV prevention program, (d) the fund or account from which the loan was made has a need for the moneys to increase eligibility criteria or add new drugs and services to the ADAP Program or the HIV prevention program, or (e) there is no longer a need for the moneys in the fund or account that received the loan.

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 the major changes to the ADAP Estimate.

Issue 6: Center for Health Care Quality Estimate

Center for Health Care Quality Program Estimate – Governor's Budget. The budget includes expenditure authority for the Center for Health Care Quality of $341.1 million ($4.3 million General Fund, $96.6 million federal funds, and $240.2 million special funds and reimbursements) in 2020-21, a decrease of $9.9 million or 2.8 percent compared to the 2020 Budget Act, and $391.5 million ($4.3 million General Fund, $101.5 million federal funds, and $285.7 million special funds and reimbursements) in 2021-22, an increase of $50.4 million or 14.8 percent compared to the revised 2020-21 budget. According to DPH, the increase in 2021-22 is attributed to increased costs for the third year of the department's contract with Los Angeles County, implementation of a centralized application unit, and legislatively mandated requirements related to personal protective equipment stockpiles for healthcare employers, staffing compliance oversight for skilled nursing facilities, and investigation of complaints against caregivers.

CHCQ Funding Summary, November 2020 Estimate		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$4,296,000	$4,296,000
0890 – Federal Trust Fund	$96,643,000	$101,522,000
0942 – Special Deposit Fund		
Internal Departmental Quality Improvement Account	$3,600,000	$3,600,000
State Health Facilities Citation Penalty Account	$2,144,000	$2,144,000
Federal Health Facilities Citation Penalty Account	$9,873,000	$9,873,000
0995 – Reimbursements	$12,134,000	$12,914,000
3098 – Licensing and Certification Program Fund	$212,458,000	$257,178,000
Total CHCQ Funding	**$291,351,000**	**$311,429,000**
Total CHCQ Positions	**1425.3**	**1456.3**

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

History of Problems with Health Facility Oversight. L&C's regulatory oversight of health care facilities has raised concerns from the federal government, the Legislature, the California State Auditor, stakeholders, and the media for more than fifteen years. In particular, L&C has demonstrated a consistently poor record of completing investigations of health care facility complaints of abuse and neglect of residents in a timely manner. The Legislature has sought to address the ongoing issues with L&C through a variety of budget actions and reporting requirements.

2014 Budget Act – The 2014 Budget Act included trailer bill language requiring L&C to:

- Report metrics quarterly on: (1) investigations of paraprofessional complaints; (2) long-term care health facility complaints, investigations, state relicensing, and federal recertification surveys; and (3) vacancy rates and hiring within L&C.
- Report by October 2016 the above information for all facility types.
- Assess the possibilities of using professional position classifications other than health facility evaluator nurses to perform licensing and certification survey or complaint workload.
- Hold semiannual meetings for all interested stakeholders to provide feedback on improving the L&C program.

2015 Budget Act – The 2015 Budget Act included*:*

- Approval of 237 positions over two years to address the licensing and certification workload.
- $2 million from the Internal Departmental Quality Improvement Account to implement quality improvement projects.
- $14.8 million from the L&C Program Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County.
- $378,000 from the L&C Program Fund and 3 positions to provide on-site oversight and perform workload management, training, and quality improvement activities to improve the efficiency and effectiveness of the Los Angeles County contract licensing and certification activities.
- Trailer bill language to establish timeframes to complete complaint investigations at long-term care facilities, as follows:
    - For immediate jeopardy complaints the department must complete the investigation within 90 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
    - For all other categories of complaints received on or after July 1, 2017, the department must complete the investigation within 90 days of receipt, with an additional extension of 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
    - For all complaints received on or after July 1, 2018, the department must complete the investigation within 60 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
    - Report on an annual basis (in the Licensing and Certification Fee report) data on the department's compliance with these new timelines.

- Beginning with the 2018-19 Licensing and Certification November Program budget estimate, the department must evaluate the feasibility of reducing investigation timelines based on experience implementing the timeframes described above.
- States the intent of the Legislature that the department continues to seek to reduce long-term care complaint investigation timelines to less than 60 days with a goal of meeting a 45-day timeline.

2016 Budget Act – The 2016 Budget Act included*:*

- $2 million from the Internal Departmental Quality Improvement Account to execute two contracts to redesign the Centralized Applications Unit (CAU) information technology systems, and the Health Facilities Consumer Information System (HFCIS).
- $2.5 million in expenditure authority from the L&C Program Fund to convert 18 existing two-year limited-term positions to permanent positions, and fund two additional positions for the Office of Legal Services, for a total of 20 positions to improve the timeliness of investigations of complaints against caregivers.
- One-time $1 million augmentation to the Long-Term Care Ombudsman Program using funds from the State Health Facilities Citation Account.
- $2.1 million from the L&C Program Fund to augment the Los Angeles County contract to account for two, three percent salary increases effective October 2015 and October 2016, an increase to the employee benefit rate from 55.1 to 57.8 percent, and a decrease in the indirect cost rate from 33.2 to 31.4 percent.

2017 Budget Act – The 2017 Budget Act included*:*

- $2 million from the Internal Departmental Quality Improvement Account for IT assessment, performance dashboards, implementation of tablet use, automation of caregiver applications, outcomes and effectiveness evaluation, quality improvement facilitation, onboarding and retention contract for Health Facilities Evaluator Nurses (HFEN), and contracts to continue the redesign of the CAU and HFCIS.
- $1.1 million to augment the Los Angeles County contract to account for salary increases approved by the Los Angeles County Board of Supervisors.
- Implementation of requirements that free-standing skilled nursing facilities have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for certified nurse assistants, beginning July 1, 2018.

2018 Budget Act – The 2018 Budget Act included*:*

- $2.6 million from the Licensing and Certification Program Fund to fund a one-year extension of the Los Angeles County contract for licensing and certification activities and to account for adjustments to the indirect cost rate, employee benefits rate, personnel costs, and lease costs.
- Budget bill language to authorize DPH to increase funding for the Los Angeles County contract as needed based on actual cost information that becomes available during 2018-19.
- Trailer bill language to authorize a supplemental license fee on facilities located in Los Angeles County to offset additional costs necessary to regulate facilities in the county.
- 22 positions and expenditure authority of $2.7 million ($2.4 million Licensing and Certification Program Fund and $294,000 Internal Departmental Quality Improvement Account) annually to allow DPH to improve core operations and effectiveness, foster quality improvement projects, and address workforce needs, particularly in the licensing of certified nurse assistants.

Vacancy Rates: Center for Health Care Quality and HFEN Classification. According to DPH's Vacancy Reports Metrics Dashboard, the Center for Health Care Quality, which oversees the L&C Division, had a 7.1 percent vacancy rate for all positions reported as of June 30, 2020, compared to 6.5 percent as of June 30, 2019. The vacancy rate for the HFEN classification, the primary classification conducting health facility oversight and investigation, was 5.3 percent as of June 30, 2020, compared to 3.9 percent as of June 30, 2019. L&C vacancies, particularly in the HFEN classification, have been a persistent concern for the program, the Legislature, and stakeholders, about the program's ability to manage its licensing and certification and complaint and entity-reported incident investigation workload. However, DPH has been relatively successful in reducing its HFEN vacancy rate, which was 19.5 percent as of June 30, 2016.

DPH indicates its successful reduction in its vacancy rate is due to recent implementation of recruitment and retention strategies. The program hired two contractors to help remedy the high vacancy rates for HFENs in the L&C program: 1) an onboarding and retention contractor assists hiring candidates to navigate the state civil service process and helps improve retention of hired staff, and 2) a recruitment contractor seeks candidates for HFEN positions at job fairs, conducts outreach to registered nurses in California, develops marketing materials and attempts to meet recruitment targets. Funding for these contracts was approved in the 2015 Budget Act from the Internal Departmental Quality Improvement Account.

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 the L&C Program, including regulatory responsibilities, organizational structure, funding, and performance.

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

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

Issue 7: Health Care and Essential Workers: Personal Protective Equipment (SB 275)

Budget Change Proposal – Governor's Budget. DPH requests one position and expenditure authority from the Licensing and Certification Fund of $164,000 annually. If approved, this position and resources would allow DPH to establish regulations for a personal protective equipment (PPE) stockpile by health care employers, pursuant to the requirements of SB 275 (Pan), Chapter 301, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$164,000	$164,000
Total Funding Request:	**$164,000**	**$164,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2022-23.

Background. During the first months of the pandemic emergency, planning for a potential surge in hospital and intensive care unit (ICU) utilization uncovered serious challenges for the state's health systems and health care providers to obtain the personal protective equipment (PPE) necessary to safely treat an influx of COVID-19 patients. In particular, hospital staff across the nation reported shortages of masks, respirators, gowns, gloves, and other equipment, with hospitals often resorting to one or more rationing procedures to ensure availability for hospital staff.

Statewide PPE Stockpile. SB 275 (Pan), Chapter 301, Statutes of 2020, requires DPH and the Governor's Office of Emergency Services (CalOES) to establish a statewide stockpile of PPE by January 1, 2022, upon appropriation and as necessary. The bill requires DPH to establish a PPE Advisory Committee comprised of representatives of various provider associations, labor organizations representing health care and other essential workers, the PPE manufacturing industry, consumers, counties, DPH, CalOES, the Emergency Medical Services Authority, and the Department of Social Services. The Committee will make recommendations to DPH and CalOES to develop guidelines for the procurement, management, and distribution of PPE.

Despite the PPE procurement challenges experienced by health care providers throughout the state during the pandemic, the budget does not include staffing or other resources to establish the statewide stockpile or to support the PPE Advisory Committee. Because the language in SB 275 conditions the establishment of a statewide stockpile on an appropriation in the budget, this omission is allowable. However, it is unclear why the Administration has neglected to include such a vital tool for the stable management of the state's supplies of PPE in its January budget.

Provider-Specific PPE Stockpiles. SB 275 also requires health care employers, including general acute care hospitals, health facilities, certain medical practices, and dialysis clinics, to maintain an inventory of unexpired PPE for use in the event of a pandemic or other emergency. Beginning January 1, 2023, health care employers would be required to maintain an inventory at least sufficient for 45 days of surge consumption, as determined by regulations promulgated by the Department of Industrial Relations (DIR) in coordination with DPH. These regulations would include, but not be limited to, the types and amount of PPE to be maintained based on the type and size of each health care employer and the composition of its workforce. Health care employers that fail to maintain the required stockpile would be subject to civil

penalties. This budget request includes staffing and resources for DPH to assist DIR in promulgating regulations. The budget includes a separate request for DIR to promulgate these regulations and enforce the requirements of SB 275.

Staffing and Resource Request. DPH requests one position and expenditure authority from the Licensing and Certification Fund of $164,000 annually to assist DIR in the establishment of regulations for health care employers' PPE stockpiles. Specifically, DPH requests the following partial positions:

- **0.5 Research Scientist Supervisor I (Epidemiology/Biostatistics)** would conduct research, analysis, and compilation of PPE types, amount of PPE needed, and workforce composition of health care employers, as well as provide expertise in health care associated infections.
- **0.5 Associate Governmental Program Analyst** would assist DIR in writing regulations for health care employers that would be required to maintain stockpiles of PPE.

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 explain why this request does not include resources to establish a statewide stockpile of PPE. Has the Administration determined such a stockpile is not necessary?

Issue 8: Skilled Nursing Facility Staffing Requirements Compliance (AB 81)

Budget Change Proposal – Governor's Budget. DPH requests six positions and expenditure authority from the Licensing and Certification Fund of $939,000 annually. If approved, these positions and resources would allow DPH to enforce skilled nursing facility compliance with staffing requirements, impose penalties, and manage disputes and appeals, pursuant to the requirements of AB 81 (Committee on Budget), Chapter 13, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$939,000	$939,000
Total Funding Request:	**$939,000**	**$939,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2022-23.

Background. AB 1629 (Frommer), Chapter 875, Statutes of 2004, authorized the development of a cost-based, facility-specific reimbursement rate methodology for freestanding skilled nursing facilities serving Medi-Cal beneficiaries and imposed a Quality Assurance Fee (QAF), which supports the nonfederal share of reimbursement rate increases to these facilities. The reimbursement rate methodology and QAF have been reauthorized three times since 2004. Though the basic structure of the reimbursement rate methodology and QAF have remained the same, each reauthorization has provided for the rate of reimbursement rate increases each year and imposes certain other requirements on skilled nursing facilities.

Quality and Accountability Supplemental Payment Program. SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, the first reauthorization of the AB 1629 QAF, also required the Department of Health Care Services to implement a Quality and Accountability Supplemental Payment (QASP) program to enable the reimbursement of skilled nursing facilities to be partially dependent on demonstrated quality of care improvements and adherence to quality standards. Until 2015, the QASP program withheld a portion of the annual rate increase specified in the AB 1629 QAF reauthorization until the required quality of care improvements or adherence to quality standards were demonstrated by a health facility. AB 119 (Committee on Budget), Chapter 17, Statutes of 2015, amended the structure of the QASP withhold, freezing the total reimbursement withheld at 2014-15 levels, or $81 million ($40.5 million QASP funds and $40.5 million federal funds).

Skilled Nursing Facility Minimum Staffing Requirements. SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, requires skilled nursing facilities to have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for certified nursing assistants (CNAs). Previously, the minimum staffing requirement had been 3.2 hours per patient day, with no minimum requirements for CNAs. DPH is responsible for auditing skilled nursing facilities for compliance with these minimum staffing requirements. Failure to comply may result in administrative penalties assessed by DPH, or ineligibility for payments in the QASP program.

Most Recent AB 1629 QAF Reauthorization Includes Enhanced Appeal Rights. AB 81 (Committee on Budget), Chapter 13, Statutes of 2020, the most recent reauthorization of the AB 1629 QAF, extends

the current structure until December 31, 2022, with some changes to the schedule of reimbursement rate increases, changes to the treatment of labor costs and other components of the facility-specific reimbursement rate methodology, exemption of freestanding pediatric subacute facilities from the QAF, and an enhanced right for skilled nursing facilities to appeal determinations or assessments of compliance by DPH. According to DPH, skilled nursing facilities are audited for 24 days of staffing annually to ensure compliance with the minimum requirements for direct care services hours per patient day. If a facility is non-compliant for 2 days or more, it is assessed a penalty and is determined ineligible for QASP payments. Prior to AB 81, only facilities in this category could appeal this determination, because they were assessed a penalty. However, a facility determined non-compliant for only one day is not assessed a penalty and, although it would also be ineligible for QASP payments, it previously could not appeal the determination. AB 81 expanded these appeal rights to allow skilled nursing facilities determined non-compliant for one day to appeal the determination, as well. Based on data trends, DPH expects 106 one-day non-compliant findings to be issued annually and, because this finding results in loss of QASP eligibility, expects all skilled nursing facilities with such findings would appeal. As a result, DPH expects an increase in its auditing and appeals workload.

Staffing and Resource Request. DPH requests six positions and expenditure authority from the Licensing and Certification Fund of $939,000 annually to enforce skilled nursing facility compliance with staffing requirements, impose penalties, and manage disputes and appeals. Specifically, DPH requests the following positions:

Office of Legal Services (OLS) – **Two Attorney III** positions and **one Senior Legal Analyst** would manage the additional 106 appeals of one-day non-compliant findings for skilled nursing facilities, including reviewing arguments, witnesses, and preparing or responding to any supporting documentation.

Staffing Audits Section (SAS) – **Two Associate Governmental Program Analysts** and **one Office Technician** would work as quality assurance auditors conducting on-site staffing audits, quality assurance reviews, reviewing files, and verifying all documentation is included, complete, and correct.

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 9: Timely Investigation of Caregivers

Budget Change Proposal – Governor's Budget. DPH requests seven positions and expenditure authority from the Licensing and Certification Fund of $1 million annually. If approved, these positions and resources would allow DPH to improve the timeliness of investigations of complaints against caregivers.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$1,000,000	$1,000,000
Total Funding Request:	**$1,000,000**	**$1,000,000**
Total Requested Positions:	**7.0**	**7.0**

* Positions and resources ongoing after 2022-23.

Background. DPH's Professional Certification Branch (PCB) is responsible for the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensure of nursing home administrators. It is also responsible for the investigation of allegations involving health care professionals and the enforcement of disciplinary actions. These caregivers provide approximately 80 percent of direct patient care activities for daily living in skilled nursing facilities licensed by DPH, and may also provide direct care in residences through licensed home health agencies.

Federal and state laws require investigation of complaints against caregivers. DPH received 1,310 complaints in 2017-18, 1,372 in 2018-19, and 1,116 in 2019-20. DPH indicates the decrease in complaints received in 2019-20 is due to the significant impact of the COVID-19 pandemic and expects a return to previous levels once pandemic-related restrictions are lifted. Complaints typically involve physical sexual, mental, or verbal abuse or misconduct; misappropriation of property; or other forms of unprofessional conduct. According to DPH, the backlog of pending caregiver investigations has increased from 246 in 2017-18 to 696 in 2019-20, an increase of 183 percent.

Staffing and Resource Request. DPH requests seven positions and expenditure authority from the Licensing and Certification Fund of $1 million annually to improve the timeliness of investigations of complaints against caregivers and mitigate the ongoing investigation backlog. Specifically, DPH requests **one Supervising Special Investigator I** position, who would supervise a team of **six Special Investigators** to manage the increased investigation workload.

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 10: Medical Breach Enforcement Section Expansion

Budget Change Proposal – Governor's Budget. DPH requests 17 positions and expenditure authority from the Licensing and Certification Fund of $2.6 million annually. If approved, these positions and resources would allow DPH to expand its Medical Breach Enforcement Section, which investigates complaints and administers penalties against individuals and health care providers for breaches of medical privacy.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$2,616,000	$2,616,000
Total Funding Request:	**$2,616,000**	**$2,616,000**
Total Requested Positions:	**17.0**	**17.0**

* Positions and resources ongoing after 2022-23.

Background. SB 541 (Alquist), Chapter 605, Statutes of 2008, requires investigation of and assessment of penalties on licensed medical facilities for breaches of patients' confidential medical information. SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014, transferred responsibility for the investigation of medical breaches from the California Health and Human Services Agency to DPH, along with three investigative staff. Since 2009, over 1,600 licensed health facilities have reported nearly 42,000 medical breach incidents.

Pilot Project to Test Use of Non-Clinical Staff for Medical Breach Investigations. In 2016-17, DPH expanded its medical breach investigative staff from three to 17, and included non-clinical classifications such as Special Investigators (SIs) and Associate Governmental Program Analysts (AGPAs) in a Medical Breach Enforcement Section (MBES). Previously, most medical breach investigations were conducted by Health Facility Evaluator Nurses (HFENs), the same classification that conducts investigations of abuse and neglect in skilled nursing facilities. The Center for Health Care Quality's Licensing and Certification Division, which is responsible for complaint investigations in skilled nursing facilities, had a long history of challenges completing investigations of abuse and neglect in a timely manner. In 2016-17, one of the contributing factors to these challenges was a high vacancy rate in the division for the HFEN classification. The transition from HFENs to SIs and AGPAs was intended to free up HFENs to focus on improving the timeliness of abuse and neglect complaint investigations. Since this transition began in 2016-17, DPH reports non-clinical staff from MBES have assumed all medical breach investigation workload in 12 of 19 DPH field offices.

Staffing and Resource Request. DPH requests 17 positions and expenditure authority from the Licensing and Certification Fund of $2.6 million annually to expand MBES staff to the remaining 7 DPH field offices. This expansion would allow HFENs currently performing this workload in these field offices to focus on complaint investigation workload and other duties. Specifically, DPH is requesting **four AGPAs, one Supervising Special Investigator II, one Supervising Special Investigator I, seven Special Investigators,** and **one Program Technician** for the MBES. In addition, DPH is requesting **one Attorney III** in its Legal Office to support medical breach investigations.

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 11: COVID-19 Workplace Outbreak Reporting (AB 685)

Budget Change Proposal – Governor's Budget. DPH requests three positions and General Fund expenditure authority of $677,225 annually. If approved, these positions and resources would allow DPH to create a new program to manage COVID-19 workplace outbreak reporting, pursuant to the requirements of AB 685 (Reyes), Chapter 84, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$677,225	$677,225
Total Funding Request:	**$677,225**	**$677,225**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2022-23.

Background. Due to public health interventions implemented during the COVID-19 pandemic, including stay-at-home orders and prohibitions on the operation of certain types of business and other establishments, many workplaces have transitioned employees to remote work or shut down altogether. However, certain classes of employees are considered "essential workers" and are exempt from stay-at-home orders and other restrictions. As a result, many of these workplaces have experienced outbreaks of COVID-19, as workers continue to occupy indoor spaces with other workers and customers, increasing the risk of transmission. In addition, the pandemic has disproportionately affected certain racial and ethnic groups, particularly Latinos who represent 39 percent of California's population, but 60 percent of its COVID-19 cases. According to DPH, these disparities are likely exacerbated by occupational factors such as the large number of workers from racial and ethnic minorities employed as essential workers. Preliminary data indicates that Latino workers make up 81 percent of COVID-19 fatalities in the construction industry, 79 percent in the restaurant and food service industry, and 93 percent in the crop production industry.

The Occupational Health Branch (OHB) at DPH works to prevent injury and illness on the job by: 1) identifying and evaluating workplace hazards, 2) tracking patterns of work-related injury and illness, 3) developing training and informational materials, 4) providing technical assistance, 5) working with partners to develop safer ways to work, and 6) recommending protective occupational health standards. OHB works closely with the Division of Occupational Safety and Health (Cal/OSHA) at the Department of Industrial Relations (DIR), which enforces workplace safety and health regulations.

AB 685 (Reyes) Chapter 84, Statutes of 2020, mandates employer reporting of COVID-19 outbreaks, which is defined as three or more cases at a worksite within a 14 day period. AB 685 also requires DPH to post information about COVID-19 outbreaks by industry on its website to increase public awareness. According to DPH, this reporting will allow the state to more effectively track and analyze data on workplace outbreaks, identify work-related risk factors for COVID-19 transmission, and inform preventive efforts. DPH reports it has received information about approximately 1,700 workplace outbreaks in January 2020, and plans to implement a dashboard for outbreak information on its website in February 2020. The dashboard would include information by industry, outbreak totals, and workplace settings.

Staffing and Resource Request. DPH requests three positions and General Fund expenditure authority of $677,225 annually to create the new program to manage COVID-19 workplace outbreak reporting. Specifically, DPH requests the following positions:

- **Two Research Scientist II (Epidemiology/Biostatistics)** positions would manage and analyze data on workplace outbreaks reported to the California Reportable Disease Information Exchange (CalREDIE) by local health departments. These positions would ensure data quality and integrity, analyze data to identify industries and occupations with high numbers of cases and rates of COVID-19 transmission, develop user-friendly visual representations of workplace outbreak data, and developing and delivering online training to local health departments on the accurate collection and reporting of data.
- **One Health Program Specialist II** position would conduct outreach to employers and local health departments to disseminate reporting requirements and data findings, develop partnerships and educational materials for local health departments, as well as workers and employers, receive and respond to inquiries regarding reporting requirements, assist the research scientist positions in developing visual representations of data, and update the website weekly.

Included in this request is General Fund expenditure authority of $200,000 annually to support maintenance and operations of system changes and database modifications to facilitate collection and reporting of workplace outbreak data.

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 12: Support for Alzheimer's Disease Awareness, Research, and Training

Budget Change Proposal – Governor's Budget. DPH requests General Fund expenditure authority of $17 million ($6.8 million in state operations and $10.2 million in local assistance) in 2021-22, available for encumbrance or expenditure until June 30, 2024. If approved, these resources would be available to DPH over three years to support an equitable and coordinated approach to Alzheimer's disease and related dementias, including research grants, a public awareness campaign, caregiver training and certification, community challenge grants, and statewide standards for dementia care.

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

Background. According to DPH, Alzheimer's is the seventh most common cause of death for Americans, including COVID-19. Federal Centers for Disease Control and Prevention data indicates California had 15,570 deaths attributable to Alzheimer's disease in 2016, which made it the 4th leading cause of death in the state. Alzheimer's disease disproportionately impacts women, as nearly two-thirds of Americans with Alzheimer's disease or other dementias are women. While the prevailing view has been that the difference is due to the fact that women, on average, live longer than men and older age is the greatest risk factor for Alzheimer's, many researchers question whether the risk of the disease is higher for women at any given age due to biological or genetic variations, or due to differences in life experiences. Alzheimer's disease also disproportionately impacts some communities of color. African-Americans are about two times more likely than older whites to have Alzheimer's and Hispanics are about one and one-half times more likely. Among people ages 65 and older, African Americans have the highest prevalence of Alzheimer's disease and related dementias (13.8 percent), followed by Hispanics (12.2 percent).

AB 2225 (Felando), Chapter 1601, Statutes of 1984, established the Alzheimer's Disease Program (ADP) at DPH, which seeks to reduce the human burden and economic costs associated with Alzheimer's Disease and related dementias. The program, currently funded by individual voluntary contributions by taxpayers on state tax returns, performs two primary functions:

1. *California Alzheimer's Disease Centers.* ADP established and administers a statewide network of ten California Alzheimer's Disease Centers (CADCs) at university medical centers. These Centers provide diagnostic and treatment services; professional training for medical residents, postdoctoral fellows, nurses, interns, and medical students; and community education such as caregiver training and support.
2. *Alzheimer's Disease and Related Disorders Research Fund Grants.* ADP established and administers the Alzheimer's Disease and Related Disorders Research Fund (ADRDF), which awards grants through a competitive process to scientists in California engaged in the study of Alzheimer's disease and related disorders.

Alzheimer's Disease and Related Disorders Research Grants. Since its creation, ADP has provided more than $30 million of funding for more than 130 research projects to contribute to the better

understanding, care, and support of patients and families affected by Alzheimer's Disease and related disorders. Past research grants have contributed to significant breakthroughs including: identifying a novel specific plasma biomarker for Alzheimer's Disease, improving differential diagnosis and training, and providing definitive evidence of how amyloids contribute to the basic pathophysiological abnormalities typical of Alzheimer's and other neurodegenerative diseases.

Before 2018, ADP funded between five and seven research grants with its ADRDF allocations. The 2018 Budget Act included annual General Fund expenditure authority of $3.1 million for Alzheimer's research projects in the following categories:

- *Caregiving*: strengthening caregivers' health and effectiveness
- *Prevention*: reducing risk for cognitive decline and dementia
- *Early Diagnosis and Detection*: expanding early detection and diagnosis
- *Long-Term Services and Support Systems/Health Services:* improving safety and quality of care for people living with dementia
- *Health Disparities:* understanding the prevalence, policies, environmental, and social determinants of health affecting California's diverse population.

The 2019 Budget Act included additional General Fund expenditure authority of $2.7 million annually to support research to understand the greater prevalence of Alzheimer's among women and communities of color.

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

1) A senior advisor on Alzheimer's, appointed by the Governor, to lead on implementing recommendations of the task force.
2) Support Alzheimer's research with increased funding, including a focus on historically underrepresented communities, such as women, communities of color and the LGBTQ+ community.
3) Create a multilingual, multicultural, and intergenerational Alzheimer's Disease Public Awareness campaign to shift public perceptions and reduce social stigma.
4) Build a "California Cares" digital portal to serve as a one-stop shop for information and services related to screening and diagnosis of Alzheimer's.
5) Establish voluntary savings accounts for long-term care to address affordability and access.
6) Invest in career incentives for an Alzheimer's health care workforce.
7) Establish a caregiver training and certification program.
8) Establish a California Blue Zone City Challenge to support cities in certifying certain locations and establishments as "Blue Zones" once they adopt a minimum threshold of best practices that

address the needs and challenges of people with dementia, Alzheimer's or other age related diseases.

9) Establish a Californians for All Care Corps, to provide opportunities for people of all ages and life stages to contribute meaningful public service.
10) Establish an evidence-based, statewide standard of care for Alzheimer's detection diagnosis, treatment, and care planning.

Resource Request. DPH requests General Fund expenditure authority of $17 million ($6.8 million in state operations and $10.2 million in local assistance) in 2021-22, available for encumbrance or expenditure until June 30, 2024. These resources would support an equitable and coordinated approach to Alzheimer's disease and related dementias, and reflect five of the task force recommendations described above, including:

1) Alzheimer's Research Grant Funding (Recommendation 2) – DPH requests General Fund expenditure authority of $4 million to support research grants that would continue to focus on the greater prevalence of dementia in women and communities of color, but also focus on historically underrepresented populations, such as the LGBTQ+ community. Of this request, $3.4 million would be allocated for research grants and $600,000 would support the state operations costs of administering the grant program.
2) Public Awareness Campaign (Recommendation 3) – DPH requests General Fund expenditure authority of $5 million to create a public awareness campaign focused on educating the public on the signs and symptoms of Alzheimer's Disease and related dementias. The campaign would target at-risk and disproportionately impacted populations, incorporate a culturally competent and equity-targeted messaging strategy, provide critical information about Alzheimer's and other aging-related conditions, and drive the public to linguistically and culturally competent dementia care resources delivered through multiple modalities.
3) Caregiver Training and Certification Program (Recommendation 7) – DPH requests General Fund expenditure authority of $4 million to design and, if funding is available, develop a caregiver training and certification program, The program would provide access to evidence-based dementia related education and training for both paid and unpaid caregivers, as well as those providing In-Home Supportive Services. Of this request, $3.4 million would support the training and certification programs, while $600,000 would support the state operations costs of administering the program.
4) California Blue Zone Challenge (Recommendation 8) – DPH requests General Fund expenditure authority of $2 million to allocate grants to California cities or local health jurisdictions to establish a California Blue Zone program which would, in collaboration with local public and private sector stakeholders, certify certain establishments (e.g. schools, restaurants, grocery stores, workplaces, religious institutions, etc.) as "Blue Zones" if they adopt a minimum threshold of best practices. These best practices would address the unique needs and challenges of people with Alzheimer's disease and related dementias, and other age-related diseases.
5) Statewide Standard of Dementia Care (Recommendation 10) – DPH requests General Fund expenditure authority of $2 million to design a statewide standard of care for dementia. This effort would include ensuring primary care physicians have access to a set of evidence-derived cognitive screening questions for identification of Alzheimer's disease and related dementias, developing a hub and spoke model to leverage resources of the ten California Alzheimer's Disease Centers, and incorporating family caregivers into the diagnostic and care planning process.

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

Subcommittee Staff Comment and Recommendation—Hold Open. 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. What is the Administration's plan to address the other five recommendations of the Task Force on Alzheimer's Disease Prevention and Preparedness?

Issue 13: California Parkinson's Disease Registry Program Extension (AB 2821)

Budget Change Proposal and Budget Bill Language – Governor's Budget. DPH requests General Fund expenditure authority of $408,591 in 2021-22. If approved, these resources would allow DPH to continue outreach and surveillance efforts as part of the California Parkinson's Disease Registry, which was extended by AB 2821 (Nazarian), Chapter 103, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$408,591	$-
Total Funding Request:	**$408,591**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The 2017 Budget Act included General Fund expenditure authority of $1.7 million to establish a three-year pilot program to collect data from health providers on the incidence of Parkinson's disease in California. SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, requires healthcare providers diagnosing or providing treatment to Parkinson's disease patients to report each case to DPH. The data is included in the Richard Paul Hemann California Parkinson's Disease Registry (CPDR), a statewide population-based registry utilized to measure the incidence and prevalence of Parkinson's disease.

According to DPH, as of May 31, 2020, CPDR received 272,243 records from over 500 reporting entities for 71,671 total Parkinson's patients in California. The data demonstrate the age-related increase in Parkinson's risk, with only 2,456 patients under the age of 55, just 3.4 percent of all patients. 16,450 patients, or 23 percent, were over age 85.

SB 97 required the registry to begin collecting patient records on July 1, 2018, and included a sunset date for the program of January 1, 2021. AB 2821 (Nazarian), Chapter 103, Statutes of 2020, extended the sunset date until January 1, 2022. However, no additional funding was provided for the additional year.

Resource Request. DPH requests General Fund expenditure authority of $408,591 in 2021-22 to continue outreach and surveillance efforts as part of the CPDR. DPH indicates these resources would support redirection of the following existing positions for one year:

- **One Research Scientist I** position would solicit input from stakeholders on data collection and processing to improve the data warehouse, develop an evaluation plan for CPDR data, and respond to and manage external data requests.
- **One Research Scientist II** position would oversee data collection for CPDR, ensure data quality, develop and implement the CPDR surveillance framework, and conduct analyses using epidemiologic and biostatistical techniques.

In addition to this resource request, DPH is requesting budget bill language that would authorize the Director of the department to enter into contracts, grants or other agreements to conduct the registry, as well as accept grants of public or private non-state funds to support operation of the registry. DPH reports it has received foundation funding in the past for this purpose.

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 14: Women, Infants, and Children (WIC) Program Estimate

WIC Program Estimate – Governor's Budget. The November 2020 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($940.5 million federal funds and $196.8 million WIC manufacturer rebate funds) in 2020-21 and $1.2 billion ($1 billion federal funds and $174.4 million WIC manufacturer rebate funds) in 2021-22. The federal fund amounts include state operations costs of $59.2 million in 2020-21 and 2021-22.

Women, Infants, and Children (WIC) Funding Summary			
	2020-21	**2021-22**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$59,210,000	$59,210,000	$-
Local Assistance:	$881,274,000	$950,951,000	$69,677,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$196,784,000	$174,414,000	($22,370,000)
Total WIC Expenditures	**$1,137,268,000**	**$1,184,575,000**	**$47,307,000**

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

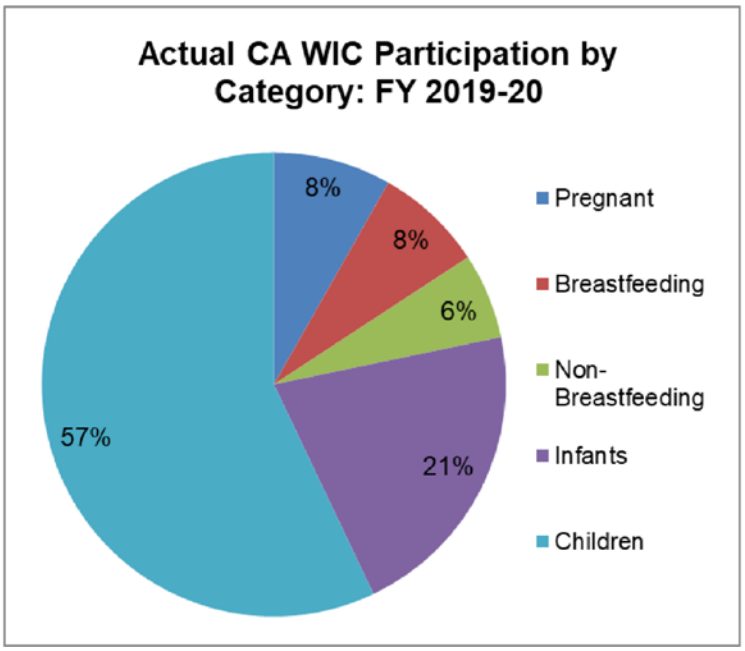
The WIC program's food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant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

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

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

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

According to the WIC program Estimate, WIC participation by category, as of 2019-20, was as follows:



Caseload Estimates. The budget assumes 951,755 average monthly WIC participants in 2020-21, an increase of 133,208 or 16.3 percent from the assumptions in the 2020 Budget Act. The budget assumes 979,983 average monthly WIC participants in 2021-22, an increase of 28,228 or three percent from the revised 2020-21 caseload estimate. According to DPH, the significant increase in participants is due to the economic impacts of the pandemic-induced recession. DPH also reports increases in participation may partially be attributable to the implementation of its electronic benefit transfer (EBT) delivery system and the auto-issuance of WIC benefits during the pandemic, both of which reduce barriers to participation in the program.

Food Expenditures Estimate. The budget includes $773.8 million in 2020-21 for WIC program food expenditures, an increase of $113.7 million or 17.2 percent, compared to the 2020 Budget Act. According to DPH, this increase in costs is due to increased participation related to the pandemic-induced recession, as well as potential impacts of implementation of EBT and auto-issuance of benefits. Of these expenditures, federally funded food expenditures are $577 million, an increase of $105.9 million from the 2020 Budget Act, and WIC Manufacturer Rebate Fund food costs are $196.8 million, an increase of $7.8 million from the 2020 Budget Act.

The budget includes $821.1 million in 2021-22 for WIC program food expenditures, an increase of $47.3 million or 6.1 percent from the revised 2020-21 food expenditures estimate. According to DPH, this increase in costs is also due to increased participation related to the pandemic-induced recession, as well as potential impacts of implementation of EBT and auto-issuance of benefits. Of these expenditures, federally funded food costs are $646.7 million, an increase of $69.7 million from the revised 2020-21 food expenditure estimate, and WIC Manufacturer Rebate Fund food costs are projected to be $174.4 million, a decrease of $22.4 million from the revised 2020-21 food expenditure estimate.

Nutrition Services and Administration (NSA) Estimate. The budget includes $304.2 million for other local assistance expenditures for the NSA budget in 2020-21 and 2021-22, which is unchanged from the level assumed in the 2020 Budget Act. The budget also includes $59.2 million for state operations expenditures in 2020-21 and 2021-22, also unchanged from the level assumed in the 2020 Budget Act.

Implementation of Electronic Benefit Transfer (EBT) System. The federal Healthy, Hunger-Free Kids Act of 2010 requires all state WIC agencies to implement an electronic benefit transfer (EBT) benefits delivery system by October 1, 2020. DPH completed statewide implementation of EBT on July 22, 2020. The California WIC Card replaces the previous paper checks required for accessing WIC benefits. In addition to the WIC Card, DPH implemented the California WIC App, which allows participants to view their food benefit balances, scan food bar codes to determine if the item is in their food benefit balance, view upcoming WIC appointments, and find WIC offices and grocery stores. These improvements have made it easier for participants to access benefits and improved the shopping experience for both participants and grocers. According to DPH, since June 2019, approximately 765,000 cards have been issued, 10 million transactions have been completed, and 100 percent of WIC authorized stores are capable of processing EBT transactions.

WIC Program COVID-19 Response. On March 18, 2020, Congress approved the Families First Coronavirus Response Act (FFCRA), which allocated $500 million to state WIC programs to support the increased need for food benefits and increased costs for providing services. These funds are available until September 30, 2021, but have not been distributed yet. Once these funds are distributed, they may offset expenditures currently supported by rebate funds.

In addition, FFCRA provided administrative flexibility to states to assist the delivery of food benefits to WIC participants. These flexibilities include waiver of in-person enrollment or re-enrollment requirements, auto-issuance of benefits, food substitution if grocer availability of certain foods is limited, and administrative and budgetary flexibilities for local WIC agencies. These flexibilities are scheduled to expire 30 days after the end of the national emergency declaration for the COVID-19 pandemic.

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 the caseload and expenditure changes for the WIC program.

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

3. Please briefly describe the program flexibilities and other actions taken by WIC to respond to the COVID-19 pandemic. Does DPH believe any of these flexibilities would benefit the program after the pandemic state of emergency ends?

Issue 15: Books for Low-Income Children

Budget Change Proposal – Governor's Budget. DPH requests General Fund expenditure authority of $5 million in 2021-22. If approved, these resources would allow DPH to support an early childhood literacy program for participants in the Women, Infants, and Children (WIC) program.

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

Background. Several pilot projects over the last thirty years have demonstrated the effectiveness of coupling WIC sites or pediatric offices with efforts to enhance the development of literacy and school readiness in young children. In pediatric settings, the Reach Out and Read model developed by Boston City Hospital promotes reading aloud as an integral part of routine preventive care, provides a picture book at each provider visit between age 6 months and 6 years, and provides waiting room volunteers to read aloud with children. These pilot projects have demonstrated clinically meaningful increases in preschool vocabulary, parent-reported literacy promoting attitudes and practices, identification of books as a favorite activity, reading aloud thought of as leading to school success, use of books at bedtime, and reading aloud three or more days per week.[1] Parent involvement with early literacy, such as those encouraged by the Reach Out and Read model, has demonstrated significant positive impacts on future reading outcomes.

In February 2020, First 5 California conducted an online survey among 58 county First 5 Commissions to inventory literacy interventions, including key details and program designs. All First 5 Commissions support one or more literacy programs, including many that provide books to children either as the primary goal or bundled along with another effort. These efforts include the Little by Little program in Los Angeles, which provides books to children at WIC offices; the Dolly Parton Imagination Library, which provides free, high-quality books by mail to children at any income level between birth and the beginning of school; and the Kit for New Parents, which provides parenting resources for parents of newborns, and includes a free picture book.

In particular, the Little by Little program in Los Angeles has demonstrated success in improving literacy through its efforts at local WIC agencies. Little by Little was funded by First 5 Los Angeles in 2003 at six WIC centers and includes three components: 1) a brief individual counseling session regarding child development for WIC staff members, 2) a brief handout with information about developmental milestones and appropriate ways to interact with a child to encourage optimal development, and 3) gift of a children's book or developmentally appropriate toy (e.g. black, white, and red chart for newborns or building blocks for 2.5 year old children). The intervention begins in the mother's third trimester of pregnancy and continues until the child's fifth birthday, or the end of WIC eligibility. According to a controlled study

[1] Needlman, R., Toker, K., Dreyer, Benard., Klass, P., Mednelsohn, A., "Effectiveness of a Primary Care Intervention to Support Reading Aloud: A Multicenter Evaluation". Ambulatory Pediatrics. Jul-Aug 2005.

published in the journal *Pediatrics*, the Little by Little intervention demonstrated statistically significant improvements in school readiness, particularly among Spanish-speaking WIC participants.[2]

Resource Request. DPH requests General Fund expenditure authority of $5 million in 2021-22 to support an early childhood literacy program for participants in the 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.

In addition, DPH indicates it would need to temporarily redirect **two Health Program Specialist I** positions to prepare the request for application process for grant funding, manage the competitive award process, and provide technical assistance and oversight for the grant program.

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

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

1. Please provide a brief overview of this proposal.

[2] Whaley, S., Jiang L., Gomez, J., Jenks, E. "Literacy Promotion for Families Participating in the Women, Infants and Children Program". Pediatrics. Feb 2011.

Issue 16: Genetic Disease Screening Program (GDSP) Estimate

Genetic Disease Screening Program Estimate – Governor's Budget. The November 2020 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $140.8 million ($32.9 million state operations and $107.9 million local assistance) in 2020-21, and $145.3 million ($33.3 million state operations and $111.9 million local assistance) in 2021-22.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2020-21	**2021-22**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$32,873,000	$33,322,000	$449,000
Local Assistance:	$107,885,000	$111,939,000	$4,054,000
Total GDSP Expenditures	**$140,758,000**	**$145,261,000**	**$4,503,000**

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

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

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

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

was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

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

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

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

NBS Caseload Estimate: The budget estimates NBS program caseload of 444,234 in 2020-21, a decrease of 6,110 or 1.4 percent, compared to the 2020 Budget Act. The budget estimates NBS program caseload of 445,840 in 2021-22, an increase of 1,606 or 0.4 percent, compared to the revised 2020-21 estimate. These estimates are based on state projections of the number of live births in California. DPH assumes 100 percent of children born in California will participate in the NBS program annually.

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

- Sequential Integrated Screening – This screen combines first and second blood test results with nuchal translucency (NT) ultrasound results, which measure the back of a fetus' neck. This measurement helps screen for Down syndrome (trisomy 21).

- Serum Integrated Screening – This screen combines a first trimester blood test screening result with a second trimester blood test screening result.
- Quad Marker Screening - One blood specimen drawn at 15 weeks - 20 weeks of pregnancy (second trimester test).

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

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

PNS Caseload Estimate: The budget estimates PNS program caseload of 485,230 in 2020-21, a decrease of 10,782 or 2.2 percent, compared to the 2020 Budget Act. The budget estimates PNS program caseload of 477,386 in 2021-22, a decrease of 7,844 or 1.6 percent, compared to the revised 2020-21 estimate. These estimates are based on state projections of the number of live births in California. DPH estimates approximately 71 percent of mothers of children born in California will have participated in the PNS program.

General Fund Loan – Genetic Disease Testing Fund. The 2020 Budget Act included provisional language to provide for a loan of up to $3 million from the Genetic Disease Testing Fund to the General Fund. This fund, which receives fee revenue from NBS and PNS screening activities, supports expenditures in GDSP. The provisional language requires the repayment of all or a portion of the loan if the Director of Finance determines that either of the following circumstances exist: (a) the fund or account from which the loan was made has a need for the moneys, or (b) there is no longer a need for the moneys in the fund or account that received the loan.

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 the caseload and expenditure changes for the Newborn Screening Program.

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

Issue 17: Improving the California Prenatal Screening Program

Budget Change Proposal – Governor's Budget. DPH requests three positions and expenditure authority from the Genetic Disease Testing Fund of $4.3 million ($449,000 for state operations and $3.9 million for local assistance) in 2021-22, and $20.6 million ($449,000 for state operations and $20.2 million for local assistance) annually thereafter. If approved, these positions and resources would allow DPH to meet current standards of care and improve the screening process for the California Prenatal Screening Program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0203 – Genetic Disease Testing Fund	$4,349,000	$20,649,000
Total Funding Request:	**$4,349,000**	**$20,649,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2022-23.

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

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

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

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

New Standard of Care for Prenatal Screening – Cell-Free DNA. A new screening methodology, known as cell-free DNA (cfDNA), has demonstrated improved performance for prenatal screening. cfDNA screens for fetal chromosomal abnormalities through the extraction of fetal DNA that is contained in a maternal blood sample. Recent guidance from the American College of Obstetricians and Gynecologists (ACOG) indicates cfDNA is the most sensitive and specific screening test for detecting common fetal aneuploidies. Fetal aneuploidies are conditions in which a fetus has one or more extra or missing chromosomes, such as trisomy 21 or trisomy 18. The American College of Medical Genetics and

Genomics (ACMGG) indicates that cfDNA has been rapidly integrated into prenatal care and new evidence suggests it can replace conventional screening for chromosomal abnormalities.

Current screening for chromosomal abnormalities in the PNS program relies on analysis of maternal blood samples for levels of two to four pregnancy hormones. The results are used to calculate the risk for two chromosomal abnormalities and neural tube defects. This screening is only available during certain critical periods of pregnancy.

Compared to the current PNS screening methodology, cfDNA has demonstrated superior performance and accuracy, may be performed at any time during a pregnancy, and provides more flexibility in the timing of testing for pregnant women. In addition, because cfDNA screening is diagnostic, rather than a risk-assessment, DPH expects adoption of cfDNA to reduce costs for public and private health care payers, as well as consumers with out-of-pocket costs, due to reduced need for follow-up screenings for chromosomal abnormalities, such as nuchal translucency examinations or amniocentesis. DPH estimates Medi-Cal would experience General Fund savings in the hundreds of thousands of dollars annually compared to current costs, beginning in 2022-23.

Staffing and Resource Request. DPH requests three positions and expenditure authority from the Genetic Disease Testing Fund of $4.3 million ($449,000 for state operations and $3.9 million for local assistance) in 2021-22, and $20.6 million ($449,000 for state operations and $20.2 million for local assistance) annually thereafter to implement cfDNA screening in the California PNS program. According to DPH, cfDNA screening would be offered to all pregnant individuals in California from 10 through 20 weeks of gestation and neural tube defect screening would be offered to all pregnant individuals between 15 and 20 weeks of gestation. DPH indicates it would require **two Health Program Specialist I** positions to support redesign of the current program and for ongoing program maintenance, and **one Health Education Consultant II** position to lead a new and ongoing statewide communication and education effort to reach all prenatal care providers and pregnant individuals. The request includes expenditure authority from the Genetic Disease Testing Fund of $449,000 annually to support these positions.

In addition, the request includes expenditure authority from the Genetic Disease Testing Fund of $3.9 million in the first year, to cover launch preparation costs for the new screening program, and $20.2 million in 2022-23 and annually thereafter to support the new screening program. According to DPH, this estimated local assistance cost assumes annual expected savings of approximately $6 million due to decreases in referrals for follow-up services due to the diagnostic capacity of cfDNA. DPH indicates it intends to contract with private laboratories to conduct the new screening.

In addition, DPH indicates the PNS fee would remain $221.60 for cfDNA, which is its current level. However, DPH would assess a separate fee of $75 for neural tube defect screening for pregnant individuals between 15 and 20 weeks of gestation, which would be established through the program's existing rulemaking process.

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. Why is DPH contracting with a private laboratory for this screening, rather than utilizing its existing laboratory resources?

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, February 16, 2021
Upon Call of the Chair
State Capitol - Room 4203

Consultant: Renita Polk

AGENDA PART B

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

5175 DEPARTMENT OF CHILD SUPPORT SERVICES (DCSS)

With a proposed 2021-22 budget of $1 billion ($333 million General Fund), the DCSS provides professional services to locate parents, establish paternity, and establish and enforce orders for financial and medical support. The department is also responsible for oversight of county and regional local child support agencies that work directly with families in the community.

Department of Child Support Services
Expenditures by Fund Source
* Dollars in thousands

Grand Total By Fund	Fiscal Year	
	2020-21	(Proposed Budget) 2021-22
General Fund	$315,354	$333,040
Federal Funds	$481,107	$571,172
Reimbursements	$123	$123
Child Support Collections Recovery Fund	$212,590	$157,447
Total All Funds	$1,009,174	$1,061,782

Issue 1: BCP – Child Support Payment Methodology Study

Governor's Proposal. The Governor's budget includes $750,000 ($255,000 General Fund) in 2021-22 and 2022-23 to contract for consulting services for data analytics and research to provide services to child support program participants.

Background. One of the central elements of the child support program is the establishment of "rightsized" child support orders that represent the parents' ability to financially support their child. To accomplish this task, the child support program adheres to statewide uniform guidelines. Every four years, the Judicial Council of California (JCC), in cooperation with the DCSS, reviews the statewide uniform guidance to recommend to the Legislature appropriate revisions. This review is referred to as the quadrennial review and is mandated to include economic data, such as the following:

- The cost of raising a child(ren).
- The treatment of income of a subsequent spouse or nonmarital partner.
- The treatment of children from prior or subsequent relationships.

In the JCC's report to the Legislature in the "Review of Statewide Uniform Child Support Guideline" on October 25, 2017, the JCC declared the importance of considering whether the current

guideline formula calculates appropriate child support obligations. The report notes that the child support formula used today was enacted in 1993. The report also details concerns about the "K factor." The K factor identifies the proportion of income used to support children within specific income brackets. It is a critical component of the guideline calculation for setting child support orders and has been called out as an area warranting further analysis and examination. The report also stressed the importance of considering labor market data in the guideline calculations.

Currently, there are over 846,000 child support cases that have an arrears balance, of which, only 564,000 have made a payment in the last fiscal year. Many of these without collections are due to parents that earn little to no income and carry the significant majority of the total statewide arrears balance (see Figure 1 below). Furthermore, a large portion of arrears are owed as government recoupment. Although DCSS makes progress in collecting arrears, the department needs data collected and analyzed to determine if these low income parents are able to pay their arrears and if the weight of government debt can be reviewed and compromised or determined as uncollectable.

Figure 1: Total and Average Amount of Arrears Owed by Income Bracket (in thousands)

Income Brackets	Total Arrears		Average Amount	
	Government	Family	Government	Family
No Reported Income	$1,346,127,574	$1,997,006,311	$21,232	$36,189
$0.01 - $10,000 annually	$1,761,750,931	$2,553,251,099	$17,735	$28,293
$10,000 - $20,000	$1,837,938,000	$2,869,980,680	$14,327	$22,302
$20,001 - $40,000	$1,332,088,959	$2,579,666,621	$12,384	$18,157
$40,001 - $60,000	$352,160,151	$901,682,698	$14,887	$20,419
$60,001 - $80,000	$122,384,916	$360,307,422	$15,745	$20,237
$80,001 - $100,000	$46,262,640	$164,614,175	$16,464	$21,390
$100,000 +	$60,194,673	$224,240,980	$19,840	$26,929
TOTAL	$6,858,907,845	$11,650,749,985	$15,737	$23,576

In 2019-20, the Governor vetoed legislation that eliminated the collection of interest that accrues on past due child support owed to the government. The Governor instead directed DCSS to review its Compromise of Arrears Program (COAP), the state's existing child support debt reduction program, and consider any needed program changes to address uncollectable debts and increase collections. The proposed study would evaluate the current COAP eligibility criteria and suggest additional factors (such as labor market conditions, parent's ability to pay, and other individual circumstances) that could be taken into account when determining COAP eligibility.

The requested resources for consulting services would support the department request to examine the appropriateness of the K factor in the mandatory statewide guideline review as well as provide improved data insights into the collectability of child support arrears. The DCSS currently lacks the expertise to statistically analyze and forecast collectability and data on various factors that may affect income and employment.

Staff Comment and Recommendation. Hold Open.

Part of the rationale the department gives for the proposal is that it does not have the in-house expertise to examine the appropriateness of the K factor. As discussed above, the JCC conducts a quadrennial review of statewide guidelines, including the K factor. Staff notes that there have been

several studies over the years examining the K factor. The 2018 quadrennial review conducted by the JCC did not propose an update to the K-Factor, in part, because "there is no perfect model" for estimating the cost of raising children and "each [study] has its strengths and weaknesses." It is unclear to staff how the proposed study is different from what is covered in the JCC's quadrennial review. Steps should be taken to ensure that the work proposed is not duplicative of the JCC quadrennial review.

The topic of arrears debt has been of interest to the Legislature for quite some time. SB 337 (Skinner), a bill that would have reduced debt on government owed child support payments deemed to be uncollectible, was vetoed with direction from the Governor to address the issue in the budget process. The Subcommittee may want to consider other items of legislative interest to include in the study, such as the issues SB 337 focused on. Staff notes that the recent legislatively driven workgroups included discussions of ways COAP eligibility and program rules could be modified to increase compliance with child support obligations owed to families and standardize the program across all LCSAs. The Subcommittee may want to request that the department provide a study of these issues in the proposal and request a draft of the research proposal and project time line to ensure that issues of interest are included prior to approval of funding. Additionally, the Subcommittee should also consider how the Legislature will be involved in implementing results of the proposed study. The Subcommittee may want to direct the department to present the findings from the study and any proposed changes resulting from it in future budget hearings.

In 2016, the federal government issued new child support program guidance, referred to as the Flexibility, Efficiency, and Modernization in Child Support Enforcement Programs (FEM) final rule. While the state already is in compliance with some components of the FEM final rule, it will need to make some changes to the guideline calculator to come into compliance with the new federal guidance. While originally required to be implemented by 2022, the federal government approved the state's request to extend the compliance deadline for those components until September 2024. The FEM final rule includes elements that impact child support guidelines and the state's quadrennial review process. The 2018 quadrennial review mentioned that additional research on components of the final rule, for example, whether a low-income adjustment accurately provides for the subsistence needs of parents, might be warranted. The Subcommittee could also consider using this research proposal as a vehicle to assess additional components of the FEM final rule.

Questions.

1. As detailed above, the JCC conducts a quadrennial review that includes a review of the K factor. How is the department working collaboratively with its Judicial Council partner to ensure that the proposed study is not duplicative of the JCC's quadrennial review?

2. What current and/or ongoing efforts has the department undertaken to reform its COAP program?

3. What options besides the K factor and COAP could the department consider in looking to address debt collectability?

4. How does the Administration plan to use the findings from the proposed research study?

Issue 2: BCP – Local Child Support Courts and Funding

Governor's Proposal. The Governor's budget includes $23.8 million ($8.1 million General Fund) ongoing for the Child Support Commissioner and Family Law Facilitator Assembly Bill (AB) 1058 program and for critical program staffing and information technology needs. $12 million ($4.1 million General Fund) will be used to increase the Judicial Council of California (JCC) contract, and $11.8 million ($4 million General Fund) will be used for personnel and operating costs at DCSS.

Background. A critical component of the child support program is the Child Support Commissioner (CSC) and Family Law Facilitator (FLF) Program established per AB 1058 (Speier), Chapter 957, Statutes of 1996. The purpose of the local child support court program is to provide a cost-effective, expedited, and accessible due process in the courts for establishing and enforcing child support orders for cases in which a Local Child Support Agency (LCSA) is responsible for. Each superior court is required to have a CSC to hear Title IV-D child support cases and an FLF office to provide legal assistance, forms, and information to self-represented litigants. Funds for the AB 1058 CSC and FLF program are provided through a cooperative agreement between DCSS and the JCC. The agreement designates a specific amount of funds for the CSC and FLF programs and requires the JCC to annually approve the funding allocations.

Since 2007-08, the AB 1058 program has been flat funded. Due to the program's flat funding, higher costs have resulted in reducing staffing levels. From 2014-15 to 2018-19, personnel costs have increased by more than 15 percent. As a result, the AB 1058 staff workforce has seen a 12 percent reduction.

This request would also allow DCSS to fill Information Technology (IT) positions to support its Child Support Enforcement (CSE) system and the new telework workforce. The requested funding will allow DCSS to move its CSE system into the cloud and to modernize the system to support teleworking staff.

Staff Comment and Recommendation. Hold open.

The 2020 budget included a reduction of $8.3 million General Fund to reduce state operation costs as part of statewide budget reductions in response to the coronavirus pandemic. This reduction was implemented via a decrease to the contract between the department and local courts and a decrease to operation costs at the department. The proposed funding would restore the reduction made to local court funding in the 2020 budget and provide an additional $1.7 million General Fund on top of that. The requested funding would not fully restore reductions made to the department's budget in 2020. Only $4 million of the $6 million reduction would be restored to the department.

Questions.

1. What is the impact of the $12 million for court funding? How many FTEs are expected to be added with this funding?

Issue 3: Local Child Support Agencies Funding Increase

Governor's Budget. The Governor's budget includes $25 million ($8.5 million General Fund) to fund basic costs at LCSAs. The additional funding would be allocated across 20 LCSAs with the highest case-to-staffing ratios as of September 2020.

Background. LCSA administration costs include salaries and benefits of county staff as well as operating costs. LCSA are responsible for case intake, court preparation to establish paternity and support obligations, and the enforcement of support obligations, including locating absent parents. LCSA administration costs are funded at $664 million for 2020-21 and $689 million for 2021-22. Funding for administration is 34 percent General Fund and 66 percent federal matching funds.

Previous Budget Actions. The topic of adequate LCSA funding has been a focus of the Subcommittee in recent years. In 2018, the budget include an additional $3 million General Fund for LCSAs as their funding levels had remained flat over several years. That same year, the Subcommittee directed the department and the LCSAs to work together to identify refinements to the existing budget methodology and identify operational efficiencies. The department submitted a report on that work to the budget committees in 2019 and the proposed 2019 Governor's budget included an ongoing funding methodology for LCSAs. The proposed funding methodology increased funding by $19.1 million in 2019-20, ramping up to $57.2 million in 2021-22.

During the 2019 budget deliberations, concerns were expressed about the inclusion of the identified operational efficiencies into the proposed funding methodology. Due to those concerns, the final 2019 budget only approved funding for the first year of the proposed funding methodology and included trailer bill language requiring the department to convene a series of stakeholder meetings to develop an ongoing funding methodology and to provide a written update to the Legislature describing recommended changes by February 1, 2020. That update was to be considered during the 2020 budget process. However, in response to the budget impacts of the COVID-19 recession the final 2020 budget reduced funding for the department and LCSAs. The 2020 budget reduced LCSA funding to 2018-19 budget levels, and the ongoing augmentation proposed in 2019 was not implemented.

Staff Comment and Recommendation. Hold open.

As mentioned above, the 2019 budget contained trailer bill language requiring the department to convene a series of meetings to develop an ongoing funding methodology to be considered during the 2020 budget deliberations. However, that discussion was tabled as a result of the COVID-19 pandemic. As that ongoing methodology has not been implemented the Subcommittee may want to revisit the child support funding structure and consider already identified program efficiencies and other policy changes to improve program operations before making further augmentations. Some of those program efficiencies include the consolidation of casework by income source, regional training, and other regional/shared services. The Subcommittee may wish to explore ways to implement and expand program efficiencies and policy changes that have been raised in previous workgroup reports, previously considered policy changes, and federally approved local pilot projects. In addition to possibly increasing child support compliance rates and customer satisfaction,

some of these changes also could provide workload relief, which would help LCSAs manage current funding reductions.

Questions.

1. How has the funding reduction implemented in the 2020 budget impacted LCSAs?

2. As mentioned above, previous budgets included language asking the Administration to identify operational efficiencies and to conduct stakeholder workgroups to discuss additional strategies that might improve customer service and cost efficiency of the child support program. As the ongoing funding methodology has yet to be implemented, what are some ways those identified efficiencies could be incorporated or considered in the ongoing funding methodology? Has the department implemented any of the previously identified efficiencies, such as the consolidation of casework by income source or regional/shared services? If not, why?

Issue 4: TBL – Local Child Support Agency (LCSA) E-Signature

Governor's Proposal. The Governor's budget includes trailer bill language allowing LCSAs to substitute "wet" signatures with electronic signatures on forms and to paper file forms with electronic signatures. The language also requires LCSAs to maintain electronic forms of documents with electronic signatures until the final disposition of the case and to make those documents available for review at the request of the court or any party of the action or proceeding.

The electronic signature solution can be expanded statewide at no additional cost if paper filing of electronic signatures is permanently authorized statewide.

Background. Current law and California Rules of Court promote the use of electronic signatures in the context of filing legal documents. Generally, however, only electronically filed documents may be signed electronically. For documents requiring signatures under penalty of perjury or signed by opposing parties such as a stipulation, an electronic signature may replace a "wet signature" only if the document is electronically filed. Only LCSAs whose courts have the ability to receive electronic filing may obtain the electronic signatures of case participants on documents.

Use of electronic signatures on documents requiring signatures from case participants has significantly improved completion times in general. Stipulations signed electronically by case participants have proven to be a key to efficiently modifying support during the COVID-19 pandemic. DCSS currently supports electronic filing within 20 California counties through its DocuSign solution. As many as 25 counties have documented abilities to electronically file legal documents via their court's public website and/or have standing emergency orders issued by their courts allowing the LCSA to paper file legal documents, such as stipulations, containing electronic signatures of parties, during the duration of the COVID emergency. Another 33 counties are still paper filing documents and do not have the ability to electronically file or use electronic signature technology. The proposed language would allow a statewide option to electronically file. An LCSA without the current ability to electronically file documents with their court would be able to utilize electronic delivery and electronic signature tools via the state's electronic signature tool account and to paper file the electronically signed legal pleadings with their local court.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposed language.

Issue 5: TBL – Suspension of Performance Incentives

Governor's Proposal. The Governor's budget includes trailer bill language suspending the performance incentive program for LCSAs until 2022-23.

Background. Family Code allocates additional funding to provide performance incentives to the top ten performing LCSAs. Currently, the funding level is set at five percent of the state's share of collections from the respective counties. These incentives have been suspended since 2002-03.

Allowing the suspension of FC 17706 to expire would result in a 100% SGF liability. Based on Federal Fiscal year performance and collection data, the estimated impact would be approximately $430,000. DCSS and the LCSAs have worked collaboratively to develop a new local administration funding model aimed at providing equitable resources to the LCSAs. The 2019-20 LCSA funding proposal included a new incentive model that gave DCSS more flexibility to disseminate incentive funding to the counties. However, funding for the department and local LCSAs was reduced in the 2020 budget. DCSS recommends continuing the suspension for two additional state fiscal years while the funding and incentive model is reevaluated.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposed language.

PROPOSALS FOR INVESTMENT RELATING TO CHILD SUPPORT SERVICES

The Subcommittee has received the following proposal for investment related to the DCSS. Note that proposal sponsors provided all information below, aside from staff comments and recommendations.

1. Adequate Funding of Local Child Support

Budget Issue. The Child Support Directors Association $19.2 million General Fund ongoing (matched with $37.3 million federal funds) to support local child support agencies.

Background. Between 2002 and 2018, funding for the child support program was held flat, forcing LCSAs to absorb operating cost increases within existing budgets. Exacerbating this problem was the absence of an allocation methodology, which resulted in significant funding variation between counties. That left many of the poorest counties with the lowest funding levels. Funding was increased by $56.5 million in 2019-2020, which was the first year of a proposed three-year series of funding increases. However, the 2020 budget reverted funding levels for LCSAs to 2018 levels, as a result of funding reductions made in response to the COVID-19 pandemic. The cumulative effect of long-term severe underfunding, particularly in California's poorest counties, has negatively impacted LCSA's abilities to effectively implement the program and to meet the needs of children and families, particularly those families that are living in poverty and are most in need of services from the child support program.

Staff Comment and Recommendation. Hold open.

Note that increasing funds for LCSAs will also result in increased federal funds of $37.3 million, for a total increase of $56.5 million. The proposed funding would restore that reduction. The Governor's budget includes a smaller augmentation of $25 million ($8.5 million General Fund) for LCSAs.

5180 DEPARTMENT OF SOCIAL SERVICES (DSS) – OFFICE OF EQUITY PROGRAMS

The Office of Equity was established in 2019 and reflects CDSS' commitment to serve all Californians. As a department providing food, shelter, safety and security, employment and job supports and training, CDSS is uniquely well-positioned to reduce structural inequities through its programs and practices.

CDSS has identified the following goals and strategies to advance equity:

- Foster a culture of diversity and inclusion that actively invites the contribution and participation of all people and is representative of the varied identities and differences (race, ethnicity, gender, disability, sexual orientation, gender identity, national origin, tribe, caste, socio-economic status, thinking, and communication styles), in California
- Use data to make inequities visible
- Advance equity through training, tools, and technical assistance
- Improve language access and access for communities with disabilities
- Support on-going partnerships with those communities most affected by inequities to advance equitable policy and systems changes

Issue 1: COVID-19 Direct Response Expenditures (Rapid Response Program)

Governor's Proposal. The Governor's budget includes $5 million for the department's Rapid Response Unit to support entities that provide critical assistance and services to immigrants during emergencies when federal funding is not available.

Background. The Rapid Response Program was created to provide critical humanitarian assistance that is often unavailable for some immigrants and their families during emergent situations. The program provides temporary assistance, such as shelter, food, and emergency medical care, through qualified and culturally competent entities.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.
2. Please provide detail on some of the activities that the program has carried out in response to the COVID pandemic.
3. Does the department anticipate a need for new funding with the discussion of federal changes to immigration policy?

Issue 2: BCPs - Increased Staffing Resources for Various Programs within the Office of Equity

Governor's Proposal. The Governor's budget includes the following proposals to provide additional support for various programs within the Office of Equity.

- $920,000 ($797,000 General Fund) for one SSM I and three AGPAs to comply with language access requirements through the implementation of a department-wide language access policy.

- $320,000 ($139,000 General Fund) for two AGPA positions to address increased workload in the department's Equal Employment Opportunity (EEO) Office.

- $450,000 ($281,000 General Fund) for three AGPA positions to address the workload related to integrating tribal consideration throughout the department.

- $316,000 General Fund for the next three years to fund two limited-term AGPA positions to meet immigrants' needs given the ongoing emergent situations.

Language Access Resources. The translation of CDSS program documents is a vital federal and state-mandated service that provides Californians with limited English proficiency have access to the programs and services administered by the department. Since 2015-16, the number of analysts within the Language Services Unit has been decreasing while the workload has been increasing. For the past three years, six analysts have been performing the job formerly performed by ten full-time analysts, greatly impacting the completion time and quality of translations. Nearly 30 percent of participants in CDSS' programs identify a language other than English as their primary language. CDSS must provide all people meaningful access to social services and this is only possible when all individuals can understand the vital documents that affect and explain their rights and responsibilities. The addition of the requested staff is projected to result in a 50 percent increase in the translations completed in the first year.

Equal Employment Opportunity (EEO) Office. The EEO Office provides agency wide leadership in advising management in the development, implementation, and maintenance of discrimination-free policies, procedures and practices, and ensures a work environment free from discrimination for all applicants and employees. CDSS is responsible for conducting investigations filed by members of the public receiving services from the department. The EEO Office responds to requests for information from the Department of Fair Employment and Housing, the Equal Employment Opportunity Commission, and the State Personnel Board when discrimination complaints are filed. CDSS is also responsible for conducting whistleblower complaint investigations. CDSS requires additional staff to complete the investigations within 180 days. Over the past seven years, CDSS has steadily seen an increase in EEO complaints (average increase of 20.6 percent). The number of complaints rose from 36 cases in 2014 to 128 cases in 2019. CDSS has taken steps to mitigate the rising workload by offering a mediation program instead of investigations when appropriate and agreeable to all parties involved. In addition, CDSS contracted with a vendor to provide automated transcription services to free up staff time from taking notes and then transcribing them. However, additional resources are still needed to meet the goal of completing investigations within 180 days.

Office of Tribal Affairs (OTA). The OTA was established in 2017 to fulfill legal and regulatory mandates involving compliance with the Indian Child Welfare Act (ICWA) and engagement with the Indian tribes in California. CDSS' engagement with the ICWA and tribal issues is based on legal requirements that mandate application of specialized laws whenever Indian children are involved in child custody proceedings. Currently, issues are identified and brought forth to CDSS by counties, tribes, and stakeholders. These issues are logged and tracked and then disseminated to the proper CDSS policy shops for response, which assists CDSS to meet its legal and regulatory obligations to tribes, counties, or other stakeholders. The tasks of tracking tribal issues as they span throughout the department presents difficulties that challenge compliance. The requested resources will allow CDSS to more closely monitor regulatory developments and initiatives that affect tribes and Indians in California in a way that includes them to the greatest extent practicable and permitted by law. The requested AGPAs will provide oversight in the coordination and facilitation of regional roundtables (three per region) comprised of county and tribal social services personnel, county counsels, and judges. This includes the establishment of workgroups and taskforces to address tribal concerns as identified through tribal communication.

Rapid Response Unit within the Immigration Services Bureau. The Rapid Response Unit was created in 2019 to develop and implement disaster assistance efforts primarily for undocumented immigrants. This unit is responsible for responding to emergency situations, where federal assistance is unavailable. The services provided are designed to meet urgent short-term needs and include shelter, food, and medical assistance. Since program implementation in 2015, CDSS has experienced significant program growth through an expansion of funding and scope of services provided. In 2020-21, two new programs, the Immigrant Legal Fellowship and ongoing DACA legal services, will require development and implementation. The requested positions will provide oversight as well as technical assistance, reporting, and site visits.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposals for additional staffing resources within the Office of Equity.

2. Please describe the progress made in the Immigrant Legal Fellowship program and the impact the department anticipates it will have over the next five years.

Issue 3: TBL – Flexibility in Allocation of Refugee Support Services Funds

Governor's Proposal. The Governor's budget includes trailer bill language to provide DSS with the authority and discretion to allocate declined or returned Refugee Support Services (RSS) funding and supplemental or targeted funding from the Office of Refugee Resettlement (ORR) to other service areas (i.e., refugee-impacted counties or qualified nonprofit organizations).

Background. Per Welfare and Institutions Code (WIC) Section 13276, California allocates appropriated federal funds for refugee social services programs to each eligible county and, if the department chooses, to a qualified nonprofit organization, based on the number of refugees receiving aid in the eligible county or the number of refugees that reside in the eligible county. If a county declines or returns funding, DSS does not have the authority to use this funding for other counties with identified needs. WIC Section 13276 requires CDSS to distribute all RSS funding, including the annual appropriation from ORR and any declined or returned funds proportionally to all eight refugee-impacted counties. There are no applicable waivers or other authority that would allow deviation from the statute's proportional distribution system. WIC Section 13276 also requires that supplemental funding from ORR (i.e., funding provided in addition to the annual appropriation) and funding from ORR designated for services for a specific population of ORR-eligible individuals (e.g., older refugees) be distributed proportionally among all eligible counties.

The proposed change in language will allow DSS to reallocate declined or returned funding to better respond to the needs of eligible refugee populations.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposed language and discuss why the department is seeking additional flexibility in this program.

2. How often is it that counties return or decline RSS or ORR funding? What are some of the reasons a county would decline funding?

5180 DEPARTMENT OF SOCIAL SERVICES (DSS) – CHILD WELFARE SERVICES

Issue 4: Child Welfare Pandemic Response Proposals

Governor's Proposal. The table below, provided by the Legislative Analyst's Office, details the proposals in the Governor's budget relating to COVID-19 response within child welfare.

Figure 4

State Funds for Pandemic Response Within Child Welfare Programs

(In Thousands)

	2019-20[a]	2020-21[b]	2021-22[c]
Cash cards for families at risk of foster care	$27,842	$28,000	—
Family Resource Centers funding	3,468	7,000	$6,000
State contracts for technology (laptops and cell phones) and hotlines for foster youth and families[d]	—	2,042	1,750
Administrative workload for child welfare social workers (overtime and pandemic outreach)	5,000	—	—
Rate flexibilities for resource families directly impacted by pandemic	3,005	9,136[e]	3,458
Flexibilities and expansions for NMDs/former NMDs who turn 21 or lose otherwise lose eligibility for EFC due to pandemic	1,846	37,133	49,487
Pre-approval funding for emergency caregivers beyond 365 days	1,312	1,234	—
Totals	**$42,473**	**$84,545**	**$60,695**

[a] For 2019-20, funds were provided April through June 2020. Activities were approved by the Legislature through the Section 36.00 letter process.

[b] For 2020-21, pandemic-response activities are proposed by the administration for January through June 2021 for all actions other than flexibilities and expansions for NMDs. The Legislature has not yet approved these activities for 2020-21, with the exception of flexibilities and expansions for NMDs, which were included in the *2020-21 Budget Act* and are in place July 1, 2020 through June 30, 2021.

[c] For 2021-22, funds are proposed by the administration for July through December 2021.

[d] Funding for state contracts for technology and hotlines in 2019-20 is included in the amount for Family Resource Centers funding.

[e] Includes $5.678 million funding from DREOA.

Note: Where applicable, amounts include assistance plus administration costs.

NMD = non-minor dependents; EFC = extended foster care; and DREOA = Disaster Response Emergency Operations Account.

Note that 2019-20 funding ended June 30, 2020. For all 2020-21 actions, other than flexibilities and expansions for nonminor dependents (NMDs), funding amounts listed in the figure reflect new proposals from the Administration as part of the 2020-21 revised budget at the time of the 2021-22 Governor's budget proposal. The Administration has indicated the proposed activities would begin in January 2021.

Background. On March 4, 2020, Governor Newsom declared a state of emergency and President Trump declared a national emergency on March 13, 2020. The funding granted from the emergency declarations for CDSS programs is to provide for the mass care, food, shelter, and essential services necessary to ensure the safety and protection of vulnerable Californians in this time of crisis. The department continues to provide funding through the regular Budget Act process, the federal Coronavirus Relief Funds (CRF), and the Disaster Response-Emergency Operations Account. Due to the timing of the recent Congressional action and Presidential approval, the DSS budget will need to be adjusted to reflect the additional federal support coming to California and its impact on the department's programs.

Staff Comment and Recommendation. Hold open.

As mentioned above, funding for the 2019-20 proposals ended on June 30, 2020, and the Administration has indicated that proposed activities in the 2020-21 revised budget would begin in January 2021. Staff notes that there appears to be a funding gap between July 2020 and January 2021. It is unclear whether activities have continued during that interim period and if authority is needed for counties to continue (or re-launch) these supports in 2020-21. The Subcommittee may want to inquire about the status of these activities and their funding mechanisms between July 2020 and January 2021.

Questions.

1. Please provide a brief overview of the proposals in the Governor's budget relating to pandemic response in child welfare.

2. For pandemic response proposals where funding ended in 2020 – have counties continued implementing these proposals? If so, have counties been using county funds to do this?

3. What is the funding mechanism for newly proposed pandemic response activities in the current year (set to begin January 2021)?

Issue 5: BCPs – Increased Staffing Resources for Various Programs within the Child and Family Services Division

Governor's Proposal. The Governor's budget includes the following proposals to provide additional support for various programs within the Child and Family Services Division.

- $499,000 ($281,000 General Fund) for two Associate Governmental Program Analysts (AGPAs) and one Staff Services Manager I (SSM I) to support California Child and Family Services Reviews (CFSR) quality assurance.

- $9.8 million ($6.7 million General Fund) for a total of 56 positions to manage increasing responsibilities, ensure state and federal compliance, and continue implementation and alignment between the Continuum of Care Reform and the federal Families First Prevention Services Act (FFPSA).

- $949,000 ($765,000 General Fund) for permanent positions to support the increasing workload of the Office of the Foster Care Ombudsperson. The proposal would make six limited-term positions permanent. The positions include one Staff Services Manager II, one SSM I, and four AGPAs.

- $767,000 ($441,000 General Fund) for permanent positions to provide oversight and monitor data required for child welfare reporting purposes. The positions include one SSM I and four AGPAs.

CFSR Background. The federal Administration for Children and Families (ACF) conducts Child and Family Services Reviews (CFSRs) approximately every four years. The federal review requirement states that the child welfare agencies must ensure that they are operating in the jurisdictions where the services are provided, have standards to evaluate the quality of services, identify strengths and needs of the service delivery system, provide relevant reports, and evaluate implemented program improvement measures. Resources are needed to help the state pass this requirement for the next CFSR.

The three requested positions will be responsible for the research, development, and execution of a new training curriculum, and provide on-site technical assistance to all 58 counties. The staff will be responsible for creating, implementing, monitoring, evaluating, and revising a training curriculum that will support the analytic and evaluative responsibilities required for completion of County Self Assessments and System Improvement Plans as part of the CFSR process.

Continuum of Care Reform (CCR) and FFPSA Implementation. Assembly Bill 403 (Stone), Chapter 773, Statutes of 2015, codified the CCR framework for state and local governments to implement child-and-family centered reforms and to develop a continuum of integrated child-welfare and behavioral health supports designed to meet the needs of children and families served by the child welfare system. The FFPSA mandated significant changes related to court hearings and congregate care. These changes to the licensing requirements and program standards increase oversight requirements and requires access to new services that are trauma informed. DSS must develop a policy and outcome framework that aligns the CCR implementation and other statewide work with FFPSA requirements. Several active steps are in process to bring individual elements of

California's system into compliance with the FFPSA Part IV requirements. DSS conducts county audits and reviews to meet its obligations for oversight of child welfare programs and to ensure the protection of children and families. FFPSA will increase and add new workload to the existing monitoring and oversight process. The FFPSA transition workload will put a strain on the state's ability to continue to provide the same level of technical assistance to counties, including the development of corrective action plans. The CCR project teams are in the best position to continue this progress while concurrently transitioning to implement the FFPSA requirements. Note that the FFPSA will be discussed in more detail in the next agenda item.

Office of Foster Care Ombudsperson. The Office of Foster Care Ombudsperson (OFCO) was created by statute in 1998 as an autonomous entity within CDSS to protect the interests of children in foster care by providing them a means to make complaints and resolve issues related to their care, placement, services, and rights. The OFCO conducts impartial investigations and provides a systemic accountability mechanism by recommending system-wide policy recommendations to the Legislature, Governor's Office, and Child Welfare organizations across California.

Additional legislative mandates have increased responsibilities and the number and type of calls made to the OFCO. AB 175 (Gipson), Chapter 416, Statutes of 2019, expanded the Foster Youth Bill of Rights and required oversight duties of the office, including providing training and technical assistance on the rights of children and youth in foster care. AB 2247 (Gipson), Chapter 674, Statutes of 2018, expanded the role of the OFCO to investigate, resolve, and provide formal recommendations to county directors regarding placement stability complaints. The impact and resources needed to address the workload are higher than originally anticipated. Between 2018-19 and 2019-20, the OFCO had a 422 percent increase in complaints regarding foster youth placement instability. In 2019-20, CDSS received limited--term funding to address the increased workload resulting from the legislative mandates to the foster care system. From 2018-19 to 2019-20, calls to the office increased by 31 percent and monthly cases increased by 64 percent. This proposal seeks to align the continuing workload that CDSS has incurred due to these legislative mandates with the need for ongoing authority.

Data Monitoring for Child Welfare Reporting Purposes. CDSS has a fiduciary responsibility to the federal government to ensure that government-funded programs use federal funding for their intended purpose and per all federal regulations. Beginning in 2020-21, CDSS will conduct biennial county monitoring reviews to ensure compliance with the federal Comprehensive Child Welfare Information System (CCWIS) data quality oversight requirements. CCWIS compliance ensures continued enhanced federal financial participation for the maintenance and operation of the current Child Welfare Services Case Management System (CWS/CMS), as well as the development and implementation of its replacement, the California Automated Response and Engagement System (CWS-CARES). Increasing workload demands have caused a reduction and delay in completion for the data quality county review tasks. Current CDSS staff perform on-site county reviews and review all CDSS programs for various aspects of administration, such as fiscal integrity, program model fidelity, and program outcomes; even with this already heavy workload, there is no dedicated staff for monitoring data quality.

The proposed resources are critical to responding to current and new child welfare services requirements. The CWS/CMS receives millions of data entries per year, requiring dedicated resources to review the data collection, reporting, and storage. These issues need to be assessed promptly to support the achievement of safety, well-being, and permanency for children. Incomplete

or inaccurate data can compromise the safety and wellbeing of at-risk children and can expose them to increased risk of abuse, exploitation, and maltreatment. The requested resources will improve program outcomes by managing local data quality more consistently and effectively.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposals for increased staffing resources within the Child and Family Services Division.

2. In December 2020, the department notified the Joint Legislative Budget Committee of its unanticipated need for additional funding due to the decertification of out-of-state facilities and the need to quickly relocate returning foster youth from out-of-state care. How will the requested positions help in serving and monitoring those returning youth? What are the department's plans to ensure these youth are cared for in the future?

3. Please discuss the role of the Foster Care Ombudsperson. Has the Ombudsperson's involvement in placement stability issues resulted in better use of best practices or a reduction in placement instability?

Issue 6: FFPSA Implementation

Governor's Proposal. The Governor's budget includes $42.7 million General Fund for the implementation of the federal FFPSA, which reflects an October 2021 implementation date. The budget also includes trailer bill language for this purpose. However, language was not available at the time of the writing of this agenda.

Background. The FFPSA was enacted in 2018. A major change implemented by Part I of the legislation was a change in the way that Title IV-E funds could be spent by states. Before the FFPSA, IV-E funds could only be used to help with the costs of foster care for eligible children, administrative expenses to manage the program, training for staff and foster parents, adoption assistance, and kinship guardian assistance. With passage of the FFPSA, states now have the option to use these funds for prevention services that would allow "candidates for foster care" to stay with their parents or relatives. States must submit a prevention plan and use evidence-based services to take advantage of this option and be eligible to receive federal matching funds for prevention services. Note that the budget does not include funding to implement Part I of the FFPSA. The DSS has indicated that the state will implement Part I at a later time.

The budget provides funding for the implementation of Part IV of the FFPSA. Part IV of the FFPSA puts in place new requirements surrounding congregate care placements. Generally, Part IV aligns with the state's commitment to reduce reliance on congregate care, embodied in the state's Continuum of Care Reform (CCR). CCR is a large-scale overhaul of the foster care system set into motion in 2015, with the release of the department's report entitled "California's Child Welfare Continuum of Care Reform." The report listed recommendations to improve assessment of children and families to make more appropriate initial placement decisions; emphasize home-based family care; support placement with available services; change the goals for group home care placement; and, increase transparency for child outcomes.

Some changes are needed to further align CCR with the FFPSA. One major component of CCR was the creation of Short-Term Residential Treatment Placements (STRTPs), which are intended to replace group homes and provide short-term, therapeutic services to stabilize children so that they may quickly return to a home-based family care setting. The FFPSA now requires California's STRTPs to provide 24/7 access to nursing consistent with their treatment model, a minimum of six months of aftercare services when a youth exits an STRTP placement to a family-based setting, and have all placements assessed by a qualified individual. Consequently, there will be additional county staff time and training required to develop these changes and meet the new requirements. The CDSS is collaborating with the Department of Health Care Services to ensure joint implementation of the new federal requirements and integration of services across programs. Other requirements of the FFPSA include the provision of at least six months of specified support services for youth and families after a youth exits congregate care, enhanced assessment and reporting around congregate care, additional training of court staff, judges, social workers, providers, and other individuals involved in the assessment process.

Staff Comment and Recommendation. Hold open.

As mentioned above, Part I of the FFPSA provides federal matching funds to help states prevent entries into the foster care system. More specifically, it provides a $1 match for $1 spent by states on certain prevention services. Currently, local family maintenance and family preservation programs provide voluntary and/or court-ordered prevention services but there is very little federal funding available for this purpose, aside from the FFPSA. The Subcommittee may wish to inquire as to why the department has chosen to delay implementation of Part I and the leveraging of additional federal funds.

As mentioned above, elements of CCR must be modified for the state to comply with the FFPSA. The FFPSA requires a qualified individual (QI), who is medically certified, to assess and report on the appropriateness of all STRTP placements. The administration's plan includes funding for QIs to participate in Child and Family Teams (CFTs), conduct the Child and Adolescent Needs and Strengths (CANS) assessment, and prepare required court documentation for all STRTP placements. However, there are certain elements of CCR that have yet to be fully implemented, such as the CFT. CFTs provide input to help determine the most appropriate placement for youth based on the youth's behavioral and mental health needs and other criteria.

Generally, the department, along with other partners, provides an update to legislative staff on CCR quarterly. However, due to the COVID public health emergency, the most recent update was canceled and has not been rescheduled. The Subcommittee may want to inquire about the status of CCR and the remaining elements to be implemented. This update will also help the Subcommittee and staff better understand the intersection between CCR and the FFPSA. The Subcommittee should be updated on how CCR is being implemented to better understand the intersection between CCR and FFPSA.

Questions.

1. Does the department have a plan in place to implement the optional Part I section of the FFPSA in the future?

2. Please detail the current department administered family maintenance and preservation programs, if any.

3. How will the transition to FFPSA enable California to ensure a more complete continuum of services for at risk youth?

Issue 7: TBL – Approved Relative Caregiver Funding Eligibility

Governor's Proposal. The Governor's budget includes trailer bill language that would allow children and nonminor dependents to participate in the Approved Relative Caregiver (ARC) Funding Program if placed out of state. With 308 children per year residing outside of CA, the General Fund impact per year is $1.87 million.

Background. The ARC Funding Program was designed to provide payments to caregivers of children and nonminor dependents, who are not eligible for federal Aid to Families with Dependent Children-Foster Care (AFDC-FC) payments. ARC payments are comprised of the applicable CalWORKs payment and supplemental general funds to bring the payment amount up to what the child or youth would receive were they covered by AFDC-FC funding. Welfare and Institutions Code Section 11461.3 established the ARC Funding Program and outlined the eligibility requirements for a child or nonminor dependent to receive payments. The current language excludes children and nonminor dependents who are placed with a relative outside of California, creating an inequity for these youth and their caregivers.

Currently, county practice ranges from recommending that this group of relative caregivers apply for CalWorks, paid for with county-only funding, to some instances in which no payment is made. Relatives of a child or nonminor dependent may live in another state, yet maintain a relationship with the youth. Changing this language will allow youth the option to live with these relatives, while upholding the efforts to foster family connections. As of September 2020, there are only 308 of these types of placements.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of the proposed language.

PROPOSALS FOR INVESTMENT RELATING TO CHILD WELFARE SERVICES

The Subcommittee has received the following proposals for investment related to the child welfare programs within the DSS. Note that proposal sponsors provided all information below, aside from staff comments and recommendations. Staff recommends all proposals be held open.

1. Increase Funding for the Emergency Child Care Bridge for Foster Children

Budget Issue. Children Now, the Child Care Resource Center, the Alliance for Children's Rights, the California Alternative Payment Program Association, the Child Care Alliance of Los Angeles, Child Care Providers United, the County Welfare Directors Association, and the USC Suzanne Dworak-Peck School of Social Work requests an additional $37 million General Fund ongoing for the Emergency Child Care Bridge Program. This will add to the $41 million already allocated for the program, bringing total funding to $78 million.

Background. The Emergency Child Care Bridge for Foster Children Program has been a huge success in addressing the timing gap for foster children to access child care. When children are removed from their homes, they are in crisis and prospective resource parents - often relatives - instantly need access to child care in order to care for their new family member and keep their jobs. Yet, state-subsidized child care programs typically operate at full capacity, with short enrollment windows that rarely align with a child's placement into foster care. This makes it nearly impossible for caregivers who work to take in young children. The Emergency Child Care Bridge was designed to address this "timing gap" so that children can be promptly placed and stabilized with loving relatives or with the right resource family. The program can help to alleviate some of the extra strain that COVID-19 has placed not only on resource families, but also on both the child welfare and child care systems. The requested funding would make the voucher available for roughly half the children in foster care between the ages of 0 to 12 (18,743 based on July 1, 2019 data).

Staff Comment and Recommendation. Hold open.

2. Improve Permanency Outcomes for Foster Youth: Reinvest in Foster Family Agency (FFA) Social Workers

Budget Issue. The California Alliance of Child and Family Services and the National Association of Social Workers, California chapter request $5.4 million General Fund ongoing to help stabilize the FFA social worker workforce.

Background. Multiple research studies show that the loss of a social worker significantly disrupts the permanency process and severs another bond creating a loss of trust and re-traumatization for the children and youth. National studies have proven that with each loss of a social worker, the rate of achieving permanency drops dramatically from 74.5% with one social worker to less than a 2% success rate of achieving permanency with three or more social workers. Child welfare social workers employed by FFAs experience a 59% turnover rate over a period of two years. The primary reason for the high turnover rate is the inability to pay competitive salaries due to the low pay rate for FFA social workers. The General Fund request of $5.4 million and $1.5 million in federal matching funds will help offset the inadequate funding of the FFA rate. The current FFA rate was

created in 2016 to be an "interim" placeholder with the plan to evaluate and create permanent rates by December 31, 2017. Unfortunately, that work has been postponed four times and will be postponed again this year. Providing additional supports to social workers will help children and youth develop strong and healthy relationships, even in challenging times, and will increase reunification, guardianship and adoption.

Staff Comment and Recommendation. Hold open.

3. Child Welfare Caregiver Stipend

Budget Issue. The Alliance for Children's Rights and Children Now request $73.2 million General Fund one-time to provide a $100 a month stipend for children placed in a resource family with an approved relative caregiver and all K-12 foster students.

Background. COVID-19 is having outsized impact on communities of color with low income Americans enduring more job losses, more difficulty getting food and medicine, and higher levels of debt. Resource parents are taking on ever more challenging and complex roles as they support the children in their care with distance learning, accessing behavioral and other supports virtually, and managing remote visits with social workers, other support services professionals, and family. This funding would be provided to all children placed in a resource family, with an approved relative, in an emergency placement, or in any other family home. This focus on supporting children in their placements will address the significant real-time impacts of the COVID-19 crisis on children and youth in foster care including the significant increase in time spent managing family visitation, social worker visits, medical and mental health visits and services and distance learning.

Staff Comment and Recommendation. Hold open.

4. Cash Assistance for CalWORKs Families with Children in Foster Care

Budget Issue. The County Welfare Directors Association (CWDA) requests $9 million General Fund ongoing to provide CalWORKs families whose children have been placed into foster care to receive monthly cash assistance for a period of up to 180 days while active reunification efforts are ongoing. The request also includes $500,000 for automation costs in 2022-23.

Background. Currently, CalWORKs families whose children have been removed from the home and placed in foster care cease to be eligible for CalWORKs monthly cash assistance payments. Removing cash assistance from a family that is already below the poverty line worsens housing insecurity for the family and makes reunification harder to achieve. While the child welfare agency cannot remove a child from a family due solely to homelessness, a judge cannot reunify a child to an unsheltered parent. Any parent whose eligible child or children have been removed from the home and placed into foster care while their CalWORKs case is open may be entitled to receive CalWORKs services if the county determines the services are necessary for family reunification and the parent has a family reunification plan. However, those parents are not eligible to continue to receive cash grants along with the services while reunification services are being provided. By maintaining monthly cash assistance to CalWORKs families while their children have been temporarily removed from the home, this proposal would provide greater financial stability to families seeking to reunify with their children, thereby improving outcomes for reunification.

Staff Comment and Recommendation. Hold open. Note that in the 2019-20 legislative session this proposal was put forth as a policy bill (SB 1341 (Hurtado)). However the bill was vetoed by the Governor with the direction to address the issue during the annual budget process.

5. Child Welfare Services: Prevention Services

Budget Issue. CWDA requests $50 million in 2021-22 and $100 million General Fund ongoing, matched with an equal amount of federal funds, to support counties in building services and supports to avoid foster care entries and prevent child maltreatment.

Background. Historic legislation passed by Congress provides California the opportunity to invest in vulnerable families to prevent foster care entries, and to use this new structure as a jumping-off point for investments to address the disparities shown in systemic data over time. The Federal Families First Prevention Services Act (FFPSA) of 2018 provides $1 match to every $1 invested for certain evidence-based prevention services. In order to capitalize on this new funding opportunity and help families, initial and ongoing state investment is needed to build service capacity and infrastructure. The proposal includes $45 million in 2021-22 and $95 million ongoing for local, community-driven programming, $4 million ongoing for state infrastructure, and $1 million ongoing for training.

Staff Comment and Recommendation. Hold open. Note that a policy bill (AB 3272 (Reyes)) related to FFPSA implementation was put forth in the 2019-20 legislative session but was not acted upon by the Assembly Appropriations Committee.

6. Supporting Vulnerable Minors in Extraordinary Times

Budget Issue. The Alliance for Children's Rights and the California Coalition for Youth requests $1.5 million General Fund in 2021-22 and $2.2 million in 2022-23 and 2023-24 to support minors unable to access foster care due to court closures or delays as a result of the COVID-19 pandemic. This request also includes trailer bill language to enact this change.

Background. Older youth often face barriers in accessing foster care as they may be determined to be less at risk than younger children. Sufficient data to back this statement has been difficult to prove, as evidenced by a 2019 report from the Legislative Analyst's Office (LAO) entitled Older Youth Access to Foster Care. The report finds that maltreatment substantiation rates for older youth have consistently been below younger youth; yet, it was difficult for the LAO to make more definitive conclusions due to the lack of available data. Timely entry is critical for older youth in need of support who are removed from their homes due to allegations of abuse or neglect, who often require immediate assistance with housing, transportation, and food, and are at high risk for homelessness and aging out of eligibility for services. The added stressors of the public health and economic crisis caused by the COVID-19 pandemic are creating additional pressures for youth, who are at more of a risk for reduction in hours or job losses as a result of the Stay at Home orders.

The proposal would allow a narrow exception for those older minors so that they have access to the supports and services of extended foster care when the youth has been removed from their home and the court finds that it is in their best interest to enter extended foster care. The provisions in the proposed trailer bill will sunset on January 1, 2023.

Staff Comment and Recommendation. Hold open. Note that there is a policy bill authored by Assemblymember Gipson in the current 2021-22 legislative session associated with this request.

7. Ensuring that STRTPs Achieve Stability Through One-Time COVID-19 Relief

Budget Issue. The California Alliance of Child and Family Services requests $30 million General Fund in 2021-22 and $12 million in 2022-23 to provide a one-time budget allocation to stabilize STRTPs.

Background. Short Term Residential Therapeutic Programs (STRTPs) are an integral component of the CCR continuum, providing a critical therapeutic intervention for foster youth needing a high level of care that addresses their trauma and mental/behavioral health needs in a temporary residential setting, with the goal of stabilizing them and enabling them to transition to home-based care and permanency. STRTPs have been severely impacted by the COVID-19 pandemic as organizations struggle to maintain the health and safety of the youth in their care and the staff who are committed to supporting them. The added expenses they have absorbed are posing a significant threat to their operations. STRTPs have incurred additional costs relating to unreimbursed staffing, dedicating facilities for isolation and quarantine, the purchase of personal protective equipment, and the loss of revenue due to holds placed on admissions to maintain health and safety.

Staff Comment and Recommendation. Hold open.

8. Funding for the Parents Anonymous Statewide Helpline and Parent, Children, and Youth Groups

Budget Issue. Parent's Anonymous requests $3 million per year over the next three fiscal years to support the Parents Anonymous Helpline.

Background. Data from the Child Help National Child Abuse Hotline indicates a huge increase in the number of calls and texts during the COVID pandemic. Rather than reporting abuse, many of the callers are concerned parents seeking support and help with COVID-19 specific concerns. Families are experiencing stresses and pressures brought on by unemployment, concerns about evictions or foreclosures, loss of credit and their children falling behind in school. While the pandemic may ease in the near future due to the availability of vaccines, the impact of the pandemic will undoubtedly linger on for quite some time. Thus there is a need to continue the provisions of services currently being provided by Parents Anonymous.

Staff Comment and Recommendation. Hold open.

9. Preventing and Reduce Foster Youth Homelessness

Budget Issue. John Burton Advocates for Youth requests $18.2 million in 2021-22 and $22 million annually thereafter to help provide housing stability for current and former foster youth.

Background. Current and former foster youth experience homelessness and housing instability at greater rates than the general population. During the COVID-19 crisis, maintaining stability is increasingly more difficult for this population, who are disproportionately impacted by job loss and the looming housing crisis. Unlike the general population of young adults, foster youth do not have the emotional or economic support of an extended family. Hardships exacerbated by the pandemic

include unemployment, homelessness, and long waiting lists for housing. The requested funding would be used to train child welfare workers and probation officers on the housing/homelessness response system, establish a THP-Plus Housing Supplement Program, and establish permanent Housing Navigator and Transitional Housing Programs.

Staff Comment and Recommendation. Hold open. Note that there is a policy bill (AB 413 (Ting)) pending in the current legislative session associated with this request.

10. Healthy Futures for Foster Youth – Extending the Infant Supplement

Budget Issue. John Burton Advocates for Youth, the Alliance for Children's Rights, Black Women for Wellness, the Children's Law Center of California, and the National Center for Youth Law request $729,000 ongoing to extend the infant supplement payment.

Background. Foster youth experience disproportionately high rates of pregnancy, face greater hurdles in preparing for birth than their non-foster peers, and incur greater costs due to poor birth outcomes. Youth navigating these challenges are disproportionately youth of color. California currently provides a supplemental payment to parenting foster youth to assist with the care and supervision of their child. This payment is known as the infant supplement and is provided upon the birth of their child. This proposal would start the infant supplement three months prior to the expected delivery date to ensure expectant foster youth are equipped to prepare for the birth of their child.

Staff Comment and Recommendation. Hold open. Note that there is a policy bill (AB 366 (Rubio)) pending in the current legislative session associated with this request.

11. Fully Fund the Resource Family Approval Workload in the CCR True-Up

Budget Issue. The County Welfare Directors Association requests $80million General Fund annually to fully fund costs associated with the resource family approval (RFA) workload.

Background. The state constitutional provisions of Proposition 30 require that the stat fund the net costs to each county of any new state child welfare requirements or programs enacted after 2011 and provides that counties only implement those new requirements to the extent state funding is provided. The CCR True-up is the county-by-county reconciliation of savings and costs resulting from CCR implementation. The current estimate of costs associated with the RFA workload is $80 million. Counties have been fronting these costs without reimbursement due to a disputed interpretation of the constitutional requirements of Proposition 30. The Administration believes the RFA process was in statute prior to 2011 realignment and, therefore, believes all costs associated with the statewide RFA process are a county responsibility. Although the RFA process was in statute prior to 2011, it was only a pilot project in five counties and no statewide mandate existed for RFA in statute prior to 2011. CWDA disagrees with this interpretation and requests the state provide funding.

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.

Friday, February 19, 2021
9:00 a.m.
State Capitol - Room 3191

Consultant: Scott Ogus

Item **Department** **Page**

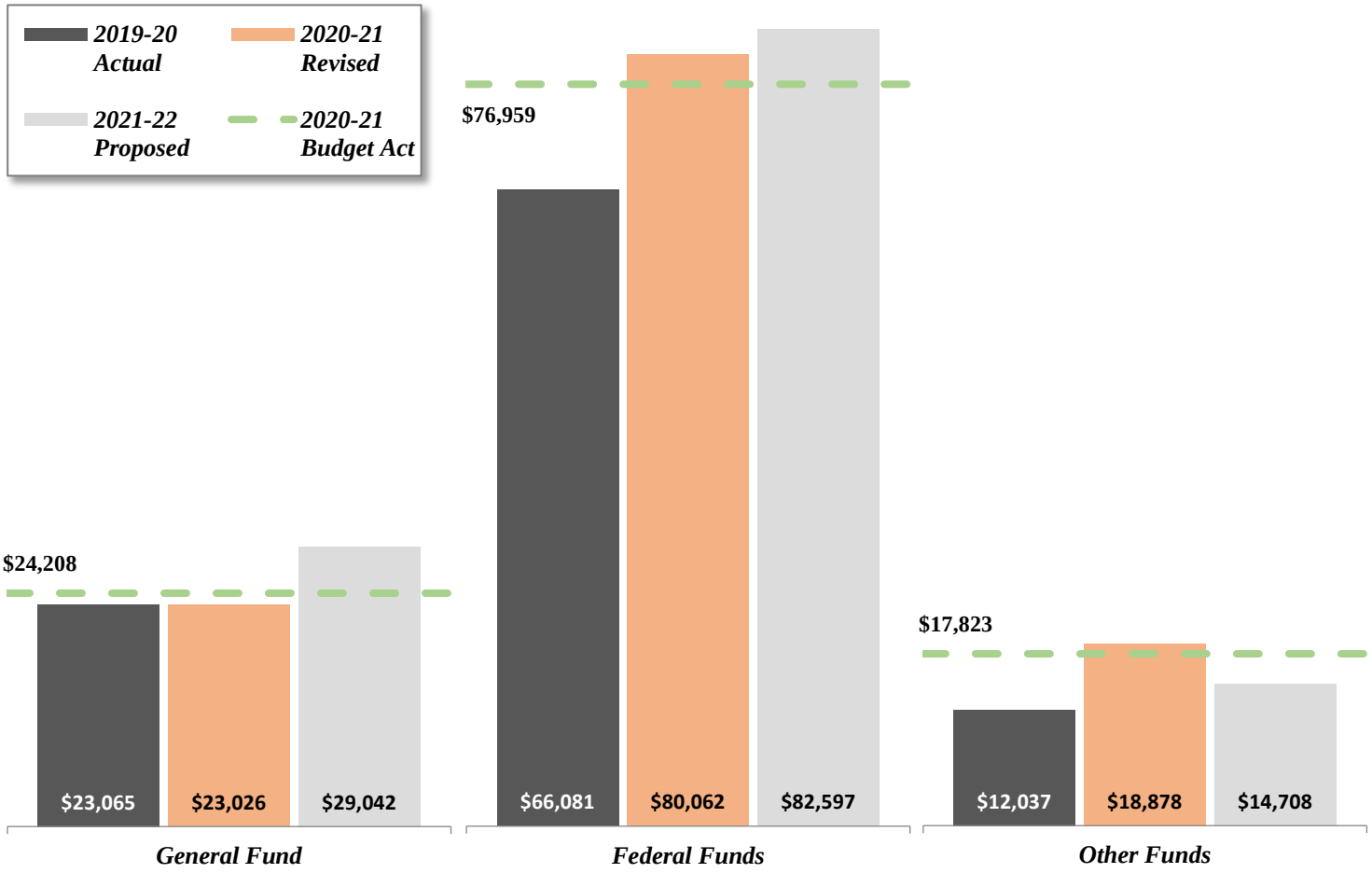
PUBLIC COMMENT

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

Department of Health Care Services – *Three-Year Funding Summary*
(dollars in millions)



Department of Health Care Services - *Department Funding Summary*			
Fund Source	**2019-20** ***Actual***	***2020-21*** ***Revised***	***2021-22*** ***Proposed***
General Fund	$23,065,202,000	$23,025,574,000	$29,042,240,000
Federal Funds	$66,080,794,000	$80,061,565,000	$82,596,990,000
Other Funds	$12,036,917,000	$18,878,071,000	$14,708,372,000
Total Department Funding:	**$101,182,913,000**	**$121,965,210,000**	**$126,347,602,000**
Total Authorized Positions:	**3600.0**	**3607.0**	**3752.5**
Other Funds Detail:			
Breast Cancer Control Account (0009)	*$9,652,000*	*$10,659,000*	*$10,848,000*
Childhood Lead Poisoning Prev Fund (0080)	*$1,058,000*	*$1,058,000*	*$1,058,000*

DUI Program Licensing Trust Fund (0139)	*$1,331,000*	*$1,253,000*	*$1,383,000*
Hospital Svc. Account, Prop 99 (0232)	*$130,657,000*	*$92,170,000*	*$77,295,000*
Physician Svcs. Account, Prop 99 (0233)	*$40,862,000*	*$26,639,000*	*$22,072,000*
Unallocated Account, Prop 99 (0236)	*$75,287,000*	*$57,071,000*	*$47,770,000*
Narc Treatment Prog Lic Trust Fund (0243)	*$1,882,000*	*$1,795,000*	*$1,913,000*
Perinatal Insurance Fund (0309)	*$19,761,000*	*$14,150,000*	*$17,177,000*
Audit Repayment Trust Fund (0816)	*$67,000*	*$67,000*	*$67,000*
Medi-Cal Inpt Payment Adj Fund (0834)	*$86,491,000*	*$105,103,000*	*$112,886,000*
Special Deposit Fund (0942)	*$71,501,000*	*$83,530,000*	*$82,796,000*
Reimbursements (0995)	*$1,413,182,000*	*$2,306,400,000*	*$1,347,799,000*
County Health Init Matching Fund (3055)	*$176,000*	*$176,000*	*$176,000*
Childrens Med Services Rebate Fund (3079)	*$61,815,000*	*$77,636,000*	*$24,600,000*
Mental Health Services Fund (3085)	*$2,168,649,000*	*$2,146,684,000*	*$2,309,484,000*
Nondesignated Public Hosp Supp. Fund (3096)	*$0*	*($236,000)*	*$0*
Priv Hospital Supplemental Fund (3097)	*$27,000,000*	*$116,255,000*	*$26,916,000*
Mental Heath Facility Lic Fund (3099)	*$382,000*	*$375,000*	*$386,000*
Residential/Outpatient Prog Lic Fund (3113)	*$8,100,000*	*$7,988,000*	*$8,655,000*
Childrens Health/Human Svcs Fund (3156)	*$0*	*$100,000,000*	*$0*
Hosp Qual Assurance Revenue Fund (3158)	*$2,890,616,000*	*$5,408,012,000*	*$3,863,457,000*
SNF Quality & Accountability Fund (3167)	*($2,279,000)*	*$2,128,000*	*($1,472,000)*
Emerg Air Trans/Children's Fund (3168)	*$6,660,000*	*$7,004,000*	*$3,446,000*
Public Hosp Invest, Improve, Inc Fund (3172)	*$860,655,000*	*$440,129,000*	*$0*
LongTerm Care Qual Assurance Fund (3213)	*$542,358,000*	*$628,556,000*	*$532,752,000*
Health and Human Svcs Spec Fund (3293)	*$640,730,000*	*$0*	*$0*
Healthcare Treatment Fund, Prop 56 (3305)	*$924,559,000*	*$992,281,000*	*$719,418,000*
Health Plan Fines/Penalties Fund (3311)	*$8,939,000*	*$26,439,000*	*$5,798,000*
Medi-Cal Emerg Med Transport Fund (3323)	*$70,896,000*	*$66,194,000*	*$69,848,000*
Medi-Cal Drug Rebate Fund (3331)	*($175,365,000)*	*$1,490,899,000*	*$1,456,697,000*
Health Care Services Special Fund (3334)	*$0*	*$2,769,657,000*	*$2,517,458,000*
Cannabis Tax Fund - DHCS (3350)	*$126,464,000*	*$206,782,000*	*$265,906,000*
PACE Oversight Fund (3362)	*$0*	*$460,000*	*$771,000*
Electronic Cigarette Products Tax Fund (3366)	*$0*	*$0*	*$0*
Loan Repayment Program Account (3375)	*$0*	*$0*	*$29,092,000*
Whole Person Care Pilot Spec Fund (8107)	*$468,356,000*	*$414,481,000*	*$273,790,000*
Global Payment Program Spec Fund (8108)	*$1,257,788,000*	*$716,011,000*	*$671,268,000*
Desig Public Hosp GME Spec Fund (8113)	*$276,859,000*	*$553,051,000*	*$206,862,000*
LIHP Fund (8502)	*$21,828,000*	*$7,214,000*	*$0*

Department of Health Care Services – *Changes to State Operations and Local Assistance*				
Fiscal Year:	**2019-20**	**2020-21 (CY)**	**2021-22 (BY)**	**CY to BY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$255,296,000	$250,029,000	$279,567,000	$29,538,000
Federal Funds[1]	$549,084,000	$476,743,000	$514,117,000	$37,374,000
Special Funds/Reimb	$173,803,000	$229,864,000	$279,567,000	$49,703,000
Total Expenditures	**$978,183,000**	**$956,636,000**	**$1,073,251,000**	**$116,615,000**
Total Auth. Positions	**3600.0**	**3607.0**	**3752.5**	**145.5**
LOCAL ASSISTANCE (*MEDI-CAL AND OTHER PROGRAMS)*				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$22,809,906,000	$22,775,545,000	$28,762,673,000	$5,987,128,000
Federal Funds[1]	$65,531,710,000	$79,584,822,000	$82,082,873,000	$2,498,051,000
Special Funds/Reimb	$11,863,114,000	$18,648,207,000	$14,428,805,000	($4,219,402,000)
Total Expenditures	**$100,204,730,000**	**$121,008,574,000**	**$125,274,351,000**	**$4,265,777,000**
[1]*Federal Funds include Funds 0890, 7502, and 7503*				

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

- ***Medi-Cal.*** DHCS serves as the single state agency for Medi-Cal, California's Medicaid program. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 13.2 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases. As of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level are also eligible for services in Medi-Cal.

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

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations. Its programs include:

Indian Health Program, Rural Health Services Development Program, Seasonal Agricultural and Migratory Workers Program, State Office of Rural Health, Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program, Small Rural Hospital Improvement Program, and the J-1 Visa Waiver Program.

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

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

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: COVID-19 Pandemic – Medi-Cal Response

Oversight – COVID-19 Pandemic: Medi-Cal 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), the Department of Public Health (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 two recently approved COVID-19 vaccines. DHCS, as the single state agency for Medi-Cal, is responsible for administration of the program's COVID-19 response to ensure Medi-Cal beneficiaries are able to receive necessary health, oral health, behavioral health, long-term care, and home- and community-based services while maintaining appropriate public health interventions to protect against transmission of COVID-19. The Medi-Cal response to the COVID-19 pandemic has been comprised of new federal requirements contained in various Congressional relief packages, as well as waivers and other flexibilities sought by the department to address the delivery of care during the pandemic.

Families First Coronavirus Response Act (FFCRA) – Increased FMAP and Continuous Coverage. The federal Families First Coronavirus Response Act (FFCRA) provided an increase in the federal medical assistance percentage (FMAP) for state Medicaid programs, including Medi-Cal, of 6.2 percent for Medi-Cal expenditures and 4.34 percent for Children's Health Insurance Program (CHIP) expenditures. According to DHCS, this increase in FMAP will offset General Fund expenditures in the Medi-Cal program by $2.9 billion in 2020-21 and $2.2 billion in 2021-22. DHCS assumes the enhanced FMAP will be available until December 31, 2021.

As a condition of the enhanced FMAP in the FFCRA, Medi-Cal beneficiaries may not be disenrolled from the program, except under limited circumstances, during the public health emergency. As a result, DHCS expects caseload impacts from the continuous coverage requirement to result in additional Medi-Cal costs of $5.2 billion ($1.7 billion General Fund and $3.6 billion federal funds) in 2020-21 and $12 billion ($3.9 billion General Fund and $8.1 billion federal funds in 2021-22.

Federal Flexibilities Approved for Medi-Cal Through Waivers and Other Authorities. Since the beginning of the public health emergency, DHCS has sought approval from the federal Centers for Medicare and Medicaid Services (CMS) for various program flexibilities to allow the continued delivery of Medi-Cal services while maintaining appropriate public health interventions to prevent the transmission of COVID-19. DHCS has sought these flexibilities through State Plan Amendments, as well as under Sections 1115 and 1135 of the Social Security Act, and Appendix K amendments to 1915(c) home- and community-based waiver programs.

State Plan Amendments. The Medicaid State Plan is a comprehensive written document that describes the nature and scope of the state's Medicaid program, known as Medi-Cal. The State plan is a contractual agreement between California and CMS and requires administration of the Medi-Cal program in conformity with federal Medicaid laws and regulations. States may request changes to a State Plan

through State Plan Amendments (SPAs). During the pandemic, California received CMS approval, or approval is pending, for the following SPAs:

- Child and Pregnancy Coverage Rules (SPA 17-0043) – Under a previously approved SPA (17-0043), DHCS used its existing authority to waive monthly premiums and other cost-sharing, such as co-pays, and to implement temporary adjustments to enrollment, eligibility determination, or determination policies for the following programs: Lower-Income Unborn Option, Medi-Cal Access Program (MCAP), Medi-Cal Access Infant Program (MCAIP), and the County Children's Health Initiative Program (CCHIP). Allows self-attestation of eligibility for application or renewal and waives monthly premiums.
- Clinical Laboratory and Long-Term Care Reimbursement (20-0024) - Allows Medi-Cal to do the following: 1) reimburse all COVID-19 related laboratory testing and collection procedures at 100 percent of Medicare reimbursement; and 2) allow a 10 percent per diem rate increase for certain long-term care facilities.
- COVID-19 Vaccination Coverage and Reimbursement (20-0040, pending CMS approval) - Seeks to add coverage for COVID-19 vaccine administration for Medi-Cal beneficiaries, and establish Medicare reimbursement rates for COVID-19 vaccine administration for all providers when furnished within their scope of practice in accordance with California state law, including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Service Memorandum of Agreement (IHS-MOA) providers. FQHCs, RHCs, and IHS-MOA providers would receive the payment outside their all-inclusive, per-visit reimbursement.
- COVID-19 Testing in Schools (20-0046, pending CMS approval) - Seeks to establish rates at 70 percent of Medicare reimbursement for COVID-19 testing when provided to Medi-Cal children in Transitional Kindergarten through 12th grade when provided in schools.
- Crisis Stabilization Units (21-0003, pending CMS approval) - Seeks to allow Medi-Cal beneficiaries to receive crisis stabilization services for up to four days (96 hours), rather than the current limit of less than 24 hours per episode. Also seeks to reimburse crisis stabilization services providers up to 20 hours for each 24 hour period for up to four consecutive days, or 80 total hours in a 96 hour period.
- Durable Medical Equipment Reimbursement (21-0016, pending CMS approval) - Seeks to increase reimbursement rates for durable medical equipment (DME) oxygen and respiratory equipment to 100 percent of the corresponding Medicare rate, for dates of service on or after March 1, 2020.

Section 1115 Waivers. Section 1115 of the Social Security Act provides CMS broad authority to allow experimental, pilot, or demonstration projects likely to assist in promoting the objectives of Medicaid. California's 1115 Waiver, Medi-Cal 2020, recently extended by one year until December 31, 2021, provides authority for a broad array of Medi-Cal programs including its managed care delivery system, the Drug Medi-Cal Organized Delivery System, Community-Based Adult Services, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, the Global Payment Program (GPP), Whole Person Care (WPC) pilots, and the Dental Transformation Initiative (DTI). Changes to the 1115 Waiver may be made through waiver amendments. During the pandemic, California received approval, or approval is pending, for the following 1115 Waiver amendments:

- Drug Medi-Cal Organized Delivery System - Allows the following changes to the Drug Medi-Cal Organized Delivery System (DMC-ODS): 1) suspends limitations on two non-continuous 90 day residential treatment regimens per year during the public health emergency; 2) suspends current 30 day (for adolescents) and 90 day (for adults) maximums for a single residential treatment stay during

the public health emergency; 3) modifies the rate-setting methodology of the DMC-ODS Certified Public Expenditure; 4) allows services to be provided in locations recognized as temporary extensions of qualified residential settings; and 5) suspends minimal clinical service hour and disallowance requirements for intensive outpatient and residential substance use disorder treatment.

- Public Hospital Redesign and Incentives in Medi-Cal and Global Payment Program - Allows modifications to the distribution of incentive payments under the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, and adjusts thresholds for the Global Payment Program (GPP).
- Community-Based Adult Services - Allows the following changes to community-based adult services (CBAS): 1) allows CBAS providers to provide limited in-center activities, as well as telephonic, telehealth, and in-home services; 2) expands settings where CBAS may be provided; and 3) allows assessments to be conducted telephonically using self-reported information by participants or caregivers.
- COVID-19 Vaccines (pending CMS approval) - Seeks to extend coverage of COVID-19 vaccines and administration to the following limited-scope benefit populations in Medi-Cal: 1) individuals eligible for tuberculosis-related benefits; 2) individuals eligible for the optional COVID-19 testing group; 3) non-citizen individuals eligible for restricted-scope benefits; 4) individuals eligible for family planning benefits under the Family Planning Access, Care and Treatment (Family PACT) program. Also seeks to allow delivery of COVID-19 vaccines through the Medi-Cal fee-for-service delivery system, rather than managed care contracts, to standardize delivery of vaccines to beneficiaries.
- COVID-19 Testing (pending CMS approval) - Seeks to extend coverage of COVID-19 testing in school settings under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening provisions for children in Transitional Kindergarten through 12th grade. Also seeks to allow delivery of COVID-19 testing through the Medi-Cal fee-for-service delivery system, rather than managed care contracts, to standardize delivery of the testing benefit.

Section 1135 Waivers. Section 1135 of the Social Security Act permits CMS to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements during a federally declared public health emergency to ensure sufficient health care items and services are available to meet the needs of individuals enrolled in public programs in the emergency area and time periods, and providers who give such services in good faith can be reimbursed and exempted from sanctions. During the pandemic, California received CMS approval for the following 1135 Waivers:

- 1135 Waiver Approval (March 2020) - Allows Medi-Cal to do the following: 1) temporarily suspend Medicaid fee-for-service prior authorization and medical necessity processes; 2) extend pre-existing authorizations a beneficiary previously received until the end of the public health emergency; 3) modify timeframe for managed care entities to resolve appeals of adverse benefit determinations prior to a fair hearing process to no less than one day; 4) modify timeframe for beneficiaries to exercise appeal rights to allow an additional 120 days to request a fair hearing; 5) waive certain provider enrollment requirements for the duration of the public health emergency; and 6) allow facilities to be fully reimbursed for services rendered in an unlicensed alternative care setting, as long as the state determines it meets minimum reasonable standards in the context of the public health emergency.
- 1135 Waiver Approval – Telehealth (August 2020) - Allows Medi-Cal to waive clinic facility requirements to permit services via telehealth.
- 1135 Waiver Approval – Fair Hearings (December 2020) - Allows Medi-Cal to do the following: 1) temporarily extend the timeframe to reinstate services and benefits after a fair hearing beyond 10 days,

but should reinstate the services and benefits as quickly as practicable, 2) allow managed care plans to continue benefits if requested within the current 10 day time frame or reinstate benefits for the beneficiary upon request between 11 and 30 days if the plan has not yet made a decision on the appeal and a fair hearing is pending.

Appendix K of 1915(c) Home- and Community-Based Services Waivers. Appendix K of the state's 1915(c) Home- and Community-Based Services Waivers allows states to request waiver amendments to respond to emergencies. Services provided under 1915(c) waivers include the Developmental Disabilities (DD) Waiver, the Home- and Community-Based Alternatives Waiver, the Assisted Living Waiver, the HIV/AIDS Waiver, and Multipurpose Senior Services Program. During the pandemic, California received CMS approval for the following Appendix K waiver amendments:

- Multi-purpose Senior Services Program - Allows Multi-purpose Senior Services Programs (MSSP) sites to conduct telephonic assessments, video conferencing, or live video interactions in lieu of face-to-face visits, in accordance with HIPAA requirements.
- HIV/AIDS Waiver – Allows the following for the HIV/AIDS Waiver: 1) telephonic or live virtual video conferencing in lieu of, or as an option for, face-to-face visits, in accordance with HIPAA requirements; 2) care management activities (level of care evaluations, home visits, and home environment assessments) to be conducted via telephonic or live video assessments in lieu of face-to-face visits; 3) digital signatures for forms that require participant or legal representatives' signatures; 4) waiver agencies to extend the time in which they have to complete level of care re-evaluations and ongoing comprehensive nursing and psychosocial reassessments by an additional 120 days beyond the current 180 day requirement.
- Assisted Living Waiver - Allows Assisted Living Waiver (ALW) Care Coordination Agencies (CCAs) to: 1) conduct telephonic or video conferencing interactions in lieu of, or as an option for, face-to-face visits for initial assessments or enrollments, in accordance with HIPAA requirements; 2) conduct telephonic or live video virtual assessments in lieu of face-to-face assessments for level of care; 3) temporarily modify incident reporting requirements for CCAs to allow facility staff to submit incident reports on non-standard forms as long as all elements of the form are present; 4) temporarily suspend the 60 day enrollment period for applicants unable to complete the application due to COVID-19 impacts; 5) temporarily allow for an extension of the 31 to 60 day re-enrollment period of waiver participants who moved from assisted living for hospitalization to retain their slot or enrollment in the waiver; 6) temporarily allow digital signature for forms that require participant or legal representatives' signatures; and 7) allows prioritization of enrollment and intake processing for applicants in an inpatient facility stay within areas of the state designated as "hot spots", without having been in an institution for 60 days.
- Home- and Community-Based Alternatives Waiver – Allows the following changes for the Home- and Community-Based Alternatives Waiver: 1) permits payment for servcies rendered by family caregivers or legally responsible individuals; 2) modifies provider qualifications to permit unlicensed waiver personal care services providers as long as they are currently in-home supportive services providers; 3) modify provider types to allow certified nurse assistants to provide private duty nursing; 4) modify licensure or other requirements for settings where waiver services are furnished, allowing telehealth (including telephonic or virtual live video conferencing) as an alternative option to face-to-face interactions; 5) modify processes for waiver eligibility level of care evaluations and re-evaluations via telephonic or virtual live video conferencing as an alternative option to face-to-face interactions, in accordance with HIPAA requirements; 6) pause waiver disenrollments of participants who are re-

institutionalized, beyond the 30 day limit, because a caregiver contracts COVID-19 or it is unsafe for them to return to the community; 7) temporarily allow digital signature for forms that require participant or legal representatives' signatures; 8) allows prioritization of enrollment and intake processing for applicants in an inpatient facility stay within areas of the state designated as "hot spots", without having been in an institution for 60 days; and 9) aligns rates with requirements in the FFCRA to allow two weeks of emergency paid sick leave when a waiver personal care service provider is unable to work due to the COVID-19 pandemic.

- Developmental Disabilities Waiver - Allows the following changes for Department of Developmental Services waiver programs: 1) temporarily changes service locations to allow services such as day services to be provided in the participant's home; 2) temporarily modify provider qualifications if a participant decides to self-direct to an individual to provide a service, as long as the individual is at least 18 years of age and possesses the skills and experience to provide the service; 3) temporarily modify service plan development requirements for in-person attendance of service plan development and monitoring meetings, allowing the option for telephonic or live virtual video conferencing; 4) temporarily allow retainer payments for habilitation, behavioral intervention services, and day services due to absences for the emergency; and 5) allows provision of technology, equipment, and training to assist waiver consumers in accessing services remotely.
- Multiple Waiver Programs – Personal Care Services – Allows a waiver personal care service provider to exceed the maximum workday limit of 12 hours per day, without penalty, when necessary to reduce a waiver participant's potential exposure to COVID-19 or when providers are unavailable as a result of the public health emergency. Also allows retainer payments for services that provide support for personal care or activities of daily living including residential habilitation, behavior intervention and day services, which include personal care or components of personal care.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of the state and federal flexibilities for eligibility, enrollment, delivery of health care services, provider reimbursement, or other activities authorized during the pandemic.

2. Please provide a brief accounting of the fiscal and programmatic impacts of these flexibilities or other federal requirements authorized during the pandemic.

Issue 3: November 2020 Medi-Cal Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2020 Medi-Cal Local Assistance Estimate includes $117.9 billion ($22.5 billion General Fund, $79 billion federal funds, and $16.4 billion special funds and reimbursements) for expenditures in 2020-21, and $122.2 billion ($28.4 billion General Fund, $81.8 billion federal funds, and $12 billion special funds and reimbursements) for expenditures in 2021-22.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2020-21 (CY)**	**2021-22 (BY)**	**CY to BY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$21,344,400,000	$27,622,057,000	$6,277,657,000
Federal Funds	$75,062,866,000	$77,513,294,000	$2,450,428,000
Special Funds/Reimbursements	$16,346,739,000	$12,013,747,000	($4,332,992,000)
Total Expenditures	**$112,754,005,000**	**$117,149,098,000**	**$4,395,093,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$1,002,510,000	$633,742,000	($368,768,000)
Federal Funds	$3,700,064,000	$3,922,743,000	$222,679,000
Special Funds and Reimbursements	$9,698,000	$5,269,000	($4,429,000)
Total Expenditures	**$4,712,272,000**	**$4,561,754,000**	**($150,518,000)**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$124,477,000	$144,153,000	$19,676,000
Federal Funds	$260,491,000	$319,600,000	$59,109,000
Special Funds and Reimbursements	$0	$0	$0
Total Expenditures	**$384,968,000**	**$463,753,000**	**$78,785,000**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$22,471,387,000	$28,399,952,000	$5,928,565,000
Federal Funds	$79,023,421,000	$81,755,637,000	$2,732,216,000
Special Funds and Reimbursements	$16,356,437,000	$12,019,016,000	($4,337,421,000)
Total Expenditures	**$117,851,245,000**	**$122,174,605,000**	**$4,323,360,000**

Caseload. In 2020-21, the budget assumes annual Medi-Cal caseload of 14 million, a decrease of 1.9 percent compared to assumptions in the 2020 Budget Act. The department estimates 83.5 percent of Medi-Cal beneficiaries, or 11.7 million, will receive services through the managed care delivery system while 16.5 percent, or 2.3 million, will receive services through the fee-for-service delivery system.

In 2021-22, the budget assumes annual Medi-Cal caseload of 15.6 million, an 11.7 percent increase compared to the revised caseload estimate for 2020-21. The department estimates 84.4 percent of Medi-Cal beneficiaries, or 13.2 million, will receive services through the managed care delivery system while 15.6 percent, or 2.4 million, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The November 2020 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

2020-21 General Fund Savings - The budget includes decreased General Fund expenditures in the Medi-Cal program of $1.2 billion in 2020-21 compared to the 2020 Budget Act. These savings are primarily attributable to the following factors:

- Reduced estimated caseload impact of COVID-19 – $665 million savings
- Savings from enhanced federal medical assistance percentage (FMAP) – $366 million savings
- Reduced estimated repayments of inappropriately claimed federal financial participation – $418 million savings)
- Increased Hospital Quality Assurance Fee payments – $176 million savings
- Various other adjustments – $245 million savings

These savings are offset by the following increased General Fund costs in 2020-21:

- Vaccine administration and other COVID-19 related costs – $80.8 million cost
- Reduced savings from delay of Medi-Cal Rx Implementation – $121 million cost
- Increase in deferrals of federal financial participation – $322 million cost
- Managed care capitation payment corrections – $335 million cost

2021-22 COVID-19 Impacts – The budget includes increased General Fund expenditures $3.6 billion related to the impact of the COVID-19 pandemic on the Medi-Cal program. Specifically, these impacts include the following factors:

- Caseload impacts – According to DHCS, the federal Families First Coronavirus Relief Act (FFCRA) prohibits states from disenrolling Medi-Cal beneficiaries, except under limited circumstances, during the public health emergency declaration. The estimate assumes the public health emergency declaration will continue until December 31, 2021. DHCS expects caseload to grow during this period as fewer individuals exit the program. In addition, DHCS expects caseload to grow due to pandemic-related job loss and other economic dislocations. The budget estimates General Fund expenditures associated with caseload to increase by $2.6 billion compared to revised expenditure estimates for 2020-21.
- Enhanced FMAP savings – DHCS assumes COVID-related enhanced FMAP will continue until December 31, 2021. Consequently, only six months of additional savings would be available in

the 2021-22 fiscal year, resulting in an estimated reduction of General Fund savings of $689 million compared to the revised estimates for 2020-21.

- Vaccine administration costs – The budget estimates the Medi-Cal program will experience increased General Fund expenditures of $107 million to reimburse Medi-Cal providers for the administration of COVID-19 vaccines to beneficiaries. The represents an increase of General Fund expenditures of $97 million compared to the revised estimates for 2020-21, consistent with the acceleration of vaccine distribution as supplies increase.
- Various other COVID-19 impacts – The budget estimates the cumulative impact of COVID-19 changes to the Medi-Cal program will result in increased General Fund expenditures of approximately $220 million compared to the revised estimates for 2020-21.

Behavioral Health Continuum Infrastructure Funding – The budget includes General Fund expenditure authority of $750 million, available over three years, to provide a continuum of behavioral health services to address short-term crisis stabilization, acute needs, peer respite, and other clinically enriched longer-term treatment and rehabilitation services for persons with behavioral health disorders. Counties would receive funding for these investments through a competitive grant process, which includes a match of local funds, with a goal of adding at least 5,000 beds, units, or rooms to existing behavioral health capacity.

California Advancing and Innovating in Medi-Cal (CalAIM) – The budget includes $1.1 billion ($541.9 million General Fund) in 2021-22, growing to $1.5 billion ($755.5 million General Fund), as well as proposed statutory changes to the Medi-Cal program to implement the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, a comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program. The budget proposes allocation of this funding to the following CalAIM components in 2021-22:

- $187.5 million ($93.7 million General Fund) to support the new enhanced care management (ECM) benefit in Medi-Cal managed care plans, beginning January 1, 2022.
- $47.9 million ($24 million General Fund to support in-lieu-of services (ILOS) benefits adopted by Medi-Cal managed care plans, beginning January 1, 2022.
- $300 million ($150 million General Fund) to fund incentives for managed care plans to invest in voluntary ILOS programs and partner with community-based organizations and providers, including but not limited to community clinics, public hospital systems, and county behavioral health systems.
- $401.6 million ($174.7 million General Fund) to support transitions of populations between the fee-for-service and managed care delivery systems, as part of the CalAIM transformation of Medi-Cal.
- $113.5 million ($57 million General Fund) for enhanced reimbursements for dental services previously included in the Dental Transformation Initiative component of Medi-Cal 2020, California's federal 1115 Medicaid Waiver.
- $21.8 million General Fund for the behavioral health quality improvement program, which helps county behavioral health programs make technical and other improvements to facilitate future behavioral health integration and payment reform efforts.
- $23.9 million ($11 million General Fund) for state operations costs related to CalAIM.

General Fund Support for Proposition 56 Supplemental Provider Payments – The budget includes General Fund expenditures of $275.3 million to support supplemental payments to Medi-Cal providers

previously supported by Proposition 56 tobacco tax revenue. According to DHCS, the reduction in available revenue is attributable to the assumed implementation of the state's ban on flavored tobacco and vaping products.

Student Behavioral Health Services Incentive Program –The budget includes $400 million ($200 million General Fund) and proposed trailer bill language to implement an incentive program for Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase utilization of preventive and early intervention behavioral health services by students. Of this expenditure authority, $389 million ($194.5 million General Fund and $194.5 million federal funds) is allocated for the incentive program in the Medi-Cal Local Assistance Estimate.

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

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

1. Please provide a brief overview of the significant General Fund changes in the Medi-Cal program in the 2020-21 and 2021-22 fiscal years.

Issue 4: November 2020 Family Health Local Assistance Estimate

Local Assistance Estimate – Governor's Budget. The November 2020 Family Health Local Assistance Estimate includes $332.1 million ($181.9 million General Fund, $44.6 million federal funds, and $105.6 million special funds and reimbursements) for expenditures in 2020-21, and $268.9 million ($212.3 million General Fund, $5.1 million federal funds, and $51.5 million special funds and reimbursements) for expenditures in 2021-22.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2020-21 (CY)**	**2021-22 (BY)**	**CY to BY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$96,679,000	$78,514,000	($18,165,000)
Federal Funds	$39,519,000	$0	($39,519,000)
Special Funds/Reimbursements	$12,664,000	$3,992,000	($8,672,000)
County Funds [non-add]	[$80,243,000]	[$81,696,000]	[$1,453,000]
Total CCS Expenditures	**$148,862,000**	**$82,506,000**	**($66,356,000)**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$70,007,000	$114,380,000	$44,373,000
Special Funds and Reimbursements	$70,390,000	$25,026,000	($45,364,000)
Total GHPP Expenditures	**$140,397,000**	**$139,406,000**	**($991,000)**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$15,182,000	$19,387,000	$4,205,000
Federal Funds	$5,128,000	$5,128,000	$0
Special Funds and Reimbursements	$22,504,000	$22,504,000	$0
Total EWC Expenditures	**$42,814,000**	**$47,019,000**	**$4,205,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$181,868,000	$212,281,000	$30,413,000
Federal Funds	$44,647,000	$5,128,000	($39,519,000)
Special Funds and Reimbursements	$105,558,000	$51,522,000	($54,036,000)
County Funds [non-add]	[$84,124,000]	[$86,088,000]	[$1,964,000]
Total Family Health Expenditures	**$332,073,000**	**$268,931,000**	**($63,142,000)**

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

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care. CCS costs for Medi-Cal eligible children are reflected in the Medi-Cal Local Assistance Estimate.
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 168,446 in 2020-21, an increase of 359 or 0.2 percent, compared to the 2020 Budget Act. The budget estimates Medi-Cal CCS caseload of 168,540 in 2021-22, an increase of 94 or 0.06 percent, compared to the revised 2021-22 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 14,571 in 2020-21, an increase of 154 or one percent, compared to the 2020 Budget Act. The budget estimates state-only CCS caseload of 14,571 in 2021-22, unchanged compared to the revised 2020-21 estimate.
- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal. GHPP costs for Medi-Cal eligible individuals are reflected in the Medi-Cal Local Assistance Estimate
  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 702 in 2020-21, an increase of 14 or two percent, compared to the 2020 Budget Act. The budget estimates Medi-Cal GHPP caseload of 710 in 2021-22, an increase of eight or 0.1 percent, compared to the revised 2020-21 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 660 in 2020-21, a decrease of two or 0.3 percent, compared to the 2020 Budget Act. The budget estimates state-only GHPP caseload of 668 in 2021-22, an increase of eight or 1.2 percent, compared to the revised 2020-21 estimate.
- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).
  Caseload Estimate: The budget estimates EWC caseload of 24,919 in 2020-21, a decrease of 2,702 or 9.8 percent, compared to the 2020 Budget Act. The budget estimates EWC caseload of 27,425 in 2021-22, an increase of 2,506 or 10.1 percent compared to the revised 2020-21 estimate.

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

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

1. Please provide a brief overview of the significant changes in Family Health Estimate programs in the 2020-21 and 2021-22 fiscal years.

Issue 5: California Advancing and Innovating in Medi-Cal (CalAIM)

Local Assistance, Budget Change Proposal, and Trailer Bill Language – Governor's Budget. DHCS requests expenditure authority of $1.1 billion ($520.8 million General Fund and $552.9 million federal funds) for local assistance costs. If approved, these resources would allow DHCS to implement the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, which seeks to transform the Medi-Cal delivery, program, and payment systems to improve beneficiary health outcomes and result in long-term cost savings.

DHCS also requests 33 positions and expenditure authority of $23.9 million ($11 million general Fund and $12.8 million federal funds) in 2021-22, 40 positions and expenditure authority of $28.2 million ($13.2 million General Fund and $15 million federal funds) in 2022-23, $25.2 million ($12 million General Fund and $13.2 million federal funds) in 2023-24, $23.9 million ($11.6 million General Fund and $12.3 million federal funds) in 2024-25, and $20.3 million ($9.8 million General Fund and $10.5 million federal funds) in 2025-26. If approved, these positions and resources would support the state operations costs of implementing the CalAIM initiative.

In addition, DHCS proposes trailer bill language to make statutory changes necessary to implement the components of the CalAIM initiative.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$520,832,000	$520,832,000
0890 – Federal Trust Fund	$552,913,000	$552,913,000
Total Funding Request:	**$1,073,745,000**	**$1,073,745,000**

* Resources ongoing after 2022-23.

Program Funding Request Summary – Budget Change Proposal		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$11,041,000	$13,230,000
0890 – Federal Trust Fund	$12,819,000	$14,960,000
Total Funding Request:	**$23,860,000**	**$28,190,000**
Total Requested Positions:	**33.0**	**40.0**

* Additional fiscal year resources requested – 2023-24: $25,193,000; 2024-25: $23,927,000; 2025-26: $20,250,000

Background. During the fall of 2019, the Administration released a comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program, known as the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. Due to the pandemic, the Administration delayed implementation of CalAIM in the 2020-21 fiscal year. In 2021, the Governor's January budget includes funding and proposed trailer bill language to commence a comprehensive effort to transform the Medi-Cal program. CalAIM is an ambitious effort to incorporate evidence-based investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's most recent 1115 Waiver, Medi-Cal 2020, and the Administration is seeking to incorporate these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed

care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

CalAIM represents a significant transformation of the health care delivery systems that provide physical health, behavioral health, and oral health care services to Medi-Cal beneficiaries. However, the proposal also represents an opportunity to build into the foundations of the new Medi-Cal program an incentive structure that achieves a healthier Medi-Cal population with a comprehensive, whole-person approach that addresses the social determinants of health and avoids cross-cutting impacts and cost shifts to other state or local social service and public safety agencies. While the Administration's CalAIM proposal contains the broad outlines of building such a foundation, the Legislature will need to carefully evaluate each component of the proposal to ensure the program changes that are ultimately implemented are consistent with the values of a publicly-supported health care program.

CURRENT MEDI-CAL STRUCTURE AND DEMONSTRATION PROJECTS

California's Section 1115 Waiver – Medi-Cal 2020. Section 1115 of the Social Security Act authorizes the federal Department of Health and Human Services to allow experimental, pilot, or demonstration projects likely to assist in promoting the objectives of Medicaid. The broad authority under Section 1115 allows states to request a waiver of Medicaid coverage requirements, such as the requirement that Medicaid benefits be offered uniformly statewide, which allows operation of demonstration components in specified counties or provision of benefits to specific populations. States may also request waiver of restrictions on expenditure authority, which allows states to receive federal financial participation for certain benefits not ordinarily eligible for federal Medicaid funds.

California's first 1115 Waiver, the Medi-Cal Hospital/Uninsured Care Demonstration, was approved in 2005 for five years and restructured the state's hospital financing system. California renewed the 1115 Waiver for an additional five years in 2010, renaming it "Bridge to Reform" and focusing on readying state health programs for implementation of the federal Affordable Care Act. Specifically, the Bridge to Reform Waiver: 1) allowed for health care coverage of up to 500,000 uninsured individuals in county Low Income Health Programs who would later become eligible for the state's optional expansion of Medi-Cal, 2) increased funding for uncompensated care, 3) improved care coordination for vulnerable populations such as individuals dually eligible for Medicare and Medi-Cal (dual-eligibles), and 4) promoted transformation of public hospital care delivery systems.

The most recent Waiver renewal, "Medi-Cal 2020", was originally approved until December 31, 2020, but was extended by one year during the COVID-19 pandemic, and contains four primary demonstration components: Whole Person Care Pilots, Public Hospital Redesign and Incentives in Medi-Cal, the Global Payment Program, and the Dental Transformation Initiative.

Whole Person Care Pilots. The Whole Person Care (WPC) Pilots coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-

being through more efficient and effective use of resources. WPC Pilots allow individual public entities or a consortium of public entities to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. WPC Pilot entities identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population progress. Allowable target populations include one or more of the following:

- High Utilizers – Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement
- Chronic Conditions – Individuals with two or more chronic conditions
- MH/SUDS – Individuals with mental health and/or substance use disorders
- Homelessness – Individuals currently experiencing homelessness
- At-Risk-Of Homelessness – Individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutional settings
- Justice-Involved – Individuals recently released from institutions, including jail or prison

WPC Pilots are permitted to provide services that would best fit the needs of their target populations and could be delivered with existing infrastructure and resources. The eight categories of services provided by the pilots are as follows[1]:

- Outreach – Outreach services to identify prospective enrollees and assess their eligibility in the field or in clinical and other settings.
- Care Coordination – Coordination of medical, behavioral health, and social services to improve health and reduce unnecessary utilization in high-risk, high utilizer target populations.
- Housing Support – Assistance in accessing and obtaining sustainable housing solutions to maximize the number of enrollees living in healthy, stable living situations. Financial assistance used to maintain and/or achieve healthy, stable living situations.
- Peer Support – WPC staff with lived experience similar to the target populations who provide knowledge, guidance, and emotional, social, or practical support to WPC enrollees. These individuals often provide care coordination and housing support services, as well as guiding and supporting enrollees through behavioral health and social services.
- Benefit Support – Assistance with applying for, obtaining, and/or appealing for public benefits (e.g., Supplemental Security Income, Cal-Fresh, etc.).
- Employment Assistance – Workforce training on resume building, interview skills, and/or other supports necessary in order to obtain a job.
- Sobering Center – A safe environment for intoxicated individuals to receive detoxification services.
- Medical Respite – Post-acute respite services for enrollees discharged from the hospital and other inpatient settings, which allow enrollees to recuperate in a safe environment until they have the resources to care for themselves.

[1] Pourat N, Chuang E, Chen X, O'Masta B, Haley LA, Lu C, Huynh MP, Albertson E, and Huerta DM. Interim Evaluation of California's Whole Person Care (WPC) Program. Los Angeles, CA: UCLA Center for Health Policy Research, September 2019.

DHCS approved 25 applications for WPC Pilots from the following entities[2]:

Lead Entity	Estimated Five-year Beneficiary Count	Total Five-Year Budget
Alameda County Health Care Services Agency	20,000	$283,453,400
City of Sacramento	4,386	$64,078,680
Contra Costa Health Services	15,600	$203,958,160
County of Marin, Dept. of Health and Human Services	3,516	$20,000,000
County of Orange, Health Care Agency	9,303	$31,066,860
County of San Diego, Health & Human Services Agency	1,049	$43,619,950
County of Santa Cruz, Health Services Agency	625	$20,892,336
County of Sonoma, Dept. of Health Services	3,040	$16,704,136
Kern Medical Center	2,000	$157,346,500
Kings County Human Services Agency	600	$12,848,360
L.A. County Department of Health Services	154,044	$1,260,352,362
Mendocino County Health and Human Services Agency	600	$10,804,720
Monterey County Health Department	500	$34,035,672
Napa County	800	$22,921,433
Placer County Health and Human Services Department	450	$20,126,290
Riverside University Health System - Behavioral Health	38,000	$35,386,995
San Bernardino Co. - Arrowhead Regional Med. Center	2,000	$24,537,000
San Francisco Department of Public Health	16,954	$161,750,000
San Joaquin County Health Care Services Agency	2,255	$18,365,004
San Mateo County Health System	5,000	$165,367,710
Santa Clara Valley Health and Hospital System	10,000	$250,191,859
Small County WPC Collaborative (San Benito, Mariposa)	287	$10,362,176
Shasta County Health and Human Services Agency	600	$19,403,550
Solano County Health & Social Services	250	$4,667,010
Ventura County Health Care Agency Pl	2,280	$107,759,837
TOTAL	**294,139**	**$3,000,000,000**

The total budget for the WPC Pilots is $3 billion ($1.5 billion local funds and $1.5 billion federal matching funds). WPC Pilots targeting individuals at risk of or experiencing homelessness were permitted to implement housing interventions, such as tenancy-based care management services or county housing pools, with the non-federal portion of pilot funding. In addition, the 2019 Budget Act included a one-time General Fund investment of $100 million to assist WPC Pilots with funding for the costs of long-term and short-term housing, such as hotel vouchers and rental subsidies, as well as capital investment for housing projects for Medi-Cal beneficiaries who are mentally ill and are experiencing homelessness, or are at risk of homelessness. These funds were distributed as follows[3]:

[2] Department of Health Care Services. "California Whole Person Care Applications Statistics". February 2019.

[3] Department of Health Care Services. "One Time Housing Fund Overview and Methodology". August 8, 2019.

ALLOCATION OF 2019 BUDGET ACT WHOLE PERSON CARE HOUSING FUNDING			
Pilot	***Allocation***	***Pilot***	***Allocation***
Alameda	$ 4,647,159.90	City of Sacramento	$ 3,059,351.17
Contra Costa	$ 2,058,505.04	San Benito	$ 1,600,251.33
Kern	$ 1,213,867.52	San Bernardino	$ 1,646,279.96
Kings	$ 1,166,795.01	San Diego	$ 5,327,990.32
Los Angeles	$ 36,139,682.34	San Francisco	$ 8,130,059.30
Marin	$ 2,522,162.80	San Joaquin	$ 1,366,774.54
Mariposa	$ 1,033,636.00	San Mateo	$ 2,340,849.14
Mendocino	$ 1,137,158.69	Santa Clara	$ 5,680,408.35
Monterey	$ 2,407,786.57	Santa Cruz	$ 2,642,337.19
Napa	$ 1,491,766.53	Shasta	$ 1,198,355.90
Orange	$ 3,413,986.51	Solano	$ 1,603,827.17
Placer	$ 1,318,475.78	Sonoma	$ 3,284,476.48
Riverside	$ 1,999,856.42	Ventura	$ 1,568,200.04
		TOTAL	**$100,000,000.00**

Interim Evaluation of WPC Pilots[4]. In January 2020, researchers at the UCLA Center for Health Policy Research released a draft interim evaluation of California's WPC program, conducted under a contract with DHCS to fulfill the evaluation requirements included in the state's 1115 Waiver. The UCLA researchers surveyed the WPC pilots to identify populations served, pilot infrastructure, and whether the pilots are improving the delivery of care, improving beneficiary health, lowering costs and building a sustainable, collaborative program.

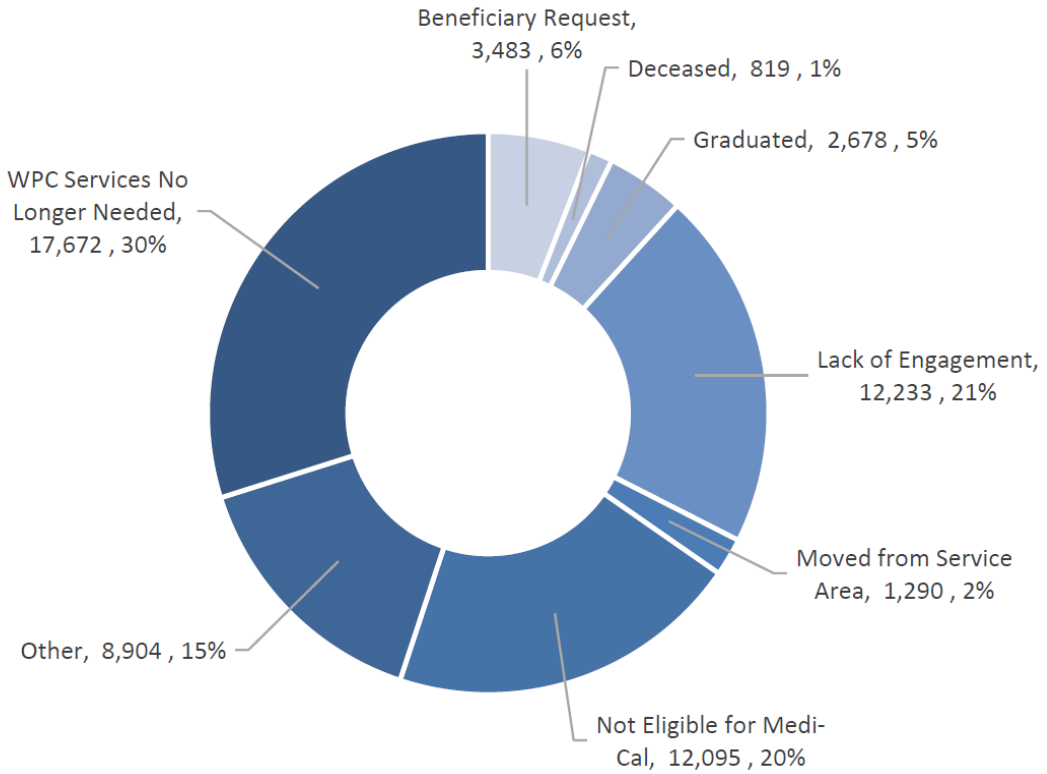
The 25 WPC Pilot programs each identified different target populations, with nine targeting just one of the six eligible populations, and one (Los Angeles) targeting all six. 16 pilots targeted High Utilizers, five targeted Chronic Conditions, 11 targeted MH/SUDS, 15 targeted Homelessness, 10 targeted At-Risk-Of Homelessness, and four targeted Justice-Involved.

Pilots reported using a wide range of outreach strategies to identify eligible beneficiaries, including use of administrative and electronic medical record data, referrals and warm hand-offs from partner organizations, self-referrals, and street outreach.

Between January 2017 and December 2018, cumulative enrollment in WPC Pilots was 108,667 unique individuals, with 60,776 currently enrolled at that point in time. 49.4 percent of enrollees (53,697) had been enrolled continuously, 43.9 percent of enrollees (47,755) disenrolled permanently, and 6.9 percent (7,461) enrolled and disenrolled multiple times. The primary reasons for disenrollment were: 1) WPC Services No Longer Needed (30 percent), 2) Lack of Engagement (21 percent), 3) Not Eligible for Medi-

[4] Pourat N, et al., September 2019.

Cal (20 percent), 4) Other (15 percent), 5) Beneficiary Request (6 percent), 6) Graduated (5 percent), 7) Moved from Service Area (2 percent), and 8) Deceased (1 percent).



During the evaluation period, WPC Pilot enrollees were more likely to be male (55 percent), age 50-64 (35 percent), and white (28 percent). Most target populations were consistent with these overall results with some notable exceptions, including: 1) High Utilizers were the only population that were majority female (53 percent), while other populations ranged from 56 percent male (Chronic Conditions) to 74 percent (Justice-Involved); 2) Justice-Involved were the only population whose enrollees were most often age 18-34 (48 percent), as well as more often Latino (38 percent).

WPC Enrollee Demographics – Gender

Gender	**Male**	**Female**
OVERALL	**55%**	**45%**
High Utilizers	47%	53%
Chronic Conditions	56%	44%
MH/SUDS	59%	41%
Homelessness	66%	34%
At-Risk-Of Homelessness	65%	35%
Justice-Involved	74%	26%

WPC Enrollee Demographics – Race/Ethnicity

Race/ Ethnicity	White	African American	Latino	Asian American/ Pacific Islander	American Indian/ Alaska Native	Other/ Unknown
OVERALL	**28%**	**25%**	**23%**	**6%**	**<1%**	**16%**
High Utilizers	29%	22%	24%	8%	<1%	17%
Chronic Conditions	35%	11%	33%	7%	<1%	12%
MH/SUDS	40%	10%	27%	6%	<1%	15%
Homelessness	31%	28%	21%	4%	<1%	16%
At-Risk-Of Homelessness	32%	24%	32%	2%	<1%	9%
Justice-Involved	35%	17%	38%	1%	<1%	9%

WPC Enrollee Demographics – Age Group

Age Group	0-17	18-34	35-49	50-64	65+
OVERALL	**1%**	**27%**	**28%**	**35%**	**9%**
High Utilizers	1%	29%	26%	33%	12%
Chronic Conditions	<1%	25%	28%	41%	6%
MH/SUDS	<1%	26%	29%	38%	8%
Homelessness	<1%	24%	31%	38%	6%
At-Risk-Of Homelessness	<1%	30%	32%	35%	3%
Justice-Involved	<1%	48%	33%	17%	1%

Despite differences in target populations, WPC Pilots offered many of the same categories of benefits to beneficiaries, offering between three and seven of the eight services. 100 percent of pilots offered both Care Coordination and Housing Support services, 80 percent offered Peer Support, 72 percent offered

Benefit Support, 52 percent offered Outreach, 40 percent offered Medical Respite, 28 percent offered Sobering Centers, and 20 percent offered Employment Assistance. The percentages of pilot beneficiaries in each category that received each type of service were as follows:

Percentage of WPC Populations Receiving Services by Category[5]

	Outreach Services	Care Coordination	Housing Support	Peer Support
WPC Population:				
Enrolled	11%	77%	69%	46%
Not Enrolled	84%	0%	0%	0%
Enrolled Target Populations:				
High Utilizers	14%	83%	75%	70%
Chronic Conditions	41%	61%	32%	34%
MH/SUDS	31%	71%	50%	45%
Homelessness	21%	68%	59%	19%
At-Risk-Of Homelessness	46%	24%	19%	10%
Justice-Involved	79%	26%	18%	16%

	Benefit Support	Employment Assistance	Sobering Centers	Medical Respite
WPC Population:				
Enrolled	69%	45%	5%	3%
Not Enrolled	0%	0%	16%	0%
Enrolled Target Populations:				
High Utilizers	72%	60%	8%	1%
Chronic Conditions	28%	10%	1%	1%
MH/SUDS	34%	10%	24%	3%
Homelessness	51%	23%	5%	5%
At-Risk-Of Homelessness	47%	9%	3%	2%
Justice-Involved	20%	15%	3%	1%

In addition to these characteristics of the WPC Pilots, the UCLA evaluation made the following key observations:

1) Progress on Care Coordination – By the end of the evaluation period, Pilots had successfully formed care coordination teams, established data sharing protocols across service agencies, and standardized care coordination processes. Areas for further improvement included more formal data sharing

[5] Pourat N, et al., September 2019.

agreements, encouraging systematic use of universal consent forms, promoting field-based outreach and service delivery, using peers with lived experience on care coordination teams, training staff to improve quality and outcomes, and leveraging resources and partnerships to address structural housing problems.

2) Improvements in Care Delivery – The evaluation found substantial evidence the Pilots successfully provided better care to enrollees. Outcomes data demonstrated success in follow-up after hospitalization for mental illness at 7 and 30 days, improvements in rates of initiation and engagement in SUD treatment, and increased rates of timely provision of comprehensive care plans and suicide risk assessments.
3) Health Improvements – The evaluation found some evidence of improved health, which could not be fully attributed to the Pilot, including improvements in rates of emergency department (ED) visits, hospitalizations and all-cause readmissions in the second and third years. However, these data were not significantly different than the control group. There were also clear improvements in beneficiaries' overall and emotional health, controlled blood pressure, and A1C levels.
4) Housing Services Delivered, But Permanent Solutions Challenging – The evaluation found substantial evidence of success in delivery of housing services and potential success in reducing ED visits. However, there were challenges in retaining permanent housing, including lack of funding for direct housing provision and lack of adequate housing supply. Some Pilots worked with external partners to mitigate these challenges.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME). PRIME builds upon the public hospital delivery system reforms implemented under the previous Bridge to Reform Waiver and seeks to continue improving the way care is delivered in California's safety net hospitals to maximize health care value and move toward alternative payment models, such as capitation and other risk-sharing arrangements. Participating PRIME entities, Designated Public Hospital (DPH) systems or District/Municipal Public Hospitals (DMPH), must submit plans to achieve goals within one of the following domains:

- **Domain 1: Outpatient Delivery System Transformation and Prevention**. These projects are meant to: 1) ensure patients experience timely access to high-quality, efficient, and patient-centered care; 2) identify and increase rates of cost-effective standard approaches to prevention services for a select group of high-impact clinical conditions and populations such as cardiovascular disease, breast, cervical and colorectal cancer, and obesity; and 3) reduce disparities and variation in performance of targeted prevention services within their systems.
- **Domain 2: Targeted High-Risk or High-Cost Populations.** These projects are focused on specific populations that would benefit most significantly from care integration and alignment. Particular attention will be focused on managing and coordinating care during transitions from inpatient to outpatient and post-acute settings.
- **Domain 3: Resource Utilization Efficiency.** These projects are meant to reduce unwarranted variation in use of evidence-based diagnostics and treatments, targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services.

DHCS has approved a total of 17 plans submitted by DPHs and 37 submitted by DMPHs to become PRIME entities. These entities are eligible to receive up to $3.7 billion combined in federal Medicaid funding over five years for achieving metrics in implementing clinical projects designed to change the

way care is delivered. 1115 Waiver financing regulations require these funds to be matched with a non-federal share of funding, which is provided by other governmental health entity funds that are transferred to DHCS as intergovernmental transfers (IGTs).

Global Payment Program. The Global Payment Program establishes a statewide pool of funding for the remaining uninsured by combining federal Disproportionate Share Hospital and uncompensated care funding. The program establishes individual public hospital system "global budgets" for each hospital from overall annual threshold amounts determined through analysis of services provided to the uninsured. Public hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher-value and preventative services. The program divides services into four categories for evaluating funding:

- Traditional provider-based, face-to-face outpatient encounters
- Other non-traditional provider, groups, prevention/wellness, face-to-face
- Technology-based outpatient
- Inpatient facility

Dental Transformation Initiative. DHCS implemented four dental "domains", collectively referred to as the Dental Transformation Initiative (DTI) in order to improve the quality of care and increase utilization of dental services. The four domains of the DTI program are:

1. Increase Preventive Services Utilization for Children - This domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The domain's goal is to increase utilization among children by at least 10 percent over a five year period. DHCS offers financial incentives for dental service office locations that increase delivery of preventive oral care to Medi-Cal eligible children.
2. Caries Risk Assessment and Disease Management – Under this domain, dental providers receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under.
3. Increase the Continuity of Care - This domain aims to encourage continuity of care among Medi-Cal beneficiaries age 20 and under. Dental provider service office locations receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. Incentive payments are made annually.
4. Local Dental Pilot Programs (LDPPs) – 15 LDPPs were approved, although two have been withdrawn, to address one or more of the previous three domains through alternative programs, using strategies focused on rural areas including local case management initiatives and education partnerships. DHCS requires LDPPs to have broad-based provider and community support and collaboration including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three domains.

Health Homes Program. AB 361 (Mitchell), Chapter 642, Statues of 2013, authorizes DHCS to implement the Medicaid Health Home Program (HHP) Services benefit, which provides enhanced care coordination benefits for members with chronic conditions with the goal of reducing state Medi-Cal costs by decreasing avoidable emergency department and inpatient stays, and improving health outcomes for Medi-Cal's most vulnerable beneficiaries. Established under Section 2703 of the federal Affordable Care

Act, states that adopt the HHP benefit receive a 90 percent federal match for program services for two years. After two years, the federal match converts to the 50 percent federal matching rate.

HHP benefits are structured to be provided by a network including the managed care plan, one or more Community-Based Care Management Entities (CB-CMEs), and Community-Based Organizations (CBOs). Plans are responsible for the overall administration of HHP, including payment, member assignment to providers, oversight, data sharing and analytics, training, and ensuring timely access to care. CB-CMEs, selected and certified by the plan, serve as the single community-based entity with responsibility for ensuring access to services, either directly, or through subcontracting arrangements with other entities, including CBOs, or individuals.

To be eligible for HHP, a member must be a full-scope Medi-Cal beneficiary with no share of cost and meet the following eligibility criteria:

1. Chronic condition – A chronic condition in at least one of the following categories:
   a. At least two of the following: chronic obstructive pulmonary disease, diabetes, traumatic brain injury, chronic or congestive heart failure, coronary artery disease, chronic liver disease, chronic renal disease, dementia, substance use disorders
   b. Hypertension and one of the following: chronic obstructive pulmonary disease, diabetes, coronary artery disease, chronic or congestive heart failure
   c. One of the following: major depression disorders, bipolar disorder, osychotic disorders
   d. Asthma

2. Acuity/Complexity Criteria – Has three or more eligible chronic conditions, at least one hospital stay in the last year, three or more emergency department visits in the last year, or is chronically homeless.

The six core HHP services are as follows:

1. Comprehensive Care Management – Activities related to engaging members to participate in the HHP and collaborating with HHP members and their family/support persons to develop their comprehensive, individualized, person-centered care plan, called a Health Action Plan (HAP).
2. Care Coordination – Services to implement the HHP member's HAP including, but not limited to, navigation and coordination of health, behavioral health, and social services systems, including housing; monitoring and supporting treatment adherence; monitoring and coordinating referrals and follow ups; and sharing information with all involved parties and providers.
3. Health Promotion – Services to encourage and support HHP members to make lifestyle choices based on healthy behavior.
4. Comprehensive Transitional Care – Services to facilitate HHP members' transitions from and among treatment facilities to reduce avoidable HHP member admissions and readmissions.
5. Individual and Family Support Services – Activities that ensure the HHP member and family/support persons are knowledgeable about the member's conditions to facilitate adherence to treatment and medication management.
6. Referral to Community and Social Supports – Determining appropriate services to meet the needs of HHP members, identifying and referring members to available community resources and providers, and following up with members.

DHCS began implementing HHP in 12 counties beginning July 1, 2018, in three groups. As of September 30, 2019, a total of 14,300 members enrolled in HHP including 539 in Group 1 (San Francisco), 7,436 in Group 2 (Riverside, San Bernardino), and 6,325 in Group 3 (Alameda, Imperial, Kern, Los Angeles, Sacramento, San Diego, Santa Clara, Tulare).

Behavioral Health Services in Medi-Cal. Behavioral health services are provided to Medi-Cal beneficiaries through several different delivery systems. Three separate systems provide mental health services to Medi-Cal beneficiaries including county mental health plans, Medi-Cal managed care plans, and the fee-for-service delivery system. Three systems provide Drug Medi-Cal services including the Drug Medi-Cal Organized Delivery System, county-administered Drug Medi-Cal, and state-administered Drug Medi-Cal.

Medi-Cal Mental Health. There are three systems that currently provide mental health services to Medi-Cal beneficiaries:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal specialty mental health services (SMHS) under a federal 1915(b) waiver that includes outpatient SMHS, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's SMHS is provided under the federal requirements of the EPSDT benefit for persons under age 21. County mental health plans are responsible for the provision of SMHS and Medi-Cal enrollees must obtain SMHS through the county. SMHS is a Medi-Cal entitlement for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria.
2. **Managed care plans –** The Affordable Care Act expanded the scope of Medi-Cal mental health benefits and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

3. **Fee-For-Service Provider System -** Effective January 1, 2014 the mental health services listed below are also available through the fee-for-service provider system:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

Drug Medi-Cal. Established in 1980, the Drug Medi-Cal program provides medically necessary substance use disorder (SUD) treatment services to eligible Medi-Cal beneficiaries for specific, approved services. Beginning in 2011, administration of the Drug Medi-Cal program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS and the program was realigned to the counties as part of 2011 Realignment. Drug Medi-Cal had previously been funded with General Fund and federal funds. 2011 Realignment redirected funding for both Drug Medi-Cal and discretionary SUD programs, including those supported by the Substance Abuse Prevention and Treatment block grant, to the counties. Counties provide the non-federal share of expenditures, which are matched with federal funds, for Drug Medi-Cal services as they existed in 2011 and for individuals eligible for Drug Medi-Cal under 2011 Medi-Cal eligibility rules in place before implementation of the optional expansion of Medi-Cal.

Both DHCS and counties have specific oversight requirements for Drug Medi-Cal. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for Drug Medi-Cal services directly, or contract with DHCS, which then directly contracts with providers to deliver Drug Medi-Cal services. Counties that elect to contract with DHCS to provide services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement. DHCS has also implemented the Drug Medi-Cal Organized Delivery System Waiver, a pilot project to test organized delivery of an expanded benefit package for substance use disorder services.

Drug Medi-Cal Organized Delivery System. The Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver is a voluntary pilot program that offers California counties the opportunity to expand access to high-quality care for Medi-Cal enrollees with SUD. The goal of the DMC-ODS Waiver is to demonstrate how organized SUD care improves beneficiary health outcomes, while decreasing system-wide health care costs. Counties that choose to participate in the DMC-ODS Waiver are required to provide access to a full continuum of SUD benefits modeled after criteria developed by the American Society of Addiction Medicine (ASAM). Counties are required to submit implementation plans and proposed interim rates for all county-covered SUD services, except NTP rates, which are set by DHCS.

To receive services through the DMC-ODS Waiver, beneficiaries must meet the following criteria:

1. The beneficiary must be enrolled in Medi-Cal
2. The beneficiary must reside in a county that is participating in the DMC-ODS Waiver
3. The beneficiary must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with certain exceptions, or for youth under 21, be assessed as "at-risk" for developing a SUD
4. The beneficiary must meet the ASAM Criteria definition of medical necessity for services (or ASAM adolescent treatment criteria for youth under 21).

County Reimbursement for Behavioral Health Services in Medi-Cal. Through reforms implemented in the 1991 and 2011 Realignments, counties are responsible for the non-federal share of specialty mental health and Drug Medi-Cal services provided to most Medi-Cal beneficiaries. Counties provide for the delivery of services and submit expenditure reports to DHCS to receive federal matching funds. Claims are paid to counties on an interim basis, pending cost reporting after the end of the fiscal year. DHCS

reconciles the interim payments made to counties with the submitted cost reports and recoups from counties that received excess interim payments or makes additional payments to counties that received insufficient interim payments. In addition, DHCS audits each cost report, which may result in additional adjustments. Counties are permitted to appeal audit findings, which may lead to still more adjustments to reimbursements. The cost-based reimbursement structure for behavioral health services can often take several years to resolve, leading to uncertainty for county behavioral health system financing.

Eligibility for Specialty Mental Health and Substance Use Disorder Services. Medi-Cal beneficiaries must demonstrate medical necessity to be eligible to receive specialty mental health services or substance use disorder services from county service delivery systems. State law defines a service as medically necessary for individuals 21 years of age and older when it is reasonable and necessary to protect life, to prevent significant illness or significant disability.[6] For individuals under 21 years of age, a service is medically necessary if the service is necessary to correct or ameliorate mental illnesses and conditions.[7,8]

CALIFORNIA ADVANCING AND INNOVATING IN MEDI-CAL INITIATIVE

California Advancing and Innovating in Medi-Cal (CalAIM). In January 2021, the Administration released its updated CalAIM proposal, which would resume the previously delayed efforts to significantly reform the delivery of physical health, behavioral health, and oral health care services in the Medi-Cal program. The Administration has moved to transition many of its existing programs into managed care benefits under a new 1915(b) Waiver, maintain some programs under the previous 1115 Waiver authority, and make other changes through amendments to the State Plan. DHCS plans to submit these requests in April 2021. While the managed care authorities provided by the two waivers are similar, there are key differences. For example, while 1115 Waivers require budget neutrality (federal expenditures must not be greater under the waiver than they would have been without the waiver), 1915(b) Waivers only require the demonstration of cost effectiveness and efficiency (actual expenditures cannot exceed projected expenditures)[9].

MANAGED CARE REFORMS

Benefit Standardization. Under the Administration's CalAIM proposal, DHCS would standardize which Medi-Cal benefits are provided in the managed care delivery system and which benefits are provided in another delivery system. The proposed changes, beginning April 1, 2021, are as follows:

Managed Care Benefits ("Carved In")

- Long-term care – Effective January 1, 2023, all institutional long-term care services would become the responsibility of a beneficiary's managed care plan including skilled nursing facilities, pediatric and adult subacute care facilities, intermediate care facilities for individuals with developmental

[6] California Welfare and Institutions Code, Section 14059.5

[7] 42 United States Code Section 1396d(r)(5)

[8] California Welfare and Institutions Code, Section 14059.5

[9] MACPAC. "Features of federal Medicaid managed care authorities". January 2016.

disabilities, disabled/habilitative/nursing services, and specialized rehabilitation in a skilled nursing facility or intermediate care facility.

- Organ transplants – Effective January 1, 2022, all major organ transplants would become the responsibility of a beneficiary's managed care plan.

Fee-for-Service Benefits ("Carved Out")

- Pharmacy – Consistent with the Governor's 2019 Executive Order, and the Administration's Medi-Cal Rx proposal, all prescription drugs and/or pharmacy services billed on a pharmacy claim would be provided in the fee-for-service delivery system. This carve-out was originally scheduled to be effective April 1, 2021, but has been delayed indefinitely by DHCS due to unforeseen conflict issues arising from the merger of its pharmacy benefit contractor with a company that oversees health plans and pharmacies. When implemented, this carve-out would not apply to SCAN Health Plan, Programs for All-Inclusive Care for the Elderly (PACE), Cal MediConnect plans, and the Major Risk Medical Insurance Program (MRMIP).
- Specialty mental health services (Solano and Sacramento) – Effective January 1, 2022, specialty mental health services currently the responsibility of Kaiser health plans in Solano and Sacramento counties, would be provided by the county mental health plans.
- Multipurpose Senior Services Program – Effective January 1, 2022, the Multipurpose Senior Services Program, which had previously been scheduled to become the responsibility of Medi-Cal managed care plans in Coordinated Care Initiative counties, will instead remain a benefit under the existing 1915(c) Home- and Community-Based Services Waiver.

Standardization of Mandatory Managed Care and Fee-for-Service Populations. Under CalAIM, the Administration proposes to standardize which categories of Medi-Cal beneficiaries would be required to enroll in a managed care plan to receive benefits and which beneficiaries would be required to receive benefits in the fee-for-service delivery system. According to DHCS, standardization would enhance coordination of care and reduce complexity across the Medi-Cal program. Implementation of this change would occur in two phases: 1) non-dual-eligible populations would transition in January 1, 2022; and 2) dual-eligible populations would transition in January 1, 2023.

Transitions from Fee-for-Service to Mandatory Managed Care. Populations currently receiving benefits in the fee-for-service delivery system that would be required to enroll in a Medi-Cal managed care plan are as follows:

- Trafficking and Crime Victims Assistance Program beneficiaries, except those with a share of cost
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal
- American Indians
- Beneficiaries with other health care coverage
- Beneficiaries living in rural ZIP codes
- Individuals eligible for long-term care services, including those with a share of cost, beginning January 1, 2023

- All dual-eligible beneficiaries, not including those with a share of cost or with restricted-scope benefits, beginning January 1, 2023

Transitions from Managed Care to Mandatory Fee-for-Service. Populations currently receiving benefits in the managed care delivery system that would be required to receive benefits in the fee-for-service delivery system:

- Individuals receiving restricted-scope benefits
- Individuals with a share of cost, including in county organized health systems, Coordinated Care Initiative counties, Trafficking and Crime Victims Assistance Program, but excluding long-term care
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal, not including Medi-Cal Access Infant Program enrollees
- Omnibus Budget Reconciliation Act (OBRA) beneficiaries currently in managed care in Napa, Solano, and Yolo counties

According to DHCS, enrollment requirements for foster care children and youth will remain unchanged pending discussions and recommendations of its Foster Care Workgroup on future delivery system reforms for this population.

Long-Term Services and Supports Integration. Under CalAIM, DHCS proposes to make several changes to the delivery system for long-term services and supports (LTSS) that build upon the state's duals demonstration project, the Coordinated Care Initiative (CCI). DHCS intends to use selective contracting to move toward aligned enrollment in a Medi-Cal managed care plan and a dual-eligible special needs plan (D-SNP) operated by one integrated organization. In the seven CCI demonstration counties, all Medi-Cal beneficiaries in a Cal MediConnect plan would transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product, beginning January 1, 2023. Aligned enrollment would occur in non-CCI counties as plans are ready, but no later than the 2025 contract year. Dual-eligible beneficiaries already in a non-aligned D-SNP (not affiliated with their managed care plan) would be allowed to maintain their enrollment, but new enrollment in non-aligned D-SNPs would be closed. DHCS will also limit enrollment in Medicare Advantage plans that are D-SNP "look-alikes" beginning in 2022.

DHCS will require all D-SNPs to use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. D-SNPs would be required to: 1) develop and use integrated member materials, 2) include consumers in existing advisory boards, 3) establish joint contract management team meetings for aligned D-SNPs and managed care plans, 4) include dementia specialists in care coordination efforts, and 5) coordinate carved-out LTSS benefits including in-home supportive services (IHSS), MSSP, and other home- and community-based services waiver programs.

Beginning January 1, 2023, DHCS would implement mandatory enrollment of full- and partial-benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible long-term care residents. Long-term care benefits would be integrated into Medi-Cal managed

care statewide. Cal MediConnect plans and the Coordinated Care Initiative would also be discontinued at this time.

National Committee for Quality Assurance Accreditation. The National Committee for Quality Assurance (NCQA) is a private, non-profit organization that reports measures of healthcare quality and offers accreditation for managed care plans. NCQA is responsible for the Healthcare Effectiveness Data and Information Set (HEDIS), which evaluates more than 90 measures across six domains of care for managed care plans, consumers, and public agencies to encourage performance improvement. NCQA also offers accreditation to managed care plans and other health care-related entities in the areas of quality improvement, population health management, network management, utilization management, credentialing, member rights and responsibilities, and member connections.

Under CalAIM, DHCS would require all Medi-Cal managed care plans to be accredited by the NCQA by 2026. Currently, 26 states require Medicaid managed care plans to achieve NCQA accreditation. 17 of the 24 full-scope Medi-Cal managed care plans are currently NCQA accredited. In addition to requiring accreditation, DHCS would use information obtained from the accreditation review to satisfy certain state and federal oversight requirements of Medi-Cal managed care plans. DHCS would no longer conduct independent oversight of these requirements, but would instead focus on more robust oversight of other requirements, such as annual medical audits. While NCQA accreditation would not be required until 2026, DHCS may consider implementing deeming of select elements sooner than 2026 for plans that are already accredited.

According to DHCS, certain categories of oversight would be likely candidates for the department to use accreditation review to deem managed care plans in compliance, as the NCQA requirements exceed both federal and state compliance requirements. These categories are as follows:

- Information Requirements
- Access to Care – Availability of Services
- Access to Care – Coordination and Continuity of Care
- Access to Care – Coverage and Authorization of Services
- Structure and Operations - Confidentiality
- Quality Measurement and Improvement – Practice Guidelines
- Quality Measurement and Improvement – Quality Assessment and Performance Improvement Program
- Grievances – General Requirements
- Grievances – Timely and adequate notice of adverse benefit determination
- Grievances – Handling of grievances and appeals
- Grievances – Expedited resolution of appeals
- Grievances – Recordkeeping requirements
- Grievances – Continuation of benefits while appeal and state fair hearing are pending

In addition to these likely candidates for deeming under CalAIM, DHCS is considering, pending further analysis, the following categories of requirements that meet or exceed either the federal or state standard, or both:

- Access to Care – Emergency and post-stabilization services
- Access to Care – Availability of Services
- Access to Care – Assurances of Adequate Capacity and Services
- Access to Care – Coverage and Authorization of Services
- Structure and Operations – Provider Selection
- Structure and Operations – Subcontractual relationships and delegation
- Quality Measurement and Improvement – Health Information Systems
- Grievances

Regional Managed Care Rate-Setting. Under CalAIM, DHCS would move towards a regional managed care rate-setting methodology to simplify capitation payments for Medi-Cal managed care plans. DHCS reports it currently calculates more than 4,000 individual rates, one for each beneficiary category in each managed care plan. According to DHCS, this level of complexity limits the ability to advance value-based and outcomes-focused rate setting methodologies and complicates annual federal approval of managed care rates. The department believes regional rate-setting would incentivize efficiencies through competition with other regional plans and provide a larger, multi-county base for averaging rate components. The Administration proposes a two phased approach to the transition to regional capitated rate-setting:

- Phase I: Targeted Counties – During calendar years 2020 and 2021, DHCS would engage and collaborate with Medi-Cal managed care plans to advance new regional rate-setting approaches and streamline rate processes and methodologies in targeted counties. Beginning January 1, 2022, DHCS would implement regional rate-setting in targeted counties and Medi-Cal managed care plans. The CalAIM proposal does not identify these counties or what aspects of a county would determine eligibility to participate in this targeted approach.

- Phase II: Statewide – After evaluating and refining the regional rate-setting processes implemented in Phase I, DHCS would implement regional rate-setting statewide beginning no sooner than January 1, 2024.

Population Health Management Program. Under the Administration's CalAIM proposal, Medi-Cal managed care plans would be required to develop and maintain a population health management (PHM) program, defined as a model of care and a plan of action designed to address member health needs at all points along the continuum of care. The PHM program would adhere to NCQA standards and additional requirements established by the department. The implementation of this requirement would occur as part of the new Medi-Cal managed care plan contracts expected to begin on January 1, 2023, and the required PHM plan would be filed with the state annually. The PHM program would include assessment and risk stratification of plan members, integration of wellness and prevention services, case management, identification and delivery of in-lieu-of services, and care transition management.

ENHANCED CARE MANAGEMENT AND IN-LIEU-OF SERVICES

Enhanced Care Management. Under CalAIM, DHCS proposes to require Medi-Cal managed care plans to provide an enhanced care management benefit that addresses the clinical and non-clinical needs of high-cost or high-need beneficiaries. As part of its population health management program requirements, health

plans would be required to submit an Enhanced Care Management Model of Care proposal and complete readiness for delivery of the benefit to the following mandatory target populations:

1) High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits;
2) Individuals at risk for institutionalization with serious mental illness, children with serious emotional disturbance or substance use disorder with co-occurring chronic health conditions;
3) Individuals at-risk for institutionalization and eligible for long-term care;
4) Nursing facility residents who want to transition to the community;
5) Children or youth with complex physical, behavioral, developmental, and oral health needs;
6) Individuals experiencing chronic homelessness or at risk of becoming homeless; and
7) Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

The goals of the enhanced care management benefit would be to improve care coordination, integrate services, facilitate community resources, improve health outcomes, address social determinants of health, and decrease inappropriate utilization. The benefit would be delivered by community-based providers ("ECM Providers") contracting with Medi-Cal managed care plans. Through face-to-face visits, ECM providers would coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. In addition to care coordination, the benefit would include health promotion, comprehensive transitional care, member and family supports, and referral to community and social services.

According to DHCS, this benefit would build upon the efforts of the Whole Person Care and Health Homes pilots and eventually replace those programs. However, managed care plans would be mandated to contract with all existing local providers offering Health Homes and Whole Person Care services, with few contractual exceptions. Plans would also be mandated to contract with community-based providers that have experience serving the target populations and who have expertise in providing enhanced care management services.

Beginning January 1, 2022, all Medi-Cal managed care plans in counties with Whole Person Care pilots or Health Homes Programs would begin implementation of the enhanced care management benefit for those target populations currently receiving services in those programs. Beginning July 1, 2022, these counties would be required to implement enhanced care management for the remaining target populations. The 28 counties with Whole Person Care pilots or Health Homes Programs subject to these implementation timelines include: Alameda, Contra Costa, Imperial, Kern, Kings, Los Angeles, Marin, Mariposa, Mendocino, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Tulare, and Ventura.

For counties without Whole Person Care pilots or Health Homes Programs, implementation of enhanced care management for select target populations would begin July 1, 2022. By January 1, 2023, all Medi-Cal managed care plans in all counties would be required to have implemented enhanced care management for all target populations. The 30 counties without Whole Person Care pilots or Health Homes Programs subject to these implementation timelines include: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Inyo, Lake, Lassen, Madera, Merced, Modoc, Mono, Nevada,

Plumas, San Luis Obispo, Santa Barbara, Sierra Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolomne, Yolo, and Yuba.

In-Lieu-Of Services. Under CalAIM, the Administration proposes to allow plans to voluntarily include one or more in-lieu-of services (ILOS) in their population health management plans. According to federal rules[10], ILOS are medically appropriate and cost-effective alternatives to covered Medi-Cal services and are typically delivered by a different provider, or in a different setting than a traditional Medi-Cal service. DHCS is proposing to allow plans to choose from the following 14 services:

- Housing Transition Navigation Services – These services assist beneficiaries with obtaining housing and include assessing a beneficiary's housing needs, developing a housing support plan, navigating housing options and applications, assisting with advocacy and securing available income and housing subsidy resources, assisting with reasonable accommodation and move-in readiness, and coordinating necessary environmental modifications.
- Housing Deposits – These services assist beneficiaries with securing or funding one-time housing services that do not constitute room and board including security deposits, setup fees or deposits for utilities or other services, first month coverage of utilities, first and last month's rent if required for occupancy, health and safety services such as pest eradication or cleaning upon moving in, and medically necessary adaptive aids and services such as air conditioners or air filters.
- Housing Tenancy and Sustaining Services – These services assist beneficiaries in maintaining safe and stable tenancy after housing is secured including early identification and intervention for behaviors that may jeopardize housing, education and training on rights and responsibilities of tenants and landlords, coordination and assistance to maintain relationships with landlords and resolve disputes, advocacy and linkage to community resources to prevent eviction, health and safety visits, unit habitability inspections, and training for independent living and life skills.
- Short-Term Post-Hospitalization Housing – These services may include supported housing in an individual or shared interim housing setting and are designed to assist beneficiaries who are homeless and who have high medical or behavioral health needs with the opportunity to continue their recovery immediately after exiting an inpatient hospital, substance abuse or mental health treatment facility, custody facility, or recuperative care.
- Recuperative Care (Medical Respite) – These services provide short-term residential care for beneficiaries who no longer require hospitalization, but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. At a minimum, the service would include interim housing with a bed and meals with ongoing monitoring of the beneficiary's condition. The service may also include limited or short-term assistance with activities of daily living, coordination of transportation to post-discharge appointments, connection to other necessary health and human services benefits or housing, or stabilizing case management relationships and programs.
- Caregiver Respite – These services provide relief to caregivers of beneficiaries who require intermittent temporary supervision and may be provided by the hour on an episodic basis, by the day or overnight, or include services that attend to the beneficiary's basic self-help needs or other activities of daily living.
- Day Habilitation Programs – These services assist beneficiaries in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the beneficiary's natural

[10] 42 Code of Federal Regulations Section 438.3. "Standard contract requirements". May 6, 2016.

environment. These services may include training or assistance with the use of public transportation, personal skills development in conflict resolution, community participation, developing and maintaining interpersonal relationships, daily living skills, community resource awareness (e.g. police, fire, other local services), selecting and moving into a home, locating and choosing suitable housemates, locating household furnishings, settling disputes with landlords, managing personal financial affairs, managing needs for personal attendants, dealing with and responding to governmental agencies and personnel, asserting rights through self-advocacy, and coordinating health and human services benefits.

- Nursing Facility Transition/Diversion to Assisted Living Facilities – These services assist beneficiaries to live in the community or avoid institutionalization by transitioning to a Residential Care Facility for Elderly and Adult (RCFE) or Adult Residential Facility (ARF). These services, which do not include room and board, may include assessing housing needs and presenting options, assessing onsite service needs at the RCFE or ARF, assisting in securing a residence, communicating with facility administration and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other in-lieu-of services necessary for stable housing.
- Nursing Facility Transition to a Home – These services assist beneficiaries to live in the community and avoid institutionalization by transitioning to a private residence. These services, which do not include room and board, may include assessing housing needs and presenting options, assisting in securing housing, communicating with landlords and coordinating the move, establishing procedures and contacts to maintain housing placement, and coordinating with enhanced care management or other ILOS necessary for stable housing.
- Personal Care and Homemaker Services – These services assist beneficiaries with activities of daily living such as bathing, dressing, toileting, ambulation, or feeding. These services also assist beneficiaries with instrumental activities of daily living such as meal preparation, grocery shopping and money management. These services are provided in addition to any approved In-Home Supportive Services (IHSS) benefits approved by the county or during any IHSS waiting period.
- Environmental Accessibility Adaptations (Home Modifications) – These services provide physical adaptations to a home that are necessary to ensure the health, welfare, and safety of a beneficiary, or enable the beneficiary to function with greater independence in the home. Adaptations may include installation of ramps and grab-bars, doorway widening for beneficiaries who require a wheelchair, installation of stair lifts, bathroom or shower accessibility, installation of specialized electric or plumbing systems to accommodate medical equipment or supplies, installation and testing of a Personal Emergency Response System for beneficiaries who are alone for significant parts of the day without a caregiver and otherwise require routine supervision.
- Meals/Medically Tailored Meals – These services help beneficiaries achieve nutrition goals at critical times to help them regain and maintain their health and may include meals delivered to the home immediately following discharge from a hospital or nursing facility, or medically-tailored meals provided to the beneficiary at home to meet the unique dietary needs of a chronic condition.
- Sobering Centers – These services provide a safe, supportive environment to become sober for individuals found to be publicly intoxicated and who would otherwise be transported to an emergency department or jail. These services also include medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, homeless care support services, and screening and linkage to ongoing supportive services.

- Asthma Remediation – These services are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home without acute asthma episodes that could result in emergency utilization or hospitalization. These services would include allergen-impermeable mattress and pillow dustcovers, high-efficiency particulate air filtered vacuums, integrated pest management, de-humidifiers, air filters, other moisture-controlling interventions, minor mold removal and remediation, ventilation improvements, asthma-friendly cleaning products and supplies, and other interventions identified to be medically appropriate and cost-effective.

BEHAVIORAL HEALTH PAYMENT REFORM AND ELIGIBILITY CRITERIA

Behavioral Health Payment Reform. Under CalAIM, DHCS proposes to reform behavioral health payment methodologies in a multi-step process from the current cost-based reimbursement process to a rate-based and value-based structure using intergovernmental transfers to fund the non-federal share of services. The first step in the process would transition behavioral health services from the current claims coding system, Healthcare Common Procedure Coding System (HCPCS) Level II, to HCPCS Level I. According to DHCS, this transition would allow for more granular claiming and reporting of services provided, as well as more accurate reimbursements. This transition would occur no sooner than July 1, 2022.

DHCS expects that, concurrent with the transition to HCPCS Level I, DHCS would transition to a rate-setting process for behavioral health services by peer groups of counties with similar costs of doing business. The non-federal share of rates would be provided by counties via intergovernmental transfer (IGT), rather than the current, cost-based certified public expenditure (CPE) process. DHCS would make annual updates to established rates to ensure reimbursement reflects the costs of providing services. DHCS would, at first, make payments to counties on a monthly basis, and would eventually transition to a quarterly payment schedule.

Medical Necessity Criteria Reforms. Under CalAIM, DHCS proposes to modify the existing medical necessity criteria for behavioral health services to ensure behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties. The proposed changes would separate the concept of eligibility for services from that of medical necessity, allow counties to provide services to meet a beneficiary's behavioral health needs prior to diagnosis of a covered condition, clarify that treatment in the presence of a co-occurring substance use disorder is appropriate and reimbursable when medical necessity is met, implement a standardized screening tool to facilitate accurate determinations of which delivery system (specialty mental health, Medi-Cal managed care, or Medi-Cal fee-for-service) is most appropriate for care, implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system in which they seek care, and make other revisions and technical corrections. These changes would ensure that eligibility criteria, largely being driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, would be the driving factor for determining the delivery system in which a beneficiary should receive services. DHCS proposes to make these changes effective January 1, 2022.

Administrative Integration of Specialty Mental Health and Substance Use Disorder Services. Under CalAIM, DHCS proposes to integrate administrative activities of specialty mental health and substance

use disorder (SUD) services into one behavioral health managed care program, beginning with the approval of the next 1915(b) waiver in 2027. DHCS plans to work with counties that participate in DMC-ODS to integrate the two behavioral health programs into one single behavioral health plan structure responsible for all specialty mental health and SUD services. DHCS would also work with Drug Medi-Cal fee-for-service counties to integrate with specialty mental health, though the structure would be different due to federal requirements.

Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements. DHCS proposes to update and improve the Drug Medi-Cal Organized Delivery System (DMC-ODS), including extending the program and providing non-participating counties with another opportunity to opt-in. The improvements being considered by DHCS include the following:

- Remove the restrictions limiting residential treatment length of stay to be determined based on the individual's condition, rather than a set number of days.
- Update the definition of residential treatment to remove adolescent length-of-stay limitations, add mandatory provisions for referral to medication assisted treatment, and remove certain distinctions between adults and adolescents for these requirements.
- Clarify policies related to recovery services, including specific services, when and how the services may be accessed, and ensure beneficiaries are not prohibited from receiving long-term medication assisted treatment after accessing recovery services.
- Require SUD managed care providers demonstrate that they offer or provide referral to medication assisted treatment.
- Clarify terms of clinician consultation and remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers.
- Add contingency management as an evidence-based practice available for use by providers to meet requirements.
- Remove rarely used provider appeal process, which is already addressed under federal regulatory appeals processes.
- Increase access to SUD treatment for American Indians and Alaska Natives.
- Clarify access language for individuals leaving incarceration who have a known substance use disorder.
- Allow reimbursement for SUD assessments before a final diagnosis is determined, in alignment with the changes to specialty mental health medical necessity criteria.
- Clarify requirements for initial assessment and medical necessity determinations.
- Add a new level of care for beneficiaries under 21 to allow early intervention as an organized service that may be delivered in a wide variety of settings.

OTHER PROPOSED CHANGES

Full Integration Plans. Under CalAIM, DHCS proposes to, in consultation with stakeholders, test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. DHCS indicates that topics for consideration of this proposal would include identifying which delivery systems would be part of the plan, determining the participation criteria for entities, identifying the challenges and opportunities of a fully integrated plan, planning the steps and timelines necessary for

implementation, evaluating impacts on other non-Medi-Cal programs, consideration of blending of complex funding streams, and mechanisms for accountability. DHCS expects to implement full integration plans no sooner than January 2026 to allow sufficient time for planning and preparation, in partnership with counties, plans, and other stakeholders.

Future of Other 1115 Waiver Programs. While many elements of the Whole Person Care program would be transitioned to the enhanced care management and ILOS benefit structure under the CalAIM proposal, DHCS is proposing to transition other elements of the state's expiring 1115 Waiver, Medi-Cal 2020 into new programs under the State Plan, the state's new 1915(b) Waiver, or a limited 1115 Waiver Renewal.

- PRIME Transition to Quality Incentive Program – DHCS transitioned the PRIME funding structure into the Quality Incentive Program (QIP), which provides directed payments to hospitals that achieve specified improvement targets, beginning July 1, 2020.
- Global Payment Program – DHCS proposes to extend the Global Payment Program through a limited 1115 Waiver renewal, beginning January 1, 2022.
- Dental Transformation Initiative Transition to State Plan – DHCS proposes to transition certain incentive payments that were part of the Dental Transformation Initiative to the State Plan. Providers would receive incentive payments for: 1) a caries risk assessment bundle for ages zero to six; 2) silver diamine fluoride treatment of ages zero to six, and specified high-risk and institutional populations; and 3) pay for performance incentives for preventive services and establishing continuity of care through dental homes, available statewide for children and adults.

Local Assistance Resource Request. DHCS requests expenditure authority of $1.1 billion ($520.8 million General Fund and $552.9 million federal funds) for local assistance costs to implement the CalAIM initiative. Specifically, these resources would support the following components:

- $187.5 million ($93.8 million General Fund and $93.7 million federal funds) to support the new enhanced care management benefit in Medi-Cal managed care plans, beginning January 1, 2022.
- $47.9 million ($24 million General Fund and $24 million federal funds) to support in-lieu-of services benefits adopted by Medi-Cal managed care plans, beginning January 1, 2022.
- $300 million ($150 million General Fund and $150 million federal funds) to fund incentives for managed care plans to invest in voluntary in-lieu-of services programs and partner with community-based organizations and providers, including but not limited to community clinics, public hospital systems, and county behavioral health systems.
- $401.6 million ($174.7 million General Fund and $226.8 million federal funds) to support transitions of populations between the fee-for-service and managed care delivery systems, as part of the standardization of mandatory fee-for-service and managed care populations.
- $113.5 million ($56.7 million General Fund and $56.7 million federal funds) for enhanced reimbursements for dental services previously included in the Dental Transformation Initiative component of Medi-Cal 2020, California's federal 1115 Medicaid Waiver.
- $21.8 million General Fund for the behavioral health quality improvement program, which helps county behavioral health programs make technical and other improvements to facilitate future behavioral health integration and payment reform efforts.

State Operations - Staffing and Resource Request. DHCS requests 33 positions and expenditure authority of $23.9 million ($11 million general Fund and $12.8 million federal funds) in 2021-22, 40 positions and expenditure authority of $28.2 million ($13.2 million General Fund and $15 million federal funds) in 2022-23, $25.2 million ($12 million General Fund and $13.2 million federal funds) in 2023-24, $23.9 million ($11.6 million General Fund and $12.3 million federal funds) in 2024-25, and $20.3 million ($9.8 million General Fund and $10.5 million federal funds) in 2025-26. Specifically, these positions and resources would support the state operations costs of implementing the CalAIM initiative in the following areas:

Division	Purpose/Responsibilities
Administration Division **Effective 7/1/2021:** 1.0 Staff Services Manager I (SSM I) 1.0 Business Services Officer (BSO I) 2.0 Associate Governmental Program Analysts (AGPA) 4.0 Associate Personnel Analysts (APA) 1.0 Office Technician (OT)	1) Administrative support (contracting, human resources, facilities) for CalAIM proposals
California Medicaid Management Information System (CAMMIS) Division **Resources (7/1/2021 to 6/30/2023) equivalent to:** 1.0 Information Technology Specialist II (ITS II)	1) CA-MMIS System and CD-MMIS System change support for CalAIM proposals 2) Implement complex program policy in CA-MMIS and CD-MMIS systems 3) Modify benefit payment methodology in CA-MMIS and CD-MMIS systems. 4) Behavioral Health Payment Reform in CA-MMIS system.
Capitated Rates Development Division (CRDD) **Effective 7/1/2021:** 1.0 Research Data Analyst II (RDA II) 2.0 Research Data Specialist I (RDS I) 1.0 SSM I 2.0 AGPAs **Resources equivalent to (7/1/2021 to 6/30/2025):** 1.0 Staff Services Manager II (SSM II) 1.0 Health Program Specialist I (HPS I) 1.0 Research Data Specialist II (RDS II) 1.0 AGPA **Effective 7/1/2022:** 2.0 AGPAs 1.0 RDS I 1.0 SSM II 1.0 RDS II	Capitated Rate Development Modifications Related to: 1) Enhanced Care Management 2) In-Lieu-of-Services 3) Shared Risk, Shared Savings, and Incentive Payments 4) Managed Care Benefit Standardization

Resources equivalent to (7/1/2022 to 6/30/2025): 1.0 AGPA 1.0 RDS I 1.0 SSM I 1.0 RDA II	
Community Services Division **Resources equivalent to (7/1/2021 to 6/30/2025):** 1.0 Research Data Supervisor I (RD Sup. I) 1.0 Research Scientist III (RS III) 2.0 RDS I **Resources equivalent to (7/1/2022 to 6/30/2025):** 2.0 RDA II	Behavioral Health Data Systems and Data Analysis Support for Behavioral Health Proposals
Enterprise Data and Information Management **Resources equivalent to (7/1/2021 to 6/30/2023):** 1.0 ITS II	Data and Information support for CalAIM proposals
Enterprise Technology Services (ETS) **Effective 7/1/2021:** 1.0 ITM I 2.0 ITS II **Resources equivalent to (7/1/2021 to 6/30/2023):** 1.0 IT Sup II 1.0 ITS II 1.0 ITS I	System support for CalAIM proposals and long term support of required system changes, including, but not limited to Enhanced Care Management; Shared Risk, Shared Savings, and Incentive Payments; Managed Care Benefit Standardization; Mandatory Managed Care Enrollment; Transition to Statewide Long-Term Services and Supports, Long-Term Care & Dual Eligible Needs Plans; and Improving Beneficiary Contact and Demographic Information
Integrated Systems of Care Division **Effective 7/1/2021:** 1.0 SSM I 6.0 AGPA 1.0 HPS I	Enhancing County Oversight and Monitoring: California Children's Services and Child Health and Disability Prevention
Local Governmental Financing Division **Effective 7/1/2021:** 1.0 HPS I 1.0 AGPA	Behavioral Health Payment Reform
Managed Care Operations Division **Effective 7/1/2021:** 3.0 AGPAs 2.0 HPS I 1.0 HPS II 1.0 RDA II	Managed Care Benefit Standardization: 1) Mandatory Enrollment 2) Transition to Statewide Long-Term Services and Supports, Long-Term Care, and Dual Eligible Special Needs Plans

1.0 Research Data Manager (RDM) **Resources equivalent to (7/1/2021 to 6/30/2025):** 2.0 HPS I 1.0 Research Data Analyst I (RDA I) 1.0 RD Sup II **Resources equivalent to (7/1/2021 to 6/30/2025):** 2.0 AGPAs	
Mgd Care Quality and Monitoring Division **Effective 7/1/2021:** 8.0 AGPAs 2.0 Health Program Manager II (HPM II) 1.0 HPS II 3.0 Nurse Consultant III (NC III) 1.0 RS III 2.0 SSM I 1.0 SSM II **Resources equivalent to (7/1/2021 to 6/30/2025):** 2.0 HPS II 1.0 RDA II 2.0 RDS I 1.0 RDS II	Enhanced Care Management Benefit: 1) In Lieu of Services 2) National Committee for Quality Assurance (NCQA) Accreditation of Medi-Cal Managed Care Plans 3) Population Health Management Program 4) Transition to Statewide Long-Term Services and Supports, Long-Term Care, and Dual Eligible Special Needs Plans
Medi-Cal Behavioral Health Division **Resources equivalent to (7/1/2021 to 12/31/2027):** 2.0 SSM II 5.0 SSM I 5.0 HPS I 9.0 AGPA **Resources equivalent to (7/1/2021 to 6/30/2024):** 1.0 AGPA 1.0 HPS I	1) Integration of Infrastructure for Specialty Mental Health and Substance Use Disorder Services 2) Medical Necessity Criteria for Specialty Mental Health and Substance Use Disorder Services
Medi-Cal Dental Services Division **Effective 7/1/2021:** 1.0 SSM I **Effective 7/1/2022:** 1.0 SSM I 1.0 AMA 7.0 AGPA	New Dental Policies

1.0 Dental Hygienist Consultant (DHC)	
Medi-Cal Eligibility Division **Effective 7/1/2021:** 1.0 SSM II 1.0 SSM I 3.0 AGPA	Improving Medi-Cal Eligibility Oversight and Monitoring
Office of Administrative Hearings and Appeals **Effective 7/1/2021:** 1.0 Administrative Law Judge II	Hearings and appeals support for CalAIM
Office of Legal Services **Effective 7/1/2021:** 3.0 Attorney III **Effective 1/1/2022:** 1.0 Attorney III 1.0 Senior Legal Analyst (SLA)	Legal support for CalAIM proposals
Office of the Medical Director **Effective 7/1/2021** 2.0 AGPAs 1.0 Public Health Medical Officer III (PHMO III)	Transition of Public Hospital Redesign and Incentives in Medi-Cal (PRIME) to Quality Incentive Program (QIP)

In addition to these staffing resources, DHCS requests expenditure authority of $5.9 million in 2021-22 and $7.8 million in 2022-23 for the following contract resources for the CalAIM project:

- **Reporting and Business Intelligence** - $1 million annually for three years, beginning July 1, 2021
- **Drug Medi-Cal Evaluation** - $1.1 million annually for five years, beginning January 1, 2022
- **Drug Medi-Cal External Quality Review Organization** - $2.3 million annually for five years, beginning January 1, 2022
- **Drug Medi-Cal Technical Assistance to Counties** - $500,000 annually for five years, beginning January 1, 2022
- **SMI/SED Waiver** - $2 million annually for two years, beginning July 1, 2021
- **Contract to Maintain QIP Data Reporting Portal** - $250,000 annually ongoing
- **QIP Data Integrity** - $500,000 annually ongoing
- **QIP Annual Conference** - $150,000 annually ongoing

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

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

1. Please provide a brief overview of the following components of the department's CalAIM proposal:

    a. Managed Care Reforms
    b. Population Health Management
    c. Enhanced Care Management and other Case Management Services
    d. In-Lieu of Services
    e. LTSS Integration
    f. Behavioral Health Payment and Medical Necessity Reforms

2. Currently, counties have significant, cross-disciplinary fiscal and programmatic incentives to address the needs of the populations served by the Whole Person Care pilots and Health Homes Program. How would DHCS ensure that Medi-Cal managed care plans are effectively addressing the needs of these populations without shifting costs onto other service delivery systems?

3. Does the department have a plan for the future trajectory of in-lieu of services? For example, is there a long-term plan or timeline for counties to build up sufficient provider networks that these may become mandatory State Plan benefits? Would the department support providers of these services outside of the CalAIM framework in counties in which the managed care plans do not include them in their Model of Care planning?

4. Please describe the structure of the incentive payments for Medi-Cal managed care plans.

5. Please provide a brief overview of the state operations request for CalAIM implementation.

Issue 6: Delay or Repeal of Program and Benefit Suspensions

Budget Bill Language and Trailer Bill Language – Governor's Budget. DHCS proposes provisional budget bill language and trailer bill language to delay or repeal program and benefit suspensions first adopted in the 2019 Budget Act. Specifically, the proposed language would: 1) delay or repeal suspensions for certain supplemental payments for Medi-Cal providers supported by Proposition 56 tobacco tax revenue; 2) delay suspension of certain optional Medi-Cal benefits; 3) delay suspension of provisional post-partum extension of Medi-Cal eligibility; and 4) repeal suspension of screening, brief intervention, and referral to treatment (SBIRT) for opioids and other drugs.

Proposition 56 Provides Supplemental Reimbursements to Medi-Cal Providers. Proposition 56, approved by voters in 2016, increased the excise tax rate on cigarettes by $2 per pack, with an equivalent increase on other tobacco products, including electronic cigarettes, to provide funding for various public health and tobacco-related law enforcement programs. After allocations for administration, auditing, and backfills of other revenue streams, Proposition 56 requires 82 percent of remaining funds be transferred to the Healthcare Treatment Fund to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services in the Medi-Cal program.

The 2017 Budget Act allocated Medi-Cal funding for supplemental payments for certain physician services, dental services, women's health, intermediate care facilities for individuals with developmental disabilities (ICF-DDs), and provider serving beneficiaries of the AIDS Waiver. The 2018 Budget Act increased the allocation for physician and dental services by expanding eligible preventive service codes and the level of reimbursement for each code, as well as funding for home health services, pediatric day health centers, free-standing pediatric subacute facilities, and certain qualified community-based adult services programs, and a one-time allocation for loan repayments for physicians and dentists who serve Medi-Cal beneficiaries. The 2019 Budget Act included ongoing supplemental payments for family planning services, early developmental screenings for children, trauma screenings for children and adults, provider trainings for trauma screenings, a three-year value-based payment program for providers that meet certain quality metrics, and a second allocation for physician and dentist loan repayments.

The budget includes $3.2 billion ($975.8 million Proposition 56 and $2.3 billion federal funds) in 2020-21 and $3.2 billion ($275.3 million General Fund, $717.9 million Proposition 56 and $2.2 billion federal funds) in 2021-22 for supplemental provider payments in Medi-Cal. The supplemental payments by category are as follows:

Category/Fund	2020-21	2021-22	Category/Fund	2020-21	2021-22
Physician Services			***Pediatric Day Health Care Facilities***		
Total Fund	$1,276,175,000	$1,275,228,000	Total Fund	$17,353,000	$14,246,000
Proposition 56	$400,454,000	$426,761,000	Proposition 56	$7,741,000	$6,656,000
Federal Funds	$875,721,000	$848,467,000	Federal Funds	$9,612,000	$7,590,000
Dental Services			***Pediatric Subacute Facilities***		
Total Fund	$518,839,000	$514,291,000	Total Fund	$9,155,000	$8,943,000
Proposition 56	$180,707,000	$193,052,000	Proposition 56	$3,832,000	$4,085,000
Federal Funds	$338,132,000	$321,239,000	Federal Funds	$5,323,000	$4,858,000

Women's Health			***Community-Based Adult Svcs (CBAS)***		
Total Fund	$154,170,000	$163,957,000	Total Fund	$38,648,000	$30,753,000
Proposition 56	$21,476,000	$22,595,000	Proposition 56	$16,928,000	$14,285,000
Federal Funds	$132,694,000	$141,362,000	Federal Funds	$21,720,000	$16,468,000
Medi-Cal Family Planning			***Home Health***		
Total Fund	$436,844,000	$431,071,000	Total Fund	$167,320,000	$92,754,000
Proposition 56	$43,684,000	$43,107,000	Proposition 56	$77,152,000	$43,338,000
Federal Funds	$393,160,000	$387,964,000	Federal Funds	$90,168,000	$49,416,000
Interm. Care Facilities-Developmental Disabilities			***Developmental Screenings***		
Total Fund	$25,988,000	$25,925,000	Total Fund	$53,308,000	$61,960,000
Proposition 56	$11,076,000	$11,782,000	Proposition 56	$20,955,000	$25,878,000
Federal Funds	$14,912,000	$14,143,000	Federal Funds	$32,353,000	$36,082,000
AIDS Waiver			***Trauma (ACES) Screenings***		
Total Fund	$6,800,000	$6,800,000	Total Fund	$42,090,000	$47,682,000
Proposition 56	$2,978,000	$3,189,000	Proposition 56	$14,910,000	$18,217,000
Federal Funds	$3,822,000	$3,611,000	Federal Funds	$27,180,000	$29,465,000
Non-Emergency Medical Transportation			***Provider ACES Training***		
Total Fund	$7,925,000	$7,925,000	Total Fund	$61,924,000	$41,712,000
Proposition 56	$3,664,000	$3,892,000	Proposition 56	$30,962,000	$20,856,000
Federal Funds	$4,261,000	$4,033,000	Federal Funds	$30,962,000	$20,856,000
Behavioral Healthcare Incentive Program			***Hosp-Based Pediatric Providers (One-time)***		
Total Fund	$57,000,000	$76,000,000	Total Fund	$4,000,000	$0
Proposition 56	$24,966,000	$35,644,000	Proposition 56	$1,752,000	$0
Federal Funds	$32,034,000	$40,356,000	Federal Funds	$2,248,000	$0
Value-Based Payment (VBP) Program			***TOTAL***		
Total Fund	$364,513,000	$364,207,000	Total Fund	$3,242,052,000	$3,163,454,000
Proposition 56	$112,547,000	$119,866,000	Proposition 56*	$975,784,000	$993,203,000
Federal Funds	$251,966,000	$244,341,000	Federal Funds	$2,266,268,000	$2,170,251,000

* Due to estimated reductions in the availability of Proposition 56 revenue, approximately 28 percent of 2021-22 supplemental payments are supported by the state's General Fund.

Mandatory and Optional Benefits in Medi-Cal Federal Medicaid law requires certain benefits to be included in a state's Medicaid plan for providing services to its beneficiaries. In addition to the required benefits, states are authorized to include certain optional benefits for Medicaid beneficiaries. Both mandatory and optional benefits are eligible for federal matching funds. According to the federal Centers for Medicare and Medicaid Services, the mandatory and optional benefits in federal Medicaid laws and regulations are as follows:

Mandatory Benefits	Optional Benefits
Inpatient hospital services	Prescription Drugs
Outpatient hospital services	Clinic services
EPSDT	Physical therapy

Nursing Facility Services	Occupational therapy
Home health services	Speech, hearing and language disorder services
Physician services	Respiratory care services
Rural health clinic services	Other diag./screening/preventive/rehab. services
FQHC services	Podiatry services
Laboratory and X-ray services	Optometry services
Family planning services	Dental Services
Nurse Midwife services	Dentures
Certified Pediatric/Family NP services	Prosthetics
Freestanding Birth Center services	Eyeglasses
Transportation to medical care	Chiropractic services
Tobacco cessation counseling (pregnant women)	Other practitioner services
	Private duty nursing services
	Personal Care
	Hospice
	Case management
	Services for Individuals 65 or Older in an IMD
	Services in an ICF-DD
	State Plan HCBS - 1915(i)
	Self-Directed Pers. Assistance Services- 1915(j)
	Community First Choice Option- 1915(k)
	TB Related Services
	Inpatient psychiatric services-individuals under 21
	Other services approved by the Secretary
	Health Homes (for Chronic Conditions)- 1945

2009 Budget Actions Eliminated Many Medi-Cal Optional Benefits Until 2020. In 2009, facing a significant General Fund deficit, the budget included several reductions in reimbursement and benefits in the Medi-Cal program. AB 5 X3 (Evans), Chapter 20, Statutes of 2009, Third Extraordinary Session, eliminated several optional Medi-Cal benefits, including adult dental services, acupuncture, audiology, speech therapy, chiropractic services, optician and optical lab services, podiatric services, psychology services, and incontinence creams and washes. These benefits were not eliminated for beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program, beneficiaries in a skilled nursing facility or intermediate care facility, or pregnant beneficiaries. Over the course of several years, budget and legislative actions have restored nearly all of the eliminated benefits as of January 1, 2020, including full adult dental benefits, optical benefits, acupuncture, audiology, incontinence creams/washes, podiatry, and speech therapy.

Extension of Medi-Cal for Provisional Postpartum Care. SB 104 (Committee on Budget and Fiscal Review), Chapter 67, Statutes of 2019, extended Medi-Cal eligibility for pregnancy-only programs from

60 days to one year after delivery if the beneficiary is diagnosed with a maternal mental health disorder. The implementation of the provisional postpartum care extension occurred August 2020. The budget includes General Fund expenditure authority of $27.1 million in 2021-22 for the eligibility expansion.

Expansion of Screening, Brief Intervention, Referral to Treatment (SBIRT) to Opioids and Other Drugs. SB 78 (Committee on Budget and Fiscal Review), Chapter 38, Statutes of 2019, directed DHCS to seek federal approval to expand the Medi-Cal benefit for screening, brief intervention, and referral to treatment (SBIRT) to include screening for overuse of opioids and other illicit drugs such as heroin and methamphetamine. Effective June 9, 2020, the United States Preventive Services Task Force (USPSTF) assigned a "B" rating to SBIRT screening for opioids and other illicit drugs for adults ages 18 and older. The California Medicaid State Plan requires mandatory coverage of any benefit recommended by the USPSTF. As a result, the budget includes expenditure authority of $1.6 million ($563,000 General Fund and $1 million federal funds) in 2020-21 and $1.7 million ($622,000 General Fund and $1.1 million federal funds) in 2021-22 for the expansion of SBIRT.

Suspension of Proposition 56 Supplemental Payments, Optional Benefits, Post-Partum Care Extension and SBIRT. The 2019 Budget Act included language to suspend expenditures for certain health and human services programs on December 31, 2021. If the Director of Finance determines that projected annual General Fund revenues exceed projected annual General Fund expenditures sufficient to fund all suspended programs, the suspensions would not take effect. These suspensions were intended to address an expected General Fund shortfall in subsequent fiscal years due to a recessionary forecast. The health related programs subject to suspension included: 1) Proposition 56 supplemental provider payments, 2) Medi-Cal optional benefits, 3) provisional post-partum care Medi-Cal eligibility expansion, 4) SBIRT expansion to opioids and other drugs, 5) comprehensive HIV prevention grants, 6) sexually transmitted disease (STD) prevention grants, and 7) hepatitis C prevention grants.

The 2020 Budget Act maintained the structure of the suspensions, but accelerated suspensions of Proposition 56 supplemental provider payments to July 1, 2021 (except family planning, women's health, and the physician and dentist loan repayment program), and repealed the suspensions for the HIV, STD, and hepatitis C prevention grant programs.

Administration Proposes to Delay Some Suspensions, Repeal Others. DHCS proposes provisional budget bill language and trailer bill language to delay or repeal program and benefit suspensions. Specifically, the proposed language would make the following changes to the suspensions framework:

1) *Proposition 56 Supplemental Provider Payments* – DHCS proposes provisional budget bill language and trailer bill language that would delay the suspension of most Proposition 56 supplemental provider payments until July 1, 2022, or one year after the current suspension date. The language would suspend supplemental payments for intermediate care facilities-developmental disabilities (ICF-DDs), freestanding pediatric subacute facilities, and community-based adult services on December 31, 2022, or 18 months after the current suspension dates. The language would also repeal the suspension for supplemental payments for the AIDS waiver, home health, and pediatric day health care facilities, as DHCS does not expect federal approval for these suspensions.
2) *Optional Benefits* - DHCS proposes trailer bill language to delay the suspension of Medi-Cal optional benefits until January 1, 2023, or one year after the current suspension date. These

benefits would include podiatric services, audiology services, speech therapy, optician and optical services, and incontinence creams and washes.

3) *Provisional Post-Partum Care Eligibility Extension* – DHCS proposes trailer bill language to delay the suspension of the provisional post-partum care extension of Medi-Cal eligibility until December 31, 2022, or one year after the current suspension date.
4) *SBIRT for Opioids and Other Drugs* – DHCS proposes trailer bill language to repeal the suspension of the SBIRT benefit for opioids and other drugs, as recommendations by the USPSTF require mandatory coverage of this benefit.

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

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

1. Please provide a brief overview of these proposals.

Issue 7: AB 1705 Ground Emergency Medical Transportation Public Provider IGT Program

Budget Change Proposal – Governor's Budget. DHCS requests five positions and expenditure authority of $715,000 ($358,000 federal funds and $357,000 reimbursements) in 2021-22, and $670,000 ($335,000 federal funds and $335,000 reimbursements) annually thereafter. If approved, these positions and resources would allow DHCS to implement a new Ground Emergency Medical Transportation (GEMT) Public Provider Intergovernmental Transfer (IGT) program, pursuant to AB 1705 (Bonta), Chapter 544, Statutes of 2019.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0890 – Federal Trust Fund	$358,000	$335,000
0995 – Reimbursements	$357,000	$335,000
Total Funding Request:	**$715,000**	**$670,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and Resources ongoing after 2022-23.

Background. SB 523 (Hernandez), Chapter 773, Statutes of 2017, established the Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF) program, which assesses a fee on each emergency medical transport to support enhanced reimbursement to GEMT providers. For GEMT providers in the Medi-Cal fee-for-service delivery system, fee revenue serves as the non-federal share of a reimbursement rate add-on for transports. For GEMT providers in the Medi-Cal managed care delivery system, fee revenue serves as the non-federal share of increased capitation payments to Medi-Cal managed care plans to provide supplemental payments to noncontract providers of GEMT services. Under SB 523, the QAF program supports enhanced reimbursement for both public and private GEMT providers.

AB 1705 (Bonta), Chapter 544, Statutes of 2019, suspends the GEMT QAF program for public providers, and instead establishes a GEMT Public Provider Intergovernmental Transfer (IGT) program. Under this program, public providers would participate in a voluntary transfer of funding to DHCS, which would support the non-federal share of enhanced reimbursement to eligible GEMT providers. Similar to the GEMT QAF program, the GEMT Public Provider IGT program would provide a rate add-on in the fee-for-service delivery system, and would increase managed care capitation payments to provide supplemental payments to providers in the managed care delivery system. Managed care plans would be required to reimburse a noncontract GEMT provider an amount equal to what the provider would have received under the fee-for-service delivery system.

Under the GEMT Public Provider IGT program, DHCS would assess a 10 percent fee on each voluntary IGT to support program operations, as well as the non-federal share of health care services expenditures in the Medi-Cal program. The 10 percent assessment is a feature of other IGT programs administered by DHCS, and supports administration of the program without an impact on the state's General Fund. According to DHCS, the IGT program would likely provide a higher reimbursement rate to providers than these providers currently receive under the QAF program. DHCS reports the GEMT public provider community has communicated strong support for the implementation of this program.

Staffing and Resource Request. DHCS requests five positions and expenditure authority of $715,000 ($358,000 federal funds and $357,000 reimbursements) in 2021-22, and $670,000 ($335,000 federal funds and $335,000 reimbursements) annually thereafter to implement the GEMT Public Provider IGT program. According to DHCS, the new program would create new workload in the department's Capitated Rates Development Division (CRDD), which would require **one Staff Services Manager I** position and **four Associate Governmental Program Analysts**. These positions would work with the department's contracted actuary to develop managed care capitation rate adjustments for the program; manage the IGT agreements and revenue collections; serve as subject matter experts for the new program; oversee and develop appropriate tools and mechanisms to process GEMT public provider IGT information; research, develop, and recommend policies and standards; and communicate policies, processes, timelines, and other requirements to the GEMT public provider community.

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

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

1. Please provide a brief overview of this proposal.

Issue 8: Medi-Cal Telehealth Proposal and Remote Patient Monitoring

Local Assistance and Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to allow the delivery of certain Medi-Cal benefits, under specified circumstances, via telehealth, telephonic/audio-only, remote patient monitoring, and other virtual communication modalities. DHCS requests expenditure authority of $94.8 million ($34 million General Fund and $60.8 million federal funds) to support a new remote patient monitoring benefit as part of the telehealth proposal.

Program Funding Request Summary – Local Assistance Funding (Remote Patient Monitoring)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$-	$33,987,890
0890 – Federal Trust Fund	$-	$60,797,530
Total Funding Request:	**$-**	**$94,785,400**

Background. In response to the pandemic emergency, DHCS provided broad flexibilities for the delivery of Medi-Cal services through telehealth, telephonic/audio only, and other virtual communication modalities. According to DHCS, providing these telehealth flexibilities proved to be critically important during a time when in-person care put beneficiaries at risk of exposure to COVID-19. DHCS is proposing to allow additional Medi-Cal benefits and services to be provided via telehealth across all delivery systems when clinically appropriate.

Temporary Flexibilities During Pandemic Emergency. DHCS implemented the following temporary policy changes during the pandemic emergency, related to telehealth:

- Expanded ability for providers to render all applicable services that can be appropriately provided via telehealth modalities, including home- and community-based services, Local Education Agency, and Targeted Case Management services.
- Allowed most telehealth modalities to be provided for new and established patients.
- Allowed many covered services to be provided via telephone/audio-only for the first time.
- Allowed payment parity between services provided in-person face-to-face, by synchronous telehealth, and by telephonic/audio only when the services met the requirements of the billing code by various provider types, including federally qualified health centers (FQHCs) and rural health centers (RHCs).
- Waived site limitations for providers and patients of FQHCs and RHCs
- Allowed expanded access to telehealth through non-public technology platforms, based on a federal exemption to Health Insurance Portability and Accountability Act (HIPAA) requirements.

According to DHCS, the availability and need for telehealth has led to a significantly wider adoption of the use of these modalities for service delivery. Providers have become familiar with delivering services via telehealth and receiving reimbursement for telehealth services.

Trailer Bill Language. DHCS proposes trailer bill language to allow the delivery of certain Medi-Cal benefits, under specified circumstances, via telehealth, telephonic/audio-only, remote patient monitoring, and other virtual communication modalities. Specifically, DHCS proposes the following permanent flexibilities, contingent on federal approval:

- Allow an FQHC or RHC to establish new patients, within its federally designated service area, through synchronous telehealth only.
- Permanently remove the site limitations on the provision of services by FQHCs and RHCs.
- Expand synchronous and asynchronous telehealth services to home- and community-based services waivers, the Targeted Case Management (TCM) Program, and the Local Education Agency Billing Option Program (LEA-BOP).
- Add synchronous telehealth and telephonic/audio-only services to State Plan Drug Medi-Cal.
- Require payment parity between in-person face-to-face visits and synchronous telehealth modalities only.
- Expand use of clinically appropriate telephonic/audio-only, other virtual communication, and remote patient monitoring for established patients, subject to a separate fee schedule and not billable by FQHCs or RHCs.
- Provides that the TCM Program and LEA BOP will follow traditional certified public expenditure reimbursement methodologies when rendering services via telehealth.

According to DHCS, it is not proposing to extend the following telehealth flexibilities implemented during the pandemic emergency:

- Telephonic/audio-only modalities as a billable visit for FQHCs or RHCs reimbursed at the per-visit rate
- Telephonic/audio-only modalities to establish a new patient
- Payment parity for telephonic/audio-only modalities and virtual communications
- Various flexibilities for Tribal 638 clinics.

Local Assistance for Remote Patient Monitoring. DHCS requests expenditure authority of $94.8 million ($34 million General Fund and $60.8 million federal funds) to support a new remote patient monitoring benefit as part of the telehealth proposal. Remote patient monitoring allows clinical staff to use the results of remote physiological monitoring devices to manage a patient under a specific treatment plan. Common physiological data collected include vital signs, weight, blood pressure, and heart rate. The benefit would be implemented on July 1, 2021, for beneficiaries 21 years of age or older with a primary diagnosis of an acute or chronic condition. Beneficiaries would receive the devices from their providers, who would be reimbursed for remote monitoring activities.

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

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

1. Please provide a brief overview of the proposed extension of telehealth flexibilities and the rationale for why certain flexibilities were extended and others were not.

2. Please describe the details of the new remote patient monitoring benefit. How would providers be reimbursed for this benefit?

Issue 9: New/Restored Benefits: CGM and OTC Acetaminophen, and Cough/Cold Products

Local Assistance and Trailer Bill Language– Governor's Budget. DHCS requests expenditure authority of $10.9 million ($3.8 million General Fund and $7.1 million federal funds) to add continuous glucose monitoring (CGM) systems as a Medi-Cal benefit for beneficiaries with Type 1 diabetes. In addition, DHCS proposes trailer bill language to restore over-the-counter acetaminophen and cough and cold products as Medi-Cal benefits. DHCS expects a reduction in annual Medi-Cal expenditures of $21 million ($7.8 million General Fund and $13.2 million federal funds) due to the replacement of more costly opioids, prescription pain relievers, and other prescription cough treatments with these less costly over-the-counter options.

Program Funding Request Summary – Local Assistance Funding (CGM)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$-	$3,797,000
0890 – Federal Trust Fund	$-	$7,144,000
Total Funding Request:	**$-**	**$10,941,000**

Program Funding Request Summary – Local Assistance Funding (Acetaminophen)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	($7,761,000)	($7,777,000)
0890 – Federal Trust Fund	($13,197,000)	($13,223,000)
Total Funding Request:	**($20,958,000)**	**($21,000,000)**

Proposed New Medi-Cal Benefit - Continuous Glucose Monitoring Systems. Continuous glucose monitoring (CGM) systems use small sensors located just under a patient's skin to provide near real-time glucose data, which facilitates monitoring of time spent in the desirable target glucose range, warns users if glucose is trending toward hypoglycemia or hyperglycemia, and leads to improved glycemic control and outcomes compared to traditional self-monitoring of blood glucose for adult patients with Type 1 diabetes. In particular, use of CGM systems demonstrates sustained improvement in glycemic indicators and a reduction in adverse events such as severe hypoglycemia and episodes of ketoacidosis.[11,12] Currently, the California Children's Services (CCS) program and the Genetically Handicapped Persons Program (GHPP) provide coverage of medically necessary CGM devices for program participants.

DHCS requests expenditure authority of $10.9 million ($3.8 million General Fund and $7.1 million federal funds) to add CGM systems as a Medi-Cal benefit for beneficiaries 21 and older with Type 1 diabetes that demonstrate medical necessity. The implementation of the benefit would begin January 1, 2022. The benefit would include two physician visits for sensor placement and calibration, patient training, and a follow-up; an external CGM receiver for three years; and monthly supplies of sensors and transmitters. The CGM systems would be reimbursed as durable medical equipment. DHCS plans to enter into rebate agreements with CGM system manufacturers to offset General Fund costs for the new benefit. In addition,

[11] Danne, T., et al. "*International Consensus on Use of Continuous Glucose Monitoring*". Diabetes Care. 2017.

[12] Soupal, J., et al. "*Glycemic Outcomes in Adults With T1D Are Impacted More by Continuous Glucose Monitoring Than by Insulin Delivery Method: 3 Years of Follow-Up From the COMISAIR Study*". Diabetes Care. 2020.

DHCS estimates beneficiaries' transition from self-monitoring of blood glucose to CGM systems would result in offsetting savings to the Medi-Cal program due to a reduction in use of traditional blood glucose monitoring supplies.

Proposed Restored Benefit – Over-the-Counter Acetaminophen and Cough/Cold Products. Federal Medicaid law provides states the option to provide coverage for over-the-counter acetaminophen and cough and cold products. Prior to 2010, Medi-Cal covered these products as an inexpensive alternative to prescription pain relievers and other drugs. SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, eliminated Medi-Cal coverage for over-the-counter (OTC) acetaminophen products as part of a package of General Fund reductions to address recessionary budget shortfalls. The 2010 Budget Act assumed an annual General Fund savings of $3.1 million from eliminating the OTC acetaminophen benefit. AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, eliminated OTC cough and cold products, also to address recessionary budget shortfalls. The 2011 Budget Act assumed annual General Fund savings of $2.2 million from elimination of the OTC cough and cold product benefit.

During the COVID-19 pandemic, Medi-Cal temporarily reinstated coverage of OTC acetaminophen and cough and cold products for beneficiaries. The primary symptoms of COVID-19 include pain, aches, fever, cough, and congestion. As the preferred treatment for these symptoms are OTC fever reducers, analgesics and cough and cold products, DHCS reinstated coverage for these products.

DHCS proposes trailer bill language to permanently reinstate coverage of OTC acetaminophen and cough and cold products. According to DHCS, this policy change would result in savings for the Medi-Cal program, as these products are less costly than prescription opioids, analgesics, and cough treatments currently covered for beneficiaries. The budget assumes General Fund savings of $21 million ($7.8 million General Fund and $13.2 million federal funds) annually from implementation of this proposal. The department's current estimate that restoration of these benefits would result in savings to the Medi-Cal program suggests that the General Fund savings estimates included in the 2010 and 2011 Budget Acts for elimination of these benefits were likely erroneous.

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

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

1. Please provide a brief overview of these proposals.

Issue 10: California Community Transitions (SB 214)

Budget Change Proposal – Governor's Budget. DHCS requests General Fund expenditure authority of $432,000 in 2021-22 and $405,000 in 2022-23 and 2023-24. If approved, these resources would allow DHCS to implement and operate a temporary, state-funded California Community Transitions (CCT) program, pursuant to the requirements of SB 214 (Dodd), Chapter 300, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$432,000	$405,000
Total Funding Request:	**$432,000**	**$405,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24: $405,000.

Background. The Deficit Reduction Act of 2005 established the Money Follows the Person (MFP) rebalancing demonstration, which was designed to increase the use of home- and community-based, rather than institutional, long-term care services and eliminate barriers to enable beneficiaries to receive support for appropriate and necessary long-term services in the setting of their choice. In California, the MFP demonstration is known as California Community Transitions (CCT), which works with CCT Lead Organizations (CCTLOs) to identify eligible Medi-Cal beneficiaries who have continuously resided in state-licensed health care facilities for 90 consecutive days or longer. CCTLOs employ or contract with transition coordinators who work directly with eligible individuals, support networks, and providers to facilitate and monitor beneficiaries' transitions from facilities to the community settings of their choice. CCTLO staff meet with individuals to develop a transition plan and identify the individual's needs to safely live in the community, including skilled-nursing or in-home attendant care, medical equipment, transportation, and case management. After transition, a transition coordinator works with the individual for up to one year to address post-transition needs.

Transitions During COVID-19 Pandemic. During the pandemic, individuals over 65 years of age have been more likely to experience a more severe case of COVID-19 with 12,579 deaths occurring among skilled nursing facility residents, 27 percent of the state's total. As a result, several state efforts have been focused on reducing COVID-19 impacts on congregate care facilities, including skilled nursing facilities. Identifying eligible individuals that could transition from these facilities into a home- and community-based setting, including in the CCT program, helps decompress facilities and avoid exposure of vulnerable seniors and persons with disabilities to COVID-19. However, as a condition of federal MFP demonstration funding, individuals are only eligible for CCT services if they have continuously resided in a facility for 90 days. This requirement would not allow individuals to receive transition services immediately when determining suitability for a home- and community-based placement, but rather would require a stay of 90 days or longer in facilities that have been a locus of morbidity and mortality for COVID-19.

SB 214 Establishes a State-Only CCT Program to Eliminate 90 Day Stay Requirement. To alleviate the impact of COVID-19 on facilities, residents, and staff, SB 214 establishes a state-only program to provide CCT services to individuals residing in facilities for less than 90 days. DHCS expects the program would transition 300 eligible individuals in 2021 and 420 in 2022 from facilities to home- and community-

based settings of their choice. According to DHCS, these transitions would also result in long-term savings to the Medi-Cal program by providing lower-cost home- and community-based care to eligible individuals, rather than more costly long-term care in a facility. The state-only CCT program would sunset on January 1, 2023.

Staffing and Resource Request. DHCS requests General Fund expenditure authority of $432,000 in 2021-22 and $405,000 in 2022-23 and 2023-24 to implement and operate the temporary state-funded CCT program required by SB 214. This expenditure authority would support the **equivalent of one Associate Governmental Program Analyst, one Health Program Specialist I** position, and **one Research Data Analyst II** position. These positions would coordinate implementation and operation of the program with CCTLOs, DHCS administrative staff, and clinical staff. This workload would include processing applications and treatment authorization requests, providing enrollment packets, implementation of a separate tracking process for state-only participants, and overseeing program performance.

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

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

1. Please provide a brief overview of this proposal.

2. Given the expected long-term savings to the Medi-Cal program, would DHCS continue this program after its sunset on January 1, 2023?

Issue 11: Long-Term Health Care Facility Penalties for Improper Discharges

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to assess monetary penalties against a long-term health care facility for noncompliance with a hearing decision issued by DHCS that orders the readmission of a resident after a finding that the facility improperly transferred, discharged, or failed to readmit a resident.

Background. Federal law requires states to provide a long-term health care facility resident with a fair hearing if the resident has been refused readmission to the facility from a hospital. The hearing process, meant to protect against improper resident discharge, known as "patient dumping", is administered by the DHCS Office of Administrative Hearings and Appeals (OAHA), which conducts the hearing and issues decisions and orders related to improper discharges, transfers, or refusals to readmit. According to DHCS, once OAHA issues a decision and order, it no longer has jurisdiction or authority for enforcement, but refers the issue to the Department of Public Health (DPH). DPH handles these referrals as complaints, investigates the improper discharge, and may issue a citation to the facility.

DHCS indicates the hearing process for improper discharges, followed by an investigation by DPH, can lead to delays in returning residents to their facility of origin in a timely manner. In addition, DHCS reports its OAHA findings occasionally do not align with DPH findings in its investigative process. Because DHCS has no enforcement authority, it must defer to DPH to ensure a resident is readmitted to their facility of origin, and to impose penalties on noncompliant facilities.

DHCS proposes trailer bill language that would authorize the department to assess penalties of up to $1,000 for each calendar day the facility fails to comply with a hearing decision, beginning on the sixth calendar day after the date of service of the decision. Penalties would not exceed a total of $100,000 for each hearing decision noncompliance episode. The language would authorize DHCS to waive a portion of penalties upon a facility's successful demonstration of hardship. Penalty revenue would be deposited in the state's General Fund.

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

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

1. Please provide a brief overview of this proposal.

Issue 12: Medi-Cal Enterprise System Modernization

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority of $22.3 million ($4 million General Fund and $18.3 million federal funds) in 2021-22 and $1.3 million ($128,000 General Fund and $1.1 million federal funds) in 2022-23 to continue support of critical information technology modernization efforts.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$4,016,000	$128,000
0890 – Federal Trust Fund	$18,263,000	$1,147,000
Total Funding Request:	**$22,279,000**	**$1,275,000**
Total Requested Positions:	**0.0**	**0.0**

Background. Over the past several years, DHCS has undertaken several information technology (IT) projects to upgrade systems for payment processing, eligibility, and other functions. These projects have been managed either directly by DHCS or in partnership with the California Health and Human Services Agency and other state partners. Beginning with the 2020 Budget Act, DHCS has changed its approach from focusing on individual IT systems to focusing on a comprehensive Medi-Cal Enterprise System (MES), which coordinates these efforts. The MES would combine the following previously separate modernization efforts: 1) the California Medicaid Management Information System (CA-MMIS) Modernization project; 2) the Medi-Cal Eligibility System (MEDS) Modernization project; and 3) the Comprehensive Behavioral Health Data System Modernization (CBHDSM) project. According to DHCS, the department has already begun the process of consolidating these efforts and requires additional resources to continue to build and manage its portfolio of IT projects.

Resource Request. DHCS requests expenditure authority of $22.3 million ($4 million General Fund and $18.3 million federal funds) in 2021-22 and $1.3 million ($128,000 General Fund and $1.1 million federal funds) in 2022-23 to continue support of critical IT modernization efforts under the Medi-Cal Enterprise System. Specifically, DHCS requests the following contract resources for the following projects and components:

California Automated Recovery Management (CalARM) **–** DHCS requests expenditure authority of $3 million ($297,000 General Fund and $2.7 million federal funds) to contract with a Software-as-a-Service vendor in 2021-22 for design and implementation activities for the California Automated Recovery Management (CalARM) module, which provides support for third-party liability and recovery activities, and was previously part of the CA-MMIS modernization project. This contract would be part of the CalARM project's Project Approval Lifecycle Stage 4 submission.

Comprehensive Behavioral Health Data Systems Modernization (CBHDSM) – DHCS requests expenditure authority of $1.3 million ($128,000 General Fund and $1.1 million federal funds) in 2021-22 and 2022-23 for a contract to support completion of the Project Approval Lifecycle Stage 2 Alternatives Analysis, Stage 3 Preliminary Assessment, and the federal Implementation Advanced Planning Document (IAPD) for the Comprehensive Behavioral Health Data System Modernization (CBHDSM). This project

would modernize required data collection from county behavioral health programs as part of the department's oversight of these programs.

Federal Draw and Reporting (FDR) System – DHCS requests expenditure authority of $9.8 million ($2.5 million General Fund and $7.4 million federal funds) for an engineering services contract to build on existing functionality delivered in 2020-21 for the Federal Draw and Reporting (FDR) System, which replaces functionality currently provided by the CMS-64 system and other manual processes for reporting Medi-Cal expenditure information to the federal Centers for Medicare and Medicaid Services for the purpose of federal matching funds.

Modernization Strategy Planning and Support – DHCS requests expenditure authority of $8.2 million ($1.1 million General Fund and $7.1 million federal funds) in 2021-22 to implement its consolidation of IT projects under the Medi-Cal Enterprise System (MES). According to DHCS, MES Modernization would implement an agile organization, capable of delivering modern technology solutions that have design, technology, and development procedure consistency. To support the transformation to a modern, enterprise approach, DHCS specifically requests the following contract services:

- *Digital Support Services (DSS)*
  $2 million ($200,000 General Fund and $1.8 million federal funds)
  This contract would provide the MES Modernization effort the capability to bring resources with specialized skills to meet the project and business objectives across the comprehensive set of IT projects.
- *Modern Development Environment*
  $1 million ($100,000 General Fund and $900,000 federal funds)
  This contract would provide engineering support for the development and operations, and licensing costs for platform and tools.
- *Architecture Planning and Governance Support*
  $3.4 million ($340,000 General Fund and $3.1 million federal funds)
  This contract would enable development of the MES Modernization strategy including development of an MES Modernization approach, MES Modernization roadmap, MES Modernization product and module portfolio, MES Modernization governance structure, initial understanding of cost and timeframes, and related MES Modernization management functions.
- *Organizational Change Management*
  $735,000 ($74,000 General Fund and $662,000 federal funds)
  This contract would plan, execute, and support the transformation DHCS program and IT staff, knowledge, skills, and abilities, including the transition of culture, process, and organizational approach.
- *Independent Validation and Verification (IV&V)*
  $375,000 ($38,000 General Fund and $338,000 federal funds)
  This contract would provide oversight for all MES Modernization work efforts, to assess these efforts as a whole, rather than as individual modules.

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

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

1. Please provide a brief overview of this proposal.

Issue 13: Coordination of Benefits and Post-Payment Recovery

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to clarify requirements for third-party commercial health insurance carriers to share data with the department of post-payment recovery and coordination of benefits.

Background. Federal and state law requires Medi-Cal to be the payer of last resort for the provision of health care services. If a Medi-Cal beneficiary has other health coverage, DHCS identifies these other coverage entities and maintains that information in the department's eligibility data system. Medi-Cal providers are able to access this information when they provide services to Medi-Cal beneficiaries and are required to seek reimbursement from a beneficiary's other health coverage before they may bill Medi-Cal for any remaining balance. DHCS refers to this process as "cost avoidance". If DHCS identifies other health coverage for a Medi-Cal beneficiary after the delivery of a health care service, Medi-Cal reimburses the provider for the service and recoups allowable costs from the other health coverage entity. DHCS refers to this process as "pay and chase".

For both "cost avoidance" and "pay and chase", DHCS obtains commercial health insurance eligibility files through electronic data exchanges. Other health coverage carriers are required by existing law to provide this information to DHCS through cooperative agreements. DHCS must negotiate these agreements with each individual carrier and has limited ability to request a comprehensive data set from each carrier. DHCS reports verification of this information is also a labor-intensive process.

DHCS proposes trailer bill language that would do the following:

1) Update and clarify the list of other health coverage carriers required to enter into cooperative agreements with DHCS to include all health care entities licensed by the California Department of Insurance, third party administrators, and union trusts.
2) Remove requirements that carriers be paid at the same rate paid to the Department of Motor Vehicles for providing information.
3) Establish the specific beneficiary data required to be submitted to DHCS from third-party entities.
4) Establish other data required when available about other persons' covered under the member's policy.
5) Require entities to provide DHCS with access to real-time electronic eligibility verification, at no cost to DHCS and in a form and manner specified by DHCS as is necessary to conduct its coordination of benefits responsibilities.

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

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

1. Please provide a brief overview of this proposal.

Issue 14: Limited-Term Positions – Extension or Conversion to Permanent

Budget Change Proposals – Governor's Budget. DHCS requests expenditure authority of $8.7 million ($3.1 million General Fund and $5.6 million federal funds) in 2021-22, $1.5 million ($222,000 General Fund and $1.3 million federal funds) in 2022-23, $1.3 million ($132,000 General Fund and $1.1 million federal funds) in 2023-24 and 2024-25, and General Fund expenditure authority of $132,000 in 2025-26. If approved, these resources would allow DHCS to extend previously approved limited-term resources equivalent to 38 positions for workload in various programs.

DHCS also requests 62.5 positions and expenditure authority of $9.5 million ($3.2 million General Fund, $5.6 million federal funds, and $676,000 Hospital Quality Assurance Revenue Fund) annually. If approved, these positions and resources would allow DHCS to address ongoing workload in various programs.

Program Funding Request Summary – Extension of Limited-Term Positions		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$3,081,000	$222,000
0890 – Federal Trust Fund	$5,621,000	$1,322,000
Total Funding Request:	**$8,702,000**	**$1,544,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24 and 2024-25: $1,262,000; 2025-26: $132,000.

Program Funding Request Summary – Conversion of Limited-Term Positions to Permanent		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$3,176,000	$3,176,000
0890 – Federal Trust Fund	$5,603,000	$5,603,000
0890 – Federal Trust Fund	$676,000	$676,000
Total Funding Request:	**$9,455,000**	**$9,455,000**
Total Requested Positions:	**62.5**	**62.5**

* Positions and resources ongoing after 2022-23.

Background. Over the past several years, DHCS has received limited-term resources to support workload in the following programs:

- California Community Transitions (CCT) Demonstration Project
- Federal Managed Care Regulations
- 1115 Waiver Extension – Medi-Cal 2020
- Medi-Cal Health Enrollment Navigators
- Robert F. Kennedy Workers Medical Plan
- Legal Support for Ongoing Waiver Activities
- Health Care Reform Financial Reporting
- Private Hospital Directed Payment Program
- Medi-Cal Eligibility Systems Staffing

These resources were established as limited-term to provide support for new workload that was either seen as time-limited in scope, or to allow sufficient time to assess whether the workload was ongoing and required permanent positions and resources. DHCS is requesting resources for additional limited-term extension of resources for workload for which such a temporary extension is appropriate, and to convert limited-term resources to permanent for ongoing workload.

Extension of Limited-Term Resources. DHCS requests limited-term extension of previously approved limited-term resources equivalent to 38 positions that expire on June 30, 2021, and expenditure authority of $8.7 million ($3.1 million General Fund and $5.6 million federal funds). Specifically, DHCS is requesting the following resources in the following programs:

California Community Transitions Demonstration Project – The California Community Transitions (CCT) Demonstration Project is supported by a federal Money Follows the Person (MFP) Rebalancing Demonstration grant to assist Medi-Cal beneficiaries in an in-patient facility to return to a home- or community-based setting. Because the MFP grant is approved by Congress on a limited-term basis, resources for this program have also been approved on a limited-term basis. DHCS is requesting four-year extension of resources **equivalent to eight positions** until June 30, 2025.

Federal Managed Care Regulations and 1115 Waiver Extension – In 2015, the federal Centers for Medicare and Medicaid Services (CMS) released a final rule expanding state requirements for oversight and monitoring of managed care plans, mental health plans, prepaid inpatient hospital plans, and dental managed care plans. Also in 2015, CMS approved California's 1115 Waiver renewal titled Medi-Cal 2020. Because the waiver is only approved for five years, these resources were only approved for a limited-term. However, due to the public health emergency, this waiver was extended by an additional year. For both the federal managed care regulations and 1115 Waiver extension resources, DHCS is requesting one-year extension of resources **equivalent to 25 positions** and 15 month extension of resources **equivalent to seven positions.**

Medi-Cal Health Enrollment Navigators – The 2019 Budget Act included resources to support outreach and enrollment support for retaining and using health coverage and gaining access to necessary medical care. Because the resources were available for a limited time, resources to support program workload was also approved for a limited-term. DHCS is requesting one-year extension of resources **equivalent to four positions**, as the grant program is continuing to provide funds to counties and organizations to contact hard-to-reach target populations to engage in outreach activities.

Robert F. Kennedy (RFK) Farm Workers Medical Plan – The RFK Medical Plan is a non-governmental, self-funded, self-insured health plan subject to collective bargaining agreements between the United Farm Workers and multiple agricultural employers. The 2017 Budget Act provided support to the RFK Medical Plan to ensure its financial viability through 2026. Because the funding was limited-term, the resources were only approved for a limited-term, as well. DHCS is requesting five year extension of resources **equivalent to one positions** to continue supporting the program until funding expires in 2026.

Conversion of Limited-Term Resources to Permanent. DHCS requests 62.5 positions and expenditure authority of $9.5 million ($3.2 million General Fund, $5.6 million federal funds, and $676,000 Hospital Quality Assurance Revenue Fund) annually to allow DHCS to address ongoing workload in various

programs. Specifically, DHCS is requesting the following positions and resources in the following programs:

Federal Managed Care Regulations - In 2015, the federal Centers for Medicare and Medicaid Services (CMS) released a final rule expanding state requirements for oversight and monitoring of managed care plans, mental health plans, prepaid inpatient hospital plans, and dental managed care plans. Much of this workload is permanent, as it is unlikely CMS is going to relax these standards. DHCS is requesting authority for **30 positions** to convert these limited-term resources to permanent staff.

Legal Support for Ongoing Waiver Activities – The 1115 Waiver requires legal support and expertise for legislative, regulatory, contractual, and litigation support work. As the 1115 Waivers have been time-limited, the resources have been approved for limited-term. However, the workload is ongoing for the conclusion of this waiver and any successor programs. DHCS is requesting authority for **two positions** to convert these limited-term resources to permanent staff.

Health Care Reform Financial Reporting – The 2015 Budget Act provided limited-term resources equivalent to 18 positions to address increases in mandated reporting requirements related to the federal Affordable Care Act. This workload includes federal reporting of quarterly expense reports based on state plan amendments, waivers, and base provider payments. This workload is ongoing. DHCS is requesting authority for **18 positions** to convert these limited-term resources to permanent staff.

Private Hospital Directed Payment Program – The Private Hospital Directed Payment program implements a uniform dollar increase in reimbursement to private hospitals that provide designated inpatient and outpatient services under contract with managed care plans. DHCS must annually submit adjustments to managed care rates to comply with CMS requirements for this directed payment program. The 2018 Budget Act included three year limited-term resources equivalent to 9.5 positions to support the program. DHCS is requesting authority for **7.5 positions** to convert some of these limited-term resources to permanent.

Medi-Cal Eligibility Systems Staffing – The 2016 Budget Act provided three-year limited-term resources to support enhancements to the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), Medi-Cal Eligibility Data System (MEDS), and Statewide Automated Welfare Systems (SAWS). DHCS is requesting authority for **seven positions** to convert these limited-term resources to permanent staff.

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

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

1. Please provide a brief overview of these proposals.

Issue 15: Community Mental Health - Overview

Community Mental Health – *Three Year Funding Summary*			
Fund Source	**2019-20**	**2020-21**	**2021-22**
1991 Realignment (base and growth):			
Mental Health Subaccount	$0	$86,826,000	$72,833,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,120,551,000	$1,129,949,000	$1,120,551,000
Behavioral Health Subaccount	$1,465,202,000	$1,582,340,000	$1,545,456,000
Realignment Total	**$2,585,753,000**	**$2,799,115,000**	**$2,738,840,000**
Medi-Cal SMHS Federal Funds	**$2,925,191,000**	**$3,002,281,000**	**$3,444,951,000**
Medi-Cal SMHS General Fund	**$273,104,000**	**$412,764,000**	**$362,675,000**
MHSA Local Expenditures	**$2,141,435,000**	**$2,128,328,000**	**$2,290,554,000**
Total Funds	**$7,925,483,000**	**$8,342,488,000**	**$8,837,020,000**

Background. California's system of community mental health treatment was first established in 1957 after passage of the Short-Doyle Act. Prior to Short-Doyle, the state was primarily responsible for the care and treatment of Californians with mental illness or developmental disabilities in fourteen regional psychiatric hospitals throughout the state. Short-Doyle was enacted to allow individuals with mental illness to be treated in a community-based setting nearer to friends and family to support more successful treatment outcomes, and resulted in a significant shift of the locus of treatment out of the state's psychiatric hospitals and into the community. Covered Short-Doyle benefits included treatment and rehabilitation services in primarily outpatient settings, as well as community education and training for professionals and staff in public entities to address mental health problems early.

Mental Health Services in Medi-Cal. Medi-Cal, California's state Medicaid program, was established in 1966 and covered specific mental health-related benefits including psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists. In 1971, many of the benefits provided by local Short-Doyle community mental health programs were also included in the scope of benefits provided to Medi-Cal beneficiaries. During this period, beneficiaries could access mental health services through Short-Doyle Medi-Cal (SD/MC) or through direct fee-for-service Medi-Cal providers (FFS/MC).

State-Local Realignment Funding for Community Mental Health. In 1991, in response to a state General Fund deficit, many state programs and funding streams were realigned to local governments including community mental health programs. The Bronzan-McCorquodale Act (1991 Realignment) provided that county mental health departments would be responsible for community mental health

services for Medi-Cal beneficiaries, for payments to state hospitals for treatment of individuals civilly committed under the Lanterman-Petris-Short Act (LPS), and for Institutions for Mental Disease (IMDs) that provide short-term nursing level care to individuals with serious mental illness. Funding for these programs is provided by redirection of sales tax and vehicle license fee revenues to counties.

In 2011, additional mental health responsibilities were realigned to counties in a package primarily focused on major public safety programs (2011 Realignment). Additional sales tax and vehicle license fee revenue was allocated to counties to fund these programs, which included responsibility for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children in Medi-Cal. Funding for the 1991 Mental Health Subaccount, up to $1.12 billion, was redirected to fund maintenance of effort requirements for the California Work Opportunities and Responsibility for Kids (CalWORKs) program. This redirection of funding was replaced by $1.12 billion of 2011 Realignment revenue deposited in the 2011 Realignment Mental Health Subaccount for community mental health programs. Consequently, realignment funding for community mental health services is derived primarily from 2011 Realignment funding allocations.

Affordable Care Act Expansion of Mental Health Benefits. The federal Affordable Care Act expanded certain mental health benefits available to Medi-Cal beneficiaries. SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, First Extraordinary Session, implemented these new benefit requirements. These benefits are provided to individuals with mild to moderate levels of impairment by Medi-Cal managed care plans, rather than community mental health plans.

Medi-Cal Mental Health. There are three systems that currently provide mental health services to Medi-Cal beneficiaries:

4. **County Mental Health Plans (MHPs) -** California provides Medi-Cal specialty mental health services (SMHS) under a federal 1915(b) waiver that includes outpatient SMHS, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's SMHS is provided under the federal requirements of the EPSDT benefit for persons under age 21. County mental health plans are responsible for the provision of SMHS and Medi-Cal enrollees must obtain SMHS through the county. SMHS is a Medi-Cal entitlement for adults and children that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria.

5. **Managed care plans –** SB 1 X1 expanded the scope of Medi-Cal mental health benefits, pursuant to the federal Affordable Care Act, and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services for those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

6. **Fee-For-Service Provider System -** Effective January 1, 2014 the mental health services listed below are also available through the fee-for-service provider system:

    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

Mental Health Services Act (Proposition 63, Statutes of 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. These tax receipts are reconciled and deposited into the MHSA Fund on a "cash basis" (cash transfers) to reflect funds actually received in the fiscal year. The MHSA provides for a continuous appropriation of funds for local assistance.

The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Most MHSA funding is to be expended by county mental health departments for mental health services consistent with local Three-Year Plans with Annual Updates approved by DHCS and the required five components, as required by MHSA. The following is a brief description of the five components:

1. **Community Services and Supports for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments establish, through a stakeholder process, a listing of programs for which these funds will be used. Of total annual revenues, 80 percent is allocated to this component.

2. **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.

3. **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded from five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.

4. **Workforce Education and Training.** This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component,

for a total of $460.8 million provided to counties and the Office of Statewide Health Planning and Development (OSHPD).

5. **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

Counties are required to submit annual revenue and expenditure reports to DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC). DHCS monitors county's use of MHSA funds to ensure the county meets the MHSA and Mental Health Services Fund requirements.

Subcommittee Staff Comments and Recommendation—Hold Open. Subcommittee staff recommends holding this item open as updated estimates of caseload and expenditures will be provided at the May Revision.

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

1. Please provide a brief overview of community mental health programs overseen by DHCS.

Issue 16: Behavioral Health Continuum of Care Infrastructure

Local Assistance – Governor's Budget. DHCS requests General Fund expenditure authority of $750 million in 2021-22. If approved, these resources would allow DHCS to implement a competitive grant program for counties for the acquisition and rehabilitation of real estate assets to expand the community behavioral health continuum.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$750,000,000	$-
Total Funding Request:	**$750,000,000**	**$-**

Background. According to DHCS, California faces a significant behavioral health infrastructure deficit. Inpatient psychiatric bed capacity is 21 beds per 100,000 people, while experts estimate 50 beds per 100,000 would be required to meet the Californians' behavioral health needs. According to 2014 data, California had among the lowest inpatient psychiatric bed capacity in the country. In addition, California only licenses about 2,300 subacute mental health treatment beds and the number of substance use disorder treatment facilities has decreased by 13 percent over the last three years. DHCS reports the following factors lead to this infrastructure deficit:

1) High real estate costs, leading to challenges building new facilities
2) "Not in my backyard" attitudes and zoning restrictions, leading to challenges finding suitable locations to expand treatment facilities and low-income housing
3) Difficulty accessing low-income housing, resulting in growing homelessness, leading to increasing numbers of people with severe mental illness requiring residential care
4) Restrictive federal interpretations regarding matching funds for services provided in Institutions for Mental Disease
5) Cost-based reimbursement of county behavioral health departments, preventing county reserves that could allow for investments in behavioral health infrastructure

According to DHCS' analysis of the gaps in bed capacity:

1) 40 counties, or 69 percent, have no crisis stabilization units
2) 38 counties, or 66 percent, have no mental health rehabilitation centers
3) 37 counties, or 64 percent, have no psychiatric health facilities
4) 31 counties, or 53 percent, have no licensed inpatient psychiatric beds
5) 15 counties, or 26 percent, have no substance use disorder residential treatment beds
6) 8 counties, or 14 percent, have no permanent supportive housing beds

Investment in Mental Health Wellness Act. SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, provided $142.5 million in one-time General Fund, $4 million in ongoing Mental Health Services Act (MHSA) funding, and $2.8 million in federal matching funds (reimbursements) to provide grants for community-based mental health crisis support. Known as the Investment in Mental Health Wellness Act of 2013, SB 82 authorized the California Health Facilities Financing Authority (CHFFA) to disburse funds to California counties or their nonprofit or public agency designees to develop

mental health crisis support programs. The one-time General Fund grants support capital projects to increase capacity for crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and peer respite. The MHSA and federal funds grants support personnel costs associated with operation of mobile crisis support teams. The grants support capital improvement, expansion and limited start-up costs.

CHFFA conducted six funding rounds for competitive grant awards, approving a total of 56 grants for 79 projects (69 capital and 10 personnel) in 41 counties. Approximately $136.5 million of capital funding (General Fund) and $4 million of MHSA funding for mobile crisis support team personnel has been encumbered. As of October 2020, $96.9 million of total funding has been disbursed, representing a total of 464 beds, including the following:

- 110 mobile crisis vehicles (or equivalent IT equipment)
- 57.25 mobile crisis personnel
- 736 crisis stabilization and crisis residential treatment beds
- 6 peer respite beds

Local Assistance Resource Request. DHCS requests General Fund expenditure authority of $750 million in 2021-22 to implement a competitive grant program for counties for the acquisition and rehabilitation of real estate assets to expand the community behavioral health continuum. Specifically, these resources would support the addition of at least 5,000 beds, units, or rooms, including the following:

- **Treatment facilities** including Crisis Intervention and Stabilization, Crisis Residential, Residential Treatment, Day Rehabilitation, Day Treatment Intensive or Partial Hospitalization with Housing Supports
- **Housing facilities** including Adult and Senior Care Facilities, Room and Board with Intensive Outpatient Services, and Peer Respite and Shared housing. These facilities would include intensive wrap-around supports, such as enhanced care management, in-lieu-of services, and county behavioral health services.

The grant program would allow facilities to be directly operated by counties, or operated through a contract with qualified nonprofit providers. Counties would be required to provide a 25 percent match of local funds, which may include property, land, or philanthropic donations.

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

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

1. Please provide a brief overview of this proposal.

2. Why did the Administration choose not to augment the Investment in Mental Health Wellness Act program, which has operated a similar grant program for the past several years at CHFFA? Has DHCS coordinated with CHFFA on this proposal to identify best practices or lessons learned?

Issue 17: Increased Access to Student Behavioral Health Services

Budget Change Proposal and Local Assistance – Governor's Budget. DHCS requests expenditure authority of $389 million ($194.5 million General Fund and $194.5 million federal funds) in 2021-22. If approved, these resources would allow DHCS to implement an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services.

DHCS also requests expenditure authority of $11 million ($5.5 million General Fund and $5.5 million federal funds) in 2021-22. If approved, these resources would support implementation workload for the student behavioral health incentive program, including capitated rate development, local government financing, and managed care operations and monitoring.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$194,493,000	$-
0890 – Federal Trust Fund	$194,493,000	$-
Total Funding Request:	**$388,986,000**	**$-**

Program Funding Request Summary – Budget Change Proposal		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$5,507,000	$-
0890 – Federal Trust Fund	$5,507,000	$
Total Funding Request:	**$11,014,000**	**$**
Total Requested Positions:	**0.0**	**0.0**

Background. According to DHCS, schools are a critical point of access for preventive and early intervention behavioral health services, as children are in school for many hours a day, for approximately half the days of the year. Early identification and treatment through school-affiliated behavioral health services can reduce emergency room visits, crisis situations, inpatient stays, and placement in high-cost special education settings or out of home placement. Schools often lack on-campus behavioral health resources, making it difficult to recognize and respond appropriately to children's mental health needs.

Mental Health Student Services Act. The 2019 Budget Act included expenditure authority from the Mental Health Services Fund of $50 million in 2019-20 and $10 million annually thereafter for the Mental Health Student Services Act (MHSSA), a competitive grant program to establish mental health partnerships between county mental health or behavioral health departments and school districts, charter schools, and county offices of education. These partnerships support: (1) services provided on school campuses; (2) suicide prevention; (3) drop-out prevention; (4) outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), and youth who have been expelled or suspended from school; (5) placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services; and (6) other prevention, early intervention, and direct services, including, but not limited to, hiring

qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth.

Prior to the MHSSA, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, known as the Investment in Mental Health Wellness Act, included expenditure authority from the Mental Health Services Fund of $32 million annually for MHSOAC to support counties to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. In 2018-19 the expenditure authority was reduced to $20 million annually. According to MHSOAC, since 2017-18, 50 percent of the funding has been allocated to programs dedicated to children and youth aged 21 and under, and approximately $20 million was allocated for four School-County Collaboration Triage grants to: 1) provide school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families or caregivers; and 2) supporting the development of partnerships between behavioral health departments and educational entities. Humboldt County, Placer County, Tulare County Office of Education, and a joint powers authority in San Bernardino County were awarded $5.3 million annually over four years in this program. MHSOAC also awarded grants for school-based triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo.

Building on the partnership model in the triage grant program, MHSSA supports partnerships between county behavioral health programs and educational entities. Combining the $50 million allocation in 2019-20 with the annual $10 million allocations for the subsequent three fiscal years, MHSOAC allocated a total of $75 million over four years for funding of the MHSSA Partnership Grant Program. The funding was made available in two categories: 1) $45 million for counties with existing school mental health partnerships, and 2) $30 million for counties developing new or emerging partnerships. Within each category, funding was made available based on the population size of a county with a total of six grants at $2.5 million each made available to small counties (less than or equal to 200,000 population), six grants at $4 million each made available to medium counties (between 200,000 and 750,000 population), and six grants at $6 million each made available to large counties (greater than 750,000 population).

The January budget includes expenditure authority from the Mental Health Services Fund of $25 million in 2021-22 for additional MHSSA grants. According to MHSOAC, proposals requesting approximately $80.5 million of grant funding were not approved during the most recent funding round.

Local Assistance Resource Request. DHCS requests expenditure authority of $389 million ($194.5 million General Fund and $194.5 million federal funds) in 2021-22 to implement an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services. The incentive payments would support the following interventions:

- Local planning efforts to review existing plans and documents that articulate student needs; compile data; map existing behavioral health resources; identify gaps, disparities, and inequities; convene stakeholders; and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for students. These planning efforts would include Medi-Cal managed care plans, county behavioral health departments, schools, and other key local stakeholders.

- Execution of contracts between schools, Medi-Cal managed care plans, and county behavioral health departments to provide preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers. Incentives would be provided for reaching threshold levels of school participation and for three-way contracts between the schools, behavioral health departments and Medi-Cal managed care plans.
- Development of behavioral health wellness programs, including Mental Health First Aid or Social and Emotional Learning.
- Expand the workforce using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-aged children.
- Increase behavioral health telehealth services in schools, including access to equipment and space
- Implement adverse childhood experience (ACE) screenings and referral processes in schools
- Implement a school suicide prevention strategy
- Implement culturally appropriate and community-defined interventions and systems for behavioral health services in schools to close health equity gaps.
- Increase prenatal and postpartum access to behavioral health for teen parents
- Improve public reporting of performance and outcomes for behavioral health access and quality
- Increase access to substance use disorder prevention, early intervention and treatment
- Provide care teams to conduct outreach, engagement, and home visits, as well as linkage to social services to address non-clinical needs

State Operations Resource Request. DHCS requests expenditure authority of $11 million ($5.5 million General Fund and $5.5 million federal funds) in 2021-22 to support implementation workload for the student behavioral health incentive program, including capitated rate development, local government financing, and managed care operations and monitoring. Specifically, DHCS requests the following resources:

Capitated Rates Development Division (CRDD) – CRDD would require resources **equivalent to two Research Data Analyst II** positions and **one Health Program Specialist II** position to develop, implement, and communicate financial policies for the new incentive program to Medi-Cal managed care plans. These activities would include providing contract updates, issuing All Plan Letters, or other program communications.

Local Government Financing Division (LGFD) – LGFD would require resources **equivalent to one Research Data Analyst II** position and **two Associate Governmental Program Analysts** to manage the technical contract and act as the coordinating hub on behalf of local educational agencies (LEAs).

LGFD would also require $5.3 million ($2.6 million General Fund and $2.6 million federal funds) for a technical assistance contract to develop, implement, and manage a methodology to successfully build partnerships with the 1,037 LEAs, the 58 county mental health departments, and the 24 Medi-Cal managed care plans.

Managed Care Operations Division (MCOD) – MCOD would require resources **equivalent to two Health Program Specialist I** positions and **one Associate Governmental Program Analyst** to lead necessary contract updates for Medi-Cal managed care plans, supporting requirements to increase preventive and early intervention behavioral health services provided by managed care plans in schools.

Managed Care Quality and Monitoring Division (MCQMD) – MCQMD would require resources **equivalent to two Health Program Specialist I** positions and **one Associate Governmental Program Analyst** to lead managed care policy development, issue formal managed care plan guidance, participate in the development of the incentive program, and engage with stakeholders.

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

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

1. Please provide a brief overview of the incentive program for school behavioral health services.

2. How does this proposal interact with the other school mental health proposals at the MHSOAC and through Proposition 98, proposed in the January budget?

3. Please provide a brief overview of the state operations request for this program.

Issue 18: Mental Health Services Act Flexibilities

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to extend county flexibility for expenditures of Mental Health Services Act funding for behavioral health services by one year, until July 1, 2022. These flexibilities were originally authorized until July 1, 2021, pursuant to AB 81 (Committee on Budget), Chapter 13, Statutes of 2020.

Background. 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 directed the majority of revenues to county mental health programs and services in the following five categories:

1. Community Services and Supports (CSS) – 80 percent of county MHSA funding treats severely mentally ill Californians through a variety of programs and services, including full service partnerships and outreach and engagement activities aimed at reaching unserved populations.
2. Prevention and Early Intervention (PEI) – Up to 20 percent of county MHSA funds may be used for PEI programs, which are designed to identify early mental illness, improve timely access to services for underserved populations, and reduce negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.
3. Innovation – Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Since 2008-09, counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:

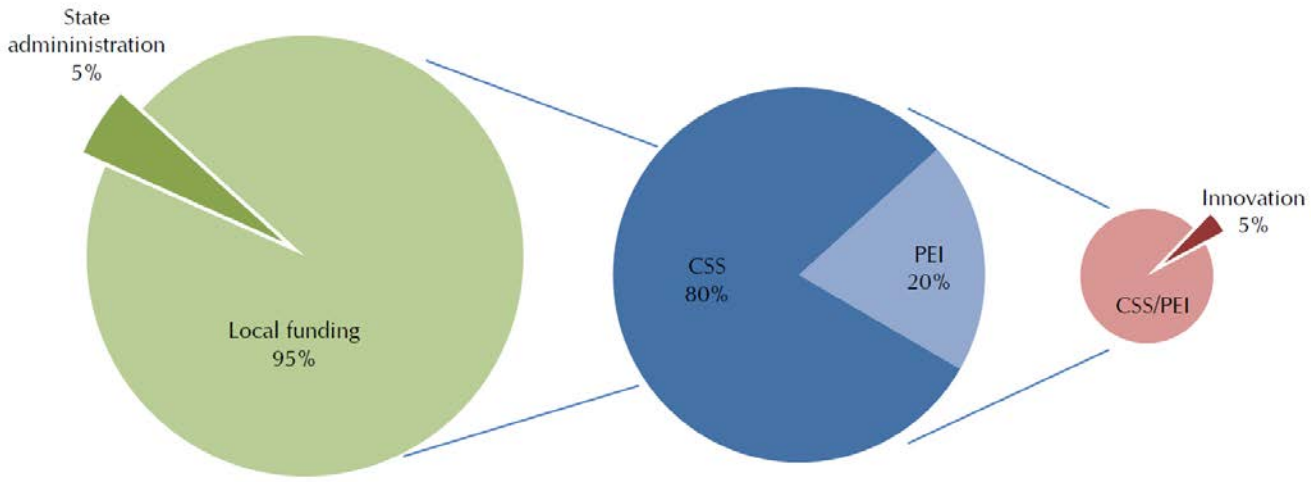
4. Workforce Education and Training – This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.
5. Capital Facilities and Technological Needs – This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties by the State Controller through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental illness in the county. Adjustments are made for the cost of living and other available funding resources. The formula also provides a minimum allocation to rural counties for the CSS and PEI components.

State Administration Funds. MHSA authorizes the use of up to five percent of annual revenues for state administration and specifies that these funds are to be used by state agencies to "implement all duties

pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs.

Apportionment of Mental Health Services Act Funds.



Source: Little Hoover Commission Report #225: *Promises to Keep: A Decade of the Mental Health Services Act* (Jan. 2015)

Reversion Requirements for Unspent County Funds. MHSA requires the reversion of unspent county funds to the state. According to Welfare and Institutions Code section 5892 (h), "any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years". However, DHCS has not reverted unspent county funds since 2008. In recent years, mental health advocates expressed concerns that counties were retaining MHSA funds that could be reverted and reallocated to the provision of additional mental health services. However, counties reported various challenges with accurate reporting of funds subject to reversion, including limitations on reporting forms from DHCS, inadequate identification of funds owed, and unclear policies for reversion.

2017 Budget Act Implemented Transparency Requirements for MHSA Reversion. In an effort to address the concerns from stakeholders and counties regarding the MHSA reversion process, the Legislature adopted several reforms in trailer bill language as part of the 2017 Budget Act. AB 114 (Committee on Budget), Chapter 38, Statutes of 2017, implemented the following changes:

1. Holds counties harmless for reversion prior to 2017-18, with funds reallocated to the counties of origin for the originally allocated purposes (e.g. prevention and early intervention, or innovative programs).
2. By July 1, 2018, requires DHCS and counties to report on the amounts owed prior to 2017-18 and requires counties to submit a plan to spend these funds by July 1, 2020.
3. Extends reversion period from three to five years for small counties (population under 200,000).
4. Requires DHCS to annually post by each October 1, the amount of each county's funds subject to reversion and when the funds will revert.

5. After July 1, 2017, requires reverted funds be reallocated to other counties for the purposes originally allocated (e.g. prevention and early intervention, or innovative programs).
6. Upon approval of an innovation plan by the Mental Health Services Oversight and Accountability Commission, allows funds allocated for innovative programs to re-start the three year period, after which the funds would be subject to reversion (five year period for small counties).

AB 114 provided clarity regarding counties' treatment of funds previously subject to reversion, provided timelines for DHCS to report annually to counties and the public regarding MHSA funds subject to reversion, and ensured MHSA funds allocated to each of the expenditure components required by the act (CSS, PEI, and Innovation) remain allocated to those components after reversion to other counties. In its October 2018 report on funds subject to reversion as of July 1, 2017, DHCS identified a total of $391 million subject to reversion that was deemed reverted and reallocated to the expenditure components to which it was first allocated. Of this amount, $5.1 million was allocated for CSS, $128.2 million for PEI, $187.5 million for Innovation, $27 million for Workforce Education and Training, and $43.2 million for Capital Facilities and Technological Needs.

2020 Budget Act Authority for Pandemic-Related MHSA Expenditure Flexibility. During the pandemic, counties requested flexibility for expenditures of MHSA funds to address the significant unmet behavioral health needs of children and adults due to social isolation, economic dislocations, and other adverse impacts of COVID-19. AB 81 (Committee on Budget), Chapter 13, Statutes of 2020, allowed temporary flexibilities as follows:

- Allows counties to spend down local MHSA prudent reserves without prior approval by DHCS
- Allows counties to spend funds within the Community Services and Supports component regardless of category restrictions, such as required allocations to Full-Service Partnerships
- Allows counties to use existing approved three-year plans or annual updates to expend local MHSA funds through 202-21 if the county certifies it was unable to submit a new three-year plan due to the pandemic
- Extends the reversion deadline for unspent county funds as of July 1, 2019, and July 1, 2020, until July 1, 2021.

DHCS Proposes to Extend MHSA Expenditure Flexibility. DHCS proposes trailer bill language to extend county flexibility for expenditures of Mental Health Services Act funding for behavioral health services, originally authorized by AB 81, by one year, until July 1, 2022. However, this proposal does not include an additional extension of the reversion deadline, which remains July 1, 2021. According to the Administration, as the pandemic continues, counties provide urgently needed mental health services at the same level or above to meet demand, especially outreach and engagement services not covered by other funding sources, and require extension of these flexibilities to support those efforts.

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

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

1. Please provide a brief overview of this proposal.

Issue 19: Behavioral Health 274 Expansion Project

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority of $1.1 million ($108,000 General Fund and $972,000 federal funds) in 2021-22 and 2022-23 to support contract costs for technical assistance to counties during the expansion of standardized format, content, and data transmission of health provider directories for county behavioral health programs.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$108,000	$108,000
0890 – Federal Trust Fund	$972,000	$972,000
Total Funding Request:	**$1,080,000**	**$1,080,000**
Total Requested Positions:	**0.0**	**0.0**

Background. According to DHCS, the 274 Health Provider Directory (HPD) Expansion Project is a department-wide initiative to standardize the format, content, and transmission of Medi-Cal managed care provider network data. The 274 HPD standard was adopted by DHCS and approved by CMS to ensure managed care provider network data is consistent, uniform, and aligns with national standards. The 274 HPD standard has been implemented for Medi-Cal managed care and dental managed care plans. DHCS is currently implementing the 274 HPD standard for behavioral health plans, including county mental health plans, the Drug Medi-Cal Organized Delivery System (DMC-ODS), and other county Drug Medi-Cal programs.

The 274 HPD will replace the current data systems used by behavioral health program areas, which collects provider data necessary for annual network monitoring and certification. Because the 274 HPD standard is new to these programs, DHCS expects the project will require significant testing, quality assurance, and the development of on-going quality control mechanisms to support data quality and integrity.

Resource Request. DHCS requests expenditure authority of $1.1 million ($108,000 General Fund and $972,000 federal funds) in 2021-22 and 2022-23 to support contract costs for technical assistance to counties during the expansion of standardized format, content, and data transmission of health provider directories for county behavioral health programs. DHCS reports it does not have the staff expertise or resources to implement the 274 HPD expansion. As a result, DHCS would contract for services from a qualified contractor equivalent to a team of one user acceptance and data analysis lead, and four user acceptance and data analysts. These contract staff would work closely with DHCS to conduct user acceptance testing, data analysis, data validation, data issue resolution , and data quality management support functions associated with the implementation of the 274 HPD standard for provider network data. According to DHCS, contract staff implemented the 274 HPD expansion for Medi-Cal managed care and dental managed care plans.

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

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

1. Please provide a brief overview of this proposal.

Issue 20: Mental Health Services Assisted Outpatient Treatment (AB 1976)

Budget Change Proposal – Governor's Budget. DHCS requests General Fund expenditure authority of $288,000 in 2021-22 and $270,000 in 2022-23 and 2023-24. If approved, these resources would allow DHCS to implement and report on additional Assisted Outpatient Treatment (AOT) programs, pursuant to AB 1976 (Eggman), Chapter 140, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$288,000	$270,000
Total Funding Request:	**$288,000**	**$270,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24: $270,000.

Background. AB 1421 (Thomson), Chapter 1017, Statutes of 2002, established the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law. Laura's Law was named after Laura Wilcox, a 19 year old Nevada County college student killed by an individual with severe mental illness who was not complying with prescribed mental health treatment. The law established an option for counties to utilize the courts, probation, and the mental health system to address the needs of individuals unable to participate on their own in mental health treatment programs without supervision. The former Department of Mental Health (now absorbed into DHCS) issued guidance to counties in 2003 specifying the submission requirements for implementation of an AOT program. For many years, Nevada County was the only county that implemented an AOT, known as the Turning Point Providence Center, as Laura's Law did not require counties to implement an AOT program and did not appropriate any additional implementation funding.

SB 585 (Steinberg), Chapter 288, Statutes of 2013, authorized counties to utilize Mental Health Services Act (MHSA) funding from Proposition 63 (2004) revenues to support implementation and operation of AOT programs. According to DHCS, since the passage of SB 585, the following counties have implemented or are planning to implement new AOT programs: Alameda, Contra Costa, El Dorado, Kern, Los Angeles, Marin, Mendocino, Nevada, Orange, Placer, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Shasta, Stanislaus, Ventura, and Yolo.

AB 1976 (Eggman), Chapter 140, Statutes of 2020, requires all counties to offer AOT services, beginning July 1, 2021, or to opt out through passage of a resolution adopted by the county's Board of Supervisors. The resolution would be required to identify the reasons for opting out and any facts or circumstances used in making that decision. Participating counties would be allowed to offer AOT services independently, or in partnership with other counties under a memorandum of understanding. DHCS expects 20 additional counties will begin offering AOT services due to the requirements of AB 1976.

DHCS is required to report outcomes for AOT programs to evaluate program efficacy and monitor funding requirements for AOT services. DHCS is required to evaluate whether individuals served by AOT programs maintain housing and contact with treatment, have reduced or avoided hospitalizations, have reduced involvement with local law enforcement, and the extent to which incarceration was reduced or avoided. In addition, to the extent available, DHCS must also report on adherence to prescribed

medication participation in employment or education services, victimization, incidents of violent behavior, substance use, type of treatment, intensity of treatment, frequency of treatment, other indicators of successful engagement, required enforcement mechanisms, improved level of social functioning, improved independent living skills, and satisfaction with program services.

Annual Reporting on AOT Programs. In its most recent annual report to the Legislature and Governor for the period between May 2018 and April 2019, DHCS reported 914 individuals were served in AOT programs. Of these individuals, 75 percent or 686 participants, responded to the initial invitation to voluntary services and did not require a court petition or process. The remaining 228 individuals participated as a result of court orders or settlements. DHCS reported the following aggregate outcomes for court-involved participants:

1) Homelessness decreased by 30 percent
2) Hospitalization decreased by 33 percent
3) Contact with law enforcement decreased by 43 percent
4) Some individuals were able to secure employment or obtain volunteer positions
5) Victimization was reduced by 85 percent
6) Violent behavior decreased by 64 percent
7) Clients presenting with a co-occurring mental health and substance use disorder reduced substance use by 34 percent
8) Most counties reported improvements in clients social functioning and independent living skills
9) Client and family satisfaction surveys indicated satisfaction with AOT services.

Resource Request. DHCS requests General Fund expenditure authority of $288,000 in 2021-22 and $270,000 in 2022-23 and 2023-24 to implement and report on additional Assisted Outpatient Treatment (AOT) programs beginning operation as a result of AB 1976. According to DHCS, one half-time position at the department supports AOT programs in 20 counties. The requested resources would support the **equivalent of one Health Program Specialist I** position and **one Associate Governmental Program Analyst** in the department's Community Services Division. These positions would assist counties with implementation and data reporting requirements, conduct oversight, track county adoption of AOT programs, and compile new county AOT program information into the annual report.

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

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

1. Please provide a brief overview of this proposal.

Issue 21: Substance Use Disorder Recovery Residences (SB 406)

Budget Change Proposal – Governor's Budget. DHCS requests four positions and General Fund expenditure authority of $594,000 in 2021-22 and $558,000 annually thereafter. If approved, these positions and resources would allow DHCS to investigate and take enforcement action against substance use disorder recovery residences providing unallowable, unlicensed health care services, pursuant to the provisions of SB 406 (Pan), Chapter 302, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$594,000	$558,000
Total Funding Request:	**$594,000**	**$558,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and Resources ongoing after 2022-23.

Background. DHCS is responsible for licensing, certifying, and monitoring alcohol and other drug (AOD) treatment facilities. Recovery residences are alcohol and drug-free living environments that promote recovery from alcohol and other drug use, and are commonly used to help individuals transition from the structure of licensed residential treatment facilities to a less restrictive routine living environment. However, because recovery residences are not permitted to provide treatment services, they are not licensed or regulated by DHCS or any other entity.

According to DHCS, licensure for residential substance use disorder treatment is required when one or more of the following treatment services is provided: incidental medical services, detoxification, individual sessions, group sessions, educational sessions, or substance use disorder treatment or recovery planning. DHCS indicates it has received reports of substance use disorder recovery residences operating as unlicensed residential treatment facilities in violation of state law and regulations. The provision of unlicensed substance use disorder treatment can place clients at risk of overdose or death, as there is no oversight or approval of the level of care occurring in the facility. Unlicensed services can also derail sobriety if incorrect information is shared by unlicensed counselors with clients.

SB 406 (Pan) Chapter 302, Statutes of 2020, authorizes DHCS to investigate allegations of unlicensed services provided by a recovery residence facility when it is associated with a facility licensed or certified by the department. If an investigation determines that an unlicensed facility is operating in violation of the law, DHCS would notify the operator of the facility that it is operating without a required license and order the cessation of operations immediately. If the facility does not cease operations, DHCS may assess a civil penalty of up to $2,000 per day until the facility notifies the department it has ceased operations.

Staffing and Resource Request. DHCS requests four positions and General Fund expenditure authority of $594,000 in 2021-22 and $558,000 annually thereafter to investigate and take enforcement action against substance use disorder recovery residences providing unallowable, unlicensed health care services. Specifically, DHCS requests **four Associate Governmental Program Analysts** in its Licensing and Certification Division. These positions would be responsible for investigations of unlicensed recovery residences including: 1) conducting on-site unannounced visits for investigations, 2) extensive research and interviews to identify if unallowable services are being provided in unlicensed facilities, 3)

coordinating with legal staff to assess penalties, 4) respond to inquiries from providers and county programs related to program and licensure requirements and the status of investigations, 5) develop provider and county trainings and outreach on program and licensure requirements, and 6) revise and develop regulations.

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

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

1. Please provide a brief overview of this proposal.

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, February 23, 2021
1:30 p.m.
State Capitol - Room 3191

Consultant: Renita Polk

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

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

The Department of Developmental Services is responsible for administering the Lanterman Developmental Disabilities Services Act (Lanterman Act). The Lanterman Act provides for the coordination and provision of services and supports to enable people with developmental disabilities to lead more independent, productive, and integrated lives. Additionally, the Early Start Program provides for the delivery of services to infants and toddlers at risk of having a developmental disability. The department carries out its responsibilities through contracts with 21 community-based, non-profit corporations known as regional centers, as well as through state-operated homes and facilities.

Department of Developmental Services
Expenditures by Fund Source
* Dollars in thousands

Grand Total By Fund	Fiscal Year	
	2020-21	(Proposed Budget) 2021-22
General Fund	$5,903,013	$6,490,683
Federal Funds	$57,022	$57,049
Reimbursements	$3,877,44	$3,954,217
Lottery Education Fund	$126	$126
Program Development Fund	$1,249	$2,289
Developmental Disabilities Services Account	$150	$150
Mental Health Services Fund	$1,240	$1,240
Total All Funds	$9,840,241	$10,505,754

Issue 1: Budget Summary and Caseload and Utilization Updates

Governor's Proposal. The Governor's Budget updates the department's 2020-21 budget to include $9.8 billion ($5.9 billion General Fund) and includes $10.5 billion ($6.5 billion General Fund) for 2021-22. The number of individuals served by regional centers (consumers) is expected to be 357,819 in the current year and increase to 386,431 in 2021-22.

Community Services (Regional Centers). The regional center budget includes $9.4 billion ($5.5 billion General Fund) in 2020-21 and $10 billion ($6.1 billion General Fund) in 2021-22. The updated current year caseload projections reflect a decrease of 8,534 consumers compared to the enacted budget. To support regional centers in addressing changes to the demand for services created by the COVID-19 pandemic, and address the anticipated backlog in new referrals, regional center operations were not adjusted for the lower caseload. For 2021-22, the department is forecasting an increase of 28,612 consumers compared to the updated current year.

State-Operated Facilities. The updated 2020-21 updated budget includes $363.7 million ($315.6 million General Fund), a decrease of $19.1 million compared to the enacted budget. The 2021-22 budget includes $344.1 million ($308.9 million General Fund), a decrease of $19.6 million ($6.7 million General Fund) compared to the updated current year budget.

Headquarters. For 2020-21, the Governor's budget includes $107.9 million ($65.8 million General Fund) for headquarters, a decrease of $6.9 million compared to the enacted budget. The decrease is comprised of compensation and retirement reductions and compensation and retirement adjustments approved through the collective bargaining process and budget Item 9800 – Employee Compensation Adjustments. For 2021-22, the Governor's budget includes $123.6 million ($73.5 million General Fund) for headquarters, an increase of $15.6 million compared to the updated current year budget.

Legislative Analyst's Office (LAO) Comments. The caseload in DDS's Early Start program, which is for infants and toddlers under age three, has grown 7.1 percent on average annually. For those ages three and older, the caseload has grown by 4.3 percent on average annually. As the pandemic set in and wore on, enrollment in the Early Start program declined by 13.9 percent over ten months, dropping from 47,594 infants and toddlers in March 2020 to 40,965 infants and toddlers in January 2021. Among individuals ages three and older, growth still occurred, but it slowed somewhat to 2.6 percent over the ten months, with caseload increasing from 303,458 to 311,416 individuals.

The pandemic has affected the number of individuals seeking services from DDS for a variety of possible reasons. With authority granted by the Governor's March 12 executive order, DDS began taking steps early to try to mitigate some of the pandemic's potential adverse effects on enrollment and access to services (discussed in more detail in the next agenda item).

Despite the steps taken by DDS to bolster enrollment, the caseload is coming in below the administration's estimate for 2020-21 in the enacted budget. The department has indicated that it will continue to make efforts to ramp up enrollment over the coming months, including maintaining funding for regional center service coordination at levels commensurate with traditional growth in caseload, rather than keeping it in line with the much lower caseload growth that occurred in 2020. The administration estimates that DDS will serve 386,431 individuals in 2021-22, up 8 percent over its revised 2020-21 caseload estimate. According to the LAO, the assumed rate of growth is very optimistic compared to historical trends. The LAO projects growth of five percent in Early Start and 3.5 percent among individuals ages three and older. Based on estimated costs per person in each group, the LAO believes that General Fund costs in the proposed 2021-22 DDS budget potentially are overstated by more than $200 million. However, particularly given the significant uncertainty with projecting caseload during an unprecedented pandemic, the LAO is not recommending that the Legislature make a downward adjustment to the DDS budget at this time.

Staff Comment and Recommendation. Hold open.

As mentioned in the LAO comment, the caseload is coming in below the Administration's estimates. While staff does not propose downward adjustments to the department's budget due to this fact, the low caseload does raise concerns around access to services. The Early Start program provides services for toddlers and infants at risk of a developmental disability. Receiving services during this time (age 0-3) is critical to development. According to the Centers for Disease Control, children with

developmental disabilities who are not identified until they are in school may be at risk for more significant delays due to missed opportunities for treatment. Lower than expected caseload suggests that eligible children that would benefit from these services are not receiving them. The Subcommittee may want to inquire about the department's plans for ensuring that all children and families who are eligible and need these services are accessing them.

Questions.

1. Please provide a brief overview of the department's budget.

2. Please describe how the department developed its caseload estimate for the 2021-22 budget year.

3. As mentioned above, the pandemic has had a significant effect on enrollment in services, particularly Early Start. Please detail the steps the department is taking to find and provide services for the children that are missing out due to the pandemic. How have school closures affected the Early Start Program?

Issue 2: COVID-19 and Emergency Response

Governor's Proposal. The Governor's budget includes $265.1 million ($183.2 million General Fund) in 2021-22 for ongoing costs related to COVID-19 response. These costs include $36.7 million for the development of "surge sites" to serve consumers diagnosed with, exposed to, or at high risk of COVID-19. The proposed funding will support an average of 25 beds each at Fairview and Porterville Developmental Centers for six months. Other funded activities include increased residential supports, respite, and quarantining in the community. The table below breaks down the increased COVID-19 costs between regional centers and state-operated facilities.

Increased Costs for COVID-19		
	2020-21	2021-22
Regional Center Services		
Community Care Facilities	$104,133	$8,010
Day Program Services	-$28,556	0
Habilitation Services	-$2,567	0
Transportation	-$13,152	-$13,973
Support Services	49,501	$3,176
In-Home Respite	$76,950	$56,110
Out-of-Home Respite	-$4,048	0
Health Care	-$20,300	0
Miscellaneous	$10,029	0
RC Surge[1]	$170,000	$175,000
State-Operated Facilities		
Surge Sites at Fairview and Porterville	$82,628	$36,746
Total	$424,618	$265,069

*Dollars in thousands

[1]Note that "RC Surge" is different from the surge sites at Porterville and Fairview Developmental Centers.

Additionally, the Governor's budget includes $2 million ($1.4 million General Fund) for twenty-one positions, one at each regional center (RC), to support emergency planning and preparation coordination by RCs.

COVID-19. On March 4, 2020, Governor Gavin Newsom declared a State of Emergency for California in response to the global COVID-19 pandemic. Because of COVID-19, the department has experienced increased costs in supporting regional center consumers. These costs include providing additional support for consumers in their homes as well as the development of "surge sites" to serve consumers diagnosed with, exposed to, or at high risk due to COVID-19. The Governor's budget supports the department's safety net program for individuals with developmental disabilities to meet the additional needs of consumers during the public health crisis. These include short-term impacts, as well as long-term challenges that will continue into 2021-22. The department's budget recognizes the need for additional resources in residential settings, including the family home, as well as the impacts of decreased access to other community services because of the COVID-19 pandemic.

DDS Directives. To mitigate the negative effects of the pandemic on the developmental services system the department has issued a series of directives since March 2020. A select few of these directives are detailed below.

- Active Directives Issued Under Executive Order (EO) N-25-20 (extended in 30-day increments as required by EO)

    - Allowing Early Start eligibility, service coordination activities, and services to be conducted remotely when requested.

    - Waiving the requirement that Early Start services end at age 3 (only applies to children who have received Early Start services and reached their third birthday during the state of emergency).

    - Allowing RC Executive Directors to grant rate adjustments for residential and/or supplemental services in residential settings.

    - Allowing Lanterman Act services to be provided in alternate locations or remotely when requested.

    - Allowing RCs to conduct intake meetings, evaluations, and assessments remotely.

    - Allowing RC to determine presumptive eligibility when they are reasonably certain an individual is eligible.

    - Waiving Family Cost Participation Program and Annual Family Program Fee costs and fees.

    - Authorizing RCs to pay a residential facility for consumer absences due to COVID-19 if no other consumer occupies the vacancy or until it is determined the consumer will not return to the facility.

- Active Directive Issued under EO N-75-20 (no expiration date)

    - Policies and procedures for utilizing Alternative Nonresidential Services including allowable services, provider certifications, service rates, etc.

- Active Directives Issued under Director Health and Safety Authority (no expiration date; effective until rescinded)

    - Requiring screening for anyone who enters Adult Residential Facilities for Persons with Special Health Care Needs (ARFSPHN) and ICF/DD-CN.

    - Limiting visits to licensed residential facilities to those who need entry as necessary for the prevention, containment, and mitigation of COVID-19.

- Requiring providers and RC to complete a Special Incident Report when an individual tests positive for COVID-19, receives medical attention due to COVID-19 symptoms, or an individual's death is related to COVID-19.

- Authorizing RCs to pay an increased rate of reimbursement for overtime hours for Participant-Directed Respite Service ($25.55 per consumer per hour).

- Authorizes RCs to reimburse Supported Living Services providers at a rate of $48.06 per hour when necessary to provide 24 hours per day supports.

- Requires RCs to develop or include in an existing plan, the RC's plan for COVID-19 testing and vaccinations.

- Allows RCs to submit to DDS proposals and requests for workload relief to focus more time on consumer health and safety.

Participant Directed Services. Participant-directed services let the consumer or family choose who to hire, schedule when the person works, and supervise the work. Individuals who live in their own home, their family home and some community living arrangements can use them. Before the COVID-19 pandemic, consumers could only use a participant-directed model for respite, day care, non-medical transportation, nursing, and day services. During the public health emergency, consumers will also be permitted to use the participant-directed model for personal assistance, independent living skills, and supported employment services.

Alternative Nonresidential Services Model. The Alternative Services model is a way for consumers to receive nonresidential services that may have been disrupted during the state of emergency. Service providers that normally offer services in a congregate setting can offer supports that differ from the traditional program design and respond to new needs that have emerged as a result of the pandemic.

Emergency Coordinators. The pandemic has focused attention on the need for emergency coordination at regional center however the regional centers have been also been grappling with wildfires, public safety shutoffs and other natural and manmade emergencies with increasing frequency over the years. The department and regional centers have indicated that they are coordinating on how best to utilize the requested emergency coordinator positions to address these emergencies. Advance planning, having pre-existing relationships, developing training and expertise, and having a dedicated point-person to coordinate efforts when the need arises are key to successfully minimizing harm and saving lives. Similarly, the activities during a response are critical: sharing information, coordinating supplies and contracted services, ensuring and verifying well-being, and reporting necessary information for incident management and planning. The department has identified the following as principal considerations at the forefront of their coordination: preparedness, response, and recovery; mutual aid; training standards; community and government engagement; and coordination versus performing. The Administration notes that each regional center has a different experience and a different set of staff experience and skills, which will be factored into future planning. Discussions between the department and regional centers will center around the following questions:

- How can the next steps for recruitment and training be operationalized, so that the IDD system can benefit from these resources before and during the coming Fall fire season?

- Given varying local needs, available skillsets, and visions for the position, how to promote inter-regional center interaction and sharing of best practices to support needed mutual aid across catchment area boundaries as dictated by the needs of a particular event?

- Are there opportunities for shared training?

- How best to develop and disseminate standard preparedness information to people with IDD and their caregivers, considering the diversity of conditions, events, geographies, and language?

- How to increase awareness about regional centers and people with IDDs among other state and local emergency operations center agencies and their employees, and in the community more generally?

Staff Comment and Recommendation. Hold open.

Panel. In addition to the Department of Developmental Services (DDS), the Department of Finance (DOF), and the Legislative Analyst's Office (LAO) the Subcommittee has requested the following panelists to provide comment on this proposal.

- Gabriel Rogin, Executive Director, North Bay Regional Center

- Mark Melanson, Executive Director, California Community Living Network

Questions

For DDS:

1. Please provide an overview of the Governor's proposals concerning COVID-19 response and emergency coordinators.

2. What are some challenges that the department has faced during the COVID-19 pandemic? How have the department-issued directives help to overcome those challenges? What challenges remain?

3. The 2019 Budget Act authorized funding for a reorganization of the department, including 21 RC liaison positions. How have these positions aided in COVID-19 response?

4. Has the department's response to the pandemic provided any insight into long-term policy changes that could be enacted to better serve consumers and address specific continuing challenges that the department faces and not just during a public health emergency?

For Gabriel Rogin:

1. What are some challenges that the regional center has faced during the COVID-19 pandemic? How have the department-issued directives helped to overcome these challenges?
2. Are there specific directives that have been especially beneficial?

3. How has the regional center had to adapt and change its operations in response to the pandemic and other emergencies such as wildfires and public safety shutoffs?

4. What are your thoughts on the proposal to add emergency coordinator positions at each regional center?

For Mark Melanson:

1. Please describe the challenges that providers of in-person services have experienced during this pandemic. What challenges remain?

2. What are some of the different ways providers have had to adapt and change their operations during the public health emergency?

3. Are there specific directives that have been especially beneficial to providers?

Issue 3: Extension of Funding Proposed for Suspension

Governor's Proposal. The Governor's budget includes $510.5 million ($297 million General Fund) in 2021-22 for the extension of the below funding through December 31, 2022.

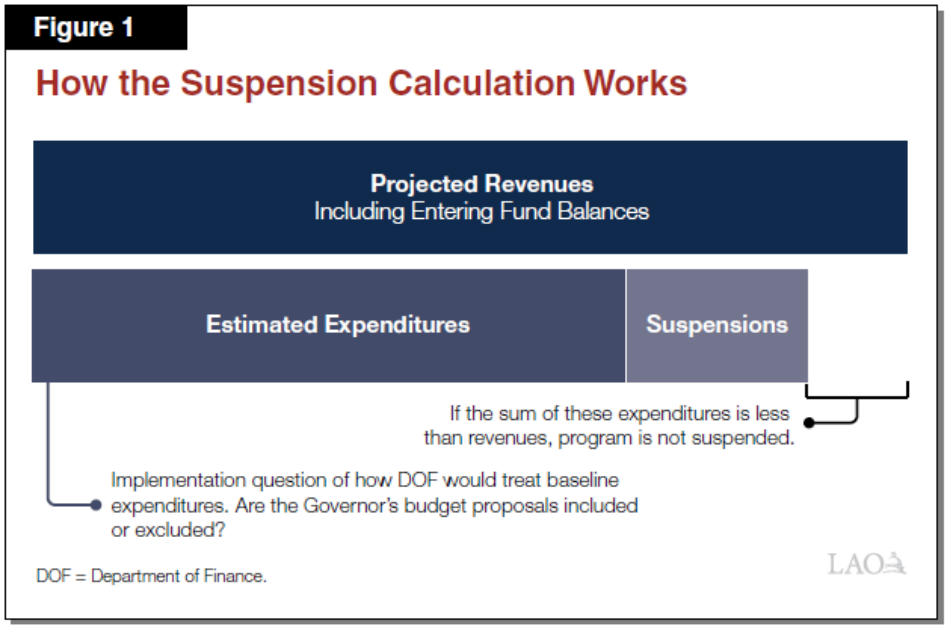
- $436.7 million ($246.4 million General Fund) in 2020-21 and $454.6 million ($261.2 million General Fund) for specified provider rate increases of up to 8.2 percent.

- $52.6 million ($33.7 million General Fund) in 2020-21 and $55.9 million ($35.8 million General Fund) for the continued suspension of the Uniform Holiday Schedule.

Note that under current law the Department of Finance (DOF) would determine whether to suspend this funding in coming years at the 2021 May Revision. The Governor proposes new suspension language that would give DOF the authority to make this calculation again at the time of the May Revision in 2022. More detail on these calculations is below.

Background. In the 2019-20 May Revision, the Administration anticipated an operating deficit would emerge—absent further actions—under its multiyear projections. In response, the final budget act made some program spending amounts subject to a potential suspension. Under this budget bill language, if certain conditions persisted, these program costs would be suspended—resulting in General Fund savings—on December 31, 2021. This language was included in both the 2019-20 and 2020-21 budget acts.

Current law empowers the DOF to administer the suspension calculation. Under the formula, DOF compares estimates of General Fund revenues to General Fund expenditures—without suspensions—in 2021-22 and 2022-23. If DOF determines projected revenues will exceed expenditures, then the programs' ongoing expenses continue on an ongoing basis. If not, expenditures across nearly a dozen different programs are automatically suspended (with no explicit provision for reinstatement).



Under current law, the suspension calculation would occur once: at the 2021 May Revision. If, at that time, DOF finds revenues exceed expenditures for both 2021-22 and 2022-23, the suspensions would not become operative and the costs would continue on an ongoing basis. Rather than executing the suspension calculation this May, the Governor's budget proposes a new suspension calculation in 2022. Specifically, the Governor proposes that the Legislature enact new suspension language that would give DOF the authority to make this calculation again at the time of the May Revision in 2022. In this case, the calculation would apply to 2022-23 and 2023-24. Suspensions would occur, under the Governor's proposal, on December 31, 2022 if revenues were not sufficient to cover expenditures.

Supplemental Rate Increases. The 2019 budget provided for $206.7 million ($125 million General Fund) to provide rate increases of up to 8.2 percent for specified service providers, effective January 1, 2020. The services authorized for the supplemental rate increases were informed by the service provider rate study submitted by the DDS to the Legislature in March 2019. The rate study suggested varying levels of provider rate increases for most, but not all service codes. While the rate study has not been implemented, the 2019 Budget Act authorized rate increases for only those services that would have received increases if the rate study were implemented.

A public comment period followed the release of the rate study. While hundreds of comments were received, the most frequent comments related to the suggested rates for Independent Living Programs, Infant Development Programs, and Early Start Specialized Therapeutic Services. The public comment identified areas where the methodology for establishing these rates (e.g. qualifications and resulting salaries for staff, etc.) was not consistent with how the services are delivered. The DDS concurred with this feedback and determined that had the rate models considered these factors initially, these services would have been recommended for increases in the March 2019 rate study and therefore would have been included in the services identified for rate increases in January 2020.

The Governor's proposed funding for supplemental rate increases was originally based on the department's rate study. The rate increases were effective January 1, 2020, for most services, with rate increases for three additional services (Independent Living Program, Infant Development Program, and Early Start Specialized Therapeutic Services) effective January 1, 2021. When originally authorized, statute indicated these rate increases would be suspended effective December 31, 2021, unless specified fiscal conditions were met. The administration is proposing accompanying trailer bill language to extend the rate increases to December 31, 2022.

Uniform Holiday Schedule. As part of a package of budget solutions passed in 2009 in response to a significant state budget deficit, the state enacted a policy prohibiting RCs from paying service providers on 14 set holidays per year. This meant that service providers either did not provide services on those days or absorbed the cost without payment. The policy also required that the 14 holidays be uniform statewide (in other words, it could not be any 14 days throughout the year). Implementation of the policy has been suspended since 2018. This suspension is currently scheduled to sunset on December 31, 2021. However, the administration is proposing accompanying trailer bill language to extend the suspension of this policy to December 31, 2022. Funding is provided to allow regional centers to provide services to consumers according to their individual holiday schedule.

Legislative Analyst's Office (LAO) Comment. The suspension language treats policies that are fundamentally ongoing in nature as temporary. For example, health and developmental services-

related spending amounts subject to suspension generally support core programmatic funding intended to improve consumer access to an entitlement program. The suspension language creates uncertainty in these programs, which can pose problems for providers and recipients of these services. The potential suspension of supplemental rate increases for developmental services providers makes staffing and planning more difficult. For example, hiring permanent staff to work directly with program consumers is more challenging when the funding is uncertain. Similarly, retaining staff may be more difficult if a provider cannot assure employees that any pay increase will remain intact. More staff turnover means less stability for consumers. In some cases, this uncertainty can work against the Legislature's objectives for the spending. The suspension language enacted into law in 2019-20 was framed as a one-time determination made in May 2021. By proposing a new suspension calculation, however, the administration appears to intend to make this calculation ongoing.

The LAO recommends the Legislature reject the Governor's proposal to create new budget bill suspension language. Considering that the cost of the suspension items directly fund core state services, including those costs in multiyear fiscal projections is appropriate. Given the state's multiyear deficits, however, the state likely will need to make changes to its budget within the next few years. As it stands, the state probably cannot afford existing programs, avoid the suspensions, and fund the Governor's proposals over the next few years. According to the LAO, General Fund costs associated with rejecting the two proposals discussed in this item amount to $159 million in 2022-23 and $325 million in 2023-24.

Staff Comment and Recommendation. Hold open.

As noted in the LAO comment, the items proposed for suspension fund core services. The Subcommittee should consider whether it makes sense to continue to suspend funding for these core services. Suspending funding for these programs, specifically the supplemental rate increases, treats these rate increase as temporary and makes it difficult for them to have their intended effect.

Staff notes that the supplemental rate increases described above were derived from the department's rate study, completed in 2019. That study found that the developmental services system as a whole is significantly underfunded (by roughly $1.8 billion). While there is an agreement that the system is inadequately funded, there is no consensus on how to approach the problem. The Legislature and the Administration must agree on what this approach will be and what will be included in that approach. Given that this funding is proposed for suspension and is not ongoing, the Legislature would like to know what the department's long-term vision is. How does the department plan to address some of its long-term challenges, such as underfunding and a growing consumer population? The Subcommittee may want to consider taking specific action to address other challenges within the system. For example, the Legislature may want to require the DDS to submit a strategic plan documenting, in detail, the long-term view of the system and how it will address its challenges.

Panel. In addition to the Department of Developmental Services (DDS), the Department of Finance (DOF), and the Legislative Analyst's Office (LAO) the Subcommittee has requested the following panelists to provide comment on this proposal.

- Jordan Lindsey, Executive Director, the ARC of California

Questions.

For DOF:

1. Please provide an overview of the proposal.

2. When originally proposed, the suspension calculations were framed as a one-time determination to be made in May. However, the Administration is now proposing a new suspension calculation. Does the Administration intend to make the suspension calculation ongoing?

For DDS:

1. How does the department plan to address some of its long-term challenges, such as underfunding, complying with federal Home and Community Based Service rules, and a growing consumer population?

For Jordan Lindsey:

1. Please describe the impacts the suspension of this funding would have on consumers and the providers that serve them.

Issue 4: Self Determination Program Implementation Update

Governor's Proposal. The Governor's budget includes a total of $24.6 million ($12.3 million General Fund) for the Self-Determination program in 2021-22. 2019-20 actual Self-Determination Pilot Program (SDP) expenditures and client counts were used in forecasting SDP. Funding was distributed to each budget category based on the percent of Home and Community Based Services waiver expenditures by budget category.

Self Determination Program. SB 468 (Emmerson), Chapter 684, Statues of 2013, allowed for the development of a statewide SDP. The California SDP is a voluntary alternative to the traditional way of providing regional center services. The SDP allows participants to have more control over selecting their services and supports. Participants (or their parents or legal representatives) are given a specific budget to purchase the services and supports that they need to make their person-centered plan work better for them. Participants may choose their services and pick which providers deliver those services. Participants are responsible for staying within their annual budget. The program consisted of a three-year phase-in period where the program was only allowed to serve a maximum of 2,500. Later this calendar year, the program will be open to all eligible consumers statewide.

A timeline of the events leading up to the statewide implementation of the program is provided below.

Date	Activity
June 11, 2014	Self-determination advisory group formed to assist the DDS in shaping the program.
December 31, 2014	The DDS submitted a Home and Community-based Services Waiver application seeking federal funding for the program.
September 29, 2015	After a public comment period and answering additional questions from the federal government, the DDS resubmitted its application seeking federal approval.
September and October 2017	The DDS began holding training for those wishing to conduct program informational meetings. RCs, consumer organizations, and community-based organizations were all invited to participate in this training. During this time, the DDS also held meetings with its SDP workgroup to provide updates on the program.
March 13, 2018	The DDS again submitted the waiver application to the federal government, after answering additional questions.
June 7, 2018	The federal government approved the application for federal funding for the SDP.
October 1, 2018	The DDS selected the initial 2,500 participants in the SDP.

December 21, 2018	The DDS released directives related to independent facilitators and financial management services in the SDP.
January 11, 2019	The DDS released a directive related to individual budget development in the SDP.
November 22, 2019	After approximately 450 consumers decided not to continue in the SDP the DDS selected additional participants for the program.
March 2, 2020	Notification providing guidelines on the use of regional center funding to support the implementation of the program went out to regional centers.

Report on SDP. Current law requires the State Council on Developmental Disabilities to issue an interim report no later than June 30, 2021, on the status of the SDP, barriers to its implementation, and recommendations to enhance the effectiveness of the program. The interim report will also provide an update to the program's status, each regional center's cap on participation and progress toward that cap, the most recent statewide and per-regional-center participant count, and the historical trend in the statewide participation count since the start of the program. The final report shall be submitted to the Legislature by December 31, 2022, and provide recommendations to enhance the effectiveness of the program.

Staff Comment and Recommendation. Hold open.

Panel. In addition to the Department of Developmental Services (DDS), the Department of Finance (DOF), and the Legislative Analyst's Office (LAO) the Subcommittee has requested the following panelists to provide comment on this issue.

- Aaron Carruthers, Executive Director, State Council on Developmental Disabilities

Questions.

For DDS:

1. Please provide an update on program implementation, including data on the number of enrollees and how many enrollees have begun to receive services through the program.

2. During the initial phase-in period, the department was able to enroll up to 2,500 consumers yet enrollees never reached that number. What is the department's plan to enroll all interested consumers once enrollment opens up to all eligible consumers later this year?

For Aaron Carruthers:

1. What are some barriers to the implementation of the program that you are seeing?

2. What are some potential solutions to these barriers?

Self-Determination Program - Regional Center Report Summary

Summary of Data for Continuing Participants

Updated from December 2020 Reports**

				Regional Center Self-Reporting										DDS Informational System	
	SDP Spaces at Each RC	Total Selected	Total Withdrawals (2018 to Date)	Continuing Participants	Number of Continuing Participants Who Completed an Orientation**	Percentage of Continuing Participants Who Completed an Orientation ***	Number of Continuing Participants Who Have an Individual Budget Certified**	Percentage of Continuing Participants Who Have an Individual Budget Certified ***	Number of Continuing Participants Who Have a Spending Plan Completed**	Percentage of Continuing Participants Who Have a Spending Plan Completed ***	Number of Continuing Participants Who Have Obtained an FMS **	Percentage of Continuing Participants Who Have Obtained an FMS ***	Number of Participants Receiving Services Through SDP (# from the Pilot)	
ACRC	179	268	162	106	81	76%	*	*	*	*	*	*	*	
CVRC	140	185	72	113	103	91%	69	61%	31	27%	31	27%	29	
ELARC	110	146	53	93	87	94%	30	32%	26	28%	32	34%	33 (18)	
FDLRC	73	90	39	51	48	94%	20	39%	19	37%	18	35%	19	
FNRC	60	85	35	50	41	82%	35	70%	27	54%	23	46%	28	
GGRC	68	89	25	64	53	83%	11	17%	*	*	*	*	*	
HRC	99	128	37	91	88	97%	26	29%	17	19%	16	18%	16	
IRC	256	317	48	269	176	65%	17	6%	14	5%	15	6%	15	
KRC	95	133	58	75	74	99%	39	52%	39	52%	41	55%	39 (28)	
NBRC	66	88	20	68	51	75%	*	*	*	*	*	*	*	
NLACRC	183	231	72	159	145	91%	26	16%	25	16%	25	16%	25	
RCEB	154	191	63	128	118	92%	31	24%	25	20%	25	20%	26	
RCOC	151	204	57	147	137	93%	56	38%	18	12%	15	10%	16	
RCRC	55	65	12	53	52	98%	38	72%	35	66%	35	66%	35 (22)	
SARC	125	158	56	102	91	89%	34	33%	26	25%	25	25%	27	
SCLARC	110	139	47	92	90	98%	*	*	*	*	*	*	*	
SDRC	207	271	69	202	155	77%	56	28%	41	20%	39	19%	40 (*)	
SGPRC	95	146	79	67	55	82%	17	25%	14	21%	15	22%	14	
TCRC	110	177	122	55	52	95%	18	33%	14	25%	*	*	* (*)	
VMRC	100	132	32	100	75	75%	53	53%	34	34%	34	34%	35	
WRC	64	83	14	69	65	94%	34	49%	18	26%	20	29%	17	
Statewide Totals	2500	3326	1172	2154	1837	85%	610	28%	423	20%	409	19%	447	72 Pilot Participants

Notes: *In accordance with DDS Data De-Identification Guidelines, counts between one and ten have been suppressed.

**Participants may engage in multiple activities related to program implementation simultaneously; numbers may be duplicative in each category and do not include participants in the process of completing a milestone.

***For the columns that express percentages, the percentage is out of the number of continuing participants.

Issue 5: Community Navigators

Governor's Proposal. The Governor's budget includes $5.3 million ($3.2 million General Fund) ongoing to contract with Family Resource Centers (FRCs) to administer community navigator programs and improve access to generic and regional center services.

The requested funding includes $500,000 in 2021-22 for a one-time evaluation focused on improving the effectiveness of existing disparity projects and $4.8 million for community navigator programs. After 2021-22, all $5.3 million would be provided for community navigator programs.

Family Resource Centers. California's network of Family Resource Centers provides family-to-family support, strengthening families' ability to fully participate in service planning and their capacity to care for their infants and toddlers. FRCs actively work in partnership with local regional centers and education agencies and help many parents, families, and children get information about early intervention services and how to navigate the Early Start system. The Early Start program provides early intervention services for families and their children from birth up to age three with developmental delays, disabilities, or conditions which place them at a high risk of disabilities. California's FRCs are staffed by parents who have children with special needs and provide information and parent-to-parent support. Each FRC is unique, reflecting the needs of its community. They may operate as independent sites or be based in regional centers, local education agencies, public health facilities, hospitals, or homes. Family support services are available in many languages and are culturally responsive to the needs of the individual family. Currently, 38 contractors provide services through 47 FRCs across the state.

Specific services provided by FRCs include:

- Parent-to-parent family support
- Peer counseling and home visits
- Information and referral
- Public awareness
- Parent education
- Assistance with transition from Early Start at age 3
- Support services in various languages
- Translation assistance
- Support services in urban and rural communities

Not including the proposal discussed here, the 2021-22 budget includes $4.7 million ($2 million General Fund) for FRCs and services.

Disparities Grants Program. Assembly Bill 1 X2 (Thurmond), Chapter 3, Statutes of 2015-2016 Second Extraordinary Session, provided $11 million General Fund to assist regional centers in the implementation of strategies to reduce purchase of services (POS) disparities. Regional centers submitted applications for funding to help address identified areas of disparity. Regional centers were also required to consult with stakeholders regarding activities that may be effective in addressing disparities and the regional center's proposed requests for funding. Each fiscal year since then the budget has included $11 million for these projects. In 2017-18, funding was opened up to community-based organizations in addition to regional centers. The department has indicated that it intends to initiate discussions with organizations that are not meeting project goals and objectives, and may determine if continued project funding is appropriate. Each organization with approved funding will be required to submit quarterly status reports, throughout the life of the project. The department will evaluate status reports to ensure funding is being used per state rules, sufficient data is being collected to measure the project's effectiveness, and the project's goals and objectives are being achieved.

A list of approved projects, their summaries, and the amount of allocated funding can be found at https://www.dds.ca.gov/rc/disparities/disparity-funds-program/awarded-projects/.

A review of 2018-19 purchase of service (POS) expenditures reflects the following average per capita expenditures for all age groups by ethnicity, illustrating existing disparity gaps:

- $27,931 for individuals who are White
- $22,941 for individuals who are Black/African American
- $14,836 for individuals who are Asian
- $11,760 for individuals who are Latinx/Hispanic

It is worth mentioning that some of these POS expenditure differences may be driven by different age concentrations and different cultural approaches to out-of-home care.

Navigator projects have utilized parents of RC consumers familiar with the system to help other families and RC consumers access services. Navigators have demonstrated a benefit to underserved communities through increased empowerment of parents, increased knowledge about generic and RC services, and a feeling of greater support and engagement for families. Navigators share a community, language, ethnicity, and culture with the families they support, offering assistance and education to reduce barriers in accessing services.

Based on a DDS analysis of purchase of services expenditures, service access increased 72 percent for participants in a Promotora project, compared to 13 percent for participants who did not participate in a Promotora project. The Promotora model uses community members who receive specialized training to provide education within their community. In other projects, participants reported an increased ability to navigate the RC system, more knowledge about generic services, and a greater sense of empowerment in seeking needed supports.

This proposal expands navigator services statewide to improve access to services that meet the needs of individuals and families and standardizes certain program activities and measures to allow for a more robust program monitoring and evaluation, according to the department. Standardizing program elements means that Community Navigators will more closely follow evidence-based and peer-reviewed program designs. According to the department, this proposal implements statewide strategies to better address barriers that individuals of color face in accessing and utilizing generic and RC services in their communities. Strategies include, but are not limited to, building trust with RC staff, providing education on available services and guidance on how to identify and request needed services, and connecting families with peer support that has experience with the RC system.

Staff Comment and Recommendation. Hold open.

The budget includes $500,000 to be used for an evaluation of the disparities grants program. However, staff is unclear on the details of the evaluation. For instance, the department is unsure of the timeline for the evaluation. The Subcommittee may want to request more detail on the evaluation and how it will be conducted. Additionally, the Subcommittee may want to modify the proposed language to ensure that specific elements of importance are included in the evaluation.

The proposed community navigator proposal is based on existing navigator projects that have been funded with disparities grants. However, as mentioned above, no formal evaluation of these programs has been conducted. The department has stated that service access increased for participants who participated in these projects, but it is unclear how service access was measured. The Subcommittee may want to ask the department to provide additional data on how project outcomes were measured.

The department plans to consult with stakeholders on the design of the community navigator proposal but there is no direction in the proposed language as to what groups should be included, such as self-advocates or FRC representatives. The Subcommittee may want to provide input on the types of stakeholders to be included, as well as other elements such as program design and outcome reporting.

Panel. In addition to the Department of Developmental Services (DDS), the Department of Finance (DOF), and the Legislative Analyst's Office (LAO) the Subcommittee has requested the following panelists to provide comment on this proposal.

- Fernando Gomez, Vice President, Disability Voices United

Questions.

For DDS:

1. Please provide an overview of the proposal and additional detail on the services the community navigators will provide. How did the department decide on the specific dollar amount? Are the funds intended to support an additional community navigator at each FRC?

2. Please provide more detail on the specific strategies the department plans to standardize with this proposal. Will the community navigators provide services that are not currently available from FRCs?

3. Please provide an update on data from the approved funded projects to address disparities. Has the department begun to see a change in the purchase of service disparities due to these projects?

4. What is the general timeline to evaluate the funded disparities projects?

For Fernando Gomez, Vice President, Disability Voices United:

1. From the family/consumer perspective, have the funded projects to address disparities been meeting their intended purpose?

2. What are your thoughts on the community navigator proposal?

For DOF:

1. How did the department determine the funding amount for this proposal? Will each FRC receive the same amount of funding?

Issue 6: TBL - Acute Crisis Clarification and Admission Extension and Residential Facilities for Special Health Care Needs

Governor's Proposal. The Governor's budget includes the following two pieces of trailer bill language:

- Trailer bill language that would update references to Stabilization, Training, Assistance, and Reintegration (STAR) residences to reflect recent developmental center closures and extend the sunset date through June 30, 2022, for Canyon Springs STAR services given challenges in developing the homes. The proposed language also clarifies the civil commitment statutes authorizing acute crisis admissions made according to Welfare & Institutions Code (WIC) 6500

- Trailer bill language to amend WIC to allow for the development and use of Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHNs) and Group Homes for Children with Special Health Care Needs (GHCSHNs) for individuals who currently reside in the community and are at risk of moving to more restrictive settings. Current law only allows for the development of these homes for individuals moving from developmental centers.

STAR Residences. Current law limits the circumstances in which an individual may be admitted to a state institution for persons with developmental disabilities (WIC Section 7505). These limitations also apply to adults admitted to acute crisis centers operated by the department (referred to as STAR residences—WIC Section 4418.7). Admission to a STAR residence requires that the individual be experiencing an "acute crisis" and is limited to a maximum of 13 months. Individuals admitted to STAR residences are provided mental health treatment for stabilization and receive all necessary services and supports to prepare them for a transition to less restrictive environments.

Sonoma Developmental Center (SDC) and Fairview Developmental Center (FDC) have closed and the acute crisis services have moved or are in the process of moving to the community. Central STAR, temporarily located at Porterville Developmental Center (PDC) is planning to move to Visalia/Tulare in late 2021 once a property is secured and appropriate renovations are completed. Additionally, current law authorizes commitment to Canyon Springs until June 30, 2021, while homes are developed in the community. Resource development has been delayed as the 2020 wildfires resulted in the loss of one of the North STAR residences, which had been near completion. There have also been challenges in securing suitable properties for the Central STAR homes due to the COVID-19 pandemic and the status of the housing market.

ARFPSHN Pilot Project. The 2003-04 Governor's budget directed DDS to develop a plan for the closure of Agnews Developmental Center (Agnews). To facilitate the closure and ensure continuity of care for individuals transitioning from Agnews, Senate Bill (SB) 962 (Chesbro), Chapter 558, Statutes of 2005, established the ARFPSHN Pilot Project. These adult residential facilities provide 24-hour nursing care and intensive support services in homelike settings to individuals who have developmental disabilities.

The DDS contracted with the Center for Human Services at the University of California, Davis, Extension to conduct an independent evaluation of the pilot project. The contractor concluded that the SB 962 pilot project was an overall success as individuals were receiving high-quality care and had access to health care in their homes and the community. Moreover, the report stated the model was cost-effective and contributed in meaningful ways to an individual's health, quality of life, level

of functioning, and overall happiness. In January 2010, the DDS announced it was initiating the closure of Lanterman Developmental Center. To support the closure, SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, authorized the additional development of ARFPSHNs. Subsequently, Assembly Bill 1472 (Committee on Budget), Chapter 25, Statutes of 2012, extended the use of ARFPSHNs to include individuals transitioning from any developmental center into the community.

As of the December 2020 Quarterly Consumer Characteristics Report, 18 percent of the consumer population has special health care requirements and 23 percent are considered to have some sort of medical problems. This proposal, consistent with the Olmstead Act, expands community licensed residential services and skilled nursing care available to consumers. The proposed language provides regional centers with the flexibility to place individuals living in skilled nursing facilities (SNF) and pediatric subacutes into less restrictive and congested environments when appropriate. The need to reduce reliance on large congregate settings and offer alternative resources has become even more evident during the current public health emergency. Consumers residing in SNFs represent approximately 7 percent of consumers testing positive for COVID-19 and approximately 22 percent of all consumers reported as deceased and COVID-19 positive as of January 20, 2021; however, less than 1 percent of regional center consumers reside in SNFs.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposed language.

2. Prior budget actions set an expiration date for Canyon Springs STAR services of June 30, 2021, with the understanding that additional community capacity would be developed to remove the need for this new category of admissions. What steps will be taken to ensure that another extension will not be needed in the future?

3. In past hearings, DDS has discussed strategies to provide treatment for individuals with exceptionally high behavioral and health needs. Please discuss the steps DDS has taken to develop crisis step down treatment for individuals at the highest level of need.

PROPOSALS FOR INVESTMENT RELATING TO DEVELOPMENTAL SERVICES

The Subcommittee has received the following proposal for investment related to the DDS. Note that proposal sponsors provided all information below, aside from staff comments and recommendations.

1. Improve Employment Opportunities for Californians with Intellectual and Developmental Disabilities (IDD)

Budget Issue. The California Disability Services Association proposes trailer bill language to amend Welfare and Institutions Code section 4870 to increase utilization of the funds set aside for the Paid Internship Program (PIP) and incentive payments for providers who place individuals into competitive integrated employment (CIE).

Background. Since 2016-17, the state budget has appropriated $29 million ($20 million General Fund) annually for the implementation of the PIP and CIE incentives program. Both are designed to increase employment opportunities and CIE outcomes, which is in line with California's Employment First policy. Over the four completed fiscal years since the programs were implemented, the state has spent approximately $1.2 million, $4.6 million, $8.5 million, and $6.2 million (through April 2020) respectively. In total, the state has underspent the $118 million appropriated over those three years by over $96 million. This proposal would make amendments to the programs to increase utilization of the programs and yield additional employment outcomes.

Staff Comment and Recommendation. Hold open.

2. Equitable Rate Adjustments in Response to State Minimum Wage Increases

Budget Issue. The Los Angeles Coalition of Service Providers and the California Disability Services Association request $13.2 million ($7 million General Fund) to provide rate adjustments for service providers in response to state minimum wage increases.

Background. Services for Californians with intellectual and developmental disabilities are funded through the State Budget under the Lanterman Developmental Services Act. Provider rates are set in a variety of ways, including rates set by DDS and through negotiation with regional centers. Rate increases are generally unavailable unless specifically included in the Budget Act. Since the passage of SB 3 (Leno), Chapter 4, Statutes of 2017, the Governor's Budget has appropriated funds each year for service provider rate adjustments to address the increased State minimum wage.

DDS currently uses two methodologies to address state minimum wage increases. For Community Care Facilities (CCFs), DDS provides an automatic increase on January 1 to reflect state minimum wage increases. For all other services, DDS utilizes a complex individualized application process requiring each agency to submit historical payroll records and requiring DDS to process each application individually. According to the proponents, in addition to the administrative burdens and costs of managing this process, it also fails to provide any relief for providers in areas where labor market conditions have compelled them to pay wages above the state minimum to serve regional center clients. In essence, it is a process where rates increase in lower-cost areas and stay stagnant in higher-cost areas. The request would slightly increase the funds currently proposed in the

Governor's budget for rate adjustments to developmental services providers linked specifically to increases in state minimum wage. The request would replace the current methodology with a uniform rate adjustment for all providers of 3.33 percent for each $1 of state minimum wage increase, and by a pro-rated amount for any increases other than $1.

Staff Comment and Recommendation. Hold open.

3. Continue the Suspension of the Family Cost Participation Program (FCCP) and Annual Family Program Fee (AFPF)

Budget Issue. Disability Rights California proposes trailer bill language to amend Welfare and Institutions Code sections 4783 and 4785 to continue the suspension of the FCCP and AFPF.

Background. According to the sponsors, while these programs were suspended to assist families during the state of emergency, the financial effects of COVID will be felt long after the end of the pandemic. These fees had a chilling effect in the past and continuing services will be vitally important as the state reopens after COVID.

Staff Comment and Recommendation. Hold open.

4. Continue Virtual Lanterman Act In-Person Meetings

Budget Issue. Disability Rights California proposes trailer bill language to amend Welfare and Institutions Code section 4646 and Government Code section 95020 to continue to waive the requirements for in-person service coordination meetings.

Background. A directive issued by the department waived the requirements for in-person meetings and allowed those meetings to be virtual. This included Individual Program Plan (IPP) and other service coordination meetings. This was done to prevent the spread of COVID, however, families have found additional benefits to having virtual meetings, including not having to travel or have other people in their homes. Meetings could also be arranged more quickly.

Staff Comment and Recommendation. Hold open.

5. Continue Regional Center Director Approval of Health and Safety Waiver Exemptions

Budget Issue. Disability Rights California proposes trailer bill language to amend Welfare and Institutions Code sections 4681.6, 4689.8, and 4691.9 to allow regional center directors to approve Health and Safety waivers.

Background. To speed up the approval of rate adjustments and supplemental services during the public health emergency, the DDS Director delegated authority to approve Health and Safety Waivers to the Regional Center Directors. According to the sponsors, Health and Safety Waiver approval has long been a problem in the system. While DDS has significantly improved the timelines to issue approvals, delays still occur. Approving Health and Safety Waivers at the local level not only speeds them up but also puts them in the hands of those who best know the local communities.

Staff Comment and Recommendation. Hold open.

6. Codify DDS COVID-19 Directives Related to Participant-Directed Services

Budget Issue. Disability Rights California proposes trailer bill language to codify an existing directive to allow consumers and families to utilize the flexibility offered by Participant Directed Services.

Background. Participant-Directed Services offer flexibility to support consumers and their families by offering more control over how and by whom some Individual Program Plan (IPP) services are provided. With this model, the consumer or family choose who to hire, schedule when the person works, and supervise their work. Participant-Directed Services are available to individuals who live in their home, their family's home, and some community living arrangements. Additionally, the provider does not need to be a regional center vendor and can be a family member, friend, or another qualified person to provide participant-directed services.

Participant-Directed Service types include (1) respite, (2) day care, (3) non-medical transportation, (4) nursing, and (5) community-based training services. In response to the public health crisis and recognition that traditional service delivery has been disrupted leaving many consumers without any services at all, DDS temporarily expanded Participant-Directed Service types to include: (1) personal assistance, (2) independent living skills; and (3) supported employment services.

Regional centers have faced well-known and long-standing difficulties securing providers to fulfill IPP services, while at the same time consumers and families clamor for more flexibility and choice about how services are delivered. Even though Self-Determination will be available to all consumers in June of this year, many consumers and families will want to remain in the traditional service delivery system and utilize the flexibility offered by Participant Directed Services. The flexibility afforded by this model is also key to reducing purchase of service disparities because it makes it easier for consumers and families to find providers that speak their preferred language and find providers during the hours for which services are needed.

Staff Comment and Recommendation. Hold open.

7. Codify DDS COVID-19 Directives Related to Early Start Remote Services

Budget Issue. Disability Rights California proposes trailer bill language to amend Government Code section 95020 to codify an existing directive to waive the requirement for in-person services for the Early Start Program.

Background. Services under the California Early Intervention Services Act requiring in-person services were waived to allow for teleservices due to COVID. This enabled infants and toddlers to receive services like, Speech Therapy, virtually when requested by a parent, guardian, or other legal representative. While this was done to prevent the spread of COVID additional benefits were found by families. These benefits include not having to participate in transportation, the child's increased comfort being in the family home, and for families with multiple children parents did not have to have an alternative caregiver to access services.

Staff Comment and Recommendation. Hold open.

8. Remove the Prohibition on Supported Living Services for Consumers who Choose to Live at Home with Family

Budget Issue. Disability Rights California proposes trailer bill language to amend Welfare and Institution Code section 4689 to remove the prohibition on supported living services for adult consumers who live at home with their parents or conservators.

Background. Supported living services (SLS) are services designed to enable adults with developmental disabilities to live in their own homes. SLS are presently available to adult regional center consumers, regardless of the degree of disability, to live in homes that they own or lease with support available as often and for as long as it is needed. Title 17 regulations additionally require that an adult consumer lives in a home "that is not the place of a residence of a parent or conservator of the consumer" to receive supported living services.

According to the sponsors, Restricting SLS to only consumers that live in homes they own or lease excludes consumers who live, or wish to live, in multi-generational households. This restriction harms consumers and families and strains the entire system by exacerbating regional center funding disparities, contributing to the housing crisis, and unnecessarily pushing consumers into congregate living settings that pose increased health risks during COVID-19 and similar pandemics.

Staff Comment and Recommendation. Hold open.

9. Require Regional Centers to Secure or Fund Critical Generic Resources to Avoid Unnecessary and Harmful Delays

Budget Issue. Disability Rights California proposes trailer bill language to amend Welfare and Institution Code sections 4659.5 and 4659.7 to require regional centers to secure or fund critical generic resources.

Background. Regional centers are charged with supporting eligible individuals, referred to as "consumers," to have the most independent and productive lives possible. Once a regional center identifies a service that can meet an identified need, it is responsible for purchasing or securing that service. Regional centers are the "payor of last resort," meaning that a regional center cannot purchase a requested service if a different publicly funded program (also known as generic agencies) is responsible for funding that service. Generic agencies include IHSS, Medi-Cal, SSI, special education services, and services offered through the Department of Rehabilitation. However, regional centers are obligated to "identify and pursue all possible sources of funding for consumers receiving regional center services."

Despite regional centers' responsibilities to identify and pursue all possible sources of funding for consumers, service coordinators often place the burden on individuals with I/DD and their families to navigate complex systems of care to fully exhaust these funding streams through generic agencies. Sometimes exhaustion means obtaining a written notice. Other times it means going pursuing an administrative appeal. The result is often that individuals with I/DD and their families often give up and go without the needed service because they are unable to meet regional center requirements to first exhaust these resources through generic agencies. Additionally, the dispute resolution process for regional centers to secure services from generic agencies is underutilized and unnecessarily

limited to children under 6 years of age. The proposed language would require a regional center to fund a service it believes that a generic agency is responsible for when the generic agency is not providing or funding the services, and the regional center chooses not to utilize the dispute resolution process.

Staff Comment and Recommendation. Hold open.

10. Developmental Services Sustainability

Budget Issue. The ARC and UCP California Collaboration request the removal of budget language that suspends supplemental rate increases provided in the 2019 budget.

Background. Beginning in March 2020, California and its citizens have been confronted with an unprecedented challenge in COVID-19. The onset of the pandemic significantly impacted all vulnerable populations, including the Intellectual and Developmental Disability (IDD) community. The IDD community responded to protect the health and safety of those we serve and ensure that participants and families maintain access to resources and services. All stakeholders within the IDD community had to make significant changes and deft pivots to maintain continuity of support; especially as local communities and Departments of Public Health made real-time decisions to close down business operations, schools, and for the IDD community, non-residential service settings.

The direct support professional (DSP) workforce is the backbone of our system, delivering the promise of the Lanterman Act to hundreds of thousands of individuals throughout the state. Due to the pandemic, in some services, DSPs confront COVID risk to deliver critical hands-on support to individuals who require it to maintain community living. These DSPs have worked long hours, often at a risk to themselves, their families, and their sense of security. Other DSPs and service coordinators had to quickly develop skills to deliver services remotely, adapting technological solutions to meet the needs of their clients. Many DSPs and service coordinators have seen their jobs change overnight and developed new skills to meet the moment.

As evidenced by the DDS Rate Study, this workforce was underpaid and undervalued even before the pandemic, as the result of a $1.4 billion underfunding of developmental services in California. Any attempt to further reduce their wages, as the result of rate decreases, would be harmful and unconscionable during this time. The potential threat of a decrease in the near future continues to cause uncertainty in the workforce. Therefore, the suspension of the supplemental rate increases should be permanently removed from statute, instead of merely postponed.

Staff Comment and Recommendation. Hold open.

11. Department of Developmental Services Director Discretion

Budget Issue. Mr. Les Rodin requests trailer bill language to amend Welfare and Institutions Code section 4519 to give the Director of the DDS the ability to apply their discretion on a case-by-case basis to allow for the provision or extension of out-of-state services for more than six months when supported by a comprehensive assessment.

Background. Welfare and Institutions Code Section 4519 lays out the requirements and conditions under which DDS and RCs may expend funds allocated for the purchase of any client service outside

the state according to the Lanterman Act. The code allows for an out-of-state provision of services for up to six months and gives the Director of DDS the discretion to grant up to one six-month extension. There is no existing authority in the code that gives the Director any discretion to go beyond the six-month extension. According to the sponsors, there are documented cases of clients who qualify for care under the Lanterman Act yet have no facility in the state that can provide the necessary level of care for which their case requires. The proposed language would give the DDS Director discretion to extend an out-of-state treatment past six months on a case-by-case basis.

Staff Comment and Recommendation. Hold open.

12. Regional Center Caseload Ratio Needs

Budget Issue. The Association of Regional Center Agencies (ARCA) and SEIU California request $55 million General Fund, to be matched with $28.3 million in federal funds, ongoing to hire enough service coordinators to meet statutory caseload ratio targets.

Background. Regional centers are currently budgeted for the correct number of service coordinators but are funded at approximately 52 percent of actual costs. This leads to caseloads that exceed statutory guidance and harms the ability of centers to both serve clients and families and work effectively with service providers. This request seeks to change this by allocating a more accurately calculated amount of funds to allow centers to hire enough service coordinators to meet statutory targets based on current costs. By making it possible for regional centers to hire sufficient service coordinators to meet caseload ratios, service coordinators will, at root, have more time for each person they serve. This means service coordinators will be able to provide more individualized case management, developing better understandings of each person's unique needs, and more effectively working with community organizations and service providers to meet those needs. The proposed funding will fund up to 850 additional service coordinators to meet statutory caseload ratio needs, inclusive of the staffing needs to support service coordinators.

Staff Comment and Recommendation. Hold open.

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.

Friday, February 26, 2021
9:00 a.m.
State Capitol - Room 3191

Consultant: Scott Ogus

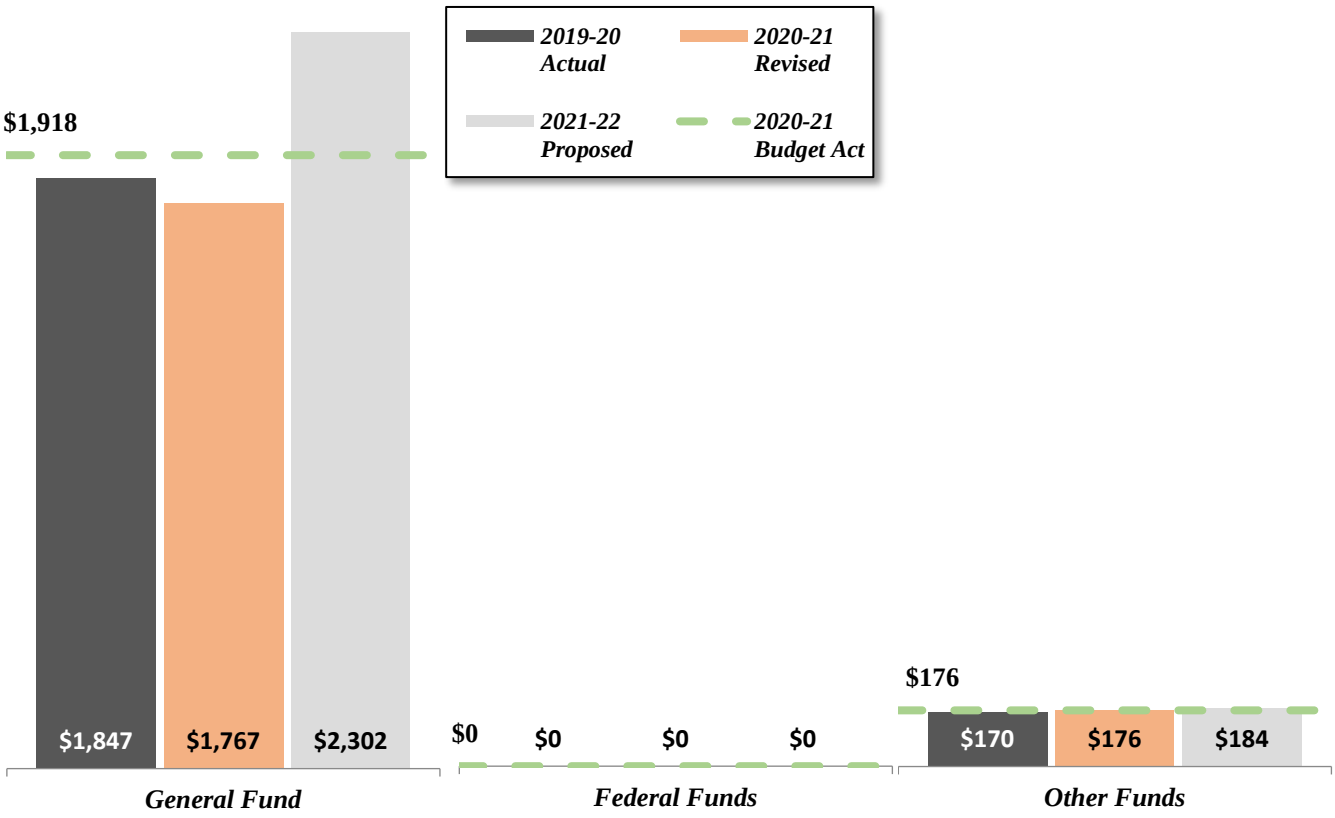
PUBLIC COMMENT

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

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Overview

Department of State Hospitals – *Three-Year Funding Summary*
(dollars in millions)



Department of State Hospitals - *Department Funding Summary*			
Fund Source	**2019-20** ***Actual***	***2020-21 Revised***	***2021-22 Proposed***
General Fund	$1,847,333,000	$1,766,753,000	$2,301,880,000
Federal Funds	$0	$0	$0
Other Funds	$170,433,000	$175,609,000	$183,711,000
Total Department Funding:	**$2,017,766,000**	**$1,942,362,000**	**$2,485,591,000**
Total Authorized Positions:	**10200.4**	**10741.4**	**11158.2**
Other Funds Detail:			
CA State Lottery Education Fund (0814)	*$87,000*	*$27,000*	*$27,000*
Reimbursements (0995)	*$170,346,000*	*$175,582,000*	*$183,684,000*

Background. DSH oversees five state hospitals which comprise the largest inpatient forensic mental health hospital system in the nation. In addition to forensic admissions, which comprise 86 percent of its population, the five state hospitals admit individuals civilly committed under the Lanterman-Petris-Short (LPS) Act because they require physically secure 24-hour care and meet legal criteria that they represent a danger to themselves or others. The categories of individuals admitted to state hospitals for treatment are:

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

- **Not Guilty by Reason of Insanity (NGI)** – NGI patients are individuals found guilty of an offense, but are admitted to DSH if a court determines the individual was "insane" at the time the crime was committed. NGI patients are committed for a term equal to the maximum sentence which could have been imposed, though may be recommitted for an additional two years if the individual represents a substantial danger of physical harm.

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

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

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

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

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

	2020-21	2021-22
Population by Hospital		
Atascadero	1,040	1,000
Coalinga	1,365	1,365
Metropolitan	797	937
Napa	1,090	1,090
Patton	1,445	1,455
Population Total	**5,737**	**5,847**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,029	1,115
Not Guilty by Reason of Insanity (NGI)	1,410	1,419
Offender with a Mental Health Disorder (OMD)	1,298	1,307
Sexually Violent Predator (SVP)	942	942
Lanterman-Petris-Short Civil Commitments (LPS)	778	784
Coleman Referrals	280	280
Jail-Based Competency Treatment (JBCT) Programs		
Kern Admission, Evaluation, and Stabilization (AES) Center	60	106
Regional JBCT	237	237
Single County JBCT	133	171
Small County Model JBCT (Mendocino, Mariposa)	N/A	N/A
Total JBCT Programs	**342**	**514**

Figure 1: State Hospital Projected Census by Hospital, Commitment Type and JBCT Programs
Source: *2021-22 Governor's Budget Estimate, Department of State Hospitals, January 2021*

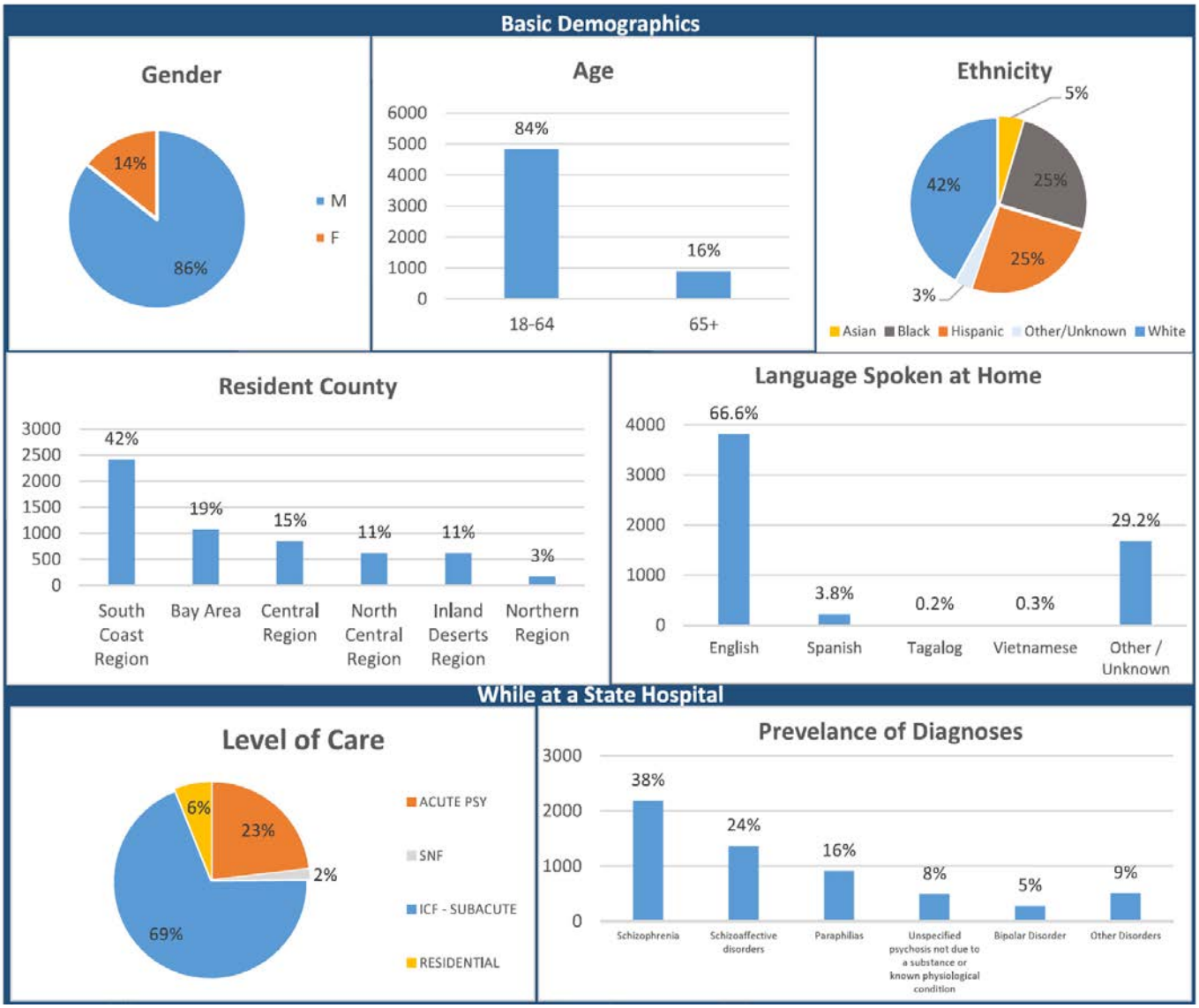


Figure 2: State Hospital Demographic Snapshot: All Commitment Types
Source: *2021-22 Governor's Budget Estimate, Department of State Hospitals, January 2021*

The five state hospitals operated by DSH are:

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

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

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

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

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

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of the State Hospital system, including major inpatient categories, treatment programs, and significant organizational changes.

Issue 2: COVID-19 Pandemic – State Hospitals' Response

Oversight – COVID-19 Pandemic: State Hospitals' 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), the Department of Public Health (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 two recently approved COVID-19 vaccines.

Due to high rates of COVID-19 transmission in congregate settings, the State Hospital system implemented several infection control measures. Shortly after the Governor's shelter-in-place order was announced in March 2020, State Hospitals temporarily suspended nearly all patient admissions until May 2020. At that time, State Hospitals decreased inpatient census to allow the establishment of Admission Observation Units (AOUs) and isolation units. State Hospitals utilized AOUs to isolate new patients for 14 days, as well as newly positive patients during a COVID-19 outbreak. According to DSH, these measures reduced the State Hospitals' patient census by approximately nine percent, from 6,235 on March 1, 2020, to 5,724 on July 1, 2020.

In addition to the creation of AOUs and isolation units, DSH reports the State Hospitals have implemented the following additional protocols to prevent COVID-19 infection:

- Primary and secondary screening of all staff entering the hospitals
- AOUs to house newly admitted patients for a quarantine period
- Isolation units to separate COVID-19 positive patients from other patients
- Patient Under Investigation (PUI) units for patients suspected, but not confirmed positive
- Increased cleaning and sanitation protocols
- Limitation of movement of staff between quarantine and non-quarantine units
- Dedicated staff for isolation units
- Observation and auditing of staff compliance with infection control protocols
- Public health teams to perform contact tracing, testing, reporting and coordination with county public health departments
- Coordinating return to work functions for staff returning from COVID-19 related leave
- Provision of all meals on unit for high risk populations and quarantined units
- Suspension of all in-person patient visits and switch to virtual visitation experience

According to DSH, 1,859 patients and 1,910 staff have tested positive for COVID-19 since May 16, 2020. 55 patients have died since May 30, 2020. The positive patients and staff, as well as deaths by hospital/location are as follows:

- Atascadero – 212 positive patients, 232 positive staff, 1 patient death
- Coalinga – 501 positive patients, 410 positive staff, 20 patient deaths
- Metropolitan – 398 positive patients, 418 positive staff, 12 patient deaths
- Metro-Norwalk ACS – 8 positive staff
- Napa – 167 positive patients, 214 positive staff, 3 patient deaths
- Patton – 581 positive patients, 624 positive staff, 19 patient deaths
- Sacramento Headquarters – 4 positive staff

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of the State Hospitals' response to the COVID-19 pandemic, including the adoption of infection control protocols, changes to admissions, as well as cumulative case and mortality rates, and current vaccination rates of patients and staff.

2. Please provide a brief accounting of allocations, if any, of state or federal funding to DSH for pandemic related expenditures in 2019-20 and 2020-21 from the following sources: SB 89, DREOA, FEMA, the Coronavirus Relief Fund, CDC grant funding, or other federal funding sources.

Issue 3: COVID-19 Direct Response Expenditures

Budget Change Proposal – Governor's Budget. DSH requests General Fund expenditure authority of $52 million in 2021-22. If approved, these resources would support response activities to the COVID-19 pandemic, primarily for staffing, supplies, testing, and logistics.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$51,982,000	$-
Total Funding Request:	**$51,982,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

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

The Administration is requesting total General Fund expenditure authority of $1.8 billion to continue its response and mitigation of the impacts of the COVID-19 pandemic. $1.4 billion of this request is allocated specifically to several departments. The remaining $400 million would be allocated through the Disaster Response-Emergency Operations Account (DREOA), pursuant to proposed budget control section language included in this request. The specified allocations for each department or entity are as follows:

- **Department of Public Health (DPH)** – DPH requests General Fund expenditure authority of $820.5 million in 2021-22 for statewide testing efforts at the Valencia Branch testing laboratory, testing specimen collection through OptumServe, and other miscellaneous services and procurements related to testing.
- **Department of General Services (DGS)** – DGS requests General Fund expenditure authority of $84.4 million in 2021-22 for three key pandemic-related programs: 1) Hotels for Healthcare Workers, which provides hotel rooms to healthcare workers providing critical care to COVID-19 patients to help them avoid bringing the virus home; 2) Housing for the Harvest, which provides hotel rooms for agricultural workers to isolate safely if they are exposed to, or test positive for COVID-19; and 3) Project Hope, which provides hotel rooms to individuals released from prison that need to quarantine safely. This request also includes DGS' contract with FedEx for testing specimen transportation costs, which would be shifted to the DPH budget.
- **Department of Corrections and Rehabilitation (CDCR)** – CDCR requests General Fund expenditure authority of $281.3 million in 2021-22 to support the California Correctional Health Care Services' (CCHCS) efforts to treat COVID-19 and minimize exposure to inmates and staff through testing, vaccinations, medical surge capacity, and personal protective equipment (PPE).
- **Department of Veterans Affairs** – The Department of Veterans Affairs requests General Fund expenditure authority of $5.3 million in 2021-22 to continue efforts to mitigate impacts of the pandemic in veterans' homes. These resources would support enhanced cleaning protocols, testing of staff and residents, procurement of PPE and cleaning products, and procurement of thermometers and medical devices.

- **Department of Social Services (DSS)** – DSS requests General Fund expenditure authority of $5 million in 2021-22 for its Rapid Response Program to support entities that provide assistance and services to immigrants during emergent situations when federal funding is not available.
- **Department of State Hospitals (DSH)** – DSH requests General Fund expenditure authority of $52 million in 2021-22 to support staff costs for cleaning, staffing coverage, environmental projects, custody tasks, screening and isolation. The request also covers commodity purchases, such as PPE, sanitation supplies, changes in food service, as well as equipment for heating and air, filtration, and information technology solutions. In addition, though most testing costs would be shifting to DPH, DSH expects some costs from a contractor hired to work onsite to collect, process, and report staff testing results.
- **Board of State and Community Corrections (BSCC)** – BSCC requests General Fund expenditure authority of $12.1 million in 2021-22 to support county probation departments with increased number of individuals released from state prison on Post-Release Community Supervision to reduce institutional populations in response to the pandemic.
- **Department of Developmental Services (DDS)** – DDS requests General Fund expenditure authority of $36.7 million in 2021-22 for development of surge sites to serve consumers diagnosed with, exposed to, or at high risk of COVID-19. The funding would support an average of 25 beds each at Fairview and Porterville Developmental Centers for six months.
- **Governor's Office of Emergency Services (CalOES)** – CalOES requests General Fund expenditure authority of $119.7 million in 2021-22 to reimburse local governments for eligible costs associated with emergency activities undertaken in response to the COVID-19 pandemic.

According to the Administration, the remaining $400 million would be allocated through the DREOA process for statewide hospital and medical surge preparation, contact tracing, and emergency operations costs. The Administration indicates it would release the departmental allocations for these funds once additional information is available.

Department of State Hospitals – Resource Request. DSH requests total General Fund expenditure authority of $52 million in 2021-22 to support response activities to the COVID-19 pandemic, primarily for staffing, supplies, testing, and logistics. Specifically, DSH requests resources in the following three categories:

- Personal Services – DSH requests General Fund expenditure authority of $10.2 million in 2021-22 for staff time directly related to COVID-19 including cleaning, sanitization, staffing coverages, environmental projects, performing custody tasks, screening staff, and isolation staff. Of this amount, $2.5 million would support regular time for staff, while $7.7 million would support overtime. The request assumes half-year costs consistent with a December 31, 2021, end date for the public health emergency.
- Operating Expense and Equipment (OE&E) – DSH requests General Fund expenditure authority of $35.2 million in 2021-22 for commodity purchases of consumable and non-consumable items. Consumable items include personal protective equipment, sanitation supplies, food, and food supplies to support safer meal provision. Non-consumable items are related to modifications of existing space, new temporary space to support COVID-19 response activities, equipment, heating and air filters, and information technology solutions. Of this amount, $12.5 million would support commodity purchases, $300,000 would support service contracts, and $22.3 million would support other operating costs. The

request assumes half-year costs consistent with a December 31, 2021, end date for the public health emergency.

- Testing – DSH requests General Fund expenditure authority of $6.6 million for testing of patients and employees. According to DSH, although most testing would be shifting to the Department of Public Health's Valencia Branch Laboratory, some testing costs would continue to be borne by the State Hospitals. A contractor works onsite at all State Hospitals to collect, process, and report staff testing results. Patient testing is conducted by DSH staff and processed at contracted laboratories. Of this amount, $5.2 million would support testing of staff, while $1.4 million would support testing of patients. The request assumes half-year costs consistent with a December 31, 2021, end date for the public health emergency.

Subcommittee Staff Comment and Recommendation—Hold Open. 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 the DSH-related components of this proposal.

Issue 4: State Hospitals Program and Caseload Updates

Program and Caseload Updates – Governor's Budget. DSH requests resources to support the following program and caseload updates in its Governor's Budget Estimate.

Program Update – Lanterman-Petris-Short (LPS) and Misdemeanor Incompetent to Stand Trial (MIST) Population and Personal Services Adjustment. LPS patients are individuals that require physically secure 24-hour care and are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship. Counties reimburse state hospitals for the costs of treatment for LPS patients.

According to DSH, the focus of treatment for the LPS population is on psychiatric stabilization and psychosocial treatments to reduce the risk of danger to themselves or others and develop basic life skills to function optimally in a lower level of care in the community. In addition, patients may be admitted under Penal Code Section 1370.01 as misdemeanor incompetent to stand trial (MIST) and are reimbursed through the same reimbursement mechanism as LPS patients. In 2019-20, DSH had a budgeted LPS and MIST population of 741. DSH estimates a 2021-22 LPS and MIST population of 784.

DSH requests additional reimbursement expenditure authority of $8.1 million in 2021-22 and annually thereafter. This additional authority would allow DSH to have sufficient authority to accept the expected LPS and MIST caseload from county commitments.

Program Update – Metropolitan: Increased Secure Bed Capacity. DSH estimates a reduction of 120.6 positions and General Fund savings of $18.6 million in 2020-21 due to delays in the activation of newly secured units at Metropolitan State Hospital to provide increased capacity for the treatment of IST patients. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings that previously housed civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients currently housed in these units will be transferred to non-secured buildings elsewhere on the Metropolitan campus and allow for additional secured capacity for the treatment of IST patients currently in county jails awaiting state hospital treatment.

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

Program Update – Enhanced Treatment Program (ETP) Staffing. DSH estimates a reduction of 30.1 positions and General Fund savings of $4.7 million in 2020-21 and 11.6 positions and $1.8 million in 2021-22 due to delayed completion of Enhanced Treatment Program (ETP) units at Atascadero and Patton State Hospitals. AB 1340 (Achadjian), Chapter 718, Statutes of 2014, authorized DSH to establish an ETP pilot project to expand the range of clinical treatment options for patients determined to be at the highest risk of dangerous behavior or violence against other patients or hospital staff and cannot be safely

treated in a standard treatment environment. According to DSH, the risk of violence against other patients or hospital staff imposes both a threat to health and safety, as well as a barrier to the effective treatment of other patients who may fear for their physical safety in a standard treatment environment with a potentially violent patient. The pilot project period extends approximately five years from the first patient admitted to the ETP and imposes certain requirements on admission and treatment within an ETP.

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

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

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

Units/Hospital	Construction Initiated (Scheduled)	Construction Completion (Scheduled)
DSH-Atascadero Unit 29	September 24, 2018	December 2020
DSH-Atascadero Unit 33	July 2021	February 2022
DSH-Atascadero Unit 34	July 2021	February 2022
DSH-Patton Unit U-06	July 2021	May 2022

Program Update – Vocational Services and Patient Minimum Wage Caseload. DSH estimates General Fund savings of $100,000 in 2020-21 due to lower than expected referrals to its Vocational Rehabilitation Program. This program serves as a therapeutic program to provide a range of vocational skills and therapeutic interventions for patients, including the development of social, occupational, life, and career skills, and confidence. Patients are paid an hourly wage for the work performed in the following jobs: custodial, kitchen worker, product assembler, laundry attendant, landscaper, painter, plumbing, barber, horticulture, multimedia production, peer mentor, office clerk, and repair technician.

The 2019 Budget Act included $3.2 million annually to implement a uniform wage structure for the DSH Vocational Rehabilitation Program, paying participants at the federal minimum wage. DSH estimates of General Fund savings in 2020-21 are due to the reduction in referrals to the program, as well as restrictions on patient work due to COVID-19.

Program Update – Mission Based Review: Direct Care Nursing. DSH reports no change in positions or General Fund expenditures compared to the 2020 Budget Act for staffing changes to implement methodologies to provide appropriate 24-hour nursing care, administration of medication, and an afterhours nursing supervisory structure. The 2019 Budget Act included a total of 379.5 positions and General Fund expenditure authority of $46 million, phased in over three years, to implement the direct care nursing staffing methodology changes. Due to the pandemic-induced recession, and resulting General Fund deficit, the 2020 Budget Act shifted these resources to be phased in across a longer time frame. DSH reports the following updates to the phase in of positions:

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

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

- Atascadero – 112.0 positions have shifted of 132.0 proposed
- Coalinga – 55.0 positions shifted out of 76.1 proposed
- Patton – 27.4 positions shifted out of 27.4 proposed
- Metropolitan – Gain of 142.5 positions once proposed shifts are complete
- Napa – Gain of 93.0 positions once proposed shifts are complete

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

Program Update – Workforce Development for Psychiatric Residency Programs and Psychiatric Technicians. DSH estimates General Fund savings of $425,000 in 2020-21 related to delays in workforce development programs for psychiatry residents, nursing staff, and psychiatric technicians. The 2019 Budget Act included eight positions and General Fund expenditure authority of $1.8 million in 2019-20, $2.2 million in 2020-21, $2.4 million in 2021-22 and 2022-23, and $2.6 million annually thereafter to implement a Psychiatric Residency Program and expand resources for nursing recruitment. DSH expected four residents would have been recruited in July 2020. However, the implementation of the program has been delayed until July 2021. DSH expects one-time General Fund savings of $239,000 due to this delay,

as well as a delay in recruitment of an Assistant Program Director. Delays in programs for nursing and psychiatric technician recruitment will result in one-time General Fund savings of $186,000.

Program Update – Mission-Based Review: Court Evaluations and Reports. DSH estimates General Fund savings of $314,000 in 2020-21 related to delays in filling positions to support court evaluation and report workload. The 2019 Budget Act included 94.6 positions and General Fund expenditure authority of $40.2 million over three years to support forensic services workload associated with court-directed patient treatment. Due to the COVID-19 pandemic, the 2020 Budget Act shifted some of these resources and positions to be phased in across a four-year period. According to DSH, the categories of positions for which savings are expected are as follows:

- Evaluations, Court Reports and Testimony – 20.8 positions have been established out of a total of 53.1 proposed to be phased in for evaluations of patients, court reports, and testimony. 19.8 positions have been filled, resulting in General Fund savings of $76,000 in 2020-21.
- Forensic Case Management and Data Tracking – 6.5 positions have been established out of a total of 16.3 positions proposed to be phased in for forensic case management and data tracking. 5.5 positions have been filled, resulting in General Fund savings of $39,000 in 2020-21.
- Neuropsychological Service – Thirteen positions have been established out of a total of 25.2 positions proposed to be phased in for conducting neuropsychological assessments and implementing a cognitive remediation pilot program. Ten positions have been filled, resulting in a General Fund savings of $199,000 in 2020-21.

Program Update – Mission Based Review: Treatment Team and Primary Care. DSH requests ten positions to support its Clinical Operations Advisory Council (COAC). In 2020-21, DSH proposed changes to its staffing methodologies for its treatment and primary care teams, including a total of 250.2 positions and General Fund expenditure authority of $64.2 million over a five year period. However, due to the pandemic induced recession and resulting General Fund shortfall, the 2020 Budget Act only included 12.5 positions and General Fund expenditure authority of $5 million in 2020-21 and 30 positions and General Fund expenditure authority of $10 million annually thereafter to support implementation of these staffing changes.

According to DSH, the 2020 Budget Act positions and resources required a prioritization on implementation of its clinical executive structure and partial implementation of primary care positions, with the remaining components delayed pending further resources. In addition, DSH administratively established ten positions to support its Clinical Operations Advisory Council (COAC), an interdisciplinary leadership team of clinicians responsible for developing best practices that can be standardized and deployed system-wide. This request would allow DSH to make the positions supporting the COAC permanent.

Program Update – Mission Based Review: Protective Services. DSH requests 12 positions annually to support hospital police officers to provide protective services in the State Hospitals. In 2020-21, DSH proposed a new staffing standard to support protective services functions including 46.3 positions and General Fund expenditure authority of $7.9 million in 2020-21, and 47.8 positions and General Fund expenditure authority of $13.4 million annually thereafter. However, due to the pandemic induced recession and resulting General Fund shortfall, the 2020 Budget Act included no positions or expenditure authority for this purpose.

According to DSH, the Department of Finance authorized the use of overtime to administratively establish positions and utilize its overtime budget to support twelve hospital police officer positions in 2020-21. This requests seeks to permanently establish authority for those positions and redirect the overtime resources to support the permanent staff costs. As a result, the request is for position authority only and no additional expenditure authority. The position request includes one position at Atascadero, seven positions at Napa, and four positions at Metropolitan.

Program Update – Telepsychiatry Resources. DSH estimates a reduction of 6.5 positions and General Fund savings of $911,000 in 2020-21 due to delays in filling positions authorized to support telepsychiatry services for patients. The 2019 Budget Act included eleven positions and General Fund expenditure authority of $2.2 million in 2019-20 and 21 positions and General Fund expenditure authority of $3.7 million annually thereafter for the telepsychiatry expansion. According to DSH, the seven positions allocated to Atascadero were never filled due to more recent success in hiring on-site psychiatrists. As a result, these positions were shifted to Coalinga, for a total of 13 allocated positions. DSH reports only three positions have been filled, resulting in General Fund savings of $570,000 in 2020-21. In addition, Napa has filled three of its five allocated positions, resulting in General Fund savings of $114,000 in 2020-21. DSH also reports a Senior Psychiatrist Supervisor in the Sacramento headquarters, authorized to provide oversight and guidance to the telepsychiatry program, is currently vacant resulting in General Fund savings of $445,000 in 2020-21.

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

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

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

Caseload Update – Forensic CONREP: Sexually Violent Predator (SVP) Program. Beginning in 1996, Sexually Violent Predators (SVP) were added to the CONREP population and are conditionally released to their county of domicile by court order with sufficient funding to provide treatment and supervision services. According to DSH, the CONREP-SVP program offers patients direct access to an array of mental health services with a forensic focus, as well as regularly scheduled sex offender risk

assessments, polygraph testing, and review of Global Position System (GPS) data and surveillance. DSH estimates a total caseload of 21 SVPs will be conditionally released into the community by June 30, 2022. Currently, there are 16 current participants in the CONREP-SVP program and less than eleven individuals with court-approved petitions for release into the program who are awaiting placement. (Due to de-identification guidelines for protected health information, DSH does not refer to numbers of individuals less than eleven). DSH is not requesting additional resources or positions for its CONREP-SVP program.

Program Update – Forensic CONREP Continuum of Care: Step-Down Transitional Program. DSH requests 0.3 positions and estimates General Fund savings of $6.6 million in 2020-21 and 0.5 positions and expenditure authority of $7.3 million annually thereafter. If approved, these positions and resources would support expansion of the CONREP Continuum of Care step-down program. The 2019 Budget Act included $5.1 million in 2019-20 and $11 million in 2020-21 to establish a 78 bed step-down program for patients ready to participate in CONREP in 18 to 24 months. DSH has identified a facility in Southern California owned and operated by a private contractor with experience working with the CONREP population and a strong interest in increasing capacity to serve clients with behavioral health challenges. The 2020 Budget Act assumed activation of this facility and patient admissions would begin in August 2020. However, regulatory approvals and other delays due to the COVID-19 pandemic have resulted in an estimated completion of construction by April 2021, depending on regulatory approvals. DSH estimates General Fund savings from this delay of $9.8 million in 2020-21.

DSH reports during the COVID-19 pandemic, its need to expand the availability of beds for patients referred to State Hospitals resulted in execution of an emergency contract with a facility in Northern California for 10 beds for treatment of state hospital patients ready for step-down into a CONREP program in 18 to 24 months. The Northern California facility was activated in July 2020 and is currently interviewing and evaluating patients for admission. DSH also reports the facility has expressed interest in expanding to a 20 bed program in 2021-22. DSH utilized the one-time savings from delayed activation of the Southern California step-down facility to support $1.7 million of General Fund costs to support the activation of the 10 bed Northern California facility. DSH requests General Fund expenditure authority of $3.6 million in 2021-22 and annually thereafter to expand the Northern California facility to 20 beds.

DSH reports it is also in negotiations with a 20 bed Mental Health Rehabilitation Center (MHRC) in Northern California to provide timely access for evaluation and treatment of individuals referred as incompetent to stand trial (IST). DSH expects program activation to occur in February 2021, and plans to utilize the one-time savings from the delayed activation of the Southern California step-down facility to support $1.5 million of General Fund costs to support the new 20 bed MHRC in 2020-21. DSH requests General Fund expenditure authority of $3.6 million in 2021-22 and annually thereafter to support the full-year costs of the 20 bed IST program at the Northern California MHRC.

DSH also requests **0.5 Staff Services Manager I, Specialist** position to serve as project manager for these positions. The position would be established January 1, 2021, resulting in augmentation of 0.3 position in 2020-21 and 0.5 position annually thereafter.

Program Update – Jail-Based Competency Treatment (JBCT) Programs and Admission, Evaluation, and Stabilization (AES) Center. DSH reports net General Fund savings of $3.2 million in 2020-21 composed of one-time cost savings of $2.2 million for COVID-19 pandemic related delays in activation of additional beds at the Kern Admission, Evaluation, and Stabilization (AES) Center, and

$960,000 for delayed activation of a jail-based competency treatment (JBCT) program in Calaveras County. DSH also requests General Fund expenditure authority of $62,000 in 2021-22 and annually thereafter to support travel reimbursement for a contracted mobile psychologist who will travel to multiple JBCT locations to deliver services. DSH contracts with county jail facilities to provide restoration of competency services in JBCT programs, treating IST patients with lower acuity and that are likely to be quickly restored to competency. DSH expects these programs to increase bed capacity by 427 in 2020-21 and 483 in 2021-22.

DSH also requests General Fund expenditure authority of $785,000 in 2020-21 and $6.3 million in 2021-22 and annually thereafter to support the proposed activation of new JBCT programs. DSH proposes: 1) a December 2020 activation of an eight bed JBCT program in a Southern California county; 2) a July 2021 activation of a six bed and a 12 bed JBCT program in a Central California county, and a five bed JBCT program in a Northern California county; and 3) a July 2021 activation of three small county JBCT programs with flexible bed counts to support local needs. According to DSH, the cost estimate is based on an expected per diem rate of $420 per patient.

DSH is also requesting General Fund expenditure authority of $3,000 in 2020-21, and $22,000 in 2021-22 and annually thereafter to support patients' rights advocates. Existing law requires patients' rights advocates to provide advocacy services for, and conduct investigations of alleged or suspected abuse and neglect of, including deaths of, persons with mental disabilities residing in state hospitals. According to DSH, these requirements include patients in JBCT programs. If approved, these resources would allow for 0.6 patients' rights advocate based on a 60 patient caseload for each advocate and an expected expanded JBCT caseload of 34 patients.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items 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 each of the program updates referenced in this item.

Issue 5: Incompetent to Stand Trial (IST) Diversion Program Expansion and Reappropriation

Local Assistance and Reappropriation – Governor's Budget. DSH requests three positions and General Fund expenditure authority of $47.6 million in 2021-22 and $1.2 million in 2022-23. If approved, these positions and resources would allow DSH to expand its community-based diversion program for individuals with potential to be determined incompetent to stand trial on felony charges.

DSH also requests reappropriation of up to $8 million of General Fund expenditure authority previously authorized in the 2018 Budget Act. If approved, this reappropriation would allow DSH to provide additional funding to county diversion programs until June 30, 2020, and to liquidate all funding to counties through June 30, 2024.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$47,584,000	$1,230,000
Total Funding Request:	**$47,584,000**	**$1,230,000**

Background. The 2018 Budget Act included General Fund expenditure authority of $100 million, available for encumbrance and expenditure until 2022-23, to establish an IST Diversion Program, which would contract with counties to serve individuals with serious mental illnesses with potential to be determined to be incompetent to stand trial (IST) on felony charges. The program prioritized $91 million of funding for these programs in the 15 counties with the highest referrals of ISTs to DSH in 2016-17, including Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Solano, Sonoma, and Stanislaus. These counties were not required to submit a competitive application. In May 2020, Stanislaus County chose not to participate due to COVID-19 related economic issues and lack of other county resources to establish the program.

Of the remaining funding, $8.5 million was made available to other counties under a competitive funding process. In June 2019, DSH awarded funding to the following counties: Del Norte, Marin, Placer, San Francisco, San Luis Obispo, Santa Cruz, and Yolo. In November 2019, DSH awarded a second round of funding to Humboldt, San Mateo, Siskiyou, and Ventura counties.

According to DSH, it used the following assumptions for establishing grant awards for each county:

- 20 to 30 percent of the three-year average of a county's felony IST referrals would be eligible for diversion.
- A three-year allocation rate of $142,000 per estimated diversion client would determine maximum funding.
- Counties must submit a program implementation plan detailing program housing and services, stablish a contract with DSH, and report data on a quarterly basis.

The funding status, population, and program start date for each county are as follows:

IST Diversion Program – County Program Status (December 2020)			
County	***Funding***	***Population (Capacity)***	***Program Start Date***
Del Norte	$426,000	9	6/1/2020
Humboldt	$979,800	23	7/1/2020
Kern	$7,891,400	56	1/13/2020
Los Angeles	$25,864,100	200	3/1/2019
Marin	$531,476	12	6/12/2020
San Bernardino	$7,464,800	53	1/1/2020
San Diego	$3,328,000	30	10/27/2020
San Francisco	$2,300,400	30	7/1/2020
San Luis Obispo	$1,278,000	9	8/20/2019
Santa Barbara	$2,644,500	18	9/22/2020
Santa Clara	$2,840,000	20	7/1/2020
Santa Cruz	$1,362,536	45	10/1/2020
Sonoma	$3,839,100	27	1/1/2020
Alameda	$3,114,100	22	Winter 2021
Contra Costa	$3,114,100	22	Winter 2021
Fresno	$5,843,700	42	Winter 2021
Placer	$1,065,000	21	Winter 2021
Sacramento	$4,478,900	32	Winter 2021
Ventura	$2,428,200	18	Winter 2021
Yolo	$1,100,000	8	Winter 2021
San Mateo	$835,757	12	TBD
Riverside	$6,910,100	48	TBD
San Joaquin	$2,986,000	21	TBD
Siskiyou	$194,000	40	TBD
Solano	$3,242,300	23	TBD
TOTAL	**$96,062,269**	**841**	

According to DSH, as of June 30, 2020, 144 individuals have been diverted to a county run diversion program, and the department is collecting data to evaluate the success of these programs. DSH reports it has provided technical assistance and training opportunities to counties participating in the program, including: 1) appropriate medications and psychopharmacology considerations for prescribers in diversion programs; 2) how to use risk assessments to inform client treatment plans; and 3) case plan review sessions with DSH, county, and external experts to assist evaluations of more difficult cases. DSH also reports it has partnered with the Department of Health Care Services and the California Institute for Behavioral Health Solutions to provide additional trainings to counties across the state.

Staffing and Resource Request. DSH requests three positions and General Fund expenditure authority of $47.6 million in 2021-22 and $1.2 million in 2022-23 to expand the IST Diversion Program. These resources would support expansion of existing programs to new clients, as well as establishing programs in new counties. DSH would utilize the same maximum funding criteria to expand to new counties as was used previously, including the 20 to 30 percent calculation of three-year felony IST referrals multiplied by the $142,000 three-year allocation. For existing counties, DSH assumes additional funding would support a ten to 20 percent increase in clients served. DSH expects $29 million would support 33

new county programs serving as many as 204 new clients, and $17.4 million would support expansion of 25 existing county programs to serve 123 new clients.

In addition to increased expenditure authority for county grants, DSH requests three positions and General Fund expenditure authority of $560,000 for five years to support administration of the expanded program. Specifically, DSH requests **one Senior Psychologist (Supervisory)**, **one Staff Services Manager II (Specialist)**, and **one Associate Governmental Program Analyst**. These positions would review county proposals, provide technical assistance, consult on measuring program effectiveness and compliance, manage contract negotiations and fiscal reporting, and provide policy expertise to DSH on diversion.

In addition, DSH is requesting General Fund expenditure authority of $2.5 million over five years to support a research contract with the University of California, Davis to support data collection and analysis from county programs. DSH also requests General Fund expenditure authority of $100,000 over five years to contract with national experts to provide technical assistance and training to counties implementing diversion programs.

Reappropriation Request. In addition to the request for new positions and resources, DSH requests reappropriation of up to $8 million of General Fund expenditure authority approved in the 2018 Budget Act. DSH reports one county declined to participate, two counties contracted for less than the maximum available funding, and other counties may be at risk of not participating or contracting for less than the maximum available funding. As a result, DSH requests this reappropriation of funding to allow DSH to encumber any remaining contract funding through June 30, 2022, and to liquidate all funding to existing counties through June 30, 2024.

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: Los Angeles Community-Based Restoration Program Expansion

Local Assistance – Governor's Budget. DSH requests General Fund expenditure authority of $9.8 million in 2020-21, one position and General Fund expenditure authority of $4.5 million in 2021-22 and $5 million annually thereafter. If approved, these positions and resources would allow DSH to expand the Los Angeles Community-Based Restoration Program.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$4,503,000	$4,978,000
Total Funding Request:	**$4,503,000**	**$4,978,000**

* Additional fiscal year resources requested – 2020-21: $9,758,000. Resources ongoing after 2022-23.

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

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

Staffing and Local Assistance Request. DSH requests General Fund expenditure authority of $9.8 million in 2020-21, one position and General Fund expenditure authority of $4.5 million in 2021-22 and $5 million annually thereafter to expand the Los Angeles CBR Program, both within Los Angeles and to other counties. According to DSH, the proposed local assistance resources would expand capacity by up to 200 beds in Los Angeles County in 2020-21 and up to 50 beds in additional counties in 2021-22. DSH indicates the scope of this request may be updated at May Revision to reflect additional counties identified to participate in the Community Care Demonstration Project for ISTs (CCDP-IST), which DSH has also proposed in the budget (see *Issue 7: Community Care Demonstration Project for Felony Incompetent to Stand Trial*).

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

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 7: Community Care Demonstration Project for Felony Incompetent to Stand Trial

Budget Change Proposal and Trailer Bill Language – Governor's Budget. DSH requests four positions and General Fund expenditure authority of $233.2 million in 2021-22 and $136.4 million annually thereafter to establish the Community Care Demonstration Project for Felony Incompetent to Stand Trial (IST), which would contract with counties to provide a continuum of services to felony ISTs in the county instead of the State Hospitals. DSH also proposes trailer bill language to implement the program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$233,187,000	$136,437,000
Total Funding Request:	**$233,187,000**	**$136,437,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and resources ongoing after 2022-23.

Background. The State Hospitals system admits individuals determined to be incompetent to stand trial (IST) under Section 1370 of the Penal Code, typically for felony offenses, and provides clinical and medical services to restore these individuals to competency. Because of capacity constraints within the state hospital system, 1,306 individuals in the IST population are housed in county jails because they are awaiting placement into a state hospital bed or jail-based competency program. This backlog, which has grown significantly in the last year due to the COVID-19 pandemic, places operational and fiscal stress on county jails and may violate the rights of individuals in custody for longer than a reasonable time to evaluate their potential for restoration to competency.

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

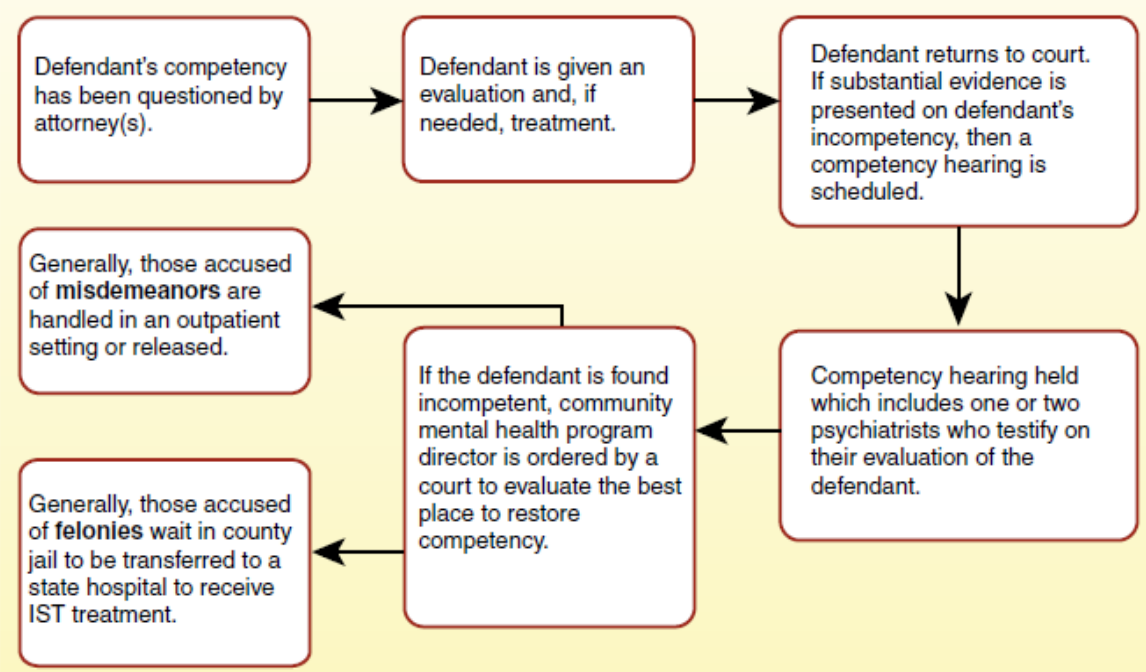


Figure 1: Incompetent to Stand Trial Commitment Process
Source: *"An Alternative Approach:Treating the Incompetent to Stand Trial", Legislative Analyst's Office, Jan 2012*

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

Administration Proposals to Increase IST Capacity in State Hospitals. Over recent years, the Administration has proposed a series of projects to expand capacity in State Hospitals for the treatment of IST patients. These proposals were in response to the growing backlog of IST patients in county jails over the last ten years. These proposals include: 1) expansion of secured bed capacity at Metropolitan State Hospital to treat IST patients; 2) expansion of existing jail-based competency treatment programs and implementation of new programs; and 3) activation of OMD bed capacity at Coalinga State Hospital to allow transfer from other secured units to provide treatment space for IST patients in other hospitals.

2018 Budget Act - IST Community-Based Diversion Program. The 2018 Budget Act included General Fund expenditure authority of $100 million, available for encumbrance and expenditure until 2022-23, to establish an IST Diversion Program, which would contract with counties to serve individuals with serious mental illnesses with potential to be determined to be incompetent to stand trial (IST) on felony charges.

The program prioritized $91 million of funding for these programs in the 15 counties with the highest referrals of ISTs to DSH in 2016-17, including Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Joaquin, Santa Barbara, Santa Clara, Solano, Sonoma, and Stanislaus. These counties did were not required to submit a competitive application. In May 2020, Stanislaus County chose not to participate due to COVID-19 related economic issues and lack of other county resources to establish the program.

Of the remaining funding, $8.5 million was made available to other counties under a competitive funding process. In June 2019, DSH awarded funding to the following counties: Del Norte, Marin, Placer, San Francisco, San Luis Obispo, Santa Cruz, and Yolo. In November 2019, DSH awarded a second round of funding to Humboldt, San Mateo, Siskiyou, and Ventura counties. The budget includes a request for General Fund expenditure authority to expand the IST diversion program (see *Issue 5: Incompetent to Stand Trial (IST) Diversion Program Expansion and Reappropriation*).

Staffing and Resource Request – Community Care Demonstration Project for Felony IST. DSH requests four positions and General Fund expenditure authority of $233.2 million in 2021-22 and $136.4 million annually thereafter to establish the Community Care Demonstration Project for Felony Incompetent to Stand Trial (CCPD-IST), which would contract with counties to provide a continuum of services to felony ISTs in the county instead of the State Hospitals. DSH also proposes trailer bill language to implement the program.

Under the CCPD-IST program, DSH would contract with several counties of various sizes that would assume full responsibility for the treatment and restoration of felony IST defendants beginning as soon as July 1, 2021. Once the contract is implemented, any felony IST defendant pending placement and any newly committed felony IST defendants thereafter would be directed to the participating county for treatment and competency restoration in the county's continuums of care. DSH would provide funding to counties equivalent to the average cost of treatment for an IST patient in a State Hospital bed (currently $699 daily bed rate at an average length of stay of 155 days, for a total of $108,345 per patient). Counties would still have access to beds in State Hospitals for IST patients that are not suitable for community treatment in the county, but the county would be charged 150 percent of the DSH daily bed rate for each day used. According to DSH, this premium charge would provide an incentive to counties to only refer the highest acuity patients that cannot be treated by county programs.

DSH assumes a continuum of treatment settings would be required to serve the felony IST population and counties would need time to develop this capacity. These settings would include: 1) county operated jail treatment programs, 2) acute inpatient psychiatric beds, 3) Institution for Mental Disease (IMD) and Mental Health Rehabilitation Center (MHRC) beds, 4) unlocked residential beds with onsite treatment services, and 5) access to State Hospital beds for individuals who need the highest level of care. DSH reports it utilized a RAND Corporation research report and actual admission rates to estimate the percentage of current IST referrals that would require a State Hospital level of care and the percentage that could be safely treated in a less restrictive setting in the community. DSH estimates 68 percent of IST referrals could be safely treated in the community and, of the remaining 32 percent, approximately ten percent would require care in a jail-based competency treatment program. Utilizing these percentages, DSH estimates the following distribution by treatment setting under the CCPD-IST program:

IST Population – Percent Distribution by Treatment Setting (Annual)		
Treatment Setting	**Percentage**	**Annual Patients**
Community Care Continuum, including:	**78 percent**	**971**
- Community Care Treatment	*68 percent*	*851*
- Jail-Based Treatment	*10 percent*	*120*
State Hospital	**22 percent**	**281**
TOTAL	**100 percent**	**1,252**

DSH expects to contract with counties sufficient to treat 1,252 individuals annually. In addition, DSH expects one-time costs for treating 460 individuals currently on the IST wait list pending placement, as well as one-time program implementation costs of $35 million to support building capacity infrastructure. DSH also expects one-time costs of $11.9 million for the costs of care for IST defendants already receiving treatment through an expansion of the Community-Based Restoration program prior to activation of the CCDP-IST.

For administration of the program, DSH requests four positions and General Fund expenditure authority of $753,000 annually to support implementation, monitoring, and evaluation activities. Specifically, DSH is requesting **one Consulting Psychologist, one Health Program Manager III** position, **one Research Data Analyst II** position, and **one Staff Services Analyst.** DSH is also requesting $45,000 for travel costs for county outreach and $60,000 to contract with national experts for consultation and training.

According to DSH, the 2021-22 costs of the program would be as follows:

2021-22 Costs	Patients	Rate	Totals
Baseline County Treatment	1,252 patients	$108,345	$135,684,055
One-Time Waitlist Treatment Cost	460 patients	$108,345	$49,838,700
One-Time Program Implementation			$35,000,000
One-Time County Program Expansion Transfer			$11,911,000
DSH Administration Support			$753,000
TOTAL 2021-22 FUNDING			**$233,186,755**

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.

2. How would this program interact with the previous IST Diversion Program and Los Angeles Community-Based Restoration Program authorized in the 2018 Budget Act, and proposed for expansion in the current budget?

3. How is DSH coordinating with other state departments and entities, including Medi-Cal and the Mental Health Services Oversight and Accountability Commission, as well as county behavioral health programs, to coordinate other state and local resources and infrastructure that would be needed to address the needs of this population at the community level?

4. Please describe how the incentives for counties would work to promote interventions prior to felony justice involvement.

Issue 8: Conditional Release Program – Mobile Forensic Assertive Community Treatment Team

Local Assistance – Governor's Budget. DSH requests two positions and General Fund expenditure authority of $5.6 million in 2021-22 and $8 million annually thereafter. If approved, these positions and resources would allow DSH to implement a mobile treatment team for CONREP services based on the forensic assertive community treatment (FACT) model of care.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$5,577,000	$7,977,000
Total Funding Request:	**$5,577,000**	**$7,977,000**
Total Positions Requested:	**2.0**	**2.0**

* Positions and resources ongoing after 2022-23.

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

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

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

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

To implement the FACT model of care, DSH would augment existing contracts with current CONREP providers and partner with new contract providers to provide: 1) clinical treatment and client support staff;

2) staff travel costs; 3) administrative support and other operational expenses; 4) client life support costs, such as clothing, food, incentives, and toiletries; and 5) client housing costs, such as rent and utilities.

DSH assumes the annual cost per client would be $75,000 and expects to serve 100 clients annually. This would result in an annual cost of $7.5 million. DSH expects half-year costs of $3.8 million for housing and treatment in 2021-22, as well as $1.5 million of start-up and program implementation costs. In 2022-23 and annually thereafter, housing and treatment costs would be $7.5 million with $150,000 ongoing implementation costs.

In addition to treatment and housing costs, and program costs, DSH is requesting two positions and other program support resources of $327,000 annually. Specifically, DSH is requesting **one Clinical Social Worker** and **one Health Program Specialist I** position to coordinate development of program operations, policies and procedures, identify and collaborate with housing providers, and negotiate and maintain program contracts.

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 9: Technical Budget Adjustment – Various Programs

Technical Adjustment – Governor's Budget. DSH requests a net-zero adjustment of positions and expenditure authority between programs to reflect current allocations and anticipated expenditures.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$-	$-
Total Funding Request:	**$-**	**$-**

* Resources ongoing after 2022-23.

Background. DSH oversees five State Hospitals which comprise the largest inpatient forensic mental health hospital system in the nation. In addition to forensic admissions, which comprise 86 percent of its population, the five state hospitals admit individuals civilly committed under the Lanterman-Petris-Short (LPS) Act because they require physically secure 24-hour care and meet legal criteria that they represent a danger to themselves or others. In addition to expenditure authority to support the five State Hospitals, the DSH budget includes expenditure authority to support the Sacramento Headquarters, as well as a variety of jail-based competency treatment programs and other contracted services.

Technical Adjustment. DSH requests a net-zero adjustment of positions and expenditure authority between programs to reflect current allocations and anticipated expenditures. Specifically, DSH requests the following adjustments:

- **Accountant Trainee (Metropolitan to Sacramento) –** DSH requests transfer of one position and General Fund expenditure authority of $97,000 from Metropolitan State Hospital to the Sacramento Headquarters. This transfer would address workload needs in the Accounting Branch.
- **Clinical Operations Advisory Council (State Hospitals to Sacramento) –** DSH requests transfer of 10 positions and General Fund expenditure authority of $2.6 million from all five of the State Hospitals to the Sacramento Headquarters. This transfer would allow establishment of positions for the Clinical Operations Advisory Council approved in the 2020 Budget Act.
- **Assistant Medical Director (Atascadero to Sacramento) –** DSH requests transfer of one position and General Fund expenditure authority of $426,000 from Atascadero State Hospital to the Sacramento Headquarters. This transfer would allow upgrade of an Assistant Medical Director position consistent with authority provided in the 2020 Budget Act.
- **Retirement Payout (Metropolitan to Sacramento)** – DSH requests transfer of General Fund expenditure authority of $193,000 from Metropolitan State Hospital to the Sacramento Headquarters. This transfer would correct allocation of retirement payout costs erroneously attributed to Metropolitan in the Governor's Budget development process. DSH indicates the error will be corrected during its May Revision process.
- **Realignment of Increased Court Appearances and Public Records Act (Sacramento to Coalinga)** – DSH requests transfer of 0.5 position and General Fund expenditure authority of $48,000 from the Sacramento Headquarters to Coalinga State Hospital. This transfer would align with the intent of resources approved in the 2019 Budget Act for increased court appearances and public records act requests.

- **Post-Incident Debriefing and Support (Sacramento to State Hospitals)** – DSH requests transfer of five positions and General Fund expenditure authority of $735,000 from the Sacramento Headquarters to the five State Hospitals. This transfer would distribute to the State Hospitals the resources approved in the 2020 Budget Act for Post-Incident Debriefing and Support.
- **Reimbursement Funding (Sacramento to State Hospitals)** – DSH requests transfer of reimbursement authority of $3.2 million from the Sacramento Headquarters to the State Hospitals. This transfer is a technical change related to a budget restructuring authorized in the 2018 Budget Act.
- **Senior Psychologist Specialist (Atascadero to Sacramento)** – DSH requests transfer of one position and General Fund expenditure authority of $203,000 from Atascadero State Hospital to the Sacramento Headquarters. This transfer of a Senior Psychologist Specialist to the Sacramento Clinical Operations Division was authorized in the 2019 Budget Act, but never made permanent.
- **Staff Services Manger I Transfer (Forensic Services Division to Sacramento)** – DSH requests transfer of one position and General Fund expenditure authority of $148,000 from its Forensic Services Division to the Sacramento Headquarters. This transfer is associated with the increased workload in processing the division's contracts.
- **Realignment of Information Technology Funding (Atascadero to Sacramento)** – DSH requests transfer of General Fund expenditure authority of $390,000 from Atascadero State Hospital to the Sacramento Headquarters. This transfer would centralize information technology costs in Sacramento, with a portion of standard complement for newly established positions authorized with approval of new Budget Change Proposals.
- **Associate Governmental Program Analyst (Forensic Services Division to CONREP)** – DSH requests transfer of one position and General Fund expenditure authority of $126,000 from the Forensic Services Division to CONREP. This transfer is intended to address expanded workload related to renewing or establishing contracts with counties and evaluators.
- **Associate Governmental Program Analyst (Contracted Patient Services to CONREP)** – DSH requests transfer of one position and $126,000 from Contracted Patient Services to CONREP. This transfer is intended to address expanded workload related to renewing or establishing contracts with counties and evaluators.
- **Student Assistants (Forensic Services Division to Contracted Patient Services)** – DSH requests transfer of General Fund expenditure authority from the Forensic Services Division to Contracted Patient Services. This transfer would support student assistants to help with administrative support functions for diversion and jail-based competency treatment programs.

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 10: Protected Health Information Permanent Implementation

Budget Change Proposal – Governor's Budget. DSH requests General Fund expenditure authority of $986,000 in 2021-22 and 2022-23. If approved, these resources would allow DSH to continue processing of invoices and payments from external medical providers containing protected health information and consolidating financial operations into a single budget unit.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$986,000	$986,000
Total Funding Request:	**$986,000**	**$986,000**
Total Positions Requested:	**0.0**	**0.0**

Background. The Health Insurance Portability and Accountability Act (HIPAA), implemented in 1996, was intended to allow for portability and continuity of an individual's health care coverage by imposing significant administrative simplification and standardization requirements on health care entities, and strict security standards for protected health information (PHI). HIPAA administrative simplification and security rules apply to certain individuals or organizations known as covered entities or business associates. According to the U.S. Department of Health and Human Services (HHS), covered entities include the following:

1. Health care providers including physicians, clinics, psychologists, dentists, chiropractors, nursing homes, and pharmacies that transmit HIPAA-protected information in an electronic format.
2. Health plans including commercial health care service plans, health insurers, group health plans, and public health care programs, such as Medicare, Medicaid, and military or veteran's health care programs.
3. Health care clearinghouses that process nonstandard information they receive from another entity into a standard electronic format or data content, or vice versa.

DSH is a covered entity under HIPAA and is responsible for the security of protected health information for its patients. According to DSH, over 63,000 invoices are processed by the department annually and more than 80 percent contain PHI. DSH patients have unique and acute medical and clinical needs that oftentimes require visits to specific external providers. These medical providers' invoices in turn contain a combination of patient information such as the patient's name, patient identification number, diagnosis, medical service received, and date of service.

The 2018 Budget Act included General Fund expenditure authority of $988,000 in 2018-19, 2019-20, and 2020-21, to support the transition of its paper-based invoice process to a third party vendor or an electronic health record. These resources supported the equivalent of eight positions to create an interim process for accounting until implementation of an electronic health record system, as well as transition invoices into a PeopleSoft accounts payable module and consolidate its six business units for each State Hospital and the Sacramento Headquarters accounting into a single business unit.

Resource Request. DSH requests 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. Approval of these resources would be a two-year extension of the resources approved in the 2018 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 11: Increased Court Appearances and Public Records Act Requests

Budget Change Proposal – Governor's Budget. DSH requests General Fund expenditure authority of $777,000 in 2021-22 and 2022-23. If approved, these resources would allow DSH to address an increase in workload for attorneys that are required to appear for court hearings and for responding to Public Records Act requests.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$777,000	$777,000
Total Funding Request:	**$777,000**	**$777,000**
Total Positions Requested:	**0.0**	**0.0**

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

According to DSH, the ongoing and growing IST waitlist has resulted in a significant amount of related litigation, including:

- County public defenders filing motions seeking Orders to Show Cause (OSCs) why DSH should not be held in contempt for not timely admitting IST patients, and seeking sanctions.
- County public defenders filing motions under Code of Civil Procedure section 177.5 seeking sanctions against DSH for not complying with superior court orders to admit IST patients by a date specified.
- Superior courts issuing OSCs seeking to sanction DSH for not timely admitting IST patients or violating court orders to admit patients.
- Courts setting status conferences, with mandatory appearances by DSH, to explain why the patients have not been transported, or admitted to its hospitals, or considering whether to hold DSH in contempt.
- County public defenders filing motions seeking standing orders requiring that DSH admit IST patients by a specified time-frame.
- County public defenders filing writs of habeas corpus, writs seeking release of IST patients held in jail awaiting admission to DSH, and writs of mandate requiring DSH to comply with various specified time-frames for admission.
- The ACLU and private law-firms filing state and federal civil-rights cases seeking injunctive relief and damages for alleged violations of IST patients' constitutional rights.

DSH attorneys must respond, object, appear, or serve as staff counsel to represent DSH in each of these types of motions, status conferences, OSCs, standing-order requests, writs, and civil rights litigation.

In addition to legal workload, DSH reports continued high volume of Public Records Act (PRA) requests. In particular, patients at Coalinga State Hospital continue to file requests seeking hospital records, meeting minutes, emails, logs, policies, procedures, and work orders. DSH reports it received 320 PRA requests in 2019, with 43 percent of them requested from Coalinga. The 2019 Budget Act included General Fund expenditure authority of $767,000 in 2019-20 and 2020-21 to support the equivalent of 5.5 positions to address these increases in court hearings at which DSH attorneys are required to appear, as well as increases in requests pursuant to the Public Records Act.

Resource Request. DSH requests 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 are a continuation of the limited-term resources approved in the 2019 Budget Act for this purpose. Like the previous requests, these 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. Approval of these resources would be a two-year extension of the resources approved in the 2019 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 12: Patient Education

Budget Change Proposal – Governor's Budget. DSH requests three positions and General Fund expenditure authority of $352,000 annually. If approved, these positions and resources would allow DSH to expand patient education services at Coalinga State Hospital to align with those offered at other State Hospitals.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$352,000	$352,000
Total Funding Request:	**$352,000**	**$352,000**
Total Positions Requested:	**3.0**	**3.0**

* Positions and resources ongoing after 2022-23.

Background. To help patients overcome educational limitations, DSH provides patient education services at their hospitals, including the administration of special education, adult basic education (ABE), vocational education, and high school equivalency programs and courses. State law requires all patients under the age of 22 admitted to a State Hospital to have a free appropriate public education offered to them if they have previously received special education services. DSH enrolls students in its education services who self-report having received prior special education services, or who DSH determines received these services through other means. Education services for patients 22 years of age and older are provided in the ABE and vocational services programs. ABE includes educational services that teach basic literacy or to work towards high school equivalency. ABE also includes academic skill building and developing life skills. DSH also offers the Arts in Mental Health program to develop arts education through art fundamentals, theater arts, poetry and creative writing, design and illustration, and Taiko drumming. DSH also offers vocational services in a pre-vocational class or industrial therapy assignment, as well as programs for computer skills, occupations skills, treatment program courses, and substance recovery programs.

Napa, Patton, Atascadero, and Metropolitan State Hospitals offer the full complement of these programs to their patients. Coalinga State Hospital, due to limited resources, does not offer the same level of educational services to its patients that are offered at the other four hospitals. Coalinga provides hooked on phonics and college distance learning through Coastline College, but does not offer ABE programs, high school equivalency programs, or special education programs. Because DSH is planning to include Coalinga in its federal Workforce Innovation and Opportunity Act grant application in the future, this request would support aligning the patient education programs offered at Coalinga with the rest of the State Hospital system.

Staffing and Resource Request. DSH requests three positions and General Fund expenditure authority of $352,000 annually to expand patient education services at Coalinga State Hospital to align with those offered at other State Hospitals. Specifically, DSH requests **one Special Education Teacher** and **two Psychiatric Technicians**. The special education teacher would plan, assign, and supervise the work of the ABE and high school equivalency programs, including designing curriculum, administering daily lessons, and managing the educational program. The psychiatric technicians would assist the teacher through assessment of patients and development of individualized education plans, and provide support

to students with completing assignments, preparing for exams, and getting the best out of the educational opportunity.

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 13: Medical and Pharmaceutical Billing System

Budget Change Proposal – Governor's Budget. DSH requests one position and General Fund expenditure authority of $794,000 in 2021-22 and $774,000 in 2022-23, 2023-24, and 2024-25. If approved, these position and resources would allow DSH to enhance system functionality for its Cost Recovery System to capture, bill, and recover eligible patient costs of care reimbursements.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$794,000	$774,000
Total Funding Request:	**$794,000**	**$774,000**
Total Positions Requested:	**1.0**	**1.0**

* Position and resources ongoing through 2024-25.

Background. Welfare and Institutions Code Sections 7275 through 7279 authorize DSH to charge the spouse, father, mother, or children of a patient, or the patient's estate or other assets, for the cost of care, support, and maintenance in a State Hospital. In addition, DSH may seek recovery of costs for care from other liable parties, including Medicare and other insurance coverage. These types of recoveries are known as third-party billing.

The 2014 Budget Act included 15 positions and authorized the creation of the Patient Cost Recovery Section (PCRS) in DSH to develop and implement a third-party billing system to include accounts management, billing and collection, assets determination, policies and procedures, compliance and auditing. PCRS works to recoup charges related to a DSH patient's cost of care from any applicable insurance or private pay parties, for deposit in the state's General Fund. PCRS primarily collects from Medicare, private pay, and insurance. According to DSH, the revenues it received from various sources between 2016-17 and 2019-20 are as follows:

Reimbursement Type	**2016-17**	**2017-18**	**2018-19**	**2019-20**
Medicare Part A and B	$753,688	$838,397	$516,104	$471,776
Medicare Part D	$921,048	$1,091,620	$1,130,527	$1,045,330
Private Pay	$3,480,176	$2,574,851	$2,538,219	$1,741,061
Other	$4,992	$109,204	$117,971	$47,609
TOTALS	**$5,159,904**	**$4,614,072**	**$4,302,821**	**$3,305,776**

PCRS utilizes a Cost Recovery System (CRS), which it shares with the Department of Developmental Services (DDS) to conduct its billing operations. CRS was built in the 1980s and uses the COBOL programming language. According to DSH, CRS is an antiquated billing system and can no longer account for the complexity of its patient population and rapidly changing needs. CRS has also been prone to errors in various billing functions, which may result in inaccurate account balances, increased workload to manually correct the errors, inaccurate Medicare claim information, not meeting current medical billing industry standards, and a heightened risk of negative audit findings.

DSH indicates it must address the technical issues in CRS through programming changes to ensure proper coding, billing, and collections of third-party resources. DSH expects these changes would significantly

reduce its Medicare billing error rates, resulting in additional collections in the tens of millions of dollars annually. DSH also expects these changes would be a short-term solution that would fulfill its recovery needs until planned implementation of a full electronic health records system in 2025.

Staffing and Resource Request. DSH requests one position and General Fund expenditure authority of $794,000 in 2021-22 and $774,000 in 2022-23, 2023-24, and 2024-25 to enhance system functionality for CRS. Specifically, DSH is requesting **one Information Technology Specialist I** position to plan and manage extension of existing programming functionality for CRS, ensure deliverables are achieved, develop the master project schedule and other work plans, and ensure adherence to technical requirements. In addition, DSH is requesting contract funding of $640,000 for COBOL Consultant programmers. DSH does not currently have staff available with a COBOL background and it is difficult to find programmers proficient in the language.

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.

2. Why does DSH attempt to recoup the costs of treatment in a State Hospital from patients' families or estates, given that nearly all are involuntarily committed to the State Hospitals' care? Would these individuals incur similar liability if they had been treated for their mental illness in a jail or prison setting?

3. What is the average net revenue recovery after accounting for operational costs of the Patient Cost Recovery Section?

Issue 14: Skilled Nursing Facility Infection Preventionists

Budget Change Proposal – Governor's Budget. DSH requests two positions and General Fund expenditure authority of $350,000 annually to support infection preventionists at skilled nursing facilities operated at Metropolitan and Napa State Hospitals, pursuant to the requirements of AB 2644 (Wood), Chapter 287, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$350,000	$350,000
Total Funding Request:	**$350,000**	**$350,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2022-23.

Background. Two of the five State Hospitals, Metropolitan and Napa, operate licensed skilled nursing facility (SNF) programs. Metropolitan's SNF has 102 beds and Napa's SNF has 36 beds. These two SNF programs provide continuous nursing treatment to both forensically and civilly committed patients and are licensed and regulated by the state Department of Public Health (DPH).

In response to the COVID-19 pandemic, DPH issued guidance and regulatory updates to health care facilities to address infection control and mitigation expectations. These guidelines included requirements for SNFs to expand existing infection control policies due to the disproportionate morbidity and mortality of COVID-19 among elderly individuals in congregate care facilities. DPH issued All Facility Letter (AFL) 20-52 on May 11, 2020, which required SNFs to submit a facility specific COVID-19 mitigation plan with specific elements within 21 calendar days. The AFL required the SNF mitigation plan to include a full-time dedicated infection preventionist. DSH reports that when the mitigation plans were implemented effective June 1, 2020, Metropolitan and Napa temporarily redirected existing Registered Nurse Health Services Specialists to cover the infection preventionist positions and address the infection control needs of the SNFs.

AB 2644 (Wood), Chapter 287, Statutes of 2020, made permanent the requirement that SNFs include a full-time dedicated infection preventionist. DSH reports the temporary staff redirections to support the infection preventionists roles implemented under the AFL requirements have resulted in the workload of the redirected staff being covered through overtime and managers. This request would allow those redirected staff to resume their previous workload.

Staffing and Resource Request. DSH requests two positions and General Fund expenditure authority of $350,000 annually to support two infection preventionists at the SNFs operated at Metropolitan and Napa State Hospitals, pursuant to the requirements of AB 2644. Specifically, DSH is requesting **two Health Services Specialists (Safety)** to plan and direct infection control program activities, monitor adherence to infection control protocols, conduct surveillance of infections, conduct outbreak investigations and tracing, conduct quality assessments, and conduct staff training.

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 15: One-Time Deferred Maintenance Allocation

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

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$15,000,000	$-
Total Funding Request:	**$15,000,000**	**$-**

Background. DSH reports it entered into an Architecture and Engineering Retainer contract to develop a comprehensive plan to address and prioritize deferred maintenance projects at the State Hospitals. DSH conducted a current needs identification and prioritization analysis of deferred maintenance projects required to address major building repairs and site-wide infrastructure needs. This analysis resulted in identification of 19 critical infrastructure projects that form the basis of this request for General Fund expenditure authority of $15 million. The project funding for each hospital is as follows:

- Atascadero - $2.1 million
- Coalinga - $6 million
- Metropolitan - $1.9 million
- Napa - $2.5 million
- Patton - $2.6 million

The 19 specific projects and estimated costs are as follows:

Facility	Project	Estimated Cost
Patton	Major plumbing repairs to preparation sink	$57,502
Patton	HVAC replacement in patient cafeterias	$328,282
Atascadero	Replace pumps for chilled water system	$100,000
Patton	Repair sink hole in parking lot to resolve staff safety issue	$333,000
Metropolitan	Roof replacement and foundation repair for domestic water tank	$1,493,196
Atascadero	Door repairs to test, recertify, and label fire doors	$627,290
Atascadero	Pharmacy clean room	$156,823
Patton	Repair uneven walkway to create accessible path for staff safety	$15,683
Atascadero	Replace 30 year old underground fuel tank for emergency power	$333,000
Atascadero	Replace existing refrigerant system	$333,000
Coalinga	Rerouting of fire suppression and domestic water lines	$6,000,000
Napa	Replace failing boiler in central plant	$2,500,000
Patton	Repair entry threshold at north entrance due to potential fall risk	$20,910
Metropolitan	Install custodian eye wash stations	$59,802
Patton	Replace roof of Administration building	$1,100,000
Patton	Repair courtyards due to root damage and deterioration	$695,512

Atascadero	Reline domestic hot water storage tanks to prevent corrosion	$180,000
Metropolitan	Replace melamine cabinets with more durable material	$333,000
Atascadero	Repair electromagnetic fire alarm actuated door hold open devices	$333,000
TOTAL		**$15,000,000**

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 DSH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 16: Metropolitan – Consolidation of Police Operations (Capital Outlay)

Capital Outlay Budget Change Proposal – Governor's Budget. DSH requests expenditure authority from the Public Buildings Construction Fund of $22 million for the construction phase of the consolidation of police operations at Metropolitan State Hospital.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0660 – Public Buildings Construction Fund	$22,024,000	$-
Total Funding Request:	**$22,024,000**	**$-**

Background. Metropolitan State Hospital's Department of Police Services (DPS), Office of Special Investigations (OSI), and the Emergency Dispatch Center (EDC) provide essential police, security, and safety functions for the hospital campus. These entities are currently located in buildings with significant health and safety issues, including asbestos in floor tiles and non-compliance with code requirements for seismic safety in hospital and police facilities. In addition, the current buildings do not qualify as Essential Services Buildings, defined by California regulations as buildings used or designed to be used as fire stations, police stations, emergency operations centers, California Highway Patrol offices, sheriff's offices, or emergency communication dispatch centers. Essential Services Buildings must be capable of providing essential services to the public after a disaster and be designed and constructed to minimize fire hazards and to resist the forces generated by earthquakes, gravity, and winds.

The 2017 Budget Act approved General Fund expenditure authority of $1.3 million for preliminary planning for construction of a new building to consolidate DPS, OSI, and EDC and meet regulatory requirements as an Essential Services Building. The 2018 Budget Act included General Fund expenditure authority of $1.5 million in 2018-19 for design and working drawings for continuation of the project. At the time, DSH reported preliminary plans would be approved in July 2018, the project would proceed to bid in August 2019, the contract awarded in December 2019, and the project completed in December 2021. According to DSH, the project experienced delays due to a lengthy Environmental Impact Review process needed because of the demolition component of the project, which includes demolition of five existing buildings and associated improvements to include site clearing and grading, paving for roads and parking, retaining walls and site utilities. The total expected cost for the project is $25.1 million, including $1.5 million for preliminary plans (with $200,000 moved from working drawings funding), $1.6 million for working drawings, and $22 million for construction. Of the construction costs, $17.2 million would support the construction contract, $859,000 would be for contingency, $1.3 million would support architectural and engineering services, $856,000 would be for agency retained items, and $2.7 million would support other project costs. DSH expects construction to begin in September 2021, and would be completed in June 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 17: Coalinga – Hydronic Loop Replacement (Capital Outlay)

Capital Outlay Budget Change Proposal – Governor's Budget. DSH requests General Fund expenditure authority of $50.5 million for the construction phase of a hydronic loop replacement at Coalinga State Hospital.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$50,528,000	$-
Total Funding Request:	**$50,528,000**	**$-**

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.

DSH requests General Fund expenditure authority of $50.5 million for construction costs to replace the hydronic loop system at Coalinga. According to DSH, the total cost of the project is $53.7 million including $120,000 for study, $993,000 for preliminary plans, $2.1 million for working drawings, and $50.5 million for construction. Of the construction costs, $44.1 million would support the construction contract, $3.1 million would be for contingency, $1.8 million would support architectural and engineering services, and $1.6 million would support 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.

Issue 18: Statewide – Enhanced Treatment Units (Capital Outlay)

Capital Outlay Budget Change Proposal – Governor's Budget. DSH requests General Fund expenditure authority of $3.8 million to support increased construction costs for Enhanced Treatment Units at Atascadero and Patton State Hospitals.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$3,792,000	$-
Total Funding Request:	**$3,792,000**	**$-**

Background. AB 1340, Chapter 718, Statutes of 2014, authorized the construction of Enhanced Treatment Units at Atascadero and Patton State Hospitals that will provide a more secure environment for patients that become psychiatrically unstable, resulting in highly aggressive and dangerous behaviors. According to DSH, patients in this state of psychiatric crisis require individualized and intensive treatment of their underlying mental illness, while reducing highly volatile and violent behavior. The proposed units will create secure locations within the existing hospitals to provide a safe treatment environment for both staff and patients. Patients will be housed individually and provided with the heightened level of structure necessary to allow progress in their respective treatment.

Once completed, the Enhanced Treatment Program will provide 39 secured beds at Atascadero State Hospital and 10 beds (female only) at Patton State Hospital. The Atascadero project is currently under construction, and is approximately 35 percent complete. According to DSH, the total cost of the project is estimated to be $22.7 million ($929,000 for preliminary plans, $1 million for working drawings, and $20.8 million for construction. The preliminary plans and working drawings components of the project have been completed.

Of the requested resources, $3.4 million would support increased construction costs for enhanced treatment units at Atascadero. DSH reports the Atascadero project has entered into an eight month project suspension necessary to address State Fire Marshal revisions, required field changes, design errors and omissions, and unforeseen site conditions. The suspension is expected to run until July 30, 2021, with construction resuming on August 1, 2021. The remaining requested resources, $379,000, would support completion of the enhanced treatment units at Patton, which entered into a six month project suspension in the summer of 2020 due to the COVID-19 pandemic.

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.

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, March 2, 2021
1:30 p.m.
State Capitol - Room 3191

Consultant: Renita Polk

PUBLIC COMMENT

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

4170 CALIFORNIA DEPARTMENT OF AGING (CDA)
5180 DEPARTMENT OF SOCIAL SERVICES (DSS)

Issue 1: COVID-19 Response in the Home-Bound Senior Population

Governor's Proposal. The Governor's budget includes both state and federal funds to respond to the COVID-19 pandemic at CDA and DSS.

The federal stimulus funds passed to date provided needed funding for aging programs for older adults so that they had access to services while they are under stay-at-home orders. The Families First Coronavirus Response Act (FFCRA) provided funding for the Older Americans Act (OAA) Senior Nutrition programs. The Coronavirus Aid, Relief, and Economic Security (CARES) Act provided funding for OAA Senior Nutrition programs, Supportive Services and Family Caregiving, ADRC programs, and Long-Term Care Ombudsman programs.

State Operations & Local Assistance	**2019-20 Actual Expenditures**			
Program	**Older Americans Act**	**FFCRA**	**CARES**	**TOTAL**
Title IIIB- Supportive Services	$42,174,000	$0	$18,834,000	$61,008,000
Title IIIB- Ombudsman	$41,366,000	$7,945,000	$0	$49,311,000
Title IIIC1- Congregate Nutrition	$41,746,000	$7,945,000	$0	$49,691,000
Title IIIC2- Home Delivered Nutrition	$36,100,000	$16,487,000	$45,155,000	$97,742,000
Title IIID- Preventive Health	$3,062,000	$0	$0	$3,062,000
Title IIIE- Family Caregiver	$20,799,000	$0	$9,297,000	$30,096,000
Title VII Ombudsman	$1,658,000	$0	$1,881,000	$3,539,000
Title VII Elder Abuse Prevention	$499,000	$0	$0	$499,000
Nutrition Services Incentives Program (NSIP)	$13,550,000	$0	$0	$13,550,000
TOTAL, State Operations & Local Assistance	**$200,954,000**	**$32,377,000**	**$75,167,000**	**$308,498,000**

* Reflects actual expenditures only and does not include any encumbrances for 2019/20.

State Operations & Local Assistance	**2020-21 Budget**			
Program	**Older Americans Act**	**FFCRA**	**CARES**	**TOTAL**
Title IIIB- Supportive Services	$39,832,000	$0	$1,836,000	$41,668,000
Title IIIB- Ombudsman	$2,296,000	$0	$0	$2,296,000
Title IIIC1- Congregate Nutrition	$42,824,000	$0	$418,000	$43,242,000
Title IIIC2- Home Delivered Nutrition	$32,650,000	$0	$5,840,000	$38,490,000
Title IIID- Preventive Health	$2,448,000	$0	$0	$2,448,000
Title IIIE- Family Caregiver	$18,492,000	$0	$0	$18,492,000
Title VII Ombudsman	$1,872,000	$0	$200,000	$2,072,000
Title VII Elder Abuse Prevention	$471,000	$0	$0	$471,000
Nutrition Services Incentives Program (NSIP)	$13,157,000	$0	$0	$13,157,000
TOTAL, State Operations & Local Assistance	**$154,042,000**	**$0**	**$8,294,000**	**$162,336,000**

The latest stimulus funding in the Federal Fiscal Year 2021 Budget (H.R.133 - Consolidated Appropriations Act, 2021) includes a total of $168 million for Senior Nutrition Programs, and $100 million for Elder Justice funds, including Long-Term Care Ombudsman programs, for all states. CDA is awaiting the allocation amounts for these programs from the federal Administration for Community Living.

The Governor's budget includes a total of $63.9 million total funds for COVID response within the In-Home Supportive Services (IHSS) program in 2020-21 and $11.2 million in 2021-22. Savings of $456.2 million in 2021-22 and $842.6 million in 2020-21 were observed due to the temporary Federal Medical Assistance Payment (FMAP) increase provided by federal COVID relief legislation. Highlights of the state's COVID response within the IHSS program are listed below.

- COVID-19 Backup Provider System. The Governor's Budget includes $15.7 million ($8.0 million General Fund) in 2020-21 and $7.8 million ($4 million General Fund) in 2021-22 as additional funding to counties to continue operating the COVID-19 county emergency provider back-up systems. An additional $1.3 million General Fund is for service costs. These systems facilitate the process of finding back-up providers for IHSS recipients that would cover for those providers that are out due to COVID-19-related reasons.

- COVID-19 Backup Provider Wage Differential. The Governor's budget includes $6.7 million ($2.7 million General Fund) in 2020-21 and $3.3 million ($1.3 million General Fund) in 2021-22 to pay COVID-19 IHSS emergency back-up providers a $2.00 per hour differential on top of the regular county negotiated hourly wage.

- Temporary FMAP Enhancements. As outlined in The FFCRA, the federal government is providing a temporary 6.2 percent increase in the FMAP reimbursement rate for federally eligible Title XIX service expenditures. Application of the enhanced rate will result in a projected $842.6 million in General Fund savings in 2020-21 and $465.2 million in General Fund savings in 2021-22 for IHSS.

Background. Based on data from 2018[1], there were 8.2 million adults age 60 or older in California. Of those, 1.5 million lived alone, and 1.2 million were 100 percent below the federal poverty level. Beginning in March 2020, the Administration pivoted towards rapid response efforts to help protect the lives of these vulnerable Californians.

Senior Nutrition Programs. Under the CARES Act, states were allowed additional program flexibility for nutrition programs. States were allowed to transfer up to 100 percent of funding from congregate to home-delivered meals programs without prior federal approval to provide home-delivered meals to individuals homebound for social distancing purposes, and temporarily waive certain dietary guidelines for meals. The 33 Area Agencies on Aging (AAAs) adapted by reinventing and expanding nutrition services. Congregate meal programs were transformed to serve older adults through meal pick-up and home-delivery. In 2020, there were a record 27 million meals delivered to older Californians. This represents a 51% increase over 2019 numbers (17.8 million). In April, the Governor announced the Great Plates Program, which partnered with local governments and the Federal Emergency Management Agency (FEMA) to provide delivered meals to seniors at no cost to

[1] https://aging.ca.gov/download.ashx?lE0rcNUV0zYeAlJo7upINg%3d%3d

them. Note that the Great Plates program is administered by the Governor's Office of Emergency Services.

Virtual Home and Community Based Services. Community-Based Adult Services (CBAS) are day health programs that provide services to 37,000 older adults and adults with chronic conditions and/or disabilities. Due to the COVID-19 outbreak, CBAS centers were allowed to provide services through video conferencing, the phone, and door-step deliveries, as well as very limited in-center services that adhered to COVID-19 safety guidelines. The services to the frailest adults through Multipurpose Senior Services Program (MSSP), allowed for temporary suspension of home visits and virtual care as allowable methods for conducting care management activities. Waiver funds were also approved for purchases of masks and urgent needs for personal hygiene supplies.

Long-Term Care Ombudsman (LTCO) Program. The CARES Act provided flexibility in the LTCO program by allowing ombudspersons to have continued "direct access (or other access through the use of technology) to residents in long-term care facilities" during the public health emergency. Services moved to virtual, and out of residential facilities, in the wake of the pandemic. . The LTCO Program has a 24-hour toll free line to assist residents in LTC facilities and their families with issues related to day-to-day care, health, safety, and personal preference. The LTCO Program has reported between 1,500-2,000 calls per month since the onset of the pandemic. In August 2020, the LTCO Program provide guidance for local LTC Ombudsman to re-enter facilities and by October 2020 all local health jurisdictions had cleared LTCOs to resume in-person visits following health guidelines including social distancing and utilizing personal protective equipment (PPE). In December 2020, there were 1,600 on-site visits made to facilities statewide.

Information and Assistance. CDA upgraded the California Aging and Adults Info Line answered by local AAAs to meet the increased volume of calls from older adults. CDA also mailed a postcard mailer to Californians age 80 and older with information on the resources available to Stay Home and Stay Connected during the pandemic, in partnership with AARP and DMV (a total of 18 million resource cards were mailed). Resource telephone lines included 211, Friendship Line, Long Term Care Crisis Line, AARP Fraud Hotline, and several other aging and adult services, as well as info on accessible and in-language resources.

Equity and Isolation Prevention. CDA has worked to ensure that older Californians are provided with the social and emotional care needed while staying home during the pandemic. CDA contracted with the Institute on Aging to expand statewide the "Friendship Line" which is a 24-hour hotline that isolated older adults can call and speak to trained staff and volunteers, to prevent loneliness, isolation, and suicide. 71,000 Friendship Line calls were received from April 2020 through December 2020. During this pandemic, access to reliable internet and digital devices have been critical tools necessary to remain socially connected while physically distancing. As older Californians continue to stay home to save lives during the pandemic, CDA has made bridging the digital divide to combat loneliness and isolation a top priority. CDA has leveraged public-private partnerships with AT&T and Google to provide tablets and smart speakers to thousands of older Californians who are low income and live alone. Google has donated 8,500 smart speaker devices which have been distributed to local Area Agencies on Aging (AAAs) and Multipurpose Senior Services sites to distribute to their clients. CDA has also entered into an agreement with AT&T to purchase 4,000 iPad tablets that will be provided to AAAs to distribute to low-income older adults who live alone.

In-Home Supportive Services (IHSS) Program. In response to COVID-19 DSS shifted its operations on many fronts to ensure the safety of IHSS recipients, providers, and county staff. The department implemented a backup provider system to ensure recipients received services even when their primary provider was out due to COVID-19. The department also suspended requirements concerning overtime rules, parent providers, provider enrollment, in-person reassessments, and quality assurance visits. The department permitted providers with paid sick leave to take care of themselves or family members affected by COVID-19. DSS also helped to provide masks, gloves, and other protective equipment to providers and recipients to ensure recipients could remain safely in their homes while receiving services during the pandemic.

Panel. In addition to the Department of Aging (CDA), the Department of Social Services (DSS), the Department of Finance (DOF), and the Legislative Analyst's Office (LAO) the Subcommittee has requested the following panelists to provide comment on this topic.

- Cathy Senderling, Executive Director, County Welfare Directors Association
- Clay Kempf, Executive Director, Seniors Council of Santa Cruz and San Benito Counties
- Kelly Dearman, President, California Association of Public Authorities for IHSS and Executive Director, San Francisco IHSS Public Authority

Questions.

For CDA:

1. How have CDA's programs transitioned to supporting home-bound adults during the pandemic?

2. Please speak to how the additional federal relief funds have been used to support CDA programs and older Californians during the pandemic. What lessons have been learned that could guide future efforts to support older Californians?

3. Please discuss the role that senior isolation has played in CDA's planning efforts during the pandemic.

For DSS:

1. Please detail how the department had to shift its operations to respond to the COVID-19 pandemic within its programs that serve populations particularly vulnerable to COVID-19.

2. Has the current pandemic provided insight into the successes of the IHSS program (or other programs serving the senior population) and how its operations can be modified to better support the needs of older adults in the future?

For Cathy Senderling:

1. Please describe some of the challenges counties have experienced in providing services to older adults during the pandemic. Are there particular issues that the pandemic has created or exacerbated for counties?

2. How have counties used the federal COVID relief funds to help serve older adults?

3. While the promise of vaccines will help in addressing the COVID pandemic, it is clear that the effects of the pandemic will be long-lasting. What are some of the long-term issues that counties expect to face in the coming months and years because of the pandemic? Are there suggestions or recommendations for things that the state can do to help address some of these long-term issues?

For Clay Kempf:

1. How have AAAs shifted their operations in response to the COVID-19 pandemic?

2. Please describe some of the challenges AAAs have experienced in providing services to older adults during the pandemic, and how those were resolved. Are there particular issues that the pandemic has created or exacerbated for AAAs?

3. Has the AAA response to the COVID pandemic provided any insight into changes that can be made within the AAA system to better respond to future emergencies?

For Kelly Dearman:

1. Please describe the role of county Public Authorities in the development of the COVID IHSS provider backup system and any challenges public authorities have faced providing emergency backup services.

2. Has the development of this system provided insight into how the state and its partners, such as Public Authorities, can better respond to future emergencies?

4170 CALIFORNIA DEPARTMENT OF AGING (CDA)

With a proposed 2021-22 budget of $258.1 million ($67.9 million General Fund), the CDA administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the state. As the federally designated State Unit on Aging, the department administers federal Older Americans Act (OAA) programs and the Health Insurance Counseling and Advocacy Program.

California Department of Aging
Expenditures by Fund Source
* Dollars in thousands

Grand Total By Fund	Fiscal Year	
	2020-21	(Proposed Budget) 2021-22
General Fund	$67,514	$67,935
State HICAP Fund	$2,502	$2,509
Federal Funds	$178,937	$171,138
Special Deposit Fund	$2,208	$1,216
Reimbursements	$12,680	$13,039
Department of Public Health Licensing and Certification Program Fund	$400	$400
Skilled Nursing Facility Quality and Accountability Fund	$1,900	$1,900
Total All Funds	$266,141	$258,137

Issue 1: Budget Investments to Support the Master Plan on Aging

History of the Master Plan on Aging. In June 2019, Governor Newsom issued an executive order calling for the creation of a Master Plan for Aging (MPA). This plan was spurred, in large part, by the projected growth of California's over-65 population to 8.6 million by 2030. The CDA has taken a lead role in developing the MPA.

Between September 2019 and October 2020, the CDA oversaw the Together We Engage Campaign, which collected input from the public, stakeholders, and partners through pledges, surveys, meetings, webinars, and community roundtables. Public opportunities included the Together We Engage pledge and survey to identify Master Plan priorities (summer 2019); Webinar Wednesdays to hear from experts and gather community input on specific topics (winter 2020), and an Equity in Aging Town Hall to address ageism (summer 2020). In addition, the Secretary of the Health and Human Services Agency and director of the department co-hosted roundtables with various members of the Legislature to learn more about issues in their districts.

The California Health and Human Services Agency formed a Stakeholder Advisory Committee

(SAC), a Long-Term Services and Supports Subcommittee, and a Research Subcommittee in August 2020 comprised of 78 members from local government, healthcare providers, health plans, employers, community-based organizations, academia, researchers, and service recipients. The SAC formed an Equity Work Group in December 2020, tasked with ensuring that equity is fully integrated into the Master Plan.

Throughout the stakeholder engagement process, these committees and the Administration received over 240 policy recommendation letters submitted by stakeholder organizations and over 1,000 public comments. This engagement process culminated in the SAC's submission of an Equity Tool and Glossary, a Long-Term Services & Supports Stakeholder Report, a Livable Community and Purpose Stakeholder Report, a Health and Well-being Stakeholder Report, and an Economic Security, Safety, and Emergency Preparedness Stakeholder Report. The final MPA was released on January 6, 2021.

Five Goals for 2030. The Master Plan for Aging presents a comprehensive approach for every Californian to help build a California for All Ages by 2030. The plan identifies five goals and 23 strategies for state and local leaders in government, business, philanthropic, and community-based organizations to collaborate. The Master Plan for Aging is considered to be a living document for the long-term.

1. Housing for All Ages and Stages.

2. Health Reimagined.

3. Inclusion and Equity, not Isolation.

4. Caregiving that Works.

5. Affording Aging.

2021 Governor's Human Services Budget Investments to Address Aging. The Governor's January budget proposes new investments to many programs, some within the human services arena, to advance the goals of the MPA. It includes both overarching proposals to advance a California for All that will benefit all Californians as we age, as well as targeted new, and continuing, investments in aging. These investments are proposed across multiple departments in the California Health and Human Services Agency, including CDA. Targeted investments within the human services field include:

- Aging and Disability Resource Connection (ADRC). The budget includes a half-year augmentation of $5 million General Fund in 2021-22 and a half-year augmentation of $5 million General Fund in 2022-23 to maintain and expand the ADRC. This proposal is discussed in more detail later in this agenda.

- Senior Nutrition. The Governor's budget proposes to extend the suspension date for $17.5 million General Fund for the Older Americans Act Senior Nutrition program that was originally set to suspend on December 31, 2021. The Governor's budget proposes to extend funding for these programs until December 31, 2022, which will enable local Area Agencies on Aging (AAAs) to expend the full $17.5 million in 2021-22. The program provides both home-

delivered and congregate meals at community and senior centers, nutrition education, and nutrition-risk screening to individuals 60 or older.

- Expand Facilities to Support Housing. The Governor's budget includes $250 million one-time General Fund for the Department of Social Services (DSS) to acquire and rehabilitate Adult Residential Facilities (ARFs) and Residential Care Facilities of the Elderly (RCFEs) with a specific focus on expanding housing for low-income seniors who are homeless or at risk of becoming homeless. This issue was discussed during the Subcommittee's February 9, 2021 hearing.

- Placeholder Funding. The Governor's budget includes $5 million General Fund in placeholder funding for spring proposals to further implement the Master Plan for Aging.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the budget investments relating to the MPA.

2. How does the Administration envision using the $5 million placeholder MPA funding?

3. How will CDA collaborate with other departments, both within the California Health and Human Services Agency and outside of it, to forward the Master Plan for Aging's goals? Given that multiple departments and agencies are implementing MPA initiatives, how will the Administration keep the Legislature be updated on these initiatives? What is the department's plan to achieve the longer term goals of the MPA?

Issue 2: BCP/TBL – Aging and Disability Resource Connections

Governor's Proposal. The Governor's budget includes a half-year augmentation of $5 million General Fund in 2021-22 and a half-year augmentation of $5 million General Fund in 2022-23. The funds would be used to maintain and expand the Aging & Disability Resource Connection (ADRC) Infrastructure Grants Program for a Statewide "No Wrong Door" system subject to suspension on December 31, 2022. If not suspended, resources are requested to continue at an ongoing full-year funding level of $10 million General Fund.

The budget also includes trailer bill language to delay the suspension of additional funding provided in the 2019 budget for this program and Senior Nutrition programs until December 31, 2022. Rather than executing the suspension calculation this May (under current law), the Governor's budget proposes a new suspension calculation at May Revision in 2022. Specifically, the Governor proposes that the Legislature enact new suspension language that would give the Department of Finance (DOF) the authority to make this calculation again at the time of the May Revision in 2022.

Background. Since many communities currently have multiple agencies administering long-term services and supports (LTSS) and have complex, fragmented, and often duplicative intake, assessment, and eligibility functions, ADRCs are intended to act as a single coordinated system of information and access for persons seeking LTSS. The "No Wrong Door" system aims to lower the barriers that older Californians, people with disabilities, caregivers, and families face accessing the information and assistance needed to age well. Getting timely, accurate information is critical to avoiding costly institutional care, preventing health and safety emergencies, and seeking aid during disasters. The establishment of a statewide ADRC program was a key recommendation from the Master Plan on Aging (MPA) stakeholder committee. Through existing local ADRC programs, older adults, people with disabilities, caregivers, and families in some communities can connect to and access multiple services in their community with a single phone call, online contact, and/or walk-in.

Through the person-centered care model, individuals initially meet with an ADRC navigator who seeks an individual's needs, goals, and preferences and offers a choice of available options. The navigator/specialist then refers the individual to local programs in their area through warm handoffs and schedules regular follow-up sessions to see how the individual is doing and if additional support is needed. The program is also able to arrange for transportation between an individual's home and long-term services and support through a coordinated network of providers. The ADRC program enables older adults and people with disabilities to seamlessly navigate and access aging and other programs that already exist in their communities, receive assistance understanding the service options, and having a person-centered professional customize a service plan specifically to meet their needs, goals, and preferences based on initial intake and ongoing follow-up sessions.

Previous Budget Actions. The 2019 Budget Act included a $5 million annual General Fund augmentation, subject to suspension on December 31, 2021, for the ADRC Infrastructure Grants Program to support designated and emerging ADRC programs within Area Agencies on Aging (AAAs) and Independent Living Centers (ILCs). The current service level includes half-year funding of $2.5 million for the first six months of 2021-22. Of the $5 million annual augmentation, the current program provides $4.25 million annually to local ADRCs for developing and implementing a NWD System and bolstering local infrastructure for coordination and delivery of LTSS. $750,000

annually is allocated to CDA for program oversight, administration, training, guidance, and technical assistance to local ADRCs and stakeholders.

Federal Funding. Federally, ADRCs are supported by the Administration on Aging (AoA), the Administration for Community Living (ACL), the Centers for Medicare and Medicaid Services (CMS), and the Veterans Administration. However, federal grant funding for starting an ADRC is not available. Along with funding provided by the ADRC Infrastructure Grants Program, the Designated and Emerging ADRCs utilize a combination of county, state, and federal funding that is available due to their status as ILCs and AAAs to sustain local ADRCs. Recently, ADRCs received approximately $3 million from the Coronavirus Aid, Relief, and Economic Security (CARES) Act for enhancing coordination across agencies and programs/services to address urgent needs arising from the COVID-19 pandemic. That funding was allocated in September 2020. The six designated and ten emerging ADRCs each received a base allocation of $85,000, while the balance was allocated based on population, square miles, and geographic isolation.

Staff Comment and Recommendation. Hold open.

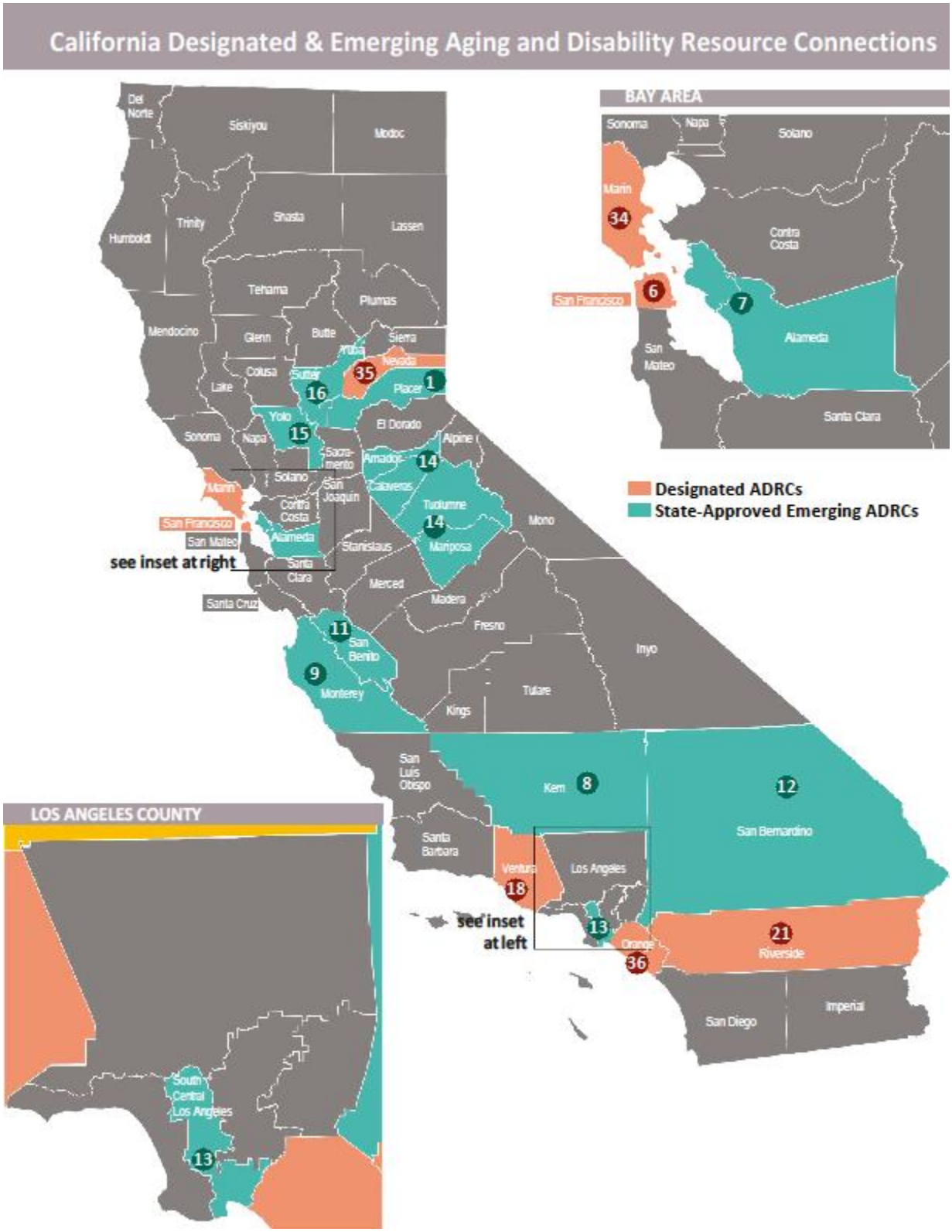
Questions.

1. Please provide an overview of the proposal.

2. Will this funding help to spread ADRCs throughout the state so that all Californians have access to their services? How many new ADRCs will the requested funding support and how are those chosen?

3. What has been the impact of the new ADRCs developed with the 2019 funding? How many communities will remain without an ADRC after this funding is exhausted?

4. As the funding for developing these new ADRCs is tied to the Administration's proposed suspension language, is the department planning for what happens if this funding is eliminated?


California Designated & Emerging Aging and Disability Resource Connections
BAY AREA
LOS ANGELES COUNTY
Designated ADRCs
State-Approved Emerging ADRCs
see inset at right
see inset at left
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Nevada
Colusa
Sutter
Yuba
Lake
Placer
Yolo
El Dorado
Sonoma
Napa
Sacramento
Amador
Alpine
Solano
Calaveras
San Joaquin
Marin
Contra Costa
Tuolumne
Mono
San Francisco
San Mateo
Alameda
Stanislaus
Mariposa
Santa Clara
Merced
Santa Cruz
Madera
Fresno
Inyo
San Benito
Monterey
Tulare
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Orange
Riverside
San Diego
Imperial
South Central Los Angeles
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PROPOSALS FOR INVESTMENT RELATED TO DEPARTMENT OF AGING

The Subcommittee has received the following proposal for investment related to the Department of Aging. Note that proposal sponsors provided all information below, aside from staff comments and recommendations.

1. Provide Permanency to the Annual Multipurpose Senior Services Program (MSSP) Budget

Budget Issue. The MSSP Site Association requests $24.7 million General Fund ongoing to make permanent a temporary rate increase for MSSP providers set to expire June 30, 2022.

Background. MSSP received a one-time supplemental increase in 2019, which allowed MSSP contractors to stabilize a program that was deteriorating due to deficient funding and increases in patient acuity. This supplement will expire on June 30, 2022. If programs must revert to the insufficient 2018 rates, which have not received a cost of living increase since 2006 and quickly followed by two recession-era cuts totaling 22.5% in 2008 and 2011, there will be a devastating impact upon the frailest, older adults in the state. Therefore, the immediate need is to make permanent the client rate that was established in the Governor's 2019 budget. Without rate permanency, this program, which serves nearly 12,000 frail older adults (65+) in their homes, faces the likelihood of closing sites with the potential disruption of care throughout California. According to the sponsors, stabilized funding will reduce the number of beneficiaries waiting for services (currently 1,500 statewide), maintain experienced and specialty care management staff, and reduce the financial burden on host agencies that may result in the closure of MSSP sites.

Staff Comment and Recommendation. Hold open.

2. Aging Disability Resource Centers (ADRCs)

Budget Issue. The California Association of Area Agencies (C4A) requests $10 million General Fund in 2021-22, $25 million General Fund in 2022-23, and $53 million General Fund in 2023-24 and ongoing to implement a statewide ADRC program.

Background. The proposed funding would be used for the development of additional ADRCs and to allow successful and emerging ADRCs to become fully operational. The proposal would strengthen the role of ADRCs in responding to the needs of older and disabled persons.

Staff Comment and Recommendation. Hold open.

3. Area Agencies on Aging – Administrative Baseline

Budget Issue. The California Association of Area Agencies (C4A) requests $3.3 million General Fund ongoing to provide for the basic operations of Area Agencies on Aging's (AAA) oversight duties and responsibilities.

Background. Currently, there is a $50,000 per year baseline distribution of federal dollars for AAAs, as well as federal funds allocated for programs and services. No adjustment to this baseline

allocation has been made since its inception 50 years ago. The proposed increased baseline would help to cover the costs of doing business, allow new opportunities for needed services, and strengthen the administrative activities of AAAs, particularly during the implementation of the Master Plan on Aging. The proposed funding would provide an additional $100,000 for each of the 33 AAAs statewide.

Staff Comment and Recommendation. Hold open.

4. Fall Prevention

Budget Issue. The California Association of Area Agencies (C4A) requests $5 million General Fund in 2021-22, $10 million General Fund in 2022-23, and $15 million General Fund in 2023-24 and ongoing to implement a fall prevention program for older persons living in their homes.

Background. The 2019 Budget Act included $5 million General Fund one-time to provide grants to local AAAs for injury prevention education and home modifications for seniors at risk of falling or institutionalization. The proposed funding would allow AAAs to expand that program to meet the needs of the senior community. The funding would allow homes to be assessed and modified to assist in creating a safe environment for adults.

Staff Comment and Recommendation. Hold open.

5. Senior Nutrition Funding

Budget Issue. The California Association of Area Agencies (C4A) requests $35 million General Fund in 2021-22, $50 million General Fund in 2022-23, and $75 million General Fund in 2023-24 and ongoing to expand the senior nutrition programs.

Background. The proposed funding would allow additional meals to be served to more older adults. Approximately 5.1 million additional meals per year would be provided with the proposed funding.

Staff Comment and Recommendation. Hold open.

6. Senior Nutrition/Meals on Wheels

Budget Issue. The Meals on Wheels (MOW) Association requests $17.5 million in 2021-22 and $35 million annually thereafter for senior nutrition programs.

Background. The level of food insecurity has always been high in the senior population but since COVID-19, food assistance needs in California have increased. Additionally, the pathological features of the COVID virus have required Meals on Wheels programs to significantly alter operations and practices in how they provide meals. Together, these conditions have increased costs and the number of individuals served. A survey of fifty MOW CA programs completed in October 2020 revealed an increase in demand of more than 70 percent, with more than a quarter of respondents indicating more than 100 percent growth. Even once the virus is under control, the state will be facing the long term effects of the pandemic, including a significant increased need for nutrition support among seniors.

Staff Comment and Recommendation. Hold open.

7. Establishment of the Office of the Patient Representative in the Department of Aging

Budget Issue. The California Association of Health Facilities requests $6 million General Fund in 2021-22 and $5.5 million annually thereafter to establish the Office of the Patient Representative within the Department of Aging.

Background. This proposal would establish an Office of Patient Representative housed in the Department of Aging, where the Long Term Care Ombudsman is also housed and funded. The Office of Patient Representative would serve as a clearinghouse for county senior programs including the Area Agencies on Aging, non-profit, faith-based, senior, patient rights, or other types of organizations who are interested in establishing a local program and serving as patient representatives.

On July 22, 2019, the California Court of Appeal issued a decision in the CAHNR v. Chapman case related to Health and Safety Code 1418.8. The Court of Appeal upheld the structure of the code for incapacitated and unrepresented nursing home patients to receive informed consent for their medically-necessary care. However, the court made clear that a patient representative must participate in the interdisciplinary team meetings. This person cannot be affiliated with or paid for by the skilled nursing facility (SNF). According to the sponsors, since the patient representative cannot be affiliated with or paid for by the SNF it will require the state to establish a system whereby individuals can be available to act as patient representatives. A patient representative structure and the funding to pay for the services for all 58 counties must be set up quickly by the Legislature and the Administration to implement the Superior Court ruling. The Office of Patient Representative will address this very time-sensitive and crucial issue.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – ADULT PROGRAMS

Issue 1: In-Home Supportive Services (IHSS) Budget Summary

Governor's Proposal. The 2021-22 IHSS budget includes $15 billion ($4.3 billion General Fund) in 2020-21 and $16.5 billion ($5.3 billion General Fund) in 2021-22. The 2020-21 budget reflects a decrease of $195.5 million (and a decrease of $171.5 million General Fund). The 2021-22 IHSS budget reflects an increase of $1.3 billion ($841.7 million General Fund) from the 2020 Budget Act, due to continued caseload growth, cost per hour, and hours per case.

The caseload for this program continues to increase. The updated caseload is projected to be 570,411 in 2020-21 and is projected to increase to 592,829 in 2021-22. The updated hours per case are 115.2 in 2020-21 and are projected to increase to 116.5 in 2021-22.

Background. The IHSS program provides personal care services to approximately 610,457 qualified low-income individuals who are blind (1.5 percent), over 65 (36.8 percent), or who have disabilities (61.7 percent). Services include feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services help program recipients avoid or delay more expensive and less desirable institutional care settings.

As of December 2020, 15 percent of IHSS consumers are 85 years of age or older, 41 percent are aged 65-84, 37 percent are aged 18-64, and 7 percent are 17 years of age or younger. There are approximately 543,100 IHSS providers. Close to 54 percent of providers are live-in.

Other IHSS Budget Highlights.

- Electronic Visit Verification (EVV) County Administration. This program provides administrative funding to counties for the implementation and maintenance of an EVV system. The Governor's budget includes $16.3 million ($4 million General Fund) for EVV County Administration in 2020-21 and $6.7 million ($1.7 million General Fund) in 2021-22. In 2019-20, counties were scheduled to transition 89 percent of the IHSS caseload from paper to electronic timesheets via the EVV system. However, implementation was delayed due to the onset of the COVID-19 pandemic and counties needing to shift their focus to prioritize the health and safety of IHSS providers and recipients. This resulted in implementation/completion dates for some counties being pushed out to 2020-21. Funding of $4.4 million in unspent funds ($1.1 million unspent General Fund) were shifted from 2019-20 to 2020-21. Note that EVV is discussed further later in the agenda.

- Restoration of the Seven Percent Cut to IHSS Service Hours. The Governor's budget includes $897.1 million ($404.9 million General Fund) in 2020-21 and $994.4 million ($449.8 million General Fund) in 2021-22 to restore the seven percent reduction in services through June 30, 2022. During the last recession, the state reduced IHSS service hours, but the Legislature has reversed this reduction every year since 2015-16. If the current law suspensions went into effect, the state would reinstate a seven percent reduction to service hours.

Note that under current law the Department of Finance (DOF) would determine whether to suspend this funding in coming years at the 2021 May Revision. The Governor proposes new suspension language that would give DOF the authority to make this calculation again at the time of the May Revision in 2022.

Legislative Analyst's Office (LAO) Comments. As with other issues proposed for suspension discussed in previous Subcommittee hearings the LAO points out that the suspension language treats policies that are fundamentally ongoing as temporary and understates the true ongoing cost of the state's policy commitments. The suspension language creates uncertainty in these programs, which can pose problems for providers and recipients of these services. Additionally, the suspension language enacted in 2019-20 was framed as a one-time determination made in May 2021. By proposing a new suspension calculation, however, the administration appears to intend to make this calculation ongoing.

Proposing to suspend funding for IHSS services may also create legal risks for the state. Proposals to reduce or eliminate IHSS services generally are vulnerable to litigation asserting that the change violates federal Medicaid rules and/or puts recipients at risk of institutional placement, which could violate the United States Americans with Disabilities Act (ADA). In the past, courts have issued temporary injunctions preventing the state from making reductions to Medicaid personal care services programs, including IHSS, due to possible violations of federal Medicaid and ADA rules. Future state proposals to eliminate or reduce IHSS services could face similar legal challenges.

The LAO recommends the Legislature reject the proposed new suspension language. Considering that the costs of the suspension item directly fund core state services, including those costs in multiyear fiscal projections is appropriate. Given the state's multiyear deficits, however, the state likely will need to make changes to its budget within the next few years.

Staff Comment and Recommendation. Hold open.

Staff notes that the proposal to suspend funding and reduce services hours for the IHSS program may open the state up to potential litigation. The Subcommittee may wish to inquire as to the Administration's view on that.

Panel. In addition to the Department of Social Services (DSS), the Department of Finance (DOF), and the Legislative Analyst's Office (LAO) the Subcommittee has requested the following panelists to provide comment on this topic.

- Sawait Seyoum, Senior Policy Advisor, Disability Rights California

Questions.

For DSS/DOF:

1. Please provide an overview of the caseload and funding levels for the IHSS program.

2. Given that the IHSS eligible population is only expected to increase in the coming years, what is the Administration's plan to address rising costs within the IHSS program? How does the department assume cost savings from avoiding institutional care by use of the IHSS program?

3. Please respond to the LAO's comments that limiting IHSS service hours could potentially violate the Americans with Disabilities Act and open the state up to litigation.

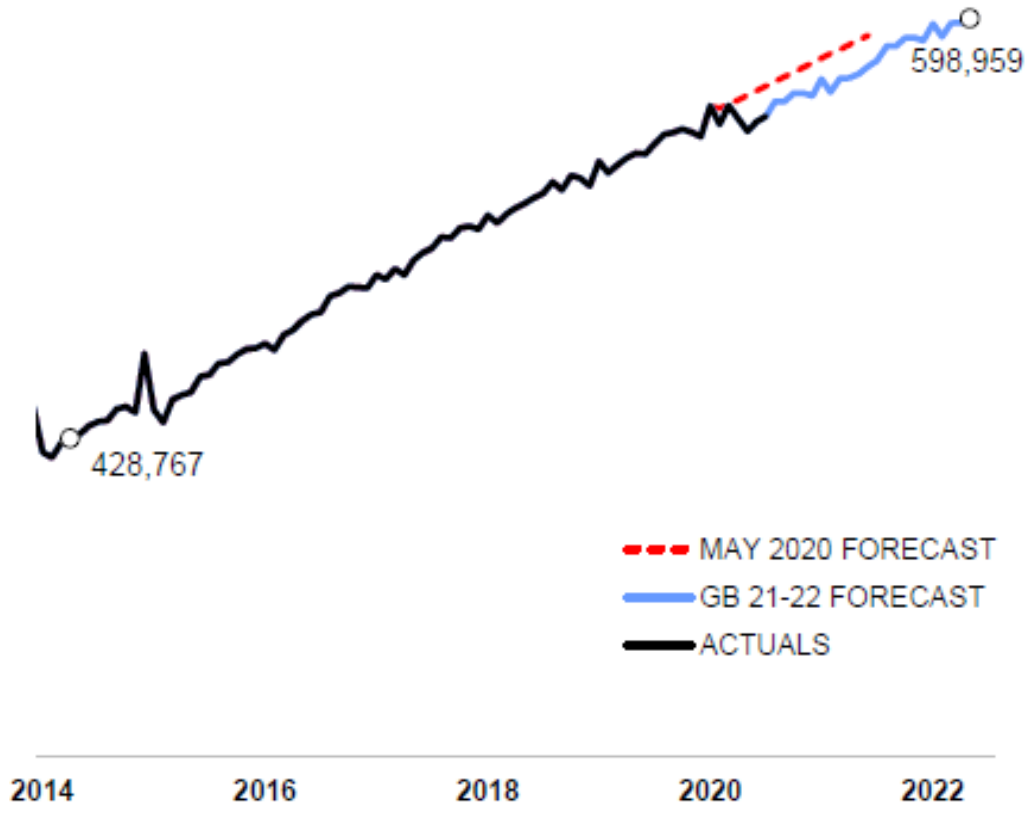
For Sawait Seyoum:

1. Please describe the impact that the reduction in IHSS service hours will have on participants in the IHSS program.

IN-HOME SUPPORTIVE SERVICES

JANUARY 2021 FORECASTS

FY	ACTUAL	YEAR-TO-YEAR % CHANGE
2017-18	516,377	5.6%
2018-19	536,628	4.8%
2019-20	555,324	3.9%
FORECASTS		
2020-21	570,411	3.5%
2021-22	592,829	2.7%



Issue 2: BCP - Electronic Visit Verification (EVV) Continuation

Governor's Proposal. The Governor's budget includes $1.2 million General Fund for an extension of limited-term resources needed for the ongoing support of EVV implementation and support for the new direct deposit and/or pay card mandate for In-Home Supportive Services program providers. The one-year, limited-term funding would support one Staff Services Manager (SSM) I, five Associate Governmental Program Analysts (AGPAs), one Attorney III, and one half Legal Secretary.

The budget also includes an additional $4.2 million ($500,000 General Fund) in 2020-21 to make Case Management Information Payrolling System (CMIPS) II modifications necessary to add the capability to identify provider locations to meet federal EVV requirements.

Note that the Governor's budget also includes $16.3 million ($4 million General Fund) for EVV County Administration in 2020-21 and $6.7 million ($1.7 million General Fund) in 2021-22.

EVV Background. The federal 21st Century Cures Act was signed in December of 2016 and contains provisions related to EVV. These provisions require states to implement EVV systems for Medicaid-funded personal care and home health care services, such as IHSS. The bill stipulates that the electronic system must verify (1) the service performed, (2) the date and time of service, (3) the location of the service, and (4) the identities of the provider and consumer. California was given until January 2021 to comply for personal care services, and until January 2024 for home care services, or escalating penalties will be incurred.

California has been implementing EVV for IHSS through an electronic timesheet that required verification of provider start and end times through the recipient's electronic signature. This approach was in alignment with IHSS stakeholder preferences, and codified in state statute, to not use GPS or other means to electronically verify location. In December 2019, the Center for Medicare and Medicaid Services (CMS) notified the Department of Health Care Services (DHCS) that the Phase I EVV system did not adequately capture the location of service. CMS has required real-time electronic verification of the time services begin and end, as well as service location. This CMS mandate to change the state's EVV implementation will result in extending the development and implementation phase of the EVV, as well as additional guidance and training being issued to counties, providers, and recipients. In light of the current pandemic and the many changes that will need to be made to comply with this requirement the state submitted a request to CMS that any non-compliance penalties be waived until January 1, 2023, and a continued 90 percent federal match for additional planning and design activities. CMS denied this request, and the state will be subject to a federal penalty of reduced federal funds, beginning January 1, 2021.

To meet the ongoing workload created by the EVV requirements and changes to statute relating to direct deposit and/or use of a payroll card, DSS requests an additional year of funding to support these positions. The limited-term funding provides programmatic and legal technical assistance and guidance to stakeholders and all 58 counties throughout the development and implementation phases of the EVV. Development and implementation will be extended to meet the CMS' requirement for real-time location reporting for the IHSS providers. Additionally, these positions will provide the

necessary technical assistance, outreach, and training to stakeholders and all 58 counties for the new direct deposit and/or pay card payment method.

Payroll Card/Direct Deposit Mandate Background. Welfare and Institutions Code 12304.4 mandates that all IHSS providers transition to direct deposit and/or a payroll card payment method by July 1, 2021. Technical assistance, outreach, and training for the counties and providers are necessary to meet the requirements of this new mandate.

Staff Comment and Recommendation. Hold open.

Note that California will incur federal penalties projected to be $15 million General Fund in 2020-21 and $16.6 million General Fund in 2021-22 for failure to meet the January 2021 EVV compliance deadline.

Questions.

1. Please give an overview of the proposal.

2. Please give an update on the plan for meeting the additional federal EVV requirements. How will the department engage with stakeholders in developing the required EVV system elements given that there was significant stakeholder opposition to location-based data collection during the initial design? What is the date that the department anticipates having the EVV federal requirements met?

3. Which of the requested positions will be focused on EVV system development versus work on the payroll card/direct deposit mandate?

4. Does the department expect that all IHSS providers will be transitioned to direct deposit or a payroll card payment method by July 1, 2021, as required in statute?

Issue 3: Supplemental Security Income/State Supplemental Payment (SSI/SSP) Budget Summary

Governor's Proposal. The Governor's budget includes $9.8 billion ($2.7 billion General Fund) in both 2020-21 and 2021-22. As compared to the 2020 enacted budget, funding for the SSI/SSP program increased by $70.1 million ($6.6 million General Fund) in 2020-21, which reflects larger grant amounts and approximately 9,200 more cases than previously projected. The Cash Assistance Program for Immigrants program costs are $162.0 million in 2020-21 and $168.2 million in 2021-22.

Grant Levels. The table below, provided by the Legislative Analyst's Office, shows monthly maximum SSI/SSP grant levels.

SSI/SSP Monthly Maximum Grant Levels[a] Governor's Proposal

	2020-21	2021-22 Governor's Estimates[b]	Change From 2020-21
Maximum Grant—Individuals			
SSI	$794.00	$811.00	$17.00
SSP	160.72	160.72	—
Totals	**$954.72**	**$971.72**	**$17.00**
Percent of federal poverty level[c]	89%	90%	
Maximum Grant—Couples			
SSI	$1,191.00	$1,217.00	$26.00
SSP	407.14	407.14	—
Totals	**$1,598.14**	**$1,624.14**	**$26.00**
Percent of federal poverty level[c]	110%	112%	

[a] The maximum monthly grants displayed refer to those for aged and disabled individuals and couples living in their own households, effective as of January 1 of the respective budget year.
[b] Reflects Governor's budget estimate of the January 2022 federal cost-of-living adjustment for the SSI portion of the grant.
[c] Compares grant level to federal poverty guidelines from the U.S. Department of Health and Human Services for 2021.

The federal government generally applies a Cost of Living Adjustment (COLA) to SSI grant levels annually. The Governor's budget estimates that the federal COLA will be 2.2 percent in 2022, increasing the maximum monthly SSI grant by $17 for individuals and $26 for couples. The current maximum SSI/SSP grant level for individuals remains below the 2021 Federal Poverty Level (FPL), while the grant level for couples remains just above the 2021 FPL. The FPL is a measure of income issued by the federal government each year to determine eligibility for programs and benefits.

Caseload. The caseload in the program has declined at an average rate of about one percent for the past five years. The Governor's budget estimates caseload will continue to decrease slightly – 0.8 percent in 2020-21 and 1.1 percent in 2021-22. In general, the average month-to-month change in total SSI/SSP cases has remained the same thus far between the period before COVID-19 and the

COVID-19 period—less than 1 percent decline. The rate has not changed because the average entry and exit rate into the SSI/SSP program generally has remained the same thus far between the pre-COVID-19 and COVID-19 period.

Federal and State Stimulus Payments. Since the onset of the COVID-19 pandemic, the federal government has provided two one-time stimulus payments to eligible adults— (1) up to $1,200 for eligible adults and an additional $500 for each eligible child in late March 2020, and (2) up to $600 for eligible singles ($1,200 for eligible married couples) and an additional $600 for each eligible child in December 2020. In general, SSI/SSP recipients were eligible to receive the federal stimulus payments. The federal stimulus payments did not affect an individual's eligibility for SSI/SSP or other means-tested programs, including Medi-Cal and CalFresh**.** On February 17, 2021, it was announced that the Legislature and Governor reached an agreement on the Golden State Stimulus proposal, which will provide $600 one-time payments to lower-income Californians, including SSI/SSP recipients. The state is currently working with the federal government (current administrators of the SSI/SSP payment system) to determine the timing of the payment to SSI/SSP recipients.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the caseload and funding levels for the SSI/SSP program, as well as an explanation for the declining caseload.

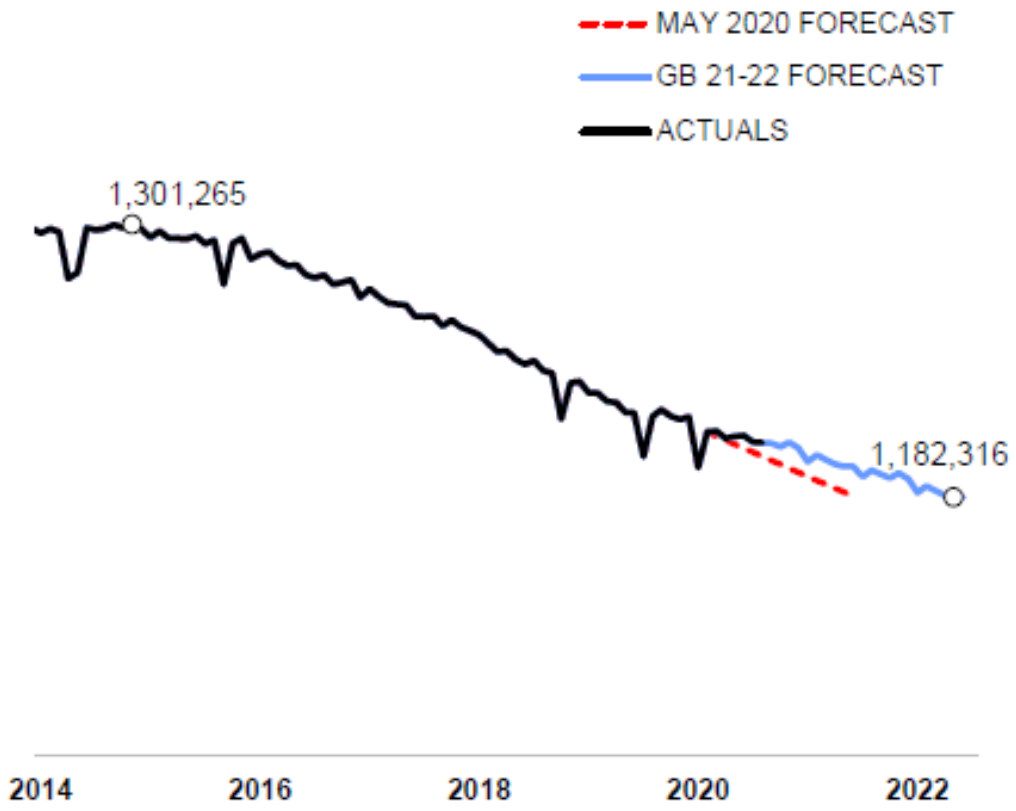
2. Please provide an update on conversations with the federal government regarding the Golden State Stimulus payments to SSI/SSP recipients.

SSI/SSP -- TOTAL

(AGED, BLIND AND DISABLED)

JANUARY 2021 FORECASTS

FY	ACTUAL	YEAR-TO-YEAR % CHANGE
2017-18	1,252,372	-1.5%
2018-19	1,228,349	-1.9%
2019-20	1,211,117	-1.4%
FORECASTS		
2020-21	1,201,565	-0.8%
2021-22	1,188,055	-1.1%



PROPOSALS FOR INVESTMENT RELATED TO DSS ADULT PROGRAMS

The Subcommittee has received the following proposal for investment related to DSS Adult Programs. Note that proposal sponsors provided all information below, aside from staff comments and recommendations.

1. Fiscal Penalty for IHSS Counties that Cannot Reach a Bargaining Agreement

Budget Issue. SEIU California and United Domestic Workers (UDW)/AFSCME Local 3930 propose trailer bill language to create a new fiscal penalty, equivalent to ten percent of a county's 2020-21 IHSS MOE, to be applied annually and automatically as long as a county does not reach a contract.

Background. In 2019, many counties across the state were at the state minimum wage of $12.00 per hour. Negotiations in these counties were either ongoing or at an impasse. Half of UDW counties were at the minimum wage and had an average contract expiration length of 38 months. In response, UDW and SEIU advocated for a fiscal penalty on counties that fail to bargain in good faith in SB 80 (Budget and Fiscal Review Committee), Chapter 27, Statutes of 2019. SB 80 imposed the following penalty: a one-time withholding of 1991 Realignment funding, equal to 1 percent of the county's 2018-19 IHSS MOE, on recalcitrant counties who met certain criteria. This provision, along with related mandatory mediation and factfinding provisions, expired on January 1, 2021. While there has been progress in achieving new contracts under this penalty, certain counties are still having difficulty coming to resolution at the bargaining table and SEIU and UDW argue some will likely revert to stagnant negotiation practices without this penalty in place. Additionally, they argue that the 1 percent fiscal penalty was not strong enough to be a deterrent of bad faith negotiations in specific counties. Seven out of 21 UDW contracts have expired or will expire in 2021. 19 out of 21 UDW contracts are anticipated to be open by the end of 2022. 22 out of 37 SEIU contracts have expired or will expire in 2021. 27 out of 37 SEIU contracts are anticipated to be open by 2022. This proposal creates a new fiscal penalty, equivalent to 10 percent of a county's 2020-21 IHSS MOE, to be applied annually and automatically, so long as a county does not reach a contract. The proposal also reinstates prior mandatory mediation and fact finding provisions. These provisions do not impact counties who bargain in good faith.

Staff Comment and Recommendation. Hold open.

2. Permanent Restoration of the Seven Percent Cut to IHSS Service Hours

Budget Issue. The California Association of Public Authorities, Disability Rights California, Justice in Aging, SEIU California, and UDW/AFSCME Local 3930 propose trailer bill language to repeal Welfare and Institutions Code Sections 12301.01 through 12301.05 and permanently restore the seven percent cut to IHSS service hours.

Background. The Legislature initially approved the seven percent reduction of IHSS service hours in 2013 as the result of a settlement agreement to prevent a massive 20 percent cut that had been proposed during the Great Recession. The purpose of these cuts was never about whether IHSS recipients needed all their hours but was solely in response to the financial crisis. Therefore, as soon as the state was fiscally able to, it restored the hours in the 2015-16 budget and through subsequent

budget actions each year thereafter. The 2019-20 budget continued the restoration of IHSS service hours but included IHSS in programs under the suspension policy that authorizes the Department of Finance to cut specified programs if General Fund revenues are expected to be less than estimated expenditures. The Governor's 2021-22 budget delays possible suspension by 12 months until December 31, 2022. However, the Administration's multiyear budget estimates assume the seven percent cut to IHSS hours will be operative in the last six months of 2022-23 and through all of 2023-24. It is especially important to note that there is no explicit provision to reverse the cut. The existing WIC statute that authorizes the 7% cut is a perpetual threat of service reductions. A permanent restoration is long overdue as IHSS services are essential to help low-income seniors and people with disabilities live safely at home rather than in unnecessary, undesired and more expensive out-of-home placement facilities. IHSS is necessary to keep Californians safe who are most at-risk of contracting COVID-19.

Note that the Governor's budget funds restoration through December 31, 2022. An additional $242.6 million General Fund would be needed for the remainder of the 2022-23 fiscal year. $540 million General Fund would be required in 2023-24.

Staff Comment and Recommendation. Hold open.

3. Continuity of IHSS Collective Bargaining Funding Mechanisms

Budget Issue. The California Association of Counties, UDW/AFSCME Local 3930, SEIU California, the California Association of Public Authorities, the County Welfare Directors Association of California, the Urban Counties of California, and the Rural County Representatives of California propose trailer bill language to provide continuity for the existing IHSS collective bargaining funding tools so that further progress on local bargaining for wage and benefit increases will be achieved. Costs associated with this change are $16 million General Fund in 2021-22 and $32 million in the out years.

Background. Under current law, counties and the state share the nonfederal cost for locally negotiated increases to wages and health benefits for IHSS providers. Counties are responsible for 35 percent of the nonfederal share and the state participates in 65 percent of the nonfederal share of cost for increases up to the state participation cap, which is set at $1.10 above the state minimum wage. For increases above that amount, the county is responsible for 100 percent of the nonfederal share. However, there is a tool available, referred to as the ten percent over three years tool, that allows the county to receive state participation above the state participation cap. With this tool, the state will participate above the state participation cap at the 65 percent share of cost in a cumulative total of up to a 10 percent increase in the sum of the combined total of changes in wages or health benefits, or both, over a three-year period. On January 1, 2022, the historic sharing ratio will flip, with the county becoming responsible for 65 percent of the nonfederal share and the state covering 35 percent of the nonfederal share. Additionally, the ten percent over three years tool is no longer available, as current law indicates that any use of this tool must begin prior to January 1, 2022.

The sponsors propose to eliminate the language in statute that would change the sharing ratio on January 1, 2022. Second, they propose that the ten percent over three years tool be extended. There are limitations in statute that require the use of this tool to begin before January 1, 2022, and for a county to only be able to use the tool for two three-year periods. This proposal would continue the use of this tool beyond January 1, 2022 and allow a county to utilize the tool more than two times.

Staff Comment and Recommendation. Hold open.

4. IHSS Electronic Forms

Budget Issue. The County Welfare Directors Association (CWDA) and the California Association of Public Authorities request $5 million General Fund ongoing, to be matched with $5 million federal funds, to allow counties to implement or expand technologies for electronic form submittal. This proposal also includes accompanying trailer bill language to require CDSS to create a plan to develop the ability to electronically sign and submit forms.

Background. The pandemic has had a disproportionately negative impact on our most vulnerable older adult population. According to the Centers for Disease Control (CDC) the risk for severe illness with COVID-19 increases with age, with older adults at the highest risk. The CDC reports 8 out of 10 deaths due to COVID-19 have been with adults 65 years of age and older. The CDSS has authorized counties to reduce in-person contact with applicants of IHSS, consumers and their providers, through virtual intakes, reassessments, and provider orientations. Advances in technology now enable counties to provide and collect forms electronically. However, not all counties have been able to procure this technology using only local resources, and not all forms are currently available through these on-line formats. The counties that do utilize these platforms report more timely completion of forms and fewer errors, which ultimately results in getting services started more expediently. CWDA estimates that $5 million General Fund (matched with $5 million Title IXX funds) will allow counties to implement and/or expand technologies used for electronic forms submittal.

Staff Comment and Recommendation. Hold open.

5. Reduce Senior Homelessness: Expand and Enhance the Adult Protective Services Program

Budget Issue. The County Welfare Directors Association and Justice in Aging request $25 million in the current year, and $100 million annually thereafter to expand the Adult Protective Services (APS) program and to build upon the APS Home Safe Program.

Background. The older adult population has been hit hard by the COVID-19 pandemic, both in terms of health and the housing crisis. The population the APS program serves -- both older adults and adults with disabilities -- is growing rapidly in tandem with California's aging population, and with that growth the program is seeing more cases with increasingly complex needs including individuals with cognitive impairments such as dementia and individuals struggling with homelessness. Research is also clear that racism, ageism, and sexism persist for older adults, and APS can play an important role in supporting people of color living safely and securely as they age. County APS programs are struggling to keep up with the growth in reports and are not currently resourced to serve the increasing number of victims with complex needs who require more intensive case management to remain safe in their homes and communities amid public health and housing crises. The proposed funding would allow APS to serve vulnerable adults aged 60-65 and expand to provide long-term case management, and expand the Home Safe Program to additional counties.

Staff Comment and Recommendation. Hold open.

6. State Supplemental Payment Savings

Budget Issue. Griffin/Stevens & Lee Consulting, on behalf of the Commonwealth of Pennsylvania, propose trailer bill language to authorize, but not require, DSS to contract with a government vendor to administer its State Supplemental Payment program.

Background. Supplemental Security Income (SSI) guarantees a minimal level of income to low-income aged, blind, and disabled individuals and is administered by the Federal Social Security Administration (SSA). In addition to the Federal benefit amount, states are permitted to make additional payments to these recipients to provide a higher level of income maintenance. These payments are known as State Supplemental Payments (SSP). A state may administer its own SSP or enter into an agreement with the SSA to make eligibility determination and payments on behalf of the state. States are required to pay a fee for Federal administration of SSP. California currently uses the SSA to administer its SSP and pays over $178 million annually for the federal government to administer its SSP. In 2004 the Pennsylvania Treasury Department, along with the Department of Public Welfare, assumed the responsibility for processing the SSP payments to eligible Pennsylvania residents. Building on the success of its program, in 2014 Pennsylvania approved legislation to allow the Pennsylvania Treasury Department to enter into contracts with other states to administer their SSP. If California chose to partner with Pennsylvania, the Pennsylvania Treasury Department would provide the same services as SSA for an all-inclusive rate of $6.20 per transaction and would lock in the all cost for the term of the contract. The proposed trailer bill language would authorize DSS to contract with a government vendor other than the SSA to administer its SSP program.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – COMMUNITY CARE LICENSING (CCL)

The CCL Division in the Department of Social Services (DSS) oversees the licensure or certification of licensed facilities that include childcare centers; family child care homes; adult daycare facilities; foster family homes; children, adult, and senior residential facilities; and certified family homes and home care organizations. CCL is responsible for protecting the health and safety of individuals served by those facilities. Licensing program analysts investigate any complaints lodged, and conduct inspections of the facilities. The CCL division has a total authorized position count of 1,486.8 positions. In 2021-22, there are 73,579 CCL licensed facilities across the state.

Issue 4: BCP - Adult Residential Facilities: Closures and Resident Transfers

Governor's Proposal. The Governor's budget includes $1.1 million General Fund ongoing to provide temporary oversight of Adult Residential Facilities (ARF) when a facility owner forfeits their license or intends to close the facility. The requested funding will be used to implement policy changes associated with Assembly Bill 2377 (Chiu), Chapter 146, Statutes of 2020, which will provide management and operation responsibilities on behalf of ARFs until a new licensee is established.

Note that this proposal is meant to work in conjunction with the Administration's proposal for a $250 million grant program for counties to purchase ARFs and Residential Care Facilities for the Elderly (RCFEs) that was discussed during the Subcommittee's February 9, 2021 hearing.

Background. As of September 1, 2020, there were over 5,400 licensed ARFs. AB 2377 requires every ARF licensee that intends to sell its property to notify the city/county, wait up to 60 days for a response to purchase, and continue operating the facility. The bill also aligned ARF closure requirements with those of Residential Care Facilities for the Elderly (RCFEs).

DSS estimates that it will require ten contracts annually to support the closure of facilities across the state. With this contract funding, DSS will provide stability for residents and persons in care in facilities that may have otherwise closed, forcing residents in a short timeframe to try to find alternative facilities. This funding will provide for temporary managers of facilities leading up to the transition of licensee when the licensee is unable to provide a safe environment. CCL reviews temporary manger applications submitted to the department to see if minimum requirements are met, maintains a registry of temporary managers, and pulls from this registry when needed. Temporary managers assume operation of facilities for 60 days, subject to an approved extension.

Funding may also provide for staff costs, back pay, or capital improvements during the time of transition. According to the department, these efforts will support the operation of facilities (by enabling cities/counties to take over the operation) and may slow down the current trend of higher facility closures annually across the state.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. The department has indicated that the requested resources may help slow down the current trend of higher facility closures across the state. How many of these facility types have closed in the past year? In the past five years? Where do the residents of closed ARFs end up living?

3. Is a temporary manager needed in every instance in which a facility is transferred from one licensee to another? In which situations is a temporary manager necessary? How has this model worked with RCFEs?

4. Advocates have said that the facilities that care for clients on SSI are struggling to cover operating costs. How does the state propose to ensure these facilities remain open?

Issue 5: BCP - Children's Residential Facilities and Reducing Law Enforcement

Governor's Proposal. The Governor's budget includes $399,000 ($334,000 General Fund) for the extension of limited-term resources to continue reducing the use of law enforcement to manage the behavior of foster youth within care facilities. The three Licensing Program Analyst (LPA) positions are set to expire on June 30, 2021. The budget extends these positions for an additional two years.

Background. The 2019 Budget Act included resources for three limited-term LPA positions for the increase in workload created by Assembly Bill 388 (Chesbro), Chapter 760, Statutes of 2014, along with other more recent legislation. This workload caused an influx of reports made to law enforcement due to incidents on the premises. These situations require the review, analysis, and disclosure of information reported by facilities. Licensees are mandated to report to DSS anytime a youth who resides at a facility encounters law enforcement, whether at school or while a child has left the facility. Unauthorized absence reports account for most law enforcement contacts and can range from a youth's visit to a local convenience store to youth becoming a runaway. DSS is required to inspect facilities with excessive law enforcement contacts by conducting visits and providing technical support, which includes in-person, onsite training, and phone consultation. DSS must also process and publish information regarding law enforcement contact. The increased workload has outweighed the existing resources to process and publish the required information promptly. After nearly four years of activity, CDSS continues to receive a high volume of incidents involving law enforcement.

Reports Received Annually			
2016	2017	2018	2019
Approximately 28,000 reports	32,082 reports	34,500 reports	33,504 reports

Note that these reports go through two review periods. First, regional offices review reports and then forward them to headquarters for a secondary review and data input. The current backlog is only referring to that secondary review. If a problem arises during the primary review by a regional office the issue can be addressed immediately. The backlog does not hinder addressing critical problems or issues that may arise in facilities.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. How has the increased review and monitoring of these facilities helped increase safety for youth in these facilities?

3. What are the reasons for increased law enforcement reports in most facilities?

Issue 6: BCP - Community Care Licensing Resources

Governor's Proposal. The Governor's budget includes $2.3 million ($1.9 million General Fund) to make permanent 13 Licensing Program Analysts (LPA) and four Associate Governmental Program Analysts (AGPA) to address ongoing complaint investigations workload and reduce license application processing time.

Background. The 2015 Budget provided resources for thirteen two-year limited-term LPA positions to focus on the backlog of complaint investigations open past 90 days. Additionally, the 2017 Budget Act approved two-year funding from the Technical Assistance Fund to further support this effort. The 2019 Budget Act also approved thirteen two-year limited-term LPAs to continue to address the backlog of complaint investigations. The limited-term resources provided handle complaints that include multiple allegations. Some complaints are highly complex and multi-layered and require increased time to conduct necessary clinical reviews.

Complaint Investigations Received Annually				
2015	2016	2017	2018	2019
15,429 reports	15,163 reports	16,036 reports	14,859 reports	13,671 reports

The 2015 Budget also provided resources for four temporary positions to address the backlog of facility license applications. According to DSS, the review process of Adult and Senior Care applications requires a high level of critical analysis, tracking/trending abilities, and proactive strategies to foster an industry that promotes quality of care and adequately supervises its vulnerable residents. In 2017, the total number of applications received was 1,390. In 2018, DSS received 1,464 applications and 1,600 applications in 2019, a nearly 10 percent increase in applications over the prior year.

Applications Received Annually		
2017	2018	2019
1,390 applications	1,464 applications	1,600 applications

Aside from requested increased resources, the department has implemented several efficiencies in the licensing process and the complaint investigation process. Some of those efficiencies include:

- Accepting electronic signatures and electronic submission of documents.
- Leveraged data to identify barriers in the intake and application review process.
- Providing technical assistance to facilities with a high number of complaints.
- Providing managers with a monthly analysis tracking the number of open complaints, new complaints, and open complaints over 90 days to help shift the allocation of field resources.

Since the original approval of funding in 2015-16, DSS improved the average number of days to process a license application. In 2015-16, the unit took an average of 750 days to process an application. In 2019-20, that number has gone down to 172 days. However, the current number of

days to process an application continues to be above the expected processing time of 90 days due to the continued increased number of applications. The authorized positions have reduced the number of applications each staff is responsible for, contributing to the overall customer service, responsiveness, application review efficiency, and lowered processing time. To sustain the improvements in production and further reduce production timeframes, DSS requests to make the limited-term positions permanent.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal and some of the methods that CCL has used to reduce time to process applications.

2. Please discuss CCL's approach to facilities with high numbers of complaints.

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.

Friday, March 5th, 2021
9:00 a.m.
State Capitol - Room 3191

Consultant: Scott Ogus

PUBLIC COMMENT

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

0000 VARIOUS DEPARTMENTS

Issue 1: Proposals for Investment

Proposals for Investment. The subcommittee has received a number of proposals for investment that augment or modify the Governor's January Budget. Brief descriptions of these proposals by state department are presented in the table below. More extensive details of these proposals may be found on the pages following the table.

PROPOSALS FOR INVESTMENT	
CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY	
Project ECHO Children's Mental Health Grant Program	
Organizational Sponsor(s)	**Funding or Language Requested**
California Children's Hospital Association	$1.8 million General Fund (GF) in 2021-22
Brief Description:	
The California Children's Hospital Association (CCHA) requests General Fund expenditure authority of $1.8 million in 2021-22 to support the Project ECHO Pediatric Mental Health Grant Program, a competitive grant program to bridge the gap between children's mental health specialists and community providers and educators.	
CHHSA Working Group on Maximizing Federal Funding for Home Visiting	
Organizational Sponsor(s)	**Funding or Language Requested**
Nurse Family Partnership	$43,000 GF in 2021-22, $75,000 in 2022-23
Brief Description:	
The Nurse Family Partnership (NFP) requests General Fund expenditure authority of $43,000 in 2021-22 and $75,000 in 2022-23 to support a workgroup in the California Health and Human Services Agency (CHHSA) to assess the feasibility for California's potential to streamline Medi-Cal funding to counties for home visiting services.	
DEPARTMENT OF HEALTH CARE SERVICES	
Medi-Cal for All Income-Eligible Seniors Regardless of Immigration Status.	
Organizational Sponsor(s)	**Funding or Language Requested**
CA Immigrant Policy Center and Health Access California	$161 million ($128.4 million GF and $32.6 million federal funds) in 2021-22 $350 million ($320 million GF and $30 million federal funds) annually
Brief Description:	

The California Immigrant Policy Center (CIPC) and Health Access California request expenditure authority of $161 million ($128.4 million General Fund and $32.6 million federal funds) in 2022-23 and $350 million ($320 million General Fund and $30 million federal funds) annually thereafter to support expansion of Medi-Cal to all income-eligible seniors regardless of immigration status beginning July 1, 2022.

Eliminate the Medi-Cal Assets Test

Organizational Sponsor(s)	Funding or Language Requested
Western Center on Law and Poverty (WCLP) and Justice in Aging	$110 million ($52.9 million GF and $57.2 million federal funds) in 2021-22 $219.6 million ($105.4 million GF and $114.1 million federal funds) annually

Brief Description:

Western Center on Law and Poverty (WCLP) and Justice in Aging request expenditure authority of $110.1 million ($52.9 million General Fund and $57.2 million federal funds) in 2021-22 and $219.6 million ($105.4 million General Fund and $114.1 million federal funds) annually thereafter to eliminate the assets test for Medi-Cal eligibility determinations for seniors and persons with disabilities, effective January 1, 2022.

Medi-Cal LTSS Data Transparency

Organizational Sponsor(s)	Funding or Language Requested
California Collaborative for Long-Term Services and Supports (CCLTSS)	$250,000 GF in 2021-22

Brief Description:

The California Collaborative for Long-Term Services and Supports (CCLTSS) requests General Fund expenditure authority of $250,000 in 2021-22 to incorporate certain data elements regarding long-term services and supports (LTSS) into its managed care plan contracts.

Quality Incentive Pool (QIP) Transition Bridge Loan for District and Municipal Hospitals

Organizational Sponsor(s)	Funding or Language Requested
District Hospital Leadership Forum	$40 million GF in 2021-22 and 2022-23

Brief Description:

The District Hospital Leadership Forum (DHLF) requests General Fund expenditure authority of $40 million in 2021-22 and 2022-23 to make two bridge loans to the 34 district and municipal hospitals to aid in the transition from the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, a quality improvement program under the state's expiring 1115 waiver, to the Quality Incentive Pool (QIP) program.

Caregiver Resource Centers Infrastructure Funding Extension

Organizational Sponsor(s)	Funding or Language Requested

Association of California Caregiver Resource Centers	$12 million GF in 2021-22, 2022-23, and 2023-24
Brief Description:	
The Association of California Caregiver Resource Centers (CRC) requests General Fund expenditure authority of $12 million annually in 2021-22, 2022-23, and 2023-24 to continue infrastructure support and to build an Equity and Inclusion Core within the CRC system.	
Drug Medi-Cal Flexibility to Prevent Overdose and Support Public Health	
Organizational Sponsor(s)	**Funding or Language Requested**
California Opioid Maintenance Providers (COMP)	$9.2 million ($2.8 million GF and $6.4 million federal funds) annually Trailer bill language
Brief Description:	
The California Opioid Maintenance Providers (COMP) request expenditure authority of $9.2 million ($2.8 million General Fund and $6.4 million federal funds) annually and trailer bill language to grant authority to DHCS to evaluate and implement changes to the Narcotic Treatment Program (NTP), including allowing new drug and disease testing.	
Field Testing of Translated Medi-Cal Materials and Equity Dashboard	
Organizational Sponsor(s)	**Funding or Language Requested**
California Pan-Ethnic Health Network (CPEHN) and WCLP	$1 million GF in 2021-22 $30,000 GF annually
Brief Description:	
The California Pan-Ethnic Health Network (CPEHN) and the Western Center on Law and Poverty (WCLP) request General Fund expenditure authority of $1 million in 2021-22 and $30,000 annually thereafter to field test translations of Medi-Cal materials and collect additional demographic data as part of the Equity Dashboard.	
COVID-19 Reimbursement Rate Extension for Pediatric Subacute Facilities	
Organizational Sponsor(s)	**Funding or Language Requested**
Totally Kids Specialty Healthcare - Sun Valley	$1 million GF in 2021-22
Brief Description:	
Totally Kids Specialty Healthcare – Sun Valley requests General Fund expenditure authority of $1 million to extend the ten percent reimbursement rate increase implemented during the COVID-19 pandemic for free-standing pediatric subacute facilities through the 2021-22 fiscal year.	
COVID-19 Reimbursement Rate Extension for ICF-DDs	
Organizational Sponsor(s)	**Funding or Language Requested**

Developmental Services Network (DSN)	$18.6 million ($9.2 million GF and $9.3 million federal funds) in 2021-22
Brief Description:	
The Developmental Services Network (DSN) requests expenditure authority of $18.6 million ($9.3 million General Fund and $9.3 million federal funds) to extend for six months the ten percent reimbursement rate increase implemented during the COVID-19 pandemic for intermediate care facilities for individuals with developmental disabilities (ICF-DDs).	
CalAIM Workgroup on ICF-DD Transition to Managed Care	
Organizational Sponsor(s)	**Funding or Language Requested**
Developmental Services Network (DSN)	Budget bill language
Brief Description:	
DSN requests budget bill language to require DHCS and DDS to convene a workgroup to address governance, procedures and processes pertaining to the transition of ICF-DDs from the fee-for-service to the Medi-Cal managed care delivery system under the California Advancing and Innovating in Medi-Cal (CalAIM) initiative.	
Expand Access to STD Services Through Family PACT	
Organizational Sponsor(s)	**Funding or Language Requested**
End the Epidemics Coalition	$7 million GF annually
Brief Description:	
The End the Epidemics coalition requests annual General Fund expenditure authority of $7 million to expand access to sexually transmitted disease (STD) services covered by the Family Planning, Access, Care, and Treatment (Family PACT) program.	
Start-Up Funds for Medi-Cal Peer Support Specialist Certification	
Organizational Sponsor(s)	**Funding or Language Requested**
California Association of Mental Health Peer Run Organizations County Behavioral Health Directors Association (CBHDA) County of Los Angeles Steinberg Institute	$9.4 million ($4.7 million GF and $4.7 million federal funds) in 2021-22, available for encumbrance and expenditure until June 30, 2023.
Brief Description:	
The California Association of Mental Health Peer Run Organizations, the County Behavioral Health Directors Association, the County of Los Angeles, and the Steinberg Institute request expenditure authority of $9.4 million ($4.7 million General Fund and $4.7 million federal funds) to support initial implementation of the Peer Support Specialist (PSS) Certification Program, pursuant to SB 803 (Beall), Chapter 150, Statutes of 2020.	
PACE Awareness in CalAIM	

Organizational Sponsor(s)	Funding or Language Requested
CalPACE	Trailer bill language
Brief Description:	
CalPACE requests trailer bill language to ensure individuals potentially eligible for a Program for All-Inclusive Care for the Elderly (PACE) are aware that PACE is an option and have an opportunity to be assessed and enroll before being enrolled in a managed care plan under the managed care transition included in the California Advancing and Innovating in Medi-Cal (CalAIM) initiative.	
PACE Flexibilities	
Organizational Sponsor(s)	**Funding or Language Requested**
CalPACE	Trailer bill language
Brief Description:	
CalPACE requests trailer bill language to make permanent the regulatory flexibilities provided to PACE organizations during the COVID-19 public health emergency that have allowed PACE organizations to safely care for and provide services to the frail seniors that PACE organizations serve.	
Medi-Cal Reimbursement for Personal Protective Equipment	
Organizational Sponsor(s)	**Funding or Language Requested**
California Dental Association (CDA)	$80 million ($40 million GF and $40 million federal funds) in 2021-22
Brief Description:	
The California Dental Association (CDA) requests expenditure authority of $80 million ($40 million General Fund and $40 million federal funds) to provide reimbursement for Medi-Cal dental providers for pandemic-related costs of new, mandatory, medically necessary infection control.	
Extension of Behavioral Health Pilot Project	
Organizational Sponsor(s)	**Funding or Language Requested**
California Hospital Association	$40 million GF, available for encumbrance or expenditure until June 30, 2024
Brief Description:	
The California Hospital Association (CHA) requests General Fund expenditure authority of $40 million, available for encumbrance or expenditure until June 30, 2024, to continue the Behavioral Health Pilot Project (BHPP), which provides funding for behavioral health counselors in emergency departments.	
Increased Medi-Cal Reimbursement for Orthotic and Prosthetic Providers	

Organizational Sponsor(s)	Funding or Language Requested
California Orthotic and Prosthetic Association (COPA)	$9 million ($4.5 million GF and $4.5 million federal funds) annually

Brief Description:

The California Orthotic and Prosthetic Association (COPA) requests expenditure authority of $9 million ($4.5 million General Fund and $4.5 million federal funds) to increase Medi-Cal reimbursement for providers of orthotics and prosthetics.

Ensure Healthcare Access for Homeless Adults in California's Safety Net Hospitals

Organizational Sponsor(s)	Funding or Language Requested
Private Essential Access Community Hospitals (PEACH)	$120 million ($50 million GF and $70 million federal funds) annually

Brief Description:

Private Essential Access Community Hospitals (PEACH) requests expenditure authority of $120 million ($50 million General Fund and $70 million federal funds) to implement a socioeconomic status (SES) adjustment factor for reimbursement of claims paid to safety net hospitals that provide care for Medi-Cal beneficiaries.

Medi-Cal Coverage for 12 Months Postpartum and Children Zero to Five

Organizational Sponsor(s)	Funding or Language Requested
American College of Obstetricians and Gynecologists (ACOG) First 5 Center for Children's Policy March of Dimes The Children's Partnership (TCP) Maternal Child Health Access (MCHA) First 5 Association of California	$100 million ($55 million GF and $55 million federal funds) in 2022-23 $220 million ($110 million GF and $110 million federal funds) annually

Brief Description:

A coalition of organizations including the American College of Obstetricians and Gynecologists (ACOG), the First 5 Center for Children's Policy, the March of Dimes, the Children's Partnership (TCP), Maternal Child Health Access (MCHA), and the First 5 Association of California, request expenditure authority of $110 million ($55 million General Fund and $55 million federal funds) in 2022-23 and $220 million ($110 million General Fund and $110 million federal funds) annually thereafter to extend pregnancy-only Medi-Cal coverage from 60 days postpartum to 12 months, and to extend continuous coverage for all children up to age five.

Telephonic Attestation for Medi-Cal

Organizational Sponsor(s)	Funding or Language Requested
WCLP	Trailer bill language

Brief Description:

The Western Center on Law and Poverty (WCLP) requests trailer bill language to permit federally allowable flexibility in the acceptance of telephonic or electronic self-attestation of eligibility requirements for Medi-Cal.

Medically Tailored Meals Pilot Extension

Organizational Sponsor(s)	Funding or Language Requested
California Food is Medicine Coalition	$9.3 million GF annually

Brief Description:

The California Food is Medicine Coalition requests General Fund expenditure authority of $9.3 million annually to continue support for a pilot project that provides medically tailored meals to Medi-Cal beneficiaries.

Clinical Laboratory Reimbursement Methodology

Organizational Sponsor(s)	Funding or Language Requested
California Clinical Laboratory Association (CCLA)	$40 million GF in 2021-22

Brief Description:

The California Clinical Laboratory Association (CCLA) requests trailer bill language and General Fund expenditure authority of $40 million in 2021-22 to remove the cap on Medi-Cal reimbursement for clinical laboratories, forgive retroactive recoupment of reimbursement reductions, and delay other reductions until 2022.

Eliminate Ten Percent Rate Reduction for Complex Rehabilitation Technology

Organizational Sponsor(s)	Funding or Language Requested
National Coalition for Assistive and Rehab Technology (NCART)	$2 million GF annually

Brief Description:

The National Coalition for Assistive and Rehab Technology (NCART) requests General Fund expenditure authority of $2 million annually to eliminate the ten percent Medi-Cal reimbursement rate reduction enacted by AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, for complex rehabilitation technology (CRT).

Restore Crossover Payments for Behavioral Health Services for Dual Eligibles in Nursing Homes

Organizational Sponsor(s)	Funding or Language Requested
CHE Behavioral Health Services	$3 million GF annually Trailer bill language

Brief Description:

CHE Behavioral Health Services requests General Fund expenditure authority of $3 million annually and trailer bill language to improve access to behavioral health services for individuals dually eligible for both Medicare and Medi-Cal (dual-eligibles) and who reside in skilled nursing facilities.

Alameda Wellness Campus	
Organizational Sponsor(s)	**Funding or Language Requested**
Alameda Point Collaborative Lifelong Medical Care	$15 million GF in 2021-22
Brief Description:	
The Alameda Point Collaborative and Lifelong Medical Care request General Fund expenditure authority of $15 million in 2021-22 to support construction of a medical respite and health clinic building at the Alameda Wellness Campus to serve unhoused adults and seniors with complex health conditions.	
Housing Support Services Benefit for People Experiencing Homelessness	
Organizational Sponsor(s)	**Funding or Language Requested**
Corporation for Supportive Housing WCLP	$100 million ($24 million GF and $76 million federal funds) in 2021-22 $150 million ($36 million GF and $114 million federal funds) in 2022-23 $250 million ($60 million GF and $190 million federal funds) annually
Brief Description:	
The Corporation for Supportive Housing and the Western Center on Law and Poverty (WCLP) request expenditure authority of $100 million ($24 million General fund and $76 million federal funds) in 2021-22, $150 million ($36 million General Fund and $114 million federal funds) in 2022-23, and $250 million ($60 million General Fund and $190 million federal funds) annually thereafter to create a Medi-Cal benefit to fund housing support services for beneficiaries experiencing homelessness and people who were homeless and are now residing in supportive housing.	
Restoring Optional Medi-Cal Benefits for Chiropractic	
Organizational Sponsor(s)	**Funding or Language Requested**
California Chiropractic Association	$1.7 million GF annually
Brief Description:	
The California Chiropractic Association requests General Fund expenditure authority of $1.7 million annually to restore chiropractic benefits in the Medi-Cal program.	

DEPARTMENT OF PUBLIC HEALTH	
State Investment in Core Public Health Infrastructure and Workforce	
Organizational Sponsor(s)	**Funding or Language Requested**
SEIU California County Health Executives Association of California (CHEAC) California State Association of Counties (CSAC) Health Officers Association of California (HOAC) Rural County Representatives of California (RCRC) Urban Counties of California (UCC)	$200 million GF annually
Brief Description:	
A coalition of counties, county health organizations, and county public health workers, requests annual General Fund expenditure authority of $200 million to support investments in stabilization and addressing key needs and issues for local health departments.	
Public Health Infrastructure and Workforce Assessment	
Organizational Sponsor(s)	**Funding or Language Requested**
CHEAC HOAC SEIU California	$3.2 million GF in 2021-22 $150,000 GF annually
Brief Description:	
The County Health Executives Association of California (CHEAC), the Health Officers Association of California (HOAC), and SEIU California request General Fund expenditure authority of $3.2 million in 2021-22 and $150,000 annually thereafter to conduct an evaluation of local health department infrastructure and make recommendations for staffing, workforce needs, and resources, in order to accurately and adequately fund local public health.	
California Health Equity Fund	
Organizational Sponsor(s)	**Funding or Language Requested**
California Black Health Network Latino Coalition for a Healthy California Public Health Institute Roots of Change	$180 million GF in 2021-22, available for encumbrance or expenditure until June 30, 2024
Brief Description:	

A coalition of organizations including the California Black Health Network, the Latino Coalition for a Healthy California, the Public Health Institute, and Roots of Change request General Fund expenditure authority of $180 million, available for encumbrance and expenditure until June 30, 2024, to implement a California Health Equity Fund, which would provide increased funding for local health departments, community-based organizations, clinics, and tribes for community-based initiatives and programs that result in decreased risk for preventable illnesses and adverse childhood experiences (ACEs) exacerbated by COVID-19.

Sustaining the California Reducing Disparities Project

Organizational Sponsor(s)	Funding or Language Requested
Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) National Association of Social Workers-California Chapter (NASW-CA)	$50 million GF in 2021-22, available for encumbrance or expenditure until June 30, 2025

Brief Description:

The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) and the National Association of Social Workers-California Chapter (NASW-CA) requests General Fund expenditure authority of $50 million in 2021-22, available for encumbrance or expenditure until June 30, 2025, to extend and expand the California Reducing Disparities Project (CRDP).

Phase Out of Skilled Nursing Facility Staffing Waivers

Organizational Sponsor(s)	Funding or Language Requested
SEIU California	Trailer bill language

Brief Description:

SEIU California requests trailer bill language to phase out workforce shortage and patient acuity waivers for statutory staffing requirements in skilled nursing facilities.

All Children Thrive Expansion

Organizational Sponsor(s)	Funding or Language Requested
Public Health Advocates	$25 million GF in 2021-22

Brief Description:

Public Health Advocates requests General Fund expenditure authority of $25 million in 2021-22 to expand the All Children Thrive pilot project to 100 new cities over five years.

Amyotrophic Lateral Sclerosis (ALS) Wraparound Model of Care Funding Extension

Organizational Sponsor(s)	Funding or Language Requested
Golden West Chapter of the ALS Association	$3 million GF annually

Brief Description:

The Golden West Chapter of the ALS Association requests General Fund expenditure authority of $3 million annually to continue to allow the current ALS wraparound treatment model to improve access to an evidence-based model of care and keep pace with the growth in the number of people diagnosed with ALS, or Lou Gehrig's Disease.

PrEP-AP Navigation and Retention Services

Organizational Sponsor(s)	Funding or Language Requested
End the Epidemics Coalition	Annual funding from ADAP Rebate Fund

Brief Description:

The End the Epidemics coalition requests expenditure authority from the AIDS Drug Assistance Program (ADAP) Rebate Fund to support pre-exposure prophylaxis (PrEP) navigation and retention services.

Hepatitis C Test Kits and Associated Costs

Organizational Sponsor(s)	Funding or Language Requested
End the Epidemics Coalition	$1 million GF in 2021-22, available for encumbrance or expenditure until June 30, 2026

Brief Description:

The End the Epidemics coalition requests General Fund expenditure authority of $1 million, available over five years, to support the purchase of hepatitis C virus (HCV) test kits, associated materials and supplies, training for test counselors, and the staffing to support a test kit program.

STD Prevention and Control Activities

Organizational Sponsor(s)	Funding or Language Requested
End the Epidemics Coalition	$3 million GF annually

Brief Description:

The End the Epidemics Coalition requests General Fund expenditure authority of $3 million annually to increase funding for sexually transmitted disease (STD) prevention and control activities.

Syringe Exchange Supply Clearinghouse Funding

Organizational Sponsor(s)	Funding or Language Requested
End the Epidemics Coalition	$3 million GF annually

Brief Description:

The End the Epidemics Coalition Requests General Fund expenditure authority of $3 million annually to increase funding for the DPH office of AIDS Syringe Exchange Supply Clearinghouse.

Medical Legal Partnerships for COVID-19 Recovery	
Organizational Sponsor(s)	**Funding or Language Requested**
The Children's Partnership	$30 million GF in 2021-22
Brief Description:	
The Children's Partnership requests General Fund expenditure authority of $30 million in 2021-22 to support COVID-19 recovery efforts for communities deeply impacted by the pandemic through a grant program that encourages partnerships between community programs and legal service organizations that support families and children.	
Transgender Wellness and Equity Funding	
Organizational Sponsor(s)	**Funding or Language Requested**
Trans Latin@ Coalition	$15 million GF annually
Brief Description:	
The Trans Latin@ Coalition requests General Fund expenditure authority of $15 million annually to support organizations providing health care services to transgender, gender non-conforming, or intersex (TGI) individuals.	
Women Infants and Children (WIC) Program Public Contracting Code Exemption	
Organizational Sponsor(s)	**Funding or Language Requested**
California WIC Association	Trailer bill language
Brief Description:	
The California WIC Association requests trailer bill language to provide flexibilities for the 84 WIC local agency contracts with DPH through an exemption in the Public Contracting Code.	
Extend Repeal Date for California Parkinson's Disease Registry	
Organizational Sponsor(s)	**Funding or Language Requested**
Michael J. Fox Foundation	Trailer bill language
Brief Description:	
The Michael J. Fox Foundation requests trailer bill language to extend or repeal the sunset date for the California Parkinson's Disease Registry.	
DEPARTMENT OF STATE HOSPITALS	
Stop DSH Patient Billing	
Organizational Sponsor(s)	**Funding or Language Requested**
WCLP	Trailer bill language
Brief Description:	

The Western Center on Law and Poverty (WCLP) requests trailer bill language to prohibit the Department of State Hospitals from billing patients and their families for the cost of care during placement.
MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
Mental Health Student Services Act Augmentation

Organizational Sponsor(s)	**Funding or Language Requested**
Children Now	$80.5 million GF in 2021-22

Brief Description:

Children Now requests General Fund expenditure authority of $80.5 million in 2021-22 to provide additional grants for partnerships between schools and county mental health programs to provide mental health services to students.

COVERED CALIFORNIA

Covered California State Subsidy Extension

Organizational Sponsor(s)	**Funding or Language Requested**
Health Access California	$400 to $500 million GF annually for three years

Brief Description:

Health Access California requests General Fund expenditure authority of $400 to $500 million annually for three years to support extension of the state subsidy program to improve health insurance affordability in the Covered California health benefits exchange.

State Subsidies to Provide Zero Premiums for Covered California Plans

Organizational Sponsor(s)	**Funding or Language Requested**
Health Access California	$15 to $19 million GF annually Trailer bill language

Brief Description:

Health Access California 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.

DETAILED DESCRIPTIONS OF PROPOSALS:

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Project ECHO Children's Mental Health Grant Program. The California Children's Hospital Association (CCHA) requests General Fund expenditure authority of $1.8 million in 2021-22 to support the Project ECHO Pediatric Mental Health Grant Program, a competitive grant program to bridge the gap between children's mental health specialists and community providers and educators. According to CCHA, COVID-19 has exacerbated the state's existing mental health crisis, and children and adolescents have been particularly affected due to school closures, lack of access to their peers, and increased stress among family members at home. Those impacts are expected to persist long after the worst of the pandemic is over. Even before the pandemic, as many as 1.8 million California youth were living with a mental health diagnosis, and the vast majority of them were not receiving treatment until their issues reached crisis levels, if at all. Left untreated, mental health needs that manifest in childhood and adolescence can lead to lifelong challenges, increased mortality and morbidity, and long-term costs for individuals, their families, and their communities. In other words, mental illness is a disease of youth, with profound long-term implications for individuals and our society.

In order to increase the capacity of the state's mental health system quickly to try and address the growing needs of children and adolescents, the state must get more individuals involved in prevention and early interventions, to stave off the development of more severe mental health issues, which are harder to treat and would far exceed the current capacity of the state's specialty mental health system. School-based professionals and primary care providers are well-positioned to implement widespread, early interventions and mental health supports for children and adolescents; however, many do not have the training or expertise they need to address these mental health needs that youth will experience in the coming months and years.

Project ECHO connects health care and mental health specialists with general practitioners virtually to bridge health workforce gaps in rural communities and anywhere access is limited. This program brings best-practice health and mental health care to patients and students who can't get it where they live, using ongoing teleECHO clinics to equip practitioners with the knowledge they need to provide specialty care in their communities. Project ECHO is a proven, nationally-recognized model that moves knowledge, instead of people - providing practitioners in underserved areas with the expertise they need to treat patients with complex health problems and mental health issues.

CHHSA Working Group on Maximizing Federal Funding for Home Visiting. The Nurse Family Partnership (NFP) requests General Fund expenditure authority of $43,000 in 2021-22 and $75,000 in 2022-23 to support a workgroup in the California Health and Human Services Agency (CHHSA) to assess the feasibility for California's potential to streamline Medi-Cal funding to counties for home visiting services. According to NFP, maternal, infant, and early childhood home visiting is a service provided by counties, using different curricula and models, directly to families experiencing risk factors that can contribute to adverse experiences and health outcomes. Within the scope of services offered through different home visiting models, some are reimbursable through Medi-Cal, and the vast majority of families using home visiting services are enrolled in Medi-Cal.

States have authority to braid Medicaid funding with complementary federal funding streams authorized to finance home visiting services, including MIECHV, TANF, Title IV-E, maximizing those funds to help states extend home visiting to as many families as possible. Since Medicaid is typically the payer of last resort, clarity and uniformity about what services and activities delivered through home visiting are covered by Medicaid, and how to best integrate managed care-enrolled beneficiaries, will help counties maximize available funding.

As such, counties' ability to access uniform directions to consistently, equitably draw down Medi-Cal, including contracting with managed care plans to receive reimbursement for covered services offered in the home by home visitors, has been hard to achieve. CHHSA, which interacts with all state departments that administer home visiting, can provide some focus on assessing the feasibility for California's potential to streamline Medi-Cal funding to counties for these purposes.

DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal for All Income-Eligible Seniors Regardless of Immigration Status. The California Immigrant Policy Center (CIPC) and Health Access California request expenditure authority of $161 million ($128.4 million General Fund and $32.6 million federal funds) in 2022-23 and $350 million ($320 million General Fund and $30 million federal funds) annually thereafter to support expansion of Medi-Cal to all income-eligible seniors regardless of immigration status beginning July 1, 2022. According to CIPC and Health Access California, undocumented seniors continue to suffer and die without access to health care. These Californians, many who have been here for decades having raised families, paid taxes, and contributed to our society and economy, are excluded from basic health coverage in the years they are most likely to need it.

This coverage is even more urgent in a pandemic that has preyed upon this population, and that will have health after-effects long after the public health emergency. Undocumented immigrant seniors are one of the most vulnerable populations in this pandemic, disproportionately impacted by the pandemic due to age, income, language, and immigration status. Those seniors that are working are overrepresented in jobs deemed "essential" during the pandemic but are excluded from comprehensive health care coverage. Those who survive and benefit from the state's COVID-19 Uninsured Group coverage in Medi-Cal, despite the deterrent of questions on immigration status, will not be covered for the ongoing care and exacerbated comorbidities going forward. Furthermore, undocumented seniors who have gone decades without so much as a check-up may have myriad chronic conditions and need preventive care and treatment for all of their health issues, not just COVID-19.

In the same way Medi-Cal was extended to undocumented children in 2016 and young adults in 2020, this budget request would require DHCS to eliminate the immigration status eligibility requirement for Medi-Cal for all income-qualifying seniors ages 65 and older, making them eligible for full-scope, instead of restricted-scope, Medi-Cal. Undocumented seniors would be able to enroll in comprehensive health care coverage through Medi-Cal, which would allow them to see a health care provider, get needed prescription medications, and address all of their health care needs. This expansion would result in a reduction in California's uninsured rate, both generally and specifically among undocumented seniors; reduction in years of life lost due to illness among undocumented adults; and a reduction in economic hardship indicators among immigrant families, including debt, unpaid or delayed rent, utilities, and other bills, or evictions.

Eliminate the Medi-Cal Assets Test. Western Center on Law and Poverty (WCLP) and Justice in Aging request expenditure authority of $110.1 million ($52.9 million General Fund and $57.2 million federal funds) in 2021-22 and $219.6 million ($105.4 million General Fund and $114.1 million federal funds) annually thereafter to eliminate the assets test for Medi-Cal eligibility determinations for seniors and persons with disabilities, effective January 1, 2022. According to WCLP and Justice in Aging, low income seniors and persons with disabilities are forced to choose between savings and health coverage leading them to go without coverage or get rid of savings that can be used as a safety net. The asset test portion of the Medi-Cal program is a barrier to enrollment and remaining on the program without breaks in coverage due to the requirement to document assets every year, even when income has not changed. In addition, the assets test perpetuates racial inequality by: 1) privileging homeownership despite the barriers to homeownership that communities of color in California have faced due to racist housing and banking policies, and 2) prevents the intergenerational transfer of wealth thus perpetuating poverty among its recipients. No other health program in California requires the divesting of assets prior to enrollment and the majority of Medi-Cal enrollees are not subject to this test. Applying the assets test to only Medi-Cal applicants and recipients who are over age 65 or disabled perpetuates inequity among populations that already have barriers to generating income. The assets test requires county workers to spend considerable time verifying assets rather than helping people who need their services and requires the state to spend roughly $4 million ($2 million General Fund and $2 million federal funds) annually for an asset verification program that seeks to find unreported assets of beneficiaries.

This request would provide funding and statutory changes to exclude the consideration of assets in determining eligibility for Medi-Cal for those whose eligibility is determined under the non-MAGI rules. The state may then modify its Medicaid state plan using the available flexibility allowed as described in guidance from the federal Centers for Medicare and Medicaid Services. As a result of this change, more low-income seniors and persons with disabilities would have access to Medi-Cal, low-income seniors and persons with disabilities on Medi-Cal would be allowed to save more, and more low-income seniors and persons with disabilities would stay enrolled on the Medi-Cal program which would increase stability in their health care.

Medi-Cal LTSS Data Transparency. The California Collaborative for Long-Term Services and Supports (CCLTSS) requests General Fund expenditure authority of $250,000 in 2021-22 to incorporate certain data elements regarding long-term services and supports (LTSS) into its managed care plan contracts. According to CCLTSS, at the federal level, the Medicaid and Medicare programs operate independently and under different funding streams. At the state level, this fragmentation often prevents individuals eligible for both programs from accessing the full range of health and long-term services and supports (LTSS). There is little data sharing and coordinated policy development focused on the needs, priorities, and experiences of individuals and their circles of support. This results in the inability to identify, plan, and effectively deliver services to Californians who need LTSS. A truly person-centered care system relies on coordination of all services- including physical health, oral health, mental health, cognitive health and LTSS—alongside and on behalf of the person.

As the state is in the process of Medi-Cal Managed Care Plan (MCP) re-procurement, CCLTSS requests the state to incorporate the following elements into the new contracts:

1. *Community Based Organizations:* DHCS would require demonstrated and measurable engagement and contracts with community-based organizations. These elements should be included in all program and benefit designs for new or amended initiatives impacting LTSS for older adults and people with disabilities administered by MCPs.
2. *MLTSS Data:* DHCS would build into its MCP contracts starting on January 1, 2022 that cover Managed LTSS (MLTSS) a requirement to provide publicly-reported quarterly data in a standardized format on access to and utilization of MLTSS, including: 1) MLTSS data that is already being reported by MCPs but not currently made publicly available on a quarterly basis; 2) disaggregated quarterly data provided by MCPs by race, ethnicity, and language spoken whenever possible; 3) disaggregated data on dual eligible enrolled in integrated systems, traditional Medicare and a Medi-Cal plan, or a non-matching Medicare Advantage plan and Medi-Cal plan, and seniors and persons with disabilities receiving MLTSS.

   DHCS would work with MCPs and stakeholders to identify to identify if the following information can be publicly reported, in a standardized format, and by the identified populations: 1) access and referrals to LTSS and non-acute medical services, such as behavioral health and dental services; 2) aggregate results of the MLTSS questions completed during the Health Risk Assessment (HRA) and the number of referrals to specialty care or social services that resulted from the information obtained in the HRA process, including data specifically on non-dual SPDs and duals not enrolled in an integrated Medicare product.
   DHCS would also work with stakeholders to determine which data elements are currently available for public reporting that would provide a more accurate beneficiary profile including data on informal caregiving, specific diagnosis, and additional demographic data. This process will help identify data gaps to inform the Department as it develops reporting requirements and additional public transparency under CalAIM and the commercial MCP re-procurement process.

Quality Incentive Pool (QIP) Transition Bridge Loan for District and Municipal Hospitals. The District Hospital Leadership Forum (DHLF) requests General Fund expenditure authority of $40 million in 2021-22 and 2022-23 to make two bridge loans to the 34 district and municipal hospitals to aid in the transition from the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, a quality improvement program under the state's expiring 1115 waiver, to the Quality Incentive Pool (QIP) program. According to DHLF, the funding and similar incentive programs embodied in PRIME are transitioning to a component of Medi-Cal managed care, the Quality Incentive Pool (QIP). This transition includes a move to directed payments versus the recent PRIME fee-for-service approach. QIP, like PRIME, requires an investment on behalf of the participating hospitals. District and municipal hospitals have and continue to invest in meeting the goals of the program by hiring staff, investing in data systems and analyses, in some cases, implementing new innovative programs, and potentially putting in place partnerships with community providers to ensure the goals are met. The incentive payments have allowed hospitals to make these investments to improve the care provided to their communities and for individual patients, while reducing costs.

In PRIME, eligible hospitals provided a report to DHCS twice a year. Once the report was determined to be complete, the IGT was requested and the federal funds then obtained and distributed to the hospitals. The report was due 90 days after the end of the reporting period (September and March). The DHCS review was approximately 30 days and the IGT and federal matching process usually took another 60 days (as a maximum). Therefore, the hospitals had funding well within 90 days. Unfortunately, the new

approach of transitioning to directed payments takes significantly more time after the end of the reporting period which, especially now, will be a significant hardship on district and municipal hospitals by delaying cash flow, especially as these hospitals struggle to meet the needs of patients with COVID. For the program year 2021, instead of receiving funding in approximately November 2021 and May 2022, the funding will not be available until the summer of 2023.

This budget request would require DHCS to make two bridge loans to these 34 hospitals. The first loan would occur in approximately the 3rd quarter of CY 2021 and the second in the 2nd or 3rd quarter of CY 2022. Repayment would be done via Medi-Cal fee-for-service recoupments beginning in late 2023 and would be done in several installments.

Caregiver Resource Centers Infrastructure Funding Extension. The Association of California Caregiver Resource Centers (CRC) requests General Fund expenditure authority of $12 million annually in 2021-22, 2022-23, and 2023-24 to continue infrastructure support and to build an Equity and Inclusion Core within the CRC system. The 2019 Budget Act included General Fund expenditure authority of $10 million for three years to expand technology systems and service delivery to caregiver resource centers, which provide support to family caregivers of adults needing assistance to allow them to remain in the community. This request would extend and increase the appropriation for the next three years (2021-22 to 2023-24) with additional funding ($2M/year) to be targeted to building an Equity and Inclusion Core within the system that provides: 1) additional bi-cultural, bi-lingual staff for CRCs with highly diverse populations; 2) direct assistance for those CRCs that may need bi-lingual, bi-cultural staff on an intermittent basis; and 3) training all CRC staff in best practices for creating a culture of equity and inclusion, with input from relevant state and national organizations.

Drug Medi-Cal Flexibility to Prevent Overdose and Support Public Health. The California Opioid Maintenance Providers (COMP) request expenditure authority of $9.2 million ($2.8 million General Fund and $6.4 million federal funds) annually and trailer bill language to grant authority to DHCS to evaluate and implement changes to the Narcotic Treatment Program (NTP), including allowing new drug and disease testing. According to COMP, under current statute DHCS is unable to reimburse NTPs for new regulatory requirements that the department determines to be essential for overdose (OD) prevention and public health. For example, despite the surge of fentanyl ODs across the state, DHCS cannot reimburse NTPs for fentanyl testing which would result in better treatment and fewer ODs. In addition, providing HIV and hepatitis C (HCV) testing is an important public health initiative. CDPH, in a presentation to NTPs, indicated that drug treatment programs offer an ideal opportunity for HCV testing and treatment. The trailer bill language would authorize DHCS to consider these changes, while the expenditure authority would cover the costs of providing these services.

Field Testing of Translated Medi-Cal Materials and Equity Dashboard. The California Pan-Ethnic Health Network (CPEHN) and the Western Center on Law and Poverty (WCLP) request General Fund expenditure authority of $1 million in 2021-22 and $30,000 annually thereafter to field test translations of Medi-Cal materials and collect additional demographic data as part of the Equity Dashboard.

According to CPEHN and WCLP, strengthening language assistance services is particularly critical in the Medi-Cal program where at least one in three Medi-Cal beneficiaries speaks a language other than English as their primary language. Such individuals are more likely to have low reading literacy or low health literacy in comparison to their English-speaking counterparts. Translated materials are also not always

culturally sensitive to the diverse Medi-Cal population. These issues limit an individual's ability to communicate effectively with their healthcare provider and access their benefits. Therefore, using language that is plain, simple, and culturally appropriate in Medi-Cal documents will significantly increase healthcare access for all Medi-Cal beneficiaries.

When translations are not field tested, they may not be understood by the intended audience. This results in translated plan materials that simply are not accessible. Such review of documents is not unprecedented. Some Medi-Cal managed care plans have already undergone more extensive community reviews of some of their materials. Covered California included community review in its most recent translation contract. DHCS' Medi-Cal Managed Care policy division has strongly encouraged plans to conduct field testing of translated forms and materials since at least 1999, but it is still not a requirement. Additionally, the Department has at times sought input from volunteers within the consumer advocacy network to review translated materials, though advocates often do not have enough resources, lead time or internal capacity to adequately field test. There have been several years of attempted legislation on the issue and extensive input by the community into CHHS' listening sessions. The state likely has the data and information it needs to move forward.

CPEHN and WCLP also request that the Administration's budget proposal to create an Equity Dashboard also upgrade the Medi-Cal Eligibility Data System (MEDS) to allow for the collection and reporting of data on disability status and more granular demographic data on age, race, ethnicity, language, sexual orientation, gender identity and disability status by DHCS and Medi-Cal managed care plans using the federal 2015 Office of National Coordinator (ONC) for HIT standards for electronic health records. The 2015 ONC standards also include data on behavioral and social risk factors which includes but is not limited to data on behavioral health conditions, ACES, domestic violence, access to housing or nutrition supports. Collection and reporting of this data will allow DHCS to set year-over-year targets for quality improvement and disparities reduction in Medi-Cal managed care and provide greater oversight of managed care plans under the new Population Health Management requirements in Cal-AIM.

COVID-19 Reimbursement Rate Extension for Pediatric Subacute Facilities. Totally Kids Specialty Healthcare – Sun Valley requests General Fund expenditure authority of $1 million to extend the ten percent reimbursement rate increase implemented during the COVID-19 pandemic for free-standing pediatric subacute facilities through the 2021-22 fiscal year. According to Totally Kids, stand-alone pediatric subacute facilities care for children who are dependent on medical technology for their survival. These facilities help medically fragile children in California stay alive, and be as healthy as they can as they live with difficult medical conditions. This unique model of care allows facilities to provide necessary medical care to young patients in an extremely cost-effective way. However, for the last several years, operational viability has eroded with the freezing of state reimbursement rates over a decade ago. In the last few years, the state has helped temporarily shore up facility budgets with annual supplemental funding. The daily rate for subacute pediatric services remained unchanged for 11 years until the Legislature included these services in the Proposition 56 tobacco tax fund in the 2020-21 budget. This support has been instrumental in averting a financial crisis among Free-Standing Pediatric Subacute facilities. Now, of course, COVID-19 has emerged to worsen facilities' already precarious fiscal situation.

The supplemental funding that has allowed us to continue to operate is vital to support the care facilities provide. Along with the current Proposition 56 supplemental payments, Totally Kids is requesting the COVID-19 ten percent increase be maintained thru the 2021-22 fiscal year, with a state General Fund cost

of $1 million. The state will be dealing with the impacts of COVID 19 for years to come and allowing facilities to maintain the rate as it is now will help in providing appropriate care to the children these facilities serve. As DHCS expects to move this facility model into Medi-Cal managed care in 2023, this rate will help facilities go into that changed environment as fiscally sound as possible.

COVID-19 Reimbursement Rate Extension for ICF-DDs. The Developmental Services Network (DSN) requests expenditure authority of $18.6 million ($9.3 million General Fund and $9.3 million federal funds) to extend for six months the ten percent reimbursement rate increase implemented during the COVID-19 pandemic for intermediate care facilities for individuals with developmental disabilities (ICF-DDs). According to DSN, the COVID-19 ten percent rate increase for long-term care services, including for small ICF-DDs, currently expires as of December 31, 2021. This is the estimated date the Governor's January Budget assumes the public health emergency will end. A six month extension of the ten percent adjustment through June 30, 2022, is urgently needed in order to stabilize residential services and to continue to offer and provide specialized medical and habilitative services for ICF-DD residents. Without continuing the adjustment through the entire fiscal year, many ICF-DDs likely face the risk of closure due to a fiscal cliff and other financial stress, including increased costs due to staffing and compensation challenges, supplies and food expenditures, facility expenditures, communication costs for virtual services, and resident vacancies.

CalAIM Workgroup on ICF-DD Transition to Managed Care. DSN requests budget bill language to require DHCS and DDS to convene a workgroup to address governance, procedures and processes pertaining to the transition of ICF-DDs from the fee-for-service to the Medi-Cal managed care delivery system under the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. According to DSN, the CalAIM proposal would transition ICF-DDs located in residential neighborhoods, to be under the auspices of Medi-Cal managed care plans. DSN reports that, despite letters and brief telephone calls, there has never been full engagement on ICF-DD issues by the Administration.

The CalAIM change does not only affect Medi-Cal reimbursement, but it also creates questions within the underlying governance structure related to the DDS and the Regional Center system. ICF-DDs must meet DDS and Regional Center program requirements, including staffing hours, types of services to be offered, required staff education and training requirements and other aspects. Further, DDS requires potential ICF-DDs to complete a comprehensive DDS application package, and to work with Regional Centers in the geographic area to determine resource needs, prior to a potential ICF-DD proceeding with development.

In addition to DDS administration, ICF-DDs are also licensed and certified by DPH. The Medi-Cal program provides ICF-DDs reimbursement but is otherwise not engaged in the governance structure of this programmatic area. Any broad movement into Medi-Cal managed care requires a clear and direct process, as well as technical assistance from DHCS and DDS in order for any aspect of this proposal to have real success. Currently, only a small component of ICF-DDs presently contract with Medi-Cal managed care.

Enactment of this budget bill language would offer an opportunity to engage the Administration, Regional Centers, managed care plans, other advocates and ICF-DDs in a joint discussion through a time-limited workgroup to unpack and address the various issues at hand. Engagement on issues is necessary in order to have a smooth and constructive transition.

Expand Access to STD Services Through Family PACT. The End the Epidemics coalition requests annual General Fund expenditure authority of $7 million to expand access to sexually transmitted disease (STD) services covered by the Family Planning, Access, Care, and Treatment (Family PACT) program. Of this amount, $5 million would support direct services to newly eligible beneficiaries, and $2 million would support necessary administrative program changes. According to the coalition, California currently does not have a state-funded episodic coverage program for STD testing or treatment. The state's family planning program, Family PACT, covers STD prevention, counseling, testing and treatment for low-income and uninsured people, but only within the context of a family planning visit. Uninsured LGBT individuals that don't have family-planning needs lack coverage options for STD services and must pay out of pocket or forgo treatment. The groups most negatively impacted by this structural inequity are young-adult LGBT Californians of color, and men who have sex with men – many have reported being turned away or asked to pay for STD testing and treatment because they were not eligible for Family PACT services because they did not need contraception.

Although the STD public health crisis is affecting communities across the state, California youth, Black, Indigenous and people of color, and gay, bisexual, and transgender people are disproportionately impacted. Statewide data indicate over half of all STDs in the state are experienced among California youth ages 15 to 24 years old. Currently, African Americans are 500 percent more likely to contract gonorrhea and chlamydia than their white counterparts. These disparities are expected to worsen during the COVID-19 pandemic. Studies conducted by the CDC suggest a range of factors linked to social determinants of health likely contribute to STD rate disparities, including inequitable access to safe, culturally competent, quality health, mental health and substance use treatment services, as well as high rates of incarceration, lack of access to economic mobility and education opportunities, adequate housing, racial segregation, and racism.

The proposed funding will support the expansion of access to STD services for low-income and uninsured LGBT patients through the Family PACT program to address rising STD rates and improve health outcomes. The program already has a network of more than 2,200 culturally competent providers well-trained to deliver STD services. Expanding the eligibility for STD services under Family PACT provides a more feasible, cost-effective and equitable pathway to STD coverage than creating separate episodic program.

The Office of Family Planning (OFP) collects data on the number of patients enrolled in Family PACT and the services received. If Family PACT eligibility is expanded to cover STD services for people with non-family planning needs, the data for this population will be captured by OFP and could be used to evaluate the program's success in reducing STD rates. The California STD Control Branch estimates that there are approximately 13,000 men who have sex with men that are also uninsured and who fall within the Family PACT program's income eligibility requirements.

Start-Up Funds for Medi-Cal Peer Support Specialist Certification. The California Association of Mental Health Peer Run Organizations, the County Behavioral Health Directors Association, the County of Los Angeles, and the Steinberg Institute request expenditure authority of $9.4 million ($4.7 million General Fund and $4.7 million federal funds) to support initial implementation of the Peer Support Specialist (PSS) Certification Program, pursuant to SB 803 (Beall), Chapter 150, Statutes of 2020. According to these organizations, these start-up funds would help California become the 49th state in the nation to include a PSS as a Medi-Cal billable provider and to add peer support services as Medi-Cal

reimbursable services. California does include limited peer services in counties that opt to implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) but does not maximize the integration of these services and peer providers. This lack of a distinct peer support services leads to a failure of maximizing federal funding for the state's public behavioral health system. Further the lack of a distinct peer support service results in confusion of who is a provider operating in a PSS role, which requires self-disclosure of a mental health or substance use condition, and a peer who has choice as to whether or not to disclose. It is the activity of self-disclosure in an evidence-based manner that yields outcomes for Peer Support Specialists.

Certifying PSS to provide peer support services in Medi-Cal is more important than ever with the COVID-19 pandemic and subsequent economic downturn wreaking havoc on the mental health of all Californians. Nearly 11 percent of American adults seriously considered suicide this June, according to CDC data. The June CDC data showed 30.9 percent of survey participants reported symptoms of an anxiety or a depressive disorder, 25.3 percent reported a traumatic or stressor-related disorder (TSRD), and 13.3 percent said they were using substances to cope with the pandemic's stressors. The CDC data exemplifies the need for an urgent response to the growing behavioral health crisis.

The sharp rise in behavioral health disorders triggered by COVID-19 is likely to linger long after the end of the pandemic itself, thus highlighting the need for an effective, comprehensive, and economically viable behavioral health care response. SB 803 is a critical component of that response. Peer Support Specialists have gone through crisis, learned resiliency tools to gain their own behavioral health wellbeing, and are trained to assist others in navigating and surviving crises. The ability of peers to connect with those in need and exemplify the path to wellness is vital in the aftermath of the pandemic.

PACE Awareness in CalAIM. CalPACE requests trailer bill language to ensure individuals potentially eligible for a Program for All-Inclusive Care for the Elderly (PACE) are aware that PACE is an option and have an opportunity to be assessed and enroll before being enrolled in a managed care plan under the managed care transition included in the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. According to CalPACE, PACE has operated as a Medi-Cal benefit since 2003 as a capitated, comprehensive care program for adults and seniors over age 55 with higher needs who qualify for nursing home placement but who wish to remain in the community. Medi-Cal beneficiaries enroll in PACE in lieu of receiving Medi-Cal services on a fee-for-service basis or through a managed care plan.

PACE organizations currently serve over 10,000 participants through 50 PACE Centers and Alternative Care Sites in 15 counties, including Alameda, Contra Costa, Fresno, Humboldt, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, and Stanislaus. PACE is expected to expand to several additional counties by 2021. Enrollment if PACE is voluntary on the part of beneficiaries.

Even though PACE is a model of care for frail seniors, many beneficiaries are unaware of PACE and how it may benefit them. The bulk of enrollment occurs through individual referrals from community sources including hospital discharge planning, senior housing, AAAs and other sources. As a result, many seniors with higher needs who could benefit from PACE are not aware of it.

As the state transitions to CalAIM and Medi-Cal managed care statewide, it is crucial that potential PACE eligible participants are aware of PACE as an option and have an opportunity to be assessed and enroll

before being enrolled in a managed care plan. This proposed CalAIM trailer bill language recognizes PACE as an option but the language does not require any type of referral or assessment.

PACE Flexibilities. CalPACE requests trailer bill language to make permanent the regulatory flexibilities provided to PACE organizations during the COVID-19 public health emergency that have allowed PACE organizations to safely care for and provide services to the frail seniors that PACE organizations serve. According to CalPACE, during the COVID-19 health emergency PACE organizations have modified the ways in which they deliver care to their participants in order to keep their participants safe. PACE organizations have successfully responded to the public health emergency by implementing rigorous infection control measures and quickly transitioning from providing center focused care to home based care. These modifications have been carried out with the approval of the CA Department of Health Care Services (DHCS) and federal Centers for Medicare and Medicaid Services (CMS). These modifications have enabled PACE to achieve significantly better health outcomes for PACE participants during the COVID-19 health emergency than comparable nursing home populations.

These flexibilities have included more extensive use of telehealth for participant assessments, monitoring and communication; deployment of PACE center nurses into participants' homes; and allowing referrals from hospital and nursing home discharge planners. The statutory changes proposed by the amendments would allow these flexibilities to continue beyond the end of the health emergency. The amendments would direct DHCS to make permanent PACE regulatory flexibilities pertaining to:

(1) Telehealth
(2) PACE enrollment agreements
(3) Adult Day Health Care (ADHC) services provided in the home
(4) Involuntary disenrollment – Out of Service Area
(5) Facility beds
(6) Marketing
(7) Marketing exams

The amendments also would direct DHCS to work with CMS to achieve waivers from the federal government where necessary.

Medi-Cal Reimbursement for Personal Protective Equipment. The California Dental Association (CDA) requests expenditure authority of $80 million ($40 million General Fund and $40 million federal funds) to provide reimbursement for Medi-Cal dental providers for pandemic-related costs of new, mandatory, medically necessary infection control. According to CDA, at the beginning of the COVID-19 pandemic, approximately 97 percent of dental offices completely closed or were only seeing emergency patients from March through May 2020. Since dental practices reopened, they have continued to have significantly increased overhead costs, combined with decreased patient volume due to COVID-19 safety guidelines and lingering public hesitation around receiving health care treatment. The high cost of personal protective equipment (PPE) is exacerbated by ongoing product scarcity and supply chain disruptions.

Dentists and dental team members have some of the highest risk of workplace exposure to airborne pathogens, especially COVID-19. These providers are in extremely close proximity every day to patients and the procedures that typically generate aerosols — which can spread COVID-19 more readily. The need for PPE in this current pandemic is especially critical — and incredibly costly to secure.

With the increased economic burden of safely operating in the current circumstances, there is a risk of providers being unable to reopen at full capacity due to unfunded costs, which could mean patients losing access to care and a constriction of the Medi-Cal dental network. Dental practices have been able to reopen and safely treat patients in this new environment, but only by implementing extensive new infection control methods and procedures. This includes changes to patient flow, addition of barriers within offices to prevent the spread of aerosols, purchase of air filtration systems and the expanded use of PPE, including N95 masks, face shields, surgical gowns and shoe coverings.

Despite the state's investment in the Medi-Cal dental program over the past several years, these dental practices cannot afford the additional overhead costs associated with the increased PPE necessary to provide care during the current public health emergency. The additional costs of treating patients during the ongoing pandemic might be the issue that tips the needle on significant improvements in the program and forces providers out of the Medi-Cal program after years of improvements. Providing PPE reimbursements to Medi-Cal dental providers would help ease the financial burden of safely providing treatment during the COVID-19 pandemic. Medi-Cal dental providers cannot raise their rates or pass along PPE surcharges or costs to Medi-Cal beneficiaries. The reimbursement would provide incentive for dentists to stay in the Medi-Cal Dental program.

Extension of Behavioral Health Pilot Project. The California Hospital Association (CHA) requests General Fund expenditure authority of $40 million, available for encumbrance or expenditure until June 30, 2024, to continue the Behavioral Health Pilot Project (BHPP), which provides funding for behavioral health counselors in emergency departments. According to CHA, over 200 hospitals currently participate in the BHPP, which has allowed them to hire a behavioral health provider or peer navigator for the emergency department to screen patients and offer intervention and referral to mental health or substance use disorder programs. An additional $40 million allocation would allow these positions to continue for the next two to three years.

Increased Medi-Cal Reimbursement for Orthotic and Prosthetic Providers. The California Orthotic and Prosthetic Association (COPA) requests expenditure authority of $9 million ($4.5 million General Fund and $4.5 million federal funds) to increase Medi-Cal reimbursement for providers of orthotics and prosthetics. According to COPA, Existing law authorizes the Medi-Cal Program to reimburse prosthetic and orthotic appliances at a rate that may not exceed 80 percent of the lowest maximum allowance for California established by Medicare for the same or similar services. These appliances are prescribed by an appropriately licensed practitioner to meet the medical equipment needs of Medi-Cal enrollees. The services for these appliances shall only be performed by an appropriately licensed practitioner or an orthotist and prosthetist nationally certified by either the Board for Orthotist Certification or the American Board of Certification in Orthotics and Prosthetics. Medi-Cal reimbursement for these appliances is fixed at a depreciating rate that does not keep pace with Medicare over time. On average, Medi-Cal currently reimburses at 51 percent of the prevailing Medicare allowable, which is unsustainable resulting in decreased access to care for people with limb loss or muscle weaknesses. This budget request would simply require that reimbursement for these appliances be set at 80 percent of the Medicare allowable rate as existing law is ambiguous and allows Medi-Cal to reimburse providers well below the actual cost of providing this medically necessary care.

Ensure Healthcare Access for Homeless Adults in California's Safety Net Hospitals. Private Essential Access Community Hospitals (PEACH) requests expenditure authority of $120 million ($50 million General Fund and $70 million federal funds) to implement a socioeconomic status (SES) adjustment factor for reimbursement of claims paid to safety net hospitals that provide care for Medi-Cal beneficiaries. According to PEACH, SES is a term sued by sociologists, economists, and other social scientists to describe the class standing of an individual or group. It is measured by la number of factors, including income, occupation and place of residence. Homelessness is a major contributor to the SES of individuals. While the number of homeless individuals is growing, the Medi-Cal program has not adjusted for the complexities that accompany this population. The 2018 data from the Office of Statewide Health Planning and Development (OSHPD) shows that – at a minimum – there were nearly 100,000 inpatient discharges of homeless adults. The preponderance of those discharges – more than 50 percent - were treated in California's safety net hospitals (those federally qualified as disproportional share hospitals – DSH). That's over half the adult homeless population treated in less than one-fourth of the hospitals. Research concludes that reimbursement mechanisms that fail to recognize the severity of SES impose a greater and disproportionate burden/penalties for safety net hospitals (Joynt, MD, MPH, Karen E.; Jha, MD, MPH, Ashish K. Characteristics of Hospitals Receiving Penalties Under the Hospital Readmissions Reduction Program, 2013. JAMA 2013:309(4): 342-343). Additionally, further research demonstrated that unadjusted reimbursement mechanisms may exacerbate disparities in care and that special attention should be devoted to safety net hospitals that are in a unique financial position and provide a disproportionate share of care to SES vulnerable adults. (Hoehn, MC, Richard S; Wima, MS, Koffi; Vestal, MHA, Matthew A. et. al. Effect of Hospital Safety Net Burden on Cost and Outcomes After Surgery, JAMA. 2016;151(2): 120-128).

The Medi-Cal fee-for-service reimbursement mechanism is a risk-based/incentive payment methodology (APR-DRG) that starts with a base rate for every discharge – the same rate for all hospitals. The base rate is then adjusted for area wage costs and medical severity. The higher the severity of illness, the higher the corresponding payment. The APR-DRG places risk on the hospital to provide efficient care and creates an incentive to keep the hospital stay only as long as is necessary to provide the appropriate level of care given the medical severity. Hospitals that cannot provide care effectively and efficiently within the standard length of stay are penalized because the level of reimbursement does not increase just because the patient is in the hospital longer. A recent study of SES impact on hospital length of stay (LOS) showed that for patients in the highest quintile of social deprivation had a mean LOS 1.1 to 1.8 days longer than those in the lowest quintile. Patients in the highest quintiles of both social and material deprivation have a mean LOS 1.8 to 3.5 days longer than those in the lowest quintile. This same study concluded that SES should be taken into account in hospital resource allocations to avoid unfairly penalizing hospitals that provide the majority of SES deprived individuals (Moore, Lynne; Cisse, Brahim, et. al.; Impact of Socio-economic Status on Hospital Length of Stay. 2015. BMC Health Serv Res. PMCID: PMC4513757).

The Medi-Cal APR-DRG formula fails to account for the social complexity of vulnerable SES patients, such as homeless adults, resulting in a payment penalty incurred from treating patients that result in higher unaccounted for costs. Further, the Medi-Cal base rate for the APR-DRG has not increased in 8 years, since the implementation of the risk-based methodology in 2013. To preserve access for the SES vulnerable homeless adult population and to mitigate, in part, the financial disparities to safety net hospitals that care for this population, the Legislature should consider an investment of $50 million General Fund ($120 million total funds) by directing the Department of Health Care Services to implement

a SES adjustment factor to the APR-DRG formula on all claims paid to safety net hospitals that provide care for the Medi-Cal adults.

Medi-Cal Coverage for 12 Months Postpartum and Children Zero to Five. A coalition of organizations including the American College of Obstetricians and Gynecologists (ACOG), the First 5 Center for Children's Policy, the March of Dimes, the Children's Partnership (TCP), Maternal Child Health Access (MCHA), and the First 5 Association of California, request expenditure authority of $110 million ($55 million General Fund and $55 million federal funds) in 2022-23 and $220 million ($110 million General Fund and $110 million federal funds) annually thereafter to extend pregnancy-only Medi-Cal coverage from 60 days postpartum to 12 months, and to extend continuous coverage for all children up to age five
. According to the coalition, under current federal and state law, those eligible for Medi-Cal because they are pregnant become ineligible for coverage on the last day of the month in which the 60th day following the end of pregnancy occurs. A recent state exception allows those postpartum beneficiaries with a mental health condition, to continue Medi-Cal coverage for 12 months postpartum. (The Governor's budget proposes continuing this 12-month coverage until December 2022.) While the remaining postpartum women may successfully transition to Covered California at this time, many cannot afford their share of the premiums or out-of-pocket costs and are left in the untenable position of being uninsured shortly after a major medical event. Those who can manage the costs will lose important continuity of care when their Medi-Cal providers do not participate in the Covered California network that is available in their area.

There are major risks to becoming uninsured shortly after experiencing pregnancy. For example, one in seven women experience symptoms of postpartum depression in the year after giving birth, and evidence suggests women with substance use disorder are more likely to experience relapse and overdose seven to 12 months postpartum. A study of maternal suicide in California found the majority of women (83 percent) died in the late postpartum period, 43 to 365 days following the end of pregnancy: 36 percent died between 43 days and 6 months and 47 percent died more than 6 months postpartum. Among other findings, approximately 85 percent of women had one or more psychosocial stressors documented near the time of death (e.g., interpersonal conflict with partner, financial hardship, and exposure to violence as a child or adult); screening and referral through Medi-Cal's Comprehensive Perinatal Services Program (CPSP) is intended to address such factors. 51 percent of these maternal suicide cases had a good to strong chance of preventability with missed opportunities to intervene—opportunities that are far more likely to be missed when the woman is dropped from Medi-Cal shortly after the end of a pregnancy.

Young children are also particularly vulnerable to the effects of gaps in coverage. In the first years of life, when 90 percent of brain development occurs, frequently scheduled well child care including visits, screenings and vaccinations are critical to ensure a healthy start. In 2000, California adopted the federal option to provide 12-months of continuous eligibility in Medicaid for children, which includes infants for their first year of life and then annual renewals thereafter. Despite this policy, coverage gaps occur, particularly after annual renewals. Such disruptions in coverage for young children are especially problematic in the first year of a child's life when children require frequent contact with the health care system.

Under the current national COVID Public Health Emergency (PHE), all Medi-Cal enrollees have temporary continuous enrollment through at least January 16, 2022. In 2021-2022, California will be required to develop a plan to unwind the federal PHE flexibilities and coverage protections for when the

PHE ends. Unless this "unwinding" plan includes these proposed policies, undoing the existing PHE continued coverage would cause major disruptions in care for postpartum women and children ages 0-5 currently enrolled in Medi-Cal. Without careful staging, the post pandemic redetermination process can result in unnecessary gaps in coverage and disorder for all Medi-Cal beneficiaries.

Cycling on and off health insurance coverage—or churning—is disruptive to continuity of health care, and is especially problematic postpartum and in early childhood when frequent contact with health care is necessary. In addition, churn disrupts a family's relationship with a pediatric health care home and postpartum care, which are important--and often the sole--sources of consistent support for families, particularly before children enter school.

Telephonic Attestation for Medi-Cal. The Western Center on Law and Poverty (WCLP) requests trailer bill language to permit federally allowable flexibility in the acceptance of telephonic or electronic self-attestation of eligibility requirements for Medi-Cal. According to WCLP, due to the pandemic, DHCS has relaxed the self-attestation requirements for situations where documentation is unavailable to someone applying for Medi-Cal. Federal law allows for self-attestation in many circumstances, save for citizenship/immigration status (though extra time is given to produce documentation) and social security numbers when they are required. DHCS guidance prior to the pandemic permits counties to accept attestation over the phone in many circumstances, but not when requiring penalty of perjury language in the attestation. This language is required most often for income discrepancies or when income documentation is unavailable. These flexibilities will expire when the public health emergency is declared over. At the same time, county workers will likely be busy with backlog of redeterminations and increased applications as the economic fallout will likely trail the pandemic for some time.

Since state and federal law already lays out when self-attestation is permitted, these amendments only aim to ensure that when it is used, the state can move away from paper to streamline the process. Federal law already requires electronic databases to be checked first for income – this proposal would not change that. DHCS would also be free to make changes as to how telephonic or electronic attestation is accepted by a county worker as needed (or as required by CMS, the federal Medicaid agency), including following the telephonic attestation procedures that already exist any time self-attestation is permitted.

These changes would make sure there is a way in all counties for people to self-attest electronically or over the phone whenever self-attestation is permitted. This would also serve as a bit of a stopgap on the application side as DHCS is working on a new procedure for accelerated enrollment that would allow for enrollment while income verification is pending, which DHCS indicates will take some time to program in on the county computer systems SAWS side. Counties have already been doing this during the pandemic, so there would likely not be implementation challenges and this would also make it easier for county workers to complete the renewals that will have to happen when the public health emergency is lifted but the emergency procedures are no longer in effect. DHCS would be required to modify its MAGI verification plan (delete the word "paper" from "paper documentation") with CMS and potentially its state plan.

Medically Tailored Meals Pilot Extension. The California Food is Medicine Coalition requests General Fund expenditure authority of $9.3 million annually to continue support for a pilot project that provides medically tailored meals to Medi-Cal beneficiaries. According to the coalition, food and nutrition insecurity – the inability to access enough high quality, nutritious foods – is a root cause of poor health

outcomes, and contributes to several chronic illnesses, costing the state more than $7.2 billion annually. 86 percent of healthcare spending nationally is for patients with at least one chronic disease condition, many of which are linked to inadequate nutrition. In California, $98 billion is spent annually on treating chronic conditions, which is 42 percent of all healthcare costs in the state. Of the chronic disease conditions, chronic vascular disease (including congestive heart failure, chronic heart disease, and stroke) is associated with the greatest expense, accounting for $37 billion annually, or 16 percent of all health care costs in California, followed by cancer at $13.9 billion, and diabetes at $12.9 billion. People of color and older adults are disproportionately impacted by these diseases in the state. COVID-19 impacts have greatly exacerbated health challenges, and have impeded the access to nutritious food, for medically-fragile people who have chronic illnesses and need to shelter at home.

Medically tailored meal (MTM) programs, which include home delivery of nutritious meals recommended by registered nutrition experts and nutrition education by registered dietitians, have proven to reduce health care costs and improve health outcomes of these vulnerable people. MTM providers in the California Food Is Medicine Coalition members are non-profit organizations in the state that have capacities to serve over 3.3 million medically tailored meals annually, if funding is assured. They have experienced a more than 50 percent increase in meal deliveries and clients, to people whose needs are not met by other programs. The need for MTMs is expected to continue growing, for low-income people who require nutrition support for their health, and their needs are not met by other program. However, MTM providers have projected funding gaps, and require consistent state support to content to meet these needs.

This request for $9.3 million is for implementation and direct service of MTM programs, to cover:
a) Costs of food/meals and materials for food preparation and packaging;
b) Staff time for food preparation, deliveries, and nutrition education;
c) Other essential operational costs, such as food safety measures and fuel for meal delivery.

The funding would be administered through the Department of Health Care Services, and contracted to one of the coalition agencies. The funding would be subcontracted to the member agencies, according to numbers of meals delivered monthly and the funding gaps in budgets for each agency, in order to provide direct services and meet increased demand by clients/patients whose costs are not covered by other funding sources. The CA Food is Medicine Coalition will continue to coordinate the program and oversee quality standards, data sharing systems, financial teams, and other systems and capacities to ensure smooth and effective implementation, service and accountability.

Clinical Laboratory Reimbursement Methodology. The California Clinical Laboratory Association (CCLA) requests trailer bill language and General Fund expenditure authority of $40 million in 2021-22 to remove the cap on Medi-Cal reimbursement for clinical laboratories, forgive retroactive recoupment of reimbursement reductions, and delay other reductions until 2022. According to CCLA, AB 1494 (Committee on Budget), Chapter 28, Statutes of 2012, called for the creation of a new methodology for the determination of Medi-Cal fee-for-service laboratory rates. The new methodology requires laboratories to submit private payer data to DHCS which uses the data to set rates based on prices other third-party payers are paying. In 2018, implementation of the Protecting Access to Medicare Act (PAMA) required a new federal methodology for determining laboratory rates for Medicare. The new federal methodology adopts the California approach and requires laboratories to report private payer data to the Centers for Medicare & Medicaid Services (CMS) which uses the data to set Medicare laboratory rates based on private payer rate information.

The problem is that during the 2003 state budget crisis the state put language in statute that no Medi-Cal laboratory rate can be more than 80 percent of the Medicare rate for the same test. This is a cap and not a benchmark. Any test that was reimbursed below 80 percent of Medicare was left at that lower rate. This provision of law, the "80 percent of Medicare cap" has stayed in statute ever since.

Laboratories have lived with this cap since 2003. However, when CMS changed the methodology for calculating laboratory rates in 2018 it drastically lowered the Medicare rates on all tests to the federal market rate. Now, to apply the "80 percent of Medicare cap" will cause an automatic trigger that will cut Medi-Cal rates up to 20 percent depending on the test. This cut is not something that DHCS was planning on doing nor was it part of any state budget plan.

California has spent years implementing its laboratory rate methodology to establish the correct reimbursement rate for each test. This automatic trigger cut caused by the federal government reducing Medicare reimbursement rates is very problematic. If the rate for certain tests drop below the California market rate the test may be taken off the testing menu at certain labs. This will lead to access issues for Medi-Cal patients.

In addition, labs will leave California and we will no longer have the testing capacity located in state when we need it. We saw this happen with the COVID-19 pandemic. Laboratory testing capacity fell drastically below what was needed to respond to the pandemic. Businesses were closed, schools were closed, and people were under a stay at home order because there was not enough capacity for laboratory testing to detect COVID-19. For these reasons we are asking for removal of the 80 percent of Medicare cap.

With everything that labs are doing to provide COVID-19 testing CCLA is also requesting forgiveness of the retroactive recoupments of cuts from 2019 and 2020, and to delay the implementation of the 2019 and 2020 cuts until July 1, 2022.

Eliminate Ten Percent Rate Reduction for Complex Rehabilitation Technology. The National Coalition for Assistive and Rehab Technology (NCART) requests General Fund expenditure authority of $2 million annually to eliminate the ten percent Medi-Cal reimbursement rate reduction enacted by AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. According to NCART, the AB 97 cuts were put in place in 2009 to deal with the Great Recession and subsequent budget deficit. This was meant to be temporary, but instead, is still in place for certain providers including durable medical equipment (DME), which is the category CRT falls under. A recently approved state plan amendment has further cut these DME rates by pegging the fee schedule to a declining Medicare rate. Now DHCS is doing a rate "claw back" for payments dating back to 2009-11. This ongoing cut on top of additional cuts, coupled with a declining Medicare fee schedule has made it difficult in the short term and impossible in the long term for CRT providers to serve the Medi-Cal population. CRT is much different from regular DME, as it is a labor-intensive process that requires a team of providers and travel out to the patient's home, neither of which are reimbursed. Therefore, CRT is disproportionately impacted by the cumulative cuts to DME. Forgiving the AB 97 cuts for CRT providers would improve reimbursement rates to CRT providers and improve delivery of care for adults and children with severe physical disabilities.

Restore Crossover Payments for Behavioral Health Services for Dual Eligibles in Nursing Homes. CHE Behavioral Health Services requests General Fund expenditure authority of $3 million annually and

trailer bill language to improve access to behavioral health services for individuals dually eligible for both Medicare and Medi-Cal (dual-eligibles) and who reside in skilled nursing facilities. According to CHE Behavioral Health Services, as many as 370,000 Californians are cared for annually in licensed long-term care facilities and women make up 61 percent of nursing home residents. Over two-thirds of California's nursing facility residents rely solely on Medi-Cal to pay for their care in a skilled nursing facility (three out of five residents). While quality behavioral health services are a fundamental need for California's vulnerable elderly population, low Medi-Cal reimbursement rates have reduced access to mental healthcare. Patients with behavioral health conditions in nursing facilities often have challenges finding access to services and can suffer with lack of evaluation and care.

Medi-Cal rates are among the lowest in the country, failing to adequately cover the cost of daily care for nursing home seniors. As a result, nursing home operators and medical professionals are providing services that go uncompensated. The funding shortfall will no doubt result in fewer facilities, leaving more senior citizens homeless, and a potentially significant collapse in the health care delivery system for aging Californians. Additionally, failure to identify and treat behavioral health disorders could result in loss of federal reimbursement opportunities for California.

There are approximately 1,200 licensed long-term care skilled nurse facilities in California and the profession employs more than 141,000 workers with payroll and benefits exceeding $5.6 billion annually. Healthcare providers of all kinds across California are adversely affected by the tremendous lack of parity between the Medi-Cal and Medicare rate structure. The majority of nursing home patients have dual eligibility (eligible for both Medicare and Medi-Cal), and in order to provide the behavioral health services our senior citizens need and deserve, fee structures must be more in line across government-funded programs at the state and federal level, and this includes crossover claims.

One way to ensure funding supports care for this vulnerable population is the establishment of a crossover claim. A crossover claim is where Medicare pays a portion of a claim for a dual eligible beneficiary and since it is prohibited to bill that beneficiary, Medi-Cal pays for the rest. For example, if Medicare reimburses the provider at 80 percent of the actual cost of the service, Medi-Cal will cover the remaining 20 percent coinsurance. Unfortunately, California state law has limited Medi-Cal's reimbursement on Medicare claims to an amount that, when combined with the Medicare payment, does not exceed Medi-Cal's maximum payment for similar services. Consequently, if the Medi-Cal rate is 80 percent or less than the Medicare rate for the service rendered, Medi-Cal will not pay anything on these crossover claims. With Medi-Cal rates consistently much lower than Medicare, this law essentially eliminates the crossover payment in California. Given the tremendous need for services in our nursing homes, especially during the time of public health emergency, we need to invest in these most vulnerable citizens and ensure they receive the care they deserve.

This proposal would amend existing law to allow Medi-Cal to pay for all or part of the remaining coinsurance from a Medicare payment for behavioral health services provided to dual eligible beneficiaries residing in skilled nursing homes. The request also includes an appropriation of $3 million to fund all or part of the coinsurance that is the Medi-Cal share of the cost.

Alameda Wellness Campus. The Alameda Point Collaborative and Lifelong Medical Care request General Fund expenditure authority of $15 million in 2021-22 to support construction of a medical respite and health clinic building at the Alameda Wellness Campus to serve unhoused adults and seniors with

complex health conditions. According to these organizations, if this request is approved the Wellness Campus would offer the state and nation a new model of integrated care for unhoused individuals with a focus on seniors and those with complex medical and behavioral health conditions. The Wellness Campus co-locates: 120 permanent supportive housing units, a 50-bed medical respite program; an on-site health care clinic; intensive homeless prevention and housing placement services; and hospice-level care for homeless adults, with an emphasis on serving unhoused seniors. The medical respite center will prevent worsening health conditions as well as unaccompanied and difficult deaths among unhoused adults in Alameda County.

The medical respite will serve homeless adults who are (a) discharged from local hospitals but are too sick to recover on the streets or a shelter, (b) undergoing intensive outpatient medical treatment such as chemotherapy, (c) identified through street medicine, or (d) seeking hospice care.

The project will realize the following beneficial outcomes:

- Provide recuperative care stays and housing placement assistance for 400 unhoused Alameda County residents with acute health conditions annually, with an estimated 50% or 200 seniors that participate in the medical respite program annually. The Wellness Campus anticipates that at least 90 percent of respite clients will have co-occurring mental health conditions.
- Provide 120 units of permanent supportive housing units for unhoused seniors in Alameda County to age in place with case management, on-site medical and behavioral health services, in-home support, and end-of-life-care.
- Provide homelessness prevention services and housing placement assistance for another 200 City of Alameda residents annually.
- Of the 720 unduplicated unhoused clients served annually, the Wellness Campus will serve an estimate 320 unhoused seniors annually.

This request would further the state's commitment to help end homelessness; reduce preventable emergency care and hospital readmissions; implement the Master Plan for Aging; and serve as a model for the new Enhanced Care Management benefit and In Lieu of Services under the state's CalAIM project to redesign Medi-Cal services.

Housing Support Services Benefit for People Experiencing Homelessness. The Corporation for Supportive Housing and the Western Center on Law and Poverty (WCLP) request expenditure authority of $100 million ($24 million General fund and $76 million federal funds) in 2021-22, $150 million ($36 million General Fund and $114 million federal funds) in 2022-23, and $250 million ($60 million General Fund and $190 million federal funds) annually thereafter to create a Medi-Cal benefit to fund housing support services for beneficiaries experiencing homelessness and people who were homeless and are now residing in supportive housing. According to these organizations, homelessness dramatically impacts health outcomes, costs, and access to care. Health costs for Medicaid beneficiaries experiencing chronic homelessness averages over $33,459 per year. Beneficiaries experiencing homelessness who are frequent hospital users often incur Medicaid costs of well over $100,000 per person. People experiencing homelessness die, on average, 25 to 30 years younger than housed people with similar health conditions.

Housing support services help people access housing and remain stably housed, and are essential for beneficiaries experiencing homelessness to access meaningful care. Thirty years of data demonstrate these

services not only dramatically improve health outcomes, but significantly decrease Medicaid costs. Data also shows that, without these services to help people stabilize in housing first, care management and other healthcare interventions are ineffective and wasteful. Outcomes remain poor, while health costs continue to increase.

The Department of Health Care Services (DHCS) created two programs to fund housing support services for people experiencing homelessness: the Whole Person Care pilot and the Health Homes Program. Though DHCS acknowledges beneficiaries experiencing homelessness need housing support interventions, the Administration's CalAIM proposal would eliminate these programs and instead providing housing support services as an option that plans may or may not choose to offer as "in lieu of services." In so doing, CalAIM proposals would halt California's progress in addressing the needs of people experiencing homelessness.

This request proposes to create a Medi-Cal benefit to fund housing support services for beneficiaries experiencing homelessness and people who were homeless and are now residing in supportive housing. In June 2015, the federal government issued an Informational Bulletin that clarified that Medicaid can pay for the housing support services people experiencing homelessness need. Through CalAIM, California should offer a separate, mandatory housing supports benefit to pay for services to help people get and stay housed. Other states are taking advantage of this federal funding match, and so should California.

This can be done through a supplemental per member, per month rate for housing transition navigation and tenancy sustaining services for beneficiaries experiencing homelessness. A benefit should be administered through a set of standardized guidelines and through funding that would attract providers with deep experience and expertise in providing services to people experiencing homelessness.
Housing support services help people access housing and remain stably housed, and are essential for beneficiaries experiencing homelessness to access meaningful health care. These services include:

- Housing transition & navigation services, to find people on the streets, form trusting relationships, assist people in completing paperwork needed to access housing subsidies, connect tenants to landlords, and help people move into and stabilize in housing;
- Housing deposits to help people gain access to housing through one-time costs of moving into housing; and
- Housing tenancy and sustaining services, to provide intensive supports to help people maintain leases, take care of their homes, and connect to treatment they need and to community supports.

Restoring Optional Medi-Cal Benefits for Chiropractic. The California Chiropractic Association requests General Fund expenditure authority of $1.7 million annually to restore chiropractic benefits in the Medi-Cal program. According to the association, the expansion of Medi-Cal made possible by the Affordable Care Act has been successful in providing many of the most vulnerable populations in California health care coverage. Additionally, we are seeing more individuals become eligible for Medi-Cal as the COVID-19 induced recession has caused many Californians to lose employer sponsored care. Medi-Cal is a vital coverage component in our healthcare system as it assists our most low-income and vulnerable populations gain access to health care providers and services. As part of ensuring that more Californians have access to adequate health services, the California Legislature has been working towards restoring Medi-Cal Optional Benefits that were cut over a decade ago. The state most recently restored services such as optical services, podiatry, speech therapy, and incontinence creams and washes. However,

chiropractic benefits have yet to be restored for the adult population of Medi-Cal beneficiaries. Chiropractic is the only optional benefit that has not been restore, thus, hindering the ability for Medi-Cal beneficiaries to fully access the breadth of health professionals at a time when our health care system is strained.

Restoring the chiropractic Medi-Cal option comes at a low cost but yields cost savings and increased access to health providers. The 2018 state estimate for restoring chiropractic benefits on an annual basis would cost $1,707,000 million - chiropractic is the second to least costly benefit to restore. For this modest investment, millions of Medi-Cal beneficiaries will have access to Doctors of Chiropractic (DCs) that have proven to be effective in providing non-pharmacological treatments to pain, reducing the need for prescription drugs such as opioids, and reducing the need for costly surgical interventions.
Additionally, populations that do retain a chiropractic benefit often are forced to settle for inadequate treatment options due to the Medi-Cal two-visit per month limitation. Therefore, we also ask that you consider adjusting the chiropractic benefit in a manner that maintains a 24 visit annual limit but removes the two visit per month cap so that Medi-Cal beneficiaries may receive clinically appropriate interventions in a timely fashion.

DEPARTMENT OF PUBLIC HEALTH

State Investment in Core Public Health Infrastructure and Workforce. A coalition of counties, county health organizations, and county public health workers, requests annual General Fund expenditure authority of $200 million to support investments in stabilization and addressing key needs and issues for local health departments. The coalition of organizations includes SEIU California, the County Health Executives Association of California (CHEAC), the California State Association of Counties (CSAC), the Health Officers Association of California (HOAC), the Rural County Representatives of California (RCRC), and the Urban Counties of California (UCC). According to the coalition, while a direct link between public health investment and improved community health or healthcare savings can take years to quantify, there is strong existing evidence of highly successful public health interventions. A 2017 systemic review of the return on investment of public health interventions in higher-income countries found a median return of 14 to 1. Another key analysis found that an additional $10 per capita in public health spending can decrease premature mortality and increase the proportion of the population in excellent health. Using these academic analyses, it is reasonable to assume that the state can invest $5 per capita towards a critical public health grant. Using recent Department of Finance population statistics for 2020, a $5 per capital equates to about $200 million. Further, this investment is likely to garner additional federal funding, such as a federal Medicaid match for some services (like Targeted Case Management services). It is foundational support that can be used to attack and retain additional federal grant dollars or even other non-governmental contracts and grants.

Under this proposal, each California local health department would be awarded a base allocation with the remaining funds distributed on the proportion that each jurisdiction contributes to:

- 2019 population (50 percent of the allocation);
- 2019 population in poverty (25 percent of the allocation); and
- 2019 population proportion each that is Black/African/American, Latinx, or Native Hawaiian/Pacific Islander (25 percent of allocation)

These funds would facilitate the stabilization of local health departments to address the following key needs and issues:

- Recruiting and retaining a modern public health workforce;
- Improving and expanding communicable disease monitoring, epidemiology, and outbreak mitigation
- Addressing health equity issues and health disparities through a wide-variety of action-oriented approaches using meaningful engagement with diverse communities who are impacted by systemic racism and through integrating public health as a core partner in addressing the social determinants of health;
- Improving and expanding environmental health and environmental justice capabilities for detecting and protecting communities from hazardous conditions in air, water, food, and other settings, and to address the impact of climate change on the diverse communities of California;
- Serving as an integral partner with the state and Medi-Cal managed care plans through CalAIM initiative that addresses population health, enhanced case management, in-lieu of services, social determinants of health, public education and other components for improving the health of Californians;
- Addressing linkages to health-related social needs, including housing instability and homelessness, family and social supports, food insecurity, nutrition education, and community violence mitigation.
- Improving access to and linkage with clinical care, including maternal, child, and family health;
- Improving and expanding chronic disease prevention functions related to asthma, cancer, cardiovascular disease, diabetes, obesity, tobacco, alcohol, and other factors;
- Supporting the use of public health nurses, health/ peer educators, and community health workers for public education, outreach, resource referral, and other functions in order to protect health, prevent disease and injury, and promote health and well-being;
- Helping to implement more fully the "Health in All Policies" approach, as adopted by the California Health and Human Services Agency; and
- Improving California's overall ranking of "middle tier" ranking by the Trust for America's Health for public health emergency preparedness (25 states are ranked above CA).

Public Health Infrastructure and Workforce Assessment. The County Health Executives Association of California (CHEAC), the Health Officers Association of California (HOAC), and SEIU California request General Fund expenditure authority of $3.2 million in 2021-22 and $150,000 annually thereafter to conduct an evaluation of local health department infrastructure and make recommendations for staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. According to these organizations, California needs to prepare for the workforce challenges facing public health – and for the next emergency or pandemic – by creating a comprehensive plan to address urgent workforce and resource needs of local health departments. California's local public health workforce faced several challenges before the outbreak of COVID-19:

- Year after year of underfunding of federal, state and local public agencies left the United States ill-prepared for the COVID-19 pandemic. The Trust for America's Health estimated in April 2019 that public health efforts nationally were underfunded by $4.5 billion and that nationally 55,000 positions were eliminated from public health between 2008 and 2017.
- According to the California Future Healthcare Workforce Commission February 2019 report, the public health workforce in California is chronically underfunded, and most local public health

agencies lack personnel with expertise in key areas such as epidemiology and the essential skills to design, implement, and evaluate comprehensive approaches to community health improvement.

- In California, both state and local public health agencies face increasing competition with the private sector, which provides higher pay, and amenities such as updated technology. Additionally, many public health leaders are nearing retirement.
- There are no federal or state guidelines for public health staffing; nor does any state or national organization provide information and data on the composition and training levels of the governmental public health workforce.
- Many local health departments in California report challenges in recruiting and retaining well-qualified workers, citing a lack of tools for recruiting, limited options for advancement, and instability of funded positions.

Public health nurses require additional education and certification, above and beyond what is required to become a registered nurse. Public health nurse certification fees in California increased by several hundred dollars recently. Rural areas of California face more difficulty recruiting the specialized staff required for public health work. It is not uncommon for rural counties to have public health nurse recruitments open for several months and have no candidates apply. The public health worker shortage has received little attention and there is not a focus on public health pipeline in California's higher education systems. Additionally, while public health work is rewarding, it is also quite challenging and the difficulty of the work may lead to burn out in the public sector.

Specifically, the funding in this request would be provided to DPH to contract with an appropriate entity to conduct an evaluation of local health department infrastructure and make recommendations for staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. The funding would also support the submission of this report by DPH to the Legislature.

The evaluation and resulting recommendations of local public health workforce needs will better prepare California to address both day-to-day public health needs and pandemics and other emergencies that threaten the health of California residents.

California Health Equity Fund. A coalition of organizations including the California Black Health Network, the Latino Coalition for a Healthy California, the Public Health Institute, and Roots of Change request General Fund expenditure authority of $180 million, available for encumbrance and expenditure until June 30, 2024, to implement a California Health Equity Fund, which would provide increased funding for local health departments, community-based organizations, clinics, and tribes for community-based initiatives and programs that result in decreased risk for preventable illnesses and adverse childhood experiences (ACEs) exacerbated by COVID-19. According to the coalition, this budget request is in direct response to the heartbreaking inequities that have been wrought by COVID-19. Communities of color and low-income communities are contracting and dying at disproportionately high rates as well as bearing the brunt of social inequities caused by the pandemic including loss of income, insecure housing, and food insecurity. Children in these communities, who were already at increased risk of adverse childhood experiences, are now at increased risk due to family stress, school closure, and loss of support networks. Much of this suffering is due to largely preventable, inequitable rates of illnesses that preceded COVID-19, such as hypertension, heart disease and diabetes. In addition, the pandemic has amplified a legacy of structural racism leading to dramatically increased social and environmental risks, including food insecurity, lack of affordable housing, unstable employment, and other harmful conditions that are risks

for poor health outcomes and ACEs. Without immediate action, California's communities of color and low-income communities face a future of increasing rates of preventable, premature illness and death due to worsening social injustices. We must step in now to stop the cycle.

Local health departments, community-based organizations, clinics and tribes are acutely aware of these needs and pre-COVID-19, many implemented successful programs, using both evidence–based and community-determined strategies, to address the social determinants of health that drive inequities in chronic disease and ACEs. However, insufficient, sporadic funding prevented organizations from taking successful programs to scale or initiating new programs to meet community needs documented by state and local data. Today, the pandemic has amplified those needs many times over. In addition, existing categorical state revenue streams, as well as CARES dollars administered by government organizations, may not allow communities to effectively address key drivers of health and social inequities at the local level.

This budget request is inspired by CDPH's COVID-19 Health Equity Playbook for Communities, published in December 2020, which recognizes that because, "there is no single solution or strategy for the response and recovery to COVID-19, this document provides a collection of options for locals to select from to support customized approaches for the assets and needs of each community." The report further goes on to say, "COVID-19 requires a comprehensive 'all of government' and multi-sectoral approach. Recovery needs to be community and data driven, both through use of quantitative data and qualitative data from community insight and experience." In recognition of these precepts, this budget request includes funding for community-based organizations, community clinics, tribes, and local health departments to use local data to identify local priorities and work together to effectively respond to today's crises.

Sustaining the California Reducing Disparities Project. The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) and the National Association of Social Workers-California Chapter (NASW-CA) requests General Fund expenditure authority of $50 million in 2021-22, available for encumbrance or expenditure until June 30, 2025, to extend and expand the California Reducing Disparities Project (CRDP). According to REMHDCO and NASW-CA, California's people of color and LGBTQ+ communities are suffering significant mental health disparities as a result of the generational lack of mental health programs that appropriately serve racial, ethnic, and LGBTQ+ communities throughout California. Decades of data have well-documented that consumers and families from these communities in every county experience disparities with regards to mental health services. Originally funded by the Proposition 63 funding, the California Reducing Disparities Project (CRDP) has served these communities since 2019 and is a beacon of hope for the state, offering a solution that addresses the needs of a majority of Californians.

However, CRDP services to communities will end in April 2022 if additional funding is not secured. The CRDP strives not only to prove the effectiveness of 35 individual pilot projects, but to promote the use of Community Defined Evidence Practices that are often preferred by people in underserved communities and will go towards reducing mental health disparities in this state. This request would allocate $50 million dollars to extend Phase 2 of the project, bring the pilot project to scale at both the state and local levels, and to plan for Phase 3 of the project.

Preliminary results from local evaluations indicate that the implementation pilot projects show success at improving mental health among the African American, Asian Pacific Islander, Latinx, LGBTQ+, and Native American populations served, however, with no additional funding, these would be based on three years of data. (Traditional "evidenced based practices" take ten years to be considered successful.) Successful programs based on six years of data would further build the evidence base and be more accepted by counties and other funders. Additional funding would allow for the lessons learned from the CRDP Phase II to be captures and disseminated to inform the larger field on the state and national level. Lessons learned would include the strategies used by the IPPs to address the unprecedented need created by the global pandemic. The power of the data collected has the potential to change the discourse on serving historically underserved, unserved, and inappropriately served Californians. Community defined practices more generally would also be more likely to scale and create systems changes resulting in greater accessibility and utilization of culturally appropriate mental health prevention programs for underserved communities and improve health and wellness outcomes.

The state must make a commitment to support CDEPs to reduce disparities. Intergenerational mental health disparities will remain intractable without a sustained and aggressive level of State investment. The State of California's support should go beyond Phase II funding of the CRDP, it must address the new mental health crisis resulting from COVID-19. The state will not reduce disparities if it continues to fund the same strategies, but must do things differently if it wants to produce different results for marginalized communities.

The funding in this request would extend the operation of CRDP individual pilot projects (IPPs) of Phase 2 for another three years. Funding would also extend the corresponding technical assistance component, and the evaluation of this project both at the local and statewide levels. In addition, there would be a component to ensure scalability of the IPPs at the county level and planning for Phase 3 of this project to reach additional underserved communities. The success and viability of these IPPs would be based on 6 years of data instead of 3 years, encouraging investment at the local, state, and federal levels not only their replication but more widespread acceptance and use of community defined practices to increase access to critical behavioral health services and prevention of the onset of more serious mental illness. Finally, the funding extension would address the disproportionate impact of COVID-19 on CRDP populations and strengthen the state's response in marginalized communities.

Phase Out of Skilled Nursing Facility Staffing Waivers. SEIU California requests trailer bill language to phase out workforce shortage and patient acuity waivers for statutory staffing requirements in skilled nursing facilities. According to SEIU California, prior to the COVID-19 pandemic, hundreds of skilled nursing facilities (SNF) received a waiver from the state mandated minimum staffing requirements that were implemented in July 2018, with many facilities receiving these waivers in consecutive years, and even more facilities have been granted temporary waivers during the COVID-19 emergency period.

SNFs have been at the epicenter of the COVID-19 pandemic, with close to 6,000 resident deaths and over 43,000 positive cases, and 169 worker deaths and over 35,000 positive worker cases as of December 19th. The nursing home employees are risking their lives daily with limited personal protective equipment (PPE) to care for the sickest people in our state, and are left to handle an overabundance of residents due to the lack of investment in the workforce by employers, with no repercussions from the state. In fact, SNFs actually received a 10 percent Medi-Cal rate increase this year to assist them with their COVID-19 related expenses in addition to federal provider relief payments, yet we have not seen evidence of hazard

pay, increased PPE, paid sick leave, or other benefits that would support the existing workforce or attract new workers to the field.

This request seeks to address issues of low staffing and the subsequent devastating impacts to workplace safety and resident care by eliminating unnecessary and over-utilized waivers, motivating operators to make greater efforts to adequately staff up, and to make waiver application standards more stringent to only allow for such waivers in specific and exceptional cases. The workforce shortage and patient acuity waivers would both be phased out by June 30th, 2022. By that date, every skilled nursing facility would be required to meet the minimum staffing levels established by SB 97: 2.4 certified nursing assistants/3.5 direct care hours per resident day. Additionally, from July 1st, 2021 through June 30th, 2022, SNFs would have to meet a number of requirements during the waiver application process and if they are approved for one, would have to abide by accountability reporting requirements throughout the duration of their waiver period.

All Children Thrive Expansion. Public Health Advocates requests General Fund expenditure authority of $25 million in 2021-22 to expand the All Children Thrive pilot project to 100 new cities over five years. According to Public Health Advocates, in 2018 the Legislature funded the successful pilot of All Children Thrive–California (ACT), a statewide initiative that supports California cities to mitigate the disparate effects of adverse childhood experiences (ACEs) on California children, especially low-income children and children of color. This request would move this initiative from the pilot to the implementation phase. ACEs are a fundamental contributor to many of California's most urgent and costly social problems, including violence, poor academic performance, homelessness, drug addiction, mental illness, and chronic health conditions like heart disease and diabetes. A source of trauma and toxic stress, ACEs are so damaging—and their causes so deeply woven into our social fabric—that their prevention and intervention have been made a top public health priority. Just as germ theory transformed our ability to treat and prevent deadly infectious diseases a century ago, we must now address childhood trauma to remedy today's most pressing public health challenges. Focusing attention at their traumatic roots can help California to reduce the prevalence of physical and behavioral health problems and their harmful impact on health care, social service, and criminal justice costs and outcomes.

ACT is a statewide initiative helping California cities prevent and mitigate the impact of Adverse Childhood Experiences (ACEs). The ACT Pilot initiated a community-led movement that has established local community-led teams that are already designing resident-initiated local policies and sharing lessons learned to ensure that all California children can thrive. In the three-year pilot funded through a $10 million budget allocation, ACT has successfully engaged communities across the state to set goals, design a roadmap for success, and adopt action plans. The initiative was implemented through a partnership between the California DPH Essentials for Childhood Initiative, Community Partners, Public Health Advocates, and the UCLA Center for Healthier Children, Families and Communities.

This proposed budget allocation would take ACT from pilot to broad-based implementation: using an overlapping cohort model, this allocation would bring 100 new California cities into ACT over the next five years. ACT cities would be eligible for grants of up to $100,000 per year to support their efforts. The ACT Equity Advisory Group would continue to meet quarterly to guide the initiative in partnership with the DPH Essentials for Childhood Initiative.

Amyotrophic Lateral Sclerosis (ALS) Wraparound Model of Care Funding Extension. The Golden West Chapter of the ALS Association requests General Fund expenditure authority of $3 million annually to continue to allow the current ALS wraparound treatment model to improve access to an evidence-based model of care and keep pace with the growth in the number of people diagnosed with ALS, or Lou Gehrig's Disease. According to the Golden West Chapter, people with ALS are at the highest risk for the most severe effects of COVID-19, as respiratory failure due to complications from a respiratory infection is the leading cause of death among those diagnosed with ALS. It is common for ALS patients to experience severely compromised respiratory function as the disease progresses. As a result of COVID-19, the chapter is experiencing new and increased demand related to every aspect of the community based wraparound program delivery model. Immediately upon understanding the nature and implications of COVID-19, the chapter began to share important information, through a variety of socially distanced efforts, including online webinars and resources related to preventing individual infection, containing virus spread and addressing the disease progression and treatment needs of people living with ALS. The chapter rapidly increased its capacity to utilize technology to deliver a wide-array of clinical and home-based programs and services which enabled the multidisciplinary team to stay connected with clients, constituents, and stakeholders. There are only two drugs approved by the FDA for ALS, neither are proven to extend life by more than 2-4 months. The only way to meaningfully extend the length and quality of life for people diagnosed with ALS is to provide them with access to this evidence-based model of care. The wraparound model of care involves the seamless integration of community and clinic based multidisciplinary services. The model is proven to help people diagnosed with ALS to live significantly longer and better than either of the two FDA approved drugs.

PrEP-AP Navigation and Retention Services. The End the Epidemics coalition requests expenditure authority from the AIDS Drug Assistance Program (ADAP) Rebate Fund to support pre-exposure prophylaxis (PrEP) navigation and retention services. According to the coalition, despite the availability of highly effective prevention and treatment tools, HIV continues to be a significant public health challenge in California. Data from the California Department of Public Health indicate that 4,747 people were newly diagnosed with HIV in 2018 – a modest 9.6 percent decrease since 2014.

While the overall number of new HIV diagnoses has declined, significant inequities remain. The rate of new HIV diagnoses among Black Californians is 4.8 times higher than whites. Latinx Californians are diagnosed with HIV at a rate 1.9 times higher than whites. Black and Latinx gay and bisexual men, Black cisgender women, transgender women and youth continue to be the populations most impacted by HIV in California. Reducing and ultimately eliminating these inequities must remain a top priority even as the state responds to the COVID-19 pandemic.

Pre-exposure prophylaxis (PrEP) is one of the most effective tools available to reduce new HIV infections. The medication, first approved by the FDA in 2012, can reduce the risk of HIV infection by over 99 percent when taken as prescribed. PrEP is a central pillar of federal, state and local efforts to end the HIV epidemic.

California has been a nationwide leader in improving access to PrEP. The state was among the first to establish a PrEP financial assistance program – known as PrEP-AP – which helps low-income Californians cover out-of-pocket costs for PrEP medication and related clinical services. California's PrEP-AP is funded through the ADAP Rebate Fund. California also allocates roughly $10 million general

fund annually for comprehensive HIV prevention services, including $2 million annually to support PrEP navigation services at nine community-based organizations across the state.

Although the number of Californians using PrEP has increased dramatically in recent years, uptake remains far below what is needed to significantly reduce HIV infections and eliminate health inequities. Current estimates suggest that just over 20 percent of people who could benefit from PrEP in California were taking it in 2018. PrEP use is lowest among populations most impacted by HIV, including Black and Latinx gay and bisexual men, Black cisgender women, transgender women and youth.

This proposal would build upon the state's existing PrEP-Assistance Program (PrEP-AP) by funding PrEP navigation and retention coordinators at local health departments and community-based organizations contracted with the Office of AIDS to provide PrEP-AP enrollment and/or clinical services. PrEP navigation and retention coordinators would be responsible for conducting PrEP outreach and education, health care and financial assistance program navigation and enrollment, care coordination and adherence support, and linkage to behavioral health, substance use and social service programs. Indirect costs would include supervision, data collection, evaluation and reporting. The Office of AIDS would also contract with an outside entity to provide staff training, program technical assistance and capacity building to all of the funded programs.

Hepatitis C Test Kits and Associated Costs. The End the Epidemics coalition requests General Fund expenditure authority of $1 million, available over five years, to support the purchase of hepatitis C virus (HCV) test kits, associated materials and supplies, training for test counselors, and the staffing to support a test kit program. This proposal would support community-based HCV prevention, testing, and linkage to care and treatment efforts. According to the coalition, driven by the opioid and other drug use crises, the HCV epidemic continues to grow among young Californians – those under age 30 – at an alarming rate, with over a third (12,373) of new cases reported in 2018 occurring in this group. From 2014 to 2016, a total of 13,683 HCV cases were reported among people ages 15-29, and the rate increased 50 percent over this time period. This population is greatly in need of HCV education, testing and treatment, with just 1 in 3 youth reporting that they thought they were at risk for HCV, and only 2 percent having received HCV treatment.

HCV also disproportionately affects Black Californians. Although Black individuals make up only 6 percent of California's population, they account 11 percent of those living with HCV. Native Americans are also disproportionately affected by HCV.

Although COVID-19 has dramatically slowed data collection, it is likely that transmission of HCV has worsened, particularly for those most vulnerable to HCV infection, during the pandemic due to increases in drug use, decreases in HCV testing, delays and disruptions in health care delivery, and disruptions in needed services for people who are using drugs.

HCV is a serious public health issue in California, but one that we can dramatically improve with an investment in testing. Left untreated, HCV can cause scarring of the liver (cirrhosis), end-stage liver disease, liver cancer and death. People with chronic liver disease, especially those with decompensated cirrhosis, are also at increased risk for hospitalization and mortality from COVID-19. The American Association for the Study of Liver Disease has stated that there is compelling data from both within the United States and internationally that demonstrate this fact.

Funding for HCV prevention, screening, and linkage to and retention in care is woefully inadequate. The U.S. Department of Health and Human Services issued the Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025) in early 2021. The report provides a framework to eliminate viral hepatitis as a public health threat in the United States. The plan calls for the strategy, in part, to address the fact that HCV rates nearly tripled from 2011 to 2018, in spite of the fact that HCV is curable in one short course of treatment. Unfortunately, the report did not call for new investments in prevention, care and treatment for viral hepatitis. Prior to COVID-19, HCV was widely recognized to be the leading infectious disease killer in the United States, with the CDC reporting at that time that HCV is responsible for more deaths than the next 59 infectious diseases combined. Despite the significant morbidity and mortality that comes from HCV, the federal government invests only approximately $39 million for viral hepatitis as a whole and California only slightly more than $5 million in HCV prevention services.

This budget request does not attempt to fill that gap, but asks for a small investment to support the community-based safety net that would ensure that some of the most vulnerable Californians, those uninsured or underinsured, unhoused or marginally housed, people using drugs and others who have limited access to traditional health care systems due to stigma and discrimination, are supported in knowing their HCV status and getting linked to care and treatment.

STD Prevention and Control Activities. The End the Epidemics Coalition requests General Fund expenditure authority of $3 million annually to increase funding for sexually transmitted disease (STD) prevention and control activities. According to the coalition, this investment would combine with previous investments for a total of $10 million for DPH's STD Control Branch to dispense throughout the state to support a comprehensive, evidence-informed approach to STD prevention and improve the capacity of local health jurisdictions to address rising STD rates in their region. Funding would be prioritized to serve communities disproportionately impacted by STDs, and would be distributed through a competitive grant process to local health jurisdictions (LHJs). Once the funds are received, LHJs would be required to sub-grant out at least 50 percent of the funding to community-based organizations.

New data released by the Centers for Disease Control and Prevention (CDC) estimates that 1 in 5 people in the U.S. have an STD. The COVID-19 pandemic has exacerbated STD rates in California and across the country that were already skyrocketing to crisis levels prior to the public health emergency. According to the latest data available, in 2018, nearly 68 million STD infections were reported nationwide with rates of syphilis, chlamydia, or gonorrhea up 40 percent since 2013. California also had the second highest syphilis rates in the nation in 2018. While 90 percent of all male syphilis cases in 2013 were among bisexual and gay men, the epidemic has spread among women. Between 2008 and 2018, the syphilis rate among women of reproductive age increased by 743 percent. In 2018, more than 329 babies were born with congenital syphilis in California and there were 20 stillbirths associated with the disease. More than 100 babies were born with congenital syphilis in Los Angeles County alone in 2020 during the COVID-19 pandemic.

Federal funding for STD prevention in the state dropped by roughly 40 percent over the last 15 years. As funding withered, county public health departments and local health jurisdictions adjusted by shutting down stand-alone STD clinics, reducing staff levels and suspending surveillance and case management programs. The timeframe in which STD rates have increased correlates with the timeline of when funding

for STD prevention public health programs began to decrease. The COVID-19 crisis has further depleted public health resources and the limited STD prevention workforce across the state have been re-assigned to COVID duty.

This request would allocate $3 million ongoing General Fund dollars – in addition to the $7 million already allocated in the state budget, for a total of $10 million – to DPH's STD Control Branch to dispense to LHJs throughout the state to support a comprehensive, evidence-informed approach to STD prevention while combatting COVID-19 and beyond. Once the funds have been fully expended the ETE Coalition would work with LHJs and community-based organizations to evaluate how the funds were spent and see if there is a correlated decrease in STD cases. The scope of the STD crisis requires a larger investment and a $10 million annual allocation is just a starting point to tackle the issue.

Syringe Exchange Supply Clearinghouse Funding. The End the Epidemics Coalition Requests General Fund expenditure authority of $3 million annually to increase funding for the DPH office of AIDS Syringe Exchange Supply Clearinghouse. According to the coalition, California syringe service programs (SSPs) distribute supplies to program participants who use drugs to prevent transmission of HIV, hepatitis B and C, skin and soft tissue infections, and other health conditions. Supplies include sharps containers for the safe recovery and disposal of syringes, syringes, fentanyl test strips, sterile water, and other materials to provide for sterile injection and safer sex. This is consistent with CDC guidelines for HIV prevention among people who use drugs. In 2016, naloxone kits to reverse overdoses were added to the Clearinghouse and in 2019 harm reduction supplies for other routes of administration were added, enabling harm reduction providers to connect to people at risk who may not be injection drug users.

SSPs have been at the forefront of the COVID-19 pandemic, quickly adapting their protocols to remain open and fill gaps in other services while also providing PPE such as face masks and hand sanitizer. SSPs access some of these supplies through the Clearinghouse and distribute them to community members at increased risk for COVID-19, including people experiencing homelessness, people living with HIV, and Black, Indigenous and people of color.

Since 2016, when the Clearinghouse was established, 18 new SSPs have been authorized in California, reaching 13 additional counties. This growth in programs represents the implementation of legislative intent and is meeting the growing need for services, particularly in rural areas with high rates of overdose and HCV. A 2020 survey administered to SSPs as part of CDPH's California Harm Reduction Initiative showed that the median increase in new participants enrolled in services at SSPs was 189 per year. There are now more programs than ever before, and the average amount of syringes distributed by programs has also increased by 51 percent since 2016. Many programs are rationing out supplies due to shortage and there is no money available for any future SSPs. Recent data from Office of AIDS shows that 8 programs completely ran out of supplies last year and 2 experienced major service disruption due to a lack of supplies.

This change is urgently needed to meet the rapid expansion of programs, and the increased number of people seeking assistance to prevent fatal overdose and the transmission of potentially deadly infections. The Clearinghouse provides harm reduction supplies and PPE for the state's syringe service programs, but it is now completely maxed out at a time when demand for supplies is increasing due to COVID-19. These funds will provide hundreds of thousands of Californians with the tools they need to protect themselves and their families.

In 2019, $15 million over four years was included in the state budget to support staffing at SSPs and provide ongoing technical assistance and program administration. These funds allow for critical expansion of services for harm reduction programs, but they cannot be used for supplies. Without a similar increase in the Clearinghouse budget, these programs will not be able to provide the full range of the supplies that their participants need. This requested budget increase would enable California to experience the full benefits of the $15 million already invested in these essential services.

Medical Legal Partnerships for COVID-19 Recovery. The Children's Partnership requests General Fund expenditure authority of $30 million in 2021-22 to support COVID-19 recovery efforts for communities deeply impacted by the pandemic through a grant program that encourages partnerships between community programs and legal service organizations that support families and children. According to the Children's Partnership, children are able to thrive when their families have access to the tools and resources necessary for a healthy and nurturing environment. During times of crisis, a team of providers, legal advocates, and family specialists offers a family the concrete support and services that address a family's needs and help minimize stress caused by challenges, particularly those that have arisen as a result of the pandemic. The COVID-19 pandemic continues to disproportionately devastate California's Latinx, Black, Pacific Islander, and immigrant families, while these very communities shoulder the front-line work keeping our state's economy running. For example, among children, Latinx, Black, Native American and Pacific Islander children make up nearly 70 percent of cases, despite making up slightly over 50 percent of the state's population of children. Further, California's immigrant communities have been devastated by the pandemic, both in job loss as well as being exposed to COVID-19 risk by working on the frontlines: one in three undocumented workers in California is employed in an industry negatively affected by the COVID-19 economic shutdown while also making up about 33 percent of the state's essential workforce. In addition, multiple surveys distributed to families across the state with partners like Parent Institute for Quality Education and the Education Trust West highlight the numerous struggles that families continue to face, including food and housing insecurity, eviction, lack of broadband access, lack of child care, and lack of mental health and health supports. Additionally, a recent report from the Legislative Analyst's Offices highlights how the Governor's 2021-22 budget proposal does not include a specific plan or strategy within the California Department of Public Health (CDPH) for COVID-19-related spending through the end of 2020-21. The integration of legal partners into family-serving system is a community-level intervention to advance health equity and address the social determinants of health in response to COVID-19. Prohibiting patient billing would allow patients to have more financial resources for independence and community integration after institutionalization, provide parity with the provision of health care within the criminal justice system, and eliminate anxiety caused from notices.

Transgender Wellness and Equity Funding. The Trans Latin@ Coalition requests General Fund expenditure authority of $15 million annually to support organizations providing health care services to transgender, gender non-conforming, or intersex (TGI) individuals. According to the coalition, the Williams Institute estimates that at least 218,400 individuals in California identify as transgender. Despite representing a significant portion of the state's population, TGI people are often left out of conversations regarding medical and mental healthcare. In a 2015 survey, 33 percent of transgender people who saw a health care provider reported having at least one negative experience related to being transgender, with higher rates of negative experiences reported by transgender people of color and transgender people with disabilities. These negative experiences include refusal of treatments, verbal harassment, physical and

sexual assault, or having to educate the provider about transgender people in order to receive appropriate and necessary care. Within that statistic, 24 percent of people that shared negative experiences with health care providers identified as non-binary. Additionally, in a national study of intersex adults in the U.S., 43 percent of participants rated their physical health as fair/poor and 53 percent reported fair/poor mental health. Prevalent health diagnoses included depression, anxiety, arthritis, and hypertension, with notable differences by age. Nearly a third reported difficulty with everyday tasks and over half reported serious difficulties with cognitive tasks.

Stigma and discrimination in healthcare practices further contribute to the dire experiences faced by TGI people. Lack of access to health care often leads TGI people, especially transgender women of color, to rely on underground economies as their primary source of transition-related care. For non-binary transgender people, access to gender affirming care is especially difficult because of provider unfamiliarity with genders beyond the traditional gender binary. As a result, gender based care is limited to cisgender care.

The significant barriers in society experienced by TGI people have only been exacerbated by the current public health crisis. Homelessness, economic instability, and difficulties in accessing health care are only a few of the barriers that have worsened during the pandemic. Lack of access to safe and stable housing is one of the primary factors that increases the risk of TGI people contracting COVID-19. Additionally, like millions of Californians, many TGI people are more likely to have lost jobs or had their work hours severely reduced, leading to financial instability. Community based TGI-serving organizations provide life-affirming critical services that help address the needs of the TGI community during this crisis. This funding is necessary to continue providing basic resources such as food, shelter, mental and emotional support programming, and much more during and following the COVID-19 pandemic and the economic downturn California now faces.

Access to safe, competent, and TGI-inclusive medical care is increasingly critical during a time when strong public health is key to controlling the spread of COVID-19 and preventing an overwhelmed health care system. While California has historically provided funding for LGBTQI+ programs and services, California would be the first state to specifically fund TGI communities. State funding is necessary for TGI-serving organizations across the state to increase their capacity and expertise to provide TGI people with appropriate care and to assist TGI people in recovery following the COVID-19 pandemic.

Women Infants and Children (WIC) Program Public Contracting Code Exemption. The California WIC Association requests trailer bill language to provide flexibilities for the 84 WIC local agency contracts with DPH through an exemption in the Public Contracting Code. According to the California WIC Association, an exemption in the Public Contracting Code would allow DPH and the WIC program to provide flexibilities in the contracts with the 84 WIC local agencies, reducing unspent WIC funds returned annually to the US Department of Agriculture. The current onerous contract process results in the inability of WIC local agencies to fully use funds during the fiscal year. As a result, there are losses for services for participants and costs to community programs that are already stretched.

Extend of Repeal Sunset Date for California Parkinson's Disease Registry. The Michael J. Fox Foundation requests trailer bill language to extend or repeal the sunset date for the California Parkinson's Disease Registry. According to the foundation, last year the Michael J. Fox Foundation for Parkinson's Research (MJFF) made the decision to fund California's Parkinson's Disease Registry for the 2020-21

fiscal year since California was facing an unprecedented budget shortfall due to COVID-19. The foundation is currently providing roughly $380,000 to fund the Registry through June 2021.

The Governor's 2021-22 budget proposal provides $409,000 in General Fund dollars to continue the California Parkinson's Disease Registry but deferred to the Legislature the decision on an appropriate repeal date for the Registry since current law sunsets the Registry on January 1, 2022. The foundation supports the Governor's funding proposal and requests that the Legislature either delete the repeal date on the Registry or extend it to June 30, 2030.

The Parkinson's research community is relying on the Registry's data for critical treatment advancements and should not be distracted every year by the uncertainty of whether or not the repeal date for the Parkinson's Registry will be extended or not. Certainty around the sunset date will increase the likelihood that state and/or private funds will be made available in the future.

DEPARTMENT OF STATE HOSPITALS

Stop DSH Patient Billing. The Western Center on Law and Poverty (WCLP) requests trailer bill language to prohibit the Department of State Hospitals from billing patients and their families for the cost of care during placement. According to WCLP, State Hospitals are charging patients for the full amount of their medical care, with bills reaching over $1 million. It is cruel and unfair to recover money from patients and patients' family members who are subject to involuntary treatment in state hospitals. Inmates in jails and prison are not subject to this, yet when transferred or awaiting trial in a State Hospital, they are charged for their medical care. These differences in treatment raise equity concerns for people with mental health disabilities. Very few people with severe mental illness can absorb the full costs of their medical care at state hospitals, especially when they often cannot work jobs that could support the payment of these bills.

Frightening notices can cause anxiety and fear among patients and their family members, with very little being actually collected. The notices are frightening as former patients are informed that they owe significant amounts, in some cases over a million dollars, for their care in a State Hospital. The bill also informs former patients that the state can go after their spouse, children, parents, and their estates for payment, which may have unintended consequence of weakening patients' family support system. There is no reason family member liability should be treated any differently for people with significant mental health problems. This also undermines state efforts to support the re-entry population and even efforts by DSH to help people enroll in health care and other public assistance prior to release.

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Mental Health Student Services Act Augmentation. Children Now requests General Fund expenditure authority of $80.5 million in 2021-22 to provide additional grants for partnerships between schools and county mental health programs to provide mental health services to students. According to Children Now, school-county partnerships are meant to prevent student mental health concerns from becoming severe and disabling; increase timely access to services; participate in outreach to recognize early signs; reduce stigma; reduce discrimination; and prevent negative outcomes. During a 2019 Request for Proposal Process, the MHSOAC was able to fund 18 of the 38 county applicants. The remaining unfunded 20

county applications, like Los Angeles, Contra Costa, Sacramento, Imperial, Mariposa and Nevada, represent turn-key partnerships ready for implementation once funded and would allow schools in those counties to begin providing much needed supports to school age children.

COVERED CALIFORNIA

Covered California State Subsidy Extension. Health Access California requests General Fund expenditure authority of $400 to $500 million annually for three years to support extension of the state subsidy program to improve health insurance affordability in the Covered California health benefits exchange. According to Health Access California, because California's premium subsidies were initially granted for only three years, without further budgetary action the additional financial assistance that Covered California enrollees rely upon will run out at the end of calendar year 2022. Because Covered California implements changes during 2020-21 and 2021-22 for open enrollment for the calendar year 2022 that commences on Oct. 1, 2021, action this year is necessary to assure smooth implementation.

Though federal proposals currently moving through the reconciliation process may result in even more federal premium assistance, the current federal proposals are also time-limited to the end of 2022. Given the context of the pandemic and ongoing issues of affordability for low- and middle-income Californians, it is important to secure California's subsidies for at least another three-year term. This is the year to extend the affordability assistance: Covered California and health insurers will need to prepare and price health plans for 2023 well before the 2022 budget is passed and signed into law.

Two years ago, California took unprecedented action to provide premium subsidy assistance to over one million low- and middle-income Covered California enrollees. The state subsidies have augmented existing federal premium subsidies for those in between 400 percent and 600 percent of the federal poverty level (FPL), about $48,000 to $75,000 for an individual, and provided more help to those 200 percent to 400 percent of the FPL, about $24,000 to $48,000 for an individual, while imposing a state-level individual mandate. As of May 2020, nearly 600,000 low to moderate income Californians earning below 400 percent of the FPL benefitted from the new state subsidies, and nearly 38,000 middle class consumers in the 400 to 600 percent FPL range received the new state subsidies.

State Subsidies to Provide Zero Premiums for Covered California Plans. Health Access California 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, and also other approaches to auto-enrollment, such as those subject to the California individual mandate penalty.

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

Questions. The subcommittee has requested LAO to briefly present each of these proposals for investment.

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

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

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.

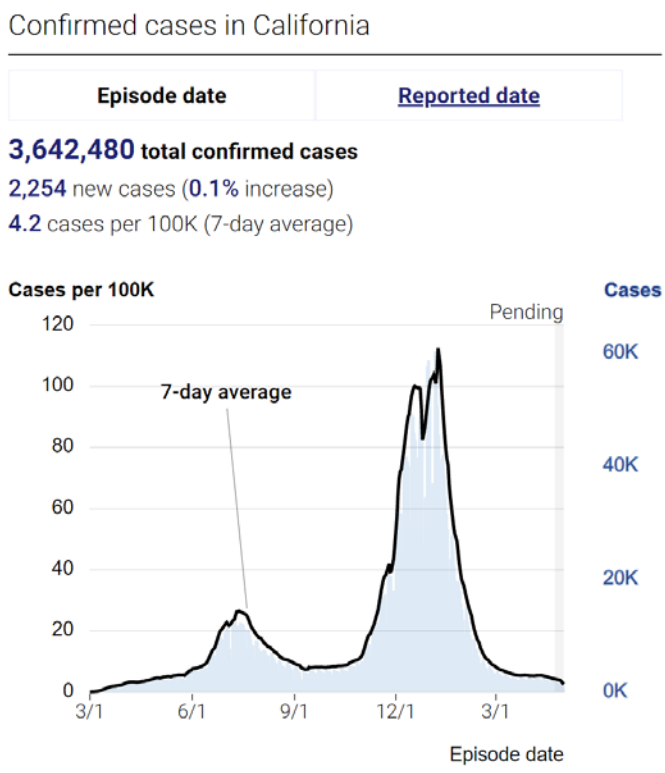
5. After the required promulgation of regulations in 2027, does DMHC expect to have to promulgate new regulations when equity and quality measures and benchmarks are updated periodically?

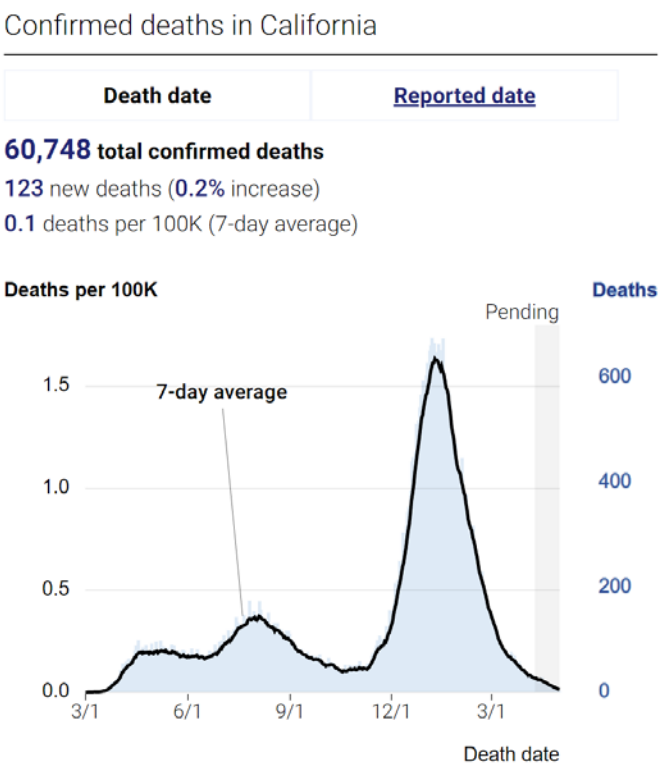
4265 DEPARTMENT OF PUBLIC HEALTH

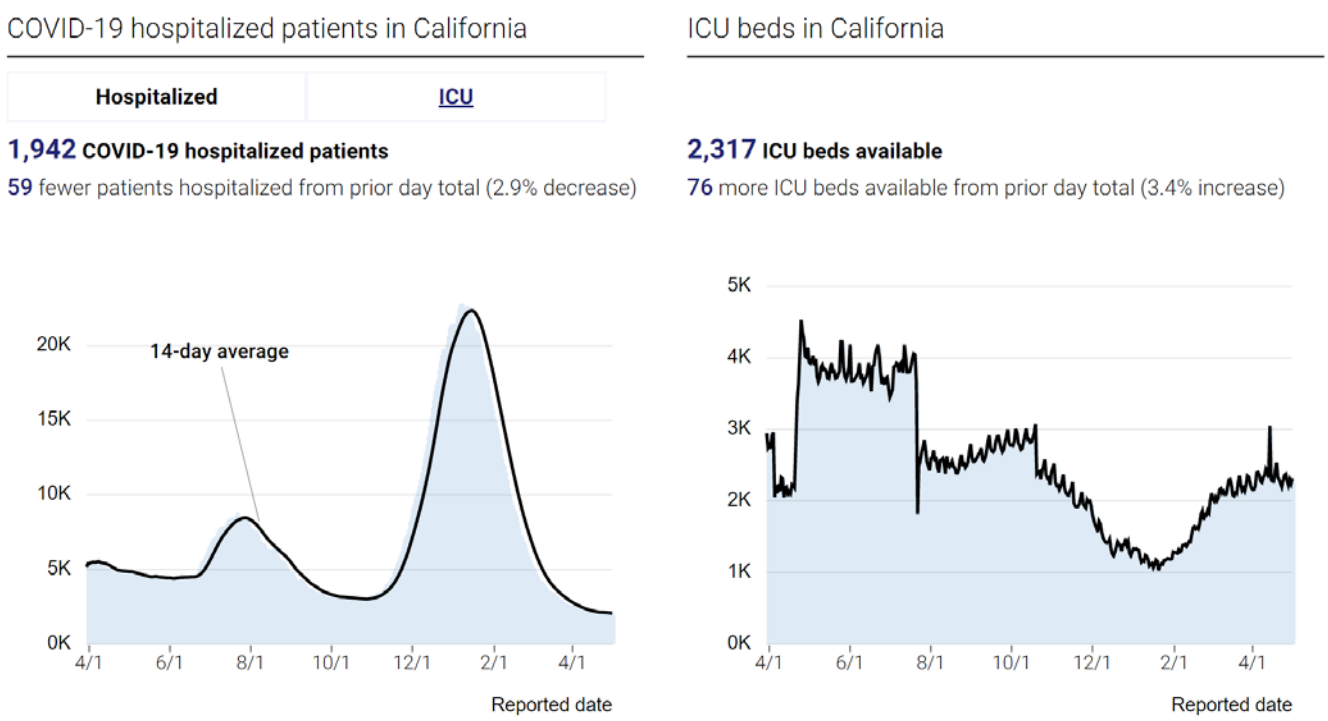
Issue 1: COVID-19 Pandemic Public Health Response Update and Infrastructure Investments

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.





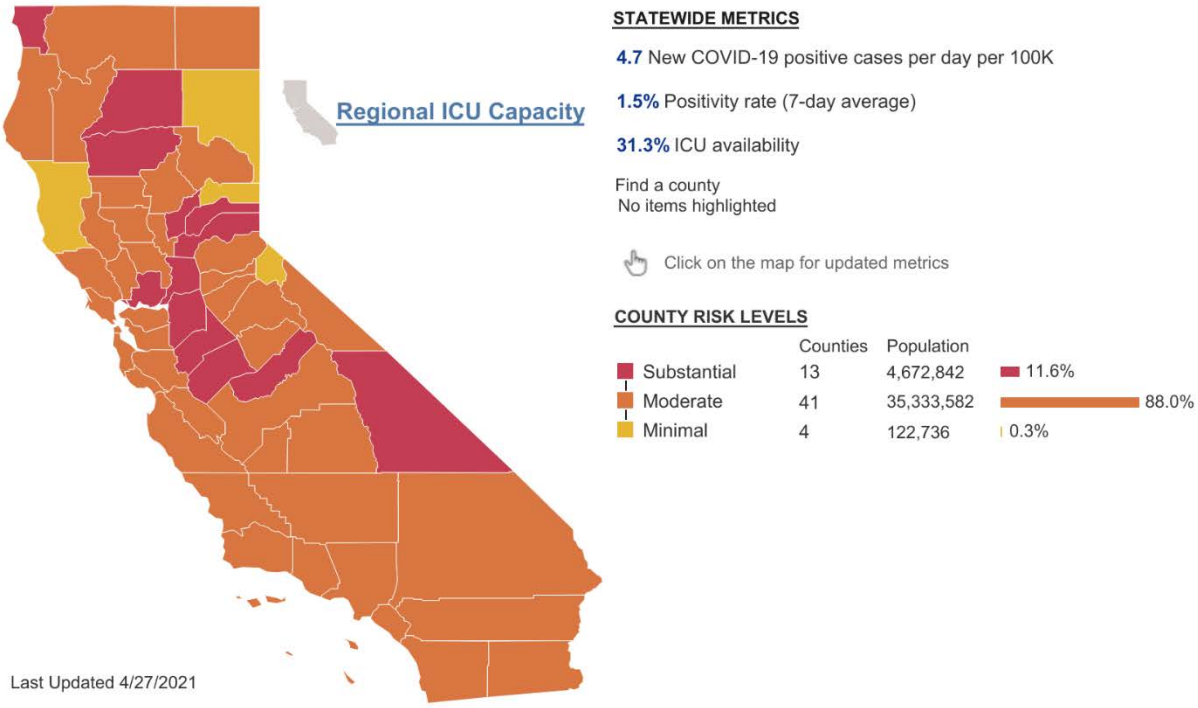


Cumulative, Daily, and 14-Day Average of COVID-19 Case Counts, Deaths, Hospitalized Patients, and ICU Capacity
Source: *California COVID-19 State Dashboard: https://covid19.ca.gov/state-dashboard/. Retrieved May 2nd, 2021.*

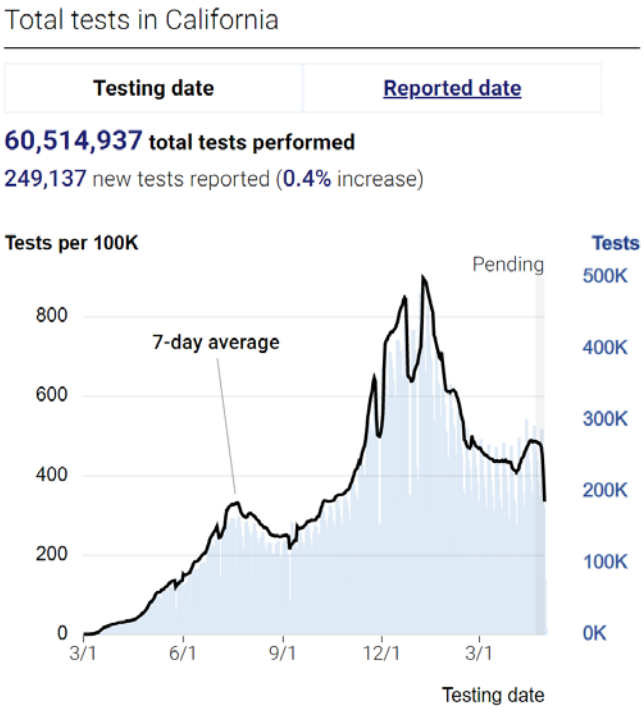
As of May 2nd, 2021, California also has the lowest case rate of any state in the nation, 31.2 weekly cases per 100,000 population, according to data from the federal Centers for Disease Control and Prevention (CDC).

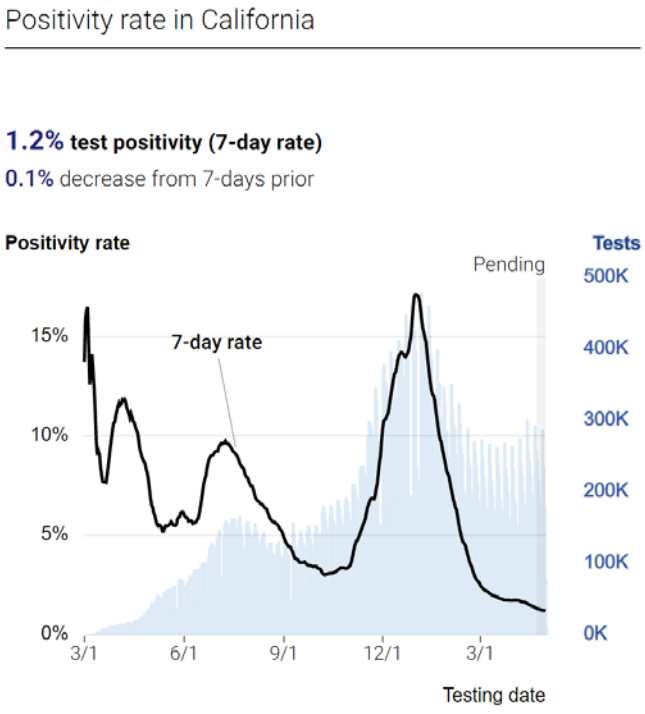
Blueprint for a Safer Economy. On August 28, 2020, DPH unveiled the Blueprint for a Safer Economy, which currently governs public health interventions and allowable activities by county. The Blueprint assigns each county to one of four tiers based on the transmission of COVID-19 in the county. Based 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.

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.

Thursday, May 6, 2021
10 a.m. or Upon Adjournment of Session
State Capitol - Room 3191

Consultant: Renita Polk

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

5160 DEPARTMENT OF REHABILITATION (DOR)

Issue 1: Spring BCP – Extension of Reimbursement Authority for the Deaf and Disabled Telecommunications Program

Spring Finance Request. The DOR requests a technical budget adjustment of $2.3 million reimbursement authority to support 3.2 limited-term positions to continue the implementation of the California Public Utilities Commission (CPUC) Deaf and Disabled Telecommunications Program (DDTP). This proposal would extend reimbursement authority to continue the pilot program, which was initially approved in the 2018 Budget Act, for an additional year through June 30, 2022.

Background. The DDTP provides speech generating devices to Californians with disabilities. To implement the DDTP, the DOR partnered with community-based service providers to serve individuals with speech disabilities by providing speech-generating software and tablets or similar assistive technology devices that enable them to become independent and provide direct access to the telecommunications network.

The DOR entered into agreements with community partners and began to distribute materials for the launch of the program, which was to take place on March 1, 2020. However, due to the pandemic, the launch of the pilot program was delayed to reexamine the service model and how the pilot could be successful when people would be required to stay at home as much as possible. From March 1 through June 1, the DOR updated its internal policies and procedures to allow for electronic signatures, remote demonstrations, in-person and remote access to services, and a complete revision to all training, materials, and considerations as to how the program would be marketed and provided.

The pilot program went live on July 1, 2020. Within the first six months of its launch, the DOR partnered with 12 community-based service providers who established 21 physical locations throughout the state in addition to providing services remotely. Many of the service providers are Independent Living Centers and were disproportionately impacted by COVID-19 since their consumers and most of their employees are people with disabilities who may be at higher risk for COVID-19. In addition, these organizations serve communities that are disproportionately impacted by wildfires and public safety power shutoffs. As a result of having to redirect significant resources in response to the pandemic, wildfires, and power shutoffs, the community-based service providers initially had lower than anticipated expenditures applied toward this pilot program. Despite all of the challenges, the DOR has provided speech-generating devices to 126 Californians. The DOR anticipates that this program will provide 200 speech-generating devices by June 31, 2021, and an additional 300 devices in 2021-22 for a sum of 500 devices distributed to Californians with speech disabilities, disorders, and/or difficulties. Since December 1, 2020, the pilot program has seen an increase in consumer interest. An extension of reimbursement authority would allow the DOR to build on this momentum and fully expend the funds that were not initially utilized due to multiple statewide emergencies.

Staff Comment and Recommendation. Hold open.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES (DCSS)

Issue 1: Spring BCP – Supporting Child Support Agency Administration

Spring Finance Request. The DCSS requests $31.1 million ($10.6 million General Fund) ongoing to support underfunded Local Child Support Agency (LCSA) staffing and services. This request is in addition to the $25 million ($8.5 million General Fund) proposed in the 2021 Governor's budget.

Background. LCSA administration costs include salaries and benefits of county staff as well as operating costs. LCSAs are responsible for case intake, court preparation to establish paternity and support obligations, and the enforcement of support obligations, including locating absent parents. LCSA administration costs are funded at $664 million for 2020-21 and $689 million for 2021-22. Funding for administration is 34 percent General Fund and 66 percent federal matching funds.

The proposed 2019 Governor's budget included an ongoing funding methodology for LCSAs. The proposed funding methodology increased funding by $19.1 million in 2019-20, ramping up to $57.2 million in 2021-22. In response to the budget impacts of the COVID-19 recession, the final 2020 budget reduced funding for the department and LCSAs to 2018-19 budget levels, and the ongoing augmentation proposed in 2019 was not implemented. The total between this proposal and the 2021 Governor's Budget proposal would return LCSA funding to 2019-20 levels ongoing, to support underfunded LCSAs staffing and program services. The request uses the LCSA funding methodology, updated with the latest 2020 caseload and calculated 2021-22 full-time equivalent cost data to identify underfunded counties. The methodology distributes funding to 29 underfunded counties, bringing these counties closer to the funding methodology.

Underfunded LCSA	Total Proposed Funding
Los Angeles	$20 million
San Bernardino	$5.5 million
Fresno	$4.5 million
Sacramento	$4.5 million
Riverside	$4 million
Kern	$3 million
San Diego	$2.8 million
San Joaquin	$2.4 million
Alameda	$1.3 million
Ventura	$1.1 million
Santa Barbara	$835,592
Stanislaus	$707,417
Merced	$660,299
Madera	$624,082
Imperial	$585,736
Monterey	$506,381
Placer	$500,107
Contra Costa	$472,643
San Francisco	$464,647
Solano	$391,472

Glenn	$233,416
Kings	$231,521
Tehama	$205,543
Yolo	$114,599
Trinity	$89,787
Sutter	$42,380
Eastern Sierra	$33,571
Lassen	$25,618
Mariposa	$1,235
Total	$56 million

Staff Comment and Recommendation. Hold open.

Issue 2: Senate Budget Options – Reduce State Inflicted Debt on Low-Income Residents

The Subcommittee has asked the Legislative Analyst's Office to present the following proposal.

Senate Budget Option. The Senate is considering a proposal to reduce and/or expunge uncollectible child support debt owed to the government, including a 2020 Governor's January budget proposal to cease enforcement of arrearages due to the state when the parent's sole source of income is from Supplemental Security Income/State Supplementary Payment (SSI/SSP) benefits, Cash Assistance for Aged, Blind, and Disabled Legal Immigrants (CAPI) benefits, a combination of SSI/SSP and Social Security Disability Insurance benefits, or Veterans Administration disability benefits. Note that this proposal would not eliminate any debt owed to families, only debt owed to government entities.

Background. Under federal law, a family receiving public assistance via TANF (which is the block grant that funds CalWORKs) must assign their rights to child support payments to the state. The state, through Local Child Support Agencies (LCSAs), collects the child support payments on behalf of the custodial parent. The noncustodial parent must reimburse the state for any CalWORKs or foster care funds expended by the state, as well as a nominal amount that is passed through to the custodial parent. Any arrears accrue with a ten percent interest rate.

When a family leaves CalWORKs, the family regains its rights to the child support payment. However, if the non-custodial parent has payments in arrears, the state continues collecting and retaining payments as reimbursement for costs associated with welfare benefits paid to the family. The cumulative amount of assistance paid to a family which has not been repaid through assigned support collections is known as the unreimbursed assistance pool (UAP). When the UAP is paid in full any continued child support is paid to the family.

The majority of outstanding public assistance debt is owed by those with low incomes, including some parents on fixed disability payments, who owe tens of thousands of dollars in debt each. A 2003 study prepared by DCSS entitled *Examining Child Support Arrears in California: The Collectability Study* found that 95 percent of the delinquent debt was likely uncollectible. Noncustodial parents making less than $10,000 owed an average of $20,000 due in part to a 10 percent interest rate on late payments. 2019 data shows that 40 percent of child support payments are for debt owed to the government[1].

Current law does attempt to right-size payments for low-income parents. Family Code Section 5246 does not allow a child support agency to withhold more than five percent of a non-custodial parent's disability benefits to pay child support arrearages. The department also administers a debt reduction program, the Compromise of Arrears Program (COAP). The program provides eligible parents with past-due child support payments the opportunity to reduce the amount of money owed to the government if their child(ren) received public assistance or were in foster care while the noncustodial parent was ordered to pay child support. To be eligible for the program the noncustodial parent must be currently making payments. This requirement makes it difficult for many low-income parents already in debt to qualify for the program.

Staff Comment and Recommendation. Hold open.

1 https://calmatters.org/projects/california-keeps-millions-in-child-support-while-parents-drown-in-debt/

As detailed above, the department currently does offer a way for some parents to reduce the amount of debt owed to the government. However, certain requirements of the program such as the requirement that the parent is making current payments prohibits many from participating in the program. The Subcommittee could consider expanding the COAP so that all parents can have the opportunity to reduce and/or eliminate the debt owed to the government, regardless of whether they are making current payments or not. The study mentioned above, as well as others, has found that the majority of child support debt owed to the government is owed by those with low income. Studies have also found that parents are less likely to make payments if those payments are going to the government and not their children. Alternatively, the Subcommittee could consider expunging the balance of the UAP, creating another avenue to ensure that families receive every dollar collected in support in the future. Expunging government-owed debt would remove a barrier to families getting the support they are owed and stop diverting money from the custodial parent to the government.

Panel. The Subcommittee has requested the following panelist to provide comments on this issue.

- Anne Stuhldreher, Director of the Financial Justice Project, Office of the San Francisco Treasurer

Questions.

For the Legislative Analyst's Office:

1. Please provide a brief overview of the proposal.

For Anne Stuhldreher:

1. Please discuss the impact of child support debt on families (both custodial and non-custodial parents).

2. Please describe the pilot program spearheaded by your office to provide debt relief on government-owed child support debt and the program's impact and outcomes.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

Issue 1: Spring BCP – Deaf Community

Spring Finance Request. The DDS requests $2.4 million ($1.6 million General Fund) for 21 regional center coordinators to support the expansion of deaf service resources, provide training and expertise to regional center staff, and coordinate with the department on statewide efforts. The DDS also requests $197,000 ($158,000 General Fund) for one Career Executive Assignment level position to provide statewide leadership and subject matter expertise on the provision of services and supports for individuals who are deaf and have intellectual or developmental disabilities.

Background. For several years, the department has been addressing service equity issues that exist within the developmental services system, with a focus on learning how to serve diverse populations within the service system with cultural and linguistic sensitivity. To that end, the department recognizes the need to evaluate supports for individuals who are deaf and have developmental disabilities and work with regional centers to identify and develop resources to provide improved services and supports. Approximately 14,300 individuals served within the system have moderate to profound hearing loss with about 510 of those individuals reportedly using American Sign Language (ASL) as their primary means of communication.

The current service delivery system is not nimble at identifying the unique cultural needs of individuals who are deaf. Factors that must be considered when serving this population include the availability of deaf service coordinators, adequate training of service coordinators, availability of ASL interpreters with experience in developmental disabilities, effective assessment of the need for individual service planning, and availability of providers with experience working with individuals who have developmental disabilities and who are deaf. Additionally, to effectively support an individual, regional centers must enhance their understanding of the varied and preferred communication methods of this group of individuals.

The proposed position will be responsible for the department's statewide efforts to provide culturally and linguistically sensitive services and supports to individuals who are deaf and have developmental disabilities. The specialist will also consult on innovative methods of service delivery and recommend solutions to improve services and supports for the targeted population, including those with the most challenging service needs. Additionally, the specialist will provide subject matter expertise, technical assistance, participate on external panels and committees, and interface with the regional center coordinators included in this request.

The proposed regional center coordinators will serve as a regional center's point person and subject matter expert on the provision of services to the deaf and hard of hearing community. Proposed duties of the regional center coordinator will include: liaising and partnering with generic agencies that provide services for individuals who are deaf and hard of hearing to expand the regional center's resource pool; and serving as the resource person for regional center staff who provide service coordination to individuals who are deaf and hard of hearing, among other duties.

Staff Comment and Recommendation. Hold open.

Issue 2: January BCP - Forensic Diversion

Governor's Proposal. The Governor's budget includes $2.3 million ($853,000 General Fund) and three positions to fully implement the recently expanded forensic diversion approach for individuals with Intellectual and Developmental Disabilities (IDD) who have been charged with a felony and are active in the criminal justice system. The additional requested positions include two senior psychologist specialists and one attorney.

Background. Many individuals have been charged with a criminal offense and remain in a jail setting pending their court hearing, placement in a competency program, or sentencing to a correctional facility setting. Alternatively, individuals can be court-ordered to a facility such as a prison, a juvenile justice facility, or the secure treatment area of Porterville Developmental Center (PDC).

In 2015, six plaintiffs filed a petition for a writ of mandamus alleging that delays in admitting incompetent to stand trial (IST) defendants for competency evaluation were unconstitutional (*Stiavetti vs. Ahlin*). In April 2019, the Alameda County Superior Court issued a final amended order. The court found that DDS and the Department of State Hospitals must commence substantive services to restore IST defendants to competency within 28 days of the transfer of responsibility. The court provided two and a half years to achieve this admission timeframe and ordered specified benchmarks. The state defendants have appealed to the California Court of Appeals, but no oral argument date has been set. The requested resources for diversion will be another avenue to reduce the pressure on the PDC Secure Treatment Program (waitlist and occupancy), may reduce admission timeframes, and ultimately, will prioritize a treatment-based approach and be responsive to the issues related to the *Stiavetti vs. Ahlin* lawsuit.

While DDS operates PDC and provides competency training and treatment, this may not be the optimal setting for particular individuals, such as those who have been charged with non-violent felony offenses and could be safely served in a community setting. According to DDS, the proposed implementation of the diversion plan will help enhance the collaboration between DDS and RCs in outreach and management for individuals who have become involved in or have a high potential for involvement in criminal conduct. Further, this will allow the services to move from a criminal justice approach to a clinical programming approach for a more effective intervention for these individuals.

Note that the 2020 Budget Act included language that expanded which individuals are eligible for diversion and provided resources for five forensic specialist positions at Regional Centers and one attorney position at headquarters. The 2020 budget also included funding for contracted wraparound services for individuals that have entered or are likely to enter the judicial system and have IDD, and temporarily expanded bed capacity at Porterville's Secure Treatment Program.

Staff Comment and Recommendation. Hold open.

Questions.

1. Will the proposed positions and/or resources be used to develop additional community resources to serve IST individuals? How is the department planning to expand community services for these individuals?

Issue 3: Senate Budget Options – Improved Services and Outcomes for the IDD Community

The Subcommittee has asked the Legislative Analyst's Office to present the following proposals.

Senate Budget Options. The Senate is considering the following proposals to improve services to the intellectual and developmental disability (IDD) community.

- Eliminate funding suspensions for:
    - Specified provider rate increases implemented in the 2019 and 2020 Budget Acts (and provide ongoing funding for that purpose).
    - Uniform Holiday Schedule and provide ongoing funding to permanently end the implementation of the Uniform Holiday Schedule. As part of a package of budget solutions passed in 2009 in response to a significant state budget deficit, the state enacted a policy prohibiting RCs from paying service providers on 14 uniform statewide holidays each year. This meant that service providers either did not provide services on those days or absorbed the cost without payment. Implementation of this policy is currently suspended but the Administration proposes to end that suspension in December 2022.

According to the LAO, General Fund costs associated with the above proposals amount to $159 million in 2022-23 and $325 million in 2023-24. For more details on these proposals please refer to the February 23, 2021 hearing agenda.

- Provide additional funding and/or adopt placeholder trailer bill language to do the following:
    - Provisional Regional Center Director Approval of Health and Safety Waivers – adopt placeholder trailer bill language that would allow RC Directors to approve Health and Safety Waivers. The current departmental directive delegates this authority for residential services and/or supplemental services in residential settings.
    - Virtual meetings – adopt placeholder trailer bill language to waive the requirement for in-person service coordination meetings and early start services.
    - Participant-Directed Services – adopt placeholder trailer bill language to allow consumers and families to utilize participant-directed services for personal assistance, independent living, and supported employment. Participant-directed services let the consumer or family choose who to hire, schedule when the person works, and supervise the work. Before the COVID-19 pandemic, consumers could only use a participant-directed model for respite, day care, non-medical transportation, nursing, and day services.
    - Critical Generic Resources – adopt placeholder trailer bill language requiring Regional Centers to secure or fund critical generic resources. Once a regional center identifies a service that can meet an identified need, it is responsible for purchasing or securing that service. Regional centers cannot purchase a requested service if a

different publicly funded program is responsible for funding that service. When a regional center believes that another agency is legally obligated to fund or provide a service, the regional center may attempt to secure that service from the agency by notifying the agency and initiating a dispute resolution process. This process is discretionary and only available for children under six years of age. The proposed language would open this process up to all consumers and require a RC to fund a service if it chooses not to utilize the dispute resolution process.

The above proposals were put forward by Disability Rights California and were heard at the Subcommittee's February 23, 2021 hearing. For more details on these proposals, please refer to the February 23, 2021 hearing agenda.

- Improve employment opportunities for Californians with IDD – adopt placeholder trailer bill language to increase utilization of the Paid Internship Program (PIP) and competitive integrated employment (CIE). The PIP was established when the state minimum wage was $10 per hour, and it allowed consumers to earn up to $10,400 per year in the program, which equates to 1,040 possible internship hours. This proposal would replace the $10,400 earnings cap with a 1,040 annual hours cap. This reflects a proposal put forth by the California Disability Services Association heard at the Subcommittee's February 23, 2021 hearing. For more detail on this proposal, please refer to the February 23, 2021 hearing agenda.

- Begin implementation of a training and certification program for Direct Support Professionals (DSPs), as recommended in the 2019 DDS vendor rate study.

Background. While the need and desire for system-wide change within the developmental services system have been a continued topic of discussion in the Subcommittee, the COVID-19 crisis highlighted that need and forced the system to adapt and make needed changes almost overnight. In response to COVID-19, the developmental services system quickly mobilized to meet the unique needs of individuals with disabilities. Service providers across the state pivoted to providing alternative support services remotely; regional centers transitioned to providing remote service coordination and other meetings virtually, and the department quickly issued directives to allow for these changes and many others.

While expanded vaccine eligibility has allowed the state to open up more, some consumers will likely continue to desire to utilize the flexibilities put into place during the pandemic. At the Subcommittee's February 23 hearing, the Subcommittee heard from Regional Center Directors, consumer advocates, providers, and other stakeholders about the importance of the above proposals, and specifically the various directives put in place by DDS since the beginning of the pandemic. Several witnesses testified in support of continuing some of those directives. The state can also use the implementation of these directives as a jumping-off point to think about broader changes within the developmental services system.

Before the COVID-19 pandemic, DSP turnover was high due to low wages, and the pandemic only exacerbated this issue. Direct support staff, who work with consumers daily, are essential to the developmental services system. Since the beginning of the pandemic, DSPs faced the risk of contracting COVID-19 to deliver services to individuals across the state. The state must invest in a quality direct support workforce. The establishment of a training/certification program for direct

support staff was suggested in the 2019 rate study submitted to DDS by Burns and Associates, Inc. The study recommended a model where direct support staff who receive more training and demonstrate greater competency are assigned to a "level" attached to higher payments, thus reflecting higher wages. The implementation of this model would require the establishment of infrastructure both within the DDS (or perhaps another state department) and the provider community.

The COVID-19 pandemic has caused a rise in unemployment, particularly among people with disabilities. According to the Society for Human Resources Management, close to one million workers with disabilities in the United States have lost their jobs since the COVID outbreak was a declared a pandemic by the World Health Organization in March 2020. In 2020, only 13.51% of RC consumers received wages, according to the RC data dashboard on the DDS website. It is imperative that the state do all it can to help those within the community find jobs if they so choose. Two avenues for obtaining employment are the paid internship program (PIP) and competitive integrated employment (CIE). Since 2016-17, the state budget has appropriated $29 million ($20 million General Fund) annually for the implementation of the PIP and CIE incentives program. Both are designed to increase employment opportunities and CIE outcomes. However, the state has underspent this appropriation by $96 million over the past four years. Increasing utilization of these programs and the designated appropriation is a first step to ensuring that all RC consumers who would like to work are able to.

Staff Comment and Recommendation. Hold open.

Panel. The Subcommittee has requested the following panelists to provide comments on the above proposals.

- Sawait Seyoum, Senior Policy Advisor, Disability Rights California
- Barry Jardini, Executive Director, California Disability Services Association
- Jordan Lindsey, Executive Director, the ARC of California

Questions.

For the Legislative Analyst's Office:

1. Please provide a brief overview of the proposals.

For Sawait Seyoum:

2. Please discuss the impact of the proposals to continue various COVID-19 directives on the IDD community and how they can help bring about system-wide change.

For Barry Jardini:

3. Please discuss the expected impact of the proposal to increase utilization of the PIP and CIE programs on employment opportunities within the IDD community.

For Jordan Lindsey:

4. Please discuss the impact COVID-19 has had on the DSP workforce.

5. Please describe the type of infrastructure currently needed to invest in a training and certification program for DSPs.

PROPOSALS FOR INVESTMENT RELATING TO DEVELOPMENTAL SERVICES

The Subcommittee has received the following proposal for investment and has asked the Legislative Analyst's Office to present it. Note that proposal sponsors provided all information below, aside from staff comments and recommendations.

1. Service Outcomes Initiative for California's Developmental Disability Community

Budget Issue. The California Community Living Network requests $2 million in 2021-22, $3 million in 2022-23, and $5 million in 2023-24 for a pilot project that will develop service outcome-based measurement, training, quality, and data collection tools for California's developmental disability services.

Background. The state has been concerned about the rising cost of providing services to individuals with developmental disabilities for several years. There is increasing pressure to understand how to provide quality services in a manner that balances the intent of the Lanterman Act, but also provides value. The requested resources would establish an administrative pilot program, administered by the DDS, to identify a limited number of services provided to individuals through California's regional center network and develop outcome metrics. The pilot would be voluntary on the part of the regional center, the service provider, and the consumer. No services would be altered, modified, limited, or otherwise changed due to this administrative pilot. The purpose of the pilot is to create and validate administrative measures to better track and measure outcomes and quality in the developmental disability service area. This approach creates the ability to measure service delivery, use of service deliverables, and the service outcome's contribution to quality-of-life goals.

Staff Comment and Recommendation. Hold open.

Note that this budget request is accompanied by a policy bill, AB 813 (Mullin), currently under consideration in the current legislative session.

4170 CALIFORNIA DEPARTMENT OF AGING (CDA)

Issue 1: Spring BCP – Extend and Increase Funding to the Aging & Disability Resource Connection

Spring Finance Request. The CDA requests $1.9 million General Fund in 2021-22 and $1.8 million General Fund in 2022-23 and ongoing to support 13 permanent positions for the expansion of the Aging & Disability Resource Connection (ADRC) Infrastructure Grants Program proposed in the 2021 Governor's Budget and to provide oversight, coordination, and assistance to the state-wide ADRC network including building the capacity to draw down additional federal funds through Medicaid.

Background. The ADRC Infrastructure Grants program supports efforts by local Area Agencies on Aging (AAAs) and Independent Living Centers (ILCs) to set up a statewide network of ADRCs. The requested state operations resources will allow CDA to support the administration of the grant program and to provide the ADRC network with statewide oversight, coordination, and assistance. CDA will provide training, guidance, and technical assistance to local ADRCs. CDA will develop centralized services and resources to prevent duplication of efforts by local ADRCs such as a statewide website and phone line. CDA will also work to establish the administrative capacity for the ADRC program to draw down federal funding through Medicaid administrative claiming.

Staff Comment and Recommendation. Hold Open.

Note that the January Governor's budget proposes a half-year augmentation of $5 million General Fund in 2021-22 and a half-year augmentation of $5 million General Fund in 2022-23 to maintain and expand this program. That issue was discussed at the Subcommittee's March 2, 2021 hearing.

Issue 2: Spring BCP – Health Insurance Counseling and Advocacy Program (HICAP) Modernization

Spring Finance Request. The CDA requests $2.1 million in 2021-22 and $2 million in 2022-23 from the HICAP special fund to support two-year limited-term resources equivalent to three positions and $1.4 million local assistance funding.

The CDA also requests the following provisional language be added to the Budget Act.

To Item 4170-001-0289:

1. Notwithstanding any other law, upon request by the Department of Aging, the Department of Finance may increase the expenditure authority in this item up to the total amount of proceeds available in the State HICAP Fund not sooner than 30 days after notification in writing of the necessity thereof is provided to the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the committees in each house of the Legislature that consider appropriations.

2. Of the funds appropriated in this item, $673,000 is a temporary augmentation to the Health Insurance and Counseling and Advocacy Program. Notwithstanding any other law, the amount of this augmentation and any increase made pursuant to Provision 1 shall be exempt from the ratio provided by subdivision (d) of Section 9541.5 of the Welfare and Institutions Code.

To Item 4170-101-0289:

1. Notwithstanding any other law, upon request by the Department of Aging, the Department of Finance may increase the expenditure authority in this item up to the total amount of proceeds available in the State HICAP Fund not sooner than 30 days after notification in writing of the necessity thereof is provided to the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the committees in each house of the Legislature that consider appropriations.

2. Of the funds appropriated in this item, $1,386,000 is a temporary augmentation to the Health Insurance and Counseling and Advocacy Program. Notwithstanding any other law, the amount of this augmentation and any increase made pursuant to Provision 1 shall be exempt from the ratio provided by subdivision (d) of Section 9541.5 of the Welfare and Institutions Code.

Background. HICAP provides free, confidential one-on-one counseling, education, and assistance to individuals and their families on Medicare, Long-Term Care insurance, other health insurance related issues, and planning ahead for Long-Term Care needs. HICAP services are provided through the statewide network of 26 local Area Agencies on Aging (AAAs).

HICAP is California's implementation of the federal State Health Insurance Assistance Program (SHIP). HICAP is primarily funded from three sources: (1) fees assessed on Medicare Health Care Service Plans deposited in the HICAP Special Fund; (2) reimbursements from the Insurance Fund; and (3) federal SHIP grant funding provided by the Administration for Community Living (ACL). HICAP Special Fund revenues have grown from $3.2 million in 2005-06 to an estimated $4.1 million in 2020-21. Meanwhile, state fund expenditure authority for local HICAP programs has not been changed from $6.7 million since 2005-06. The 2021 Governor's Budget projects that the HICAP Special Fund will have a $10.6 million balance at the end of 2021-22, given current revenue and expenditure levels, in addition to a $4 million loan balance due from the General Fund.

CDA requests provisional language which would allow expenditure authority to be increased upon 30-day notification to the Legislature during a two-year period. This flexibility will allow CDA and local HICAP programs to implement additional modernization options as priorities are developed, within existing HICAP Special Fund resources. CDA also requests provisional language, during this two-year period, to exempt this temporary augmentation and any increase made pursuant to provisional authority from matching by the Insurance Fund, as this request is a one-time investment in modernizing HICAP based on available surpluses in the HICAP Special Fund. 58 percent of HICAP service providers report insufficient staffing necessary to manage existing workload and modernization. In addition, 73 percent of HICAP service providers report insufficient funding to procure needed equipment and supplies. Several of the HICAPs have only part-time Volunteer Coordinators and no dedicated staff. The requested local assistance resources will allow each local HICAP program to retain one full-time equivalent staff position. Several of the HICAPs have only part-time Volunteer Coordinators and no dedicated staff.

Staff Comment and Recommendation. Hold open.

Issue 3: Spring BCP – Master Plan for Aging Implementation

Spring Finance Request. The CDA requests $3.3 million General Fund ongoing to support 20 permanent positions and resources equivalent to one one-year limited-term position and $300,000 contract authority to implement the Master Plan on Aging (MPA) through policy, technology, data, project management, and support. Additionally, CDA requests authority for two permanent positions for existing temporary help positions.

Background. In January 2021, the California Health & Human Services Agency published the Master Plan for Aging to serve as a comprehensive framework that will prepare the state for significant demographic changes in the years ahead, including the growth of the 60-and-over population to 10.8 million people by 2030. CDA is the lead agency responsible for coordinating the implementation of the Master Plan.

The CDA requests positions to address the following areas and implement the MPA:

- Policy Leadership and Support (10 positions)

  CDA currently does not have a dedicated policy research, analysis, and development function. Existing analyst positions in program divisions are dedicated predominantly to program operations. CDA requests the establishment of a dedicated central policy leadership function to be able to research, analyze, and develop policy for the strategic operation and development of California's aging programs. One of the positions included in this request is a Chief of Aging Policy. Other requested positions include a focus on inclusion and isolation prevention, equity, and housing.

- Information Technology Leadership and Support (5 positions)

  CDA's current Information Technology (IT) Branch consists of 11 authorized positions and is resourced to maintain existing program operations. CDA requests additional resources to provide IT leadership and expertise to implement the Master Plan. CDA is currently working with the Department of Technology and the California Health & Human Services Agency Information Officer to develop a state-wide Client Relationship Management system that will bring all aging programs and local Area Agencies on Aging onto one platform. The requested resources will also enable CDA to quickly change systems to reflect program changes implemented as part of the Master Plan.

- Master Plan for Aging Project Leadership (3 positions)

  CDA previously administratively established two temporary help positions to support the development of the Master Plan by redirecting savings achieved through operational efficiencies. As the Master Plan is a 10-year project, these positions will be needed for implementation during the entire duration of the project. CDA requests permanent position authority-only for these existing positions, as well as funding and position authority for one additional Associate Governmental Program Analyst position.

- Dignity at Home Fall Prevention Program

The 2019 Budget Act provided $5 million one-time funding for the Dignity at Home Fall Prevent Program. The 2021 Governor's Budget proposes to extend the availability of this funding through June 30, 2022, because of delays associated with COVID-19. CDA also requests one-year limited-term resources to retain the Staff Services Manager I Specialist for an additional year.

- Office of Legal Services (3 positions)

  Workload is expected to increase with the implementation of the Master Plan for Aging. CDA requests two attorney positions and one legal analyst position to support legal services.

- Human Resources Support

  CDA requests one position in the Human Resources Branch to manage the increased recruitment, hiring, and other associated workload for the positions requested in this proposal.

Staff Comment and Recommendation. Hold open.

Questions.

1. Will the Client Relationship Management system be able to interface with and/or include programs administered by other departments that most consumers of CDA aging programs also use?

Issue 4: Spring BCP – Office of Long-Term Care Patient Representative

Spring Finance Request. The CDA requests $2.5 million in 2021-22 and $4 million in 2022-23 and ongoing from the California Department of Public Health Licensing and Certification Fund for six permanent positions and local assistance resources to establish the Office of Long-Term Care (LTC) Patient Representative.

The CDA also requests statutory changes to establish the Office and the following language be added to the Budget Act:

To Item 4170-101-3098:

1. Notwithstanding any other law, upon request by the Department of Aging and in consultation with the Department of Public Health, the Department of Finance may increase expenditure authority in Schedule (1) of this item for the Office of Long-Term Care Patient Representative if the expenditure authority in this item is projected to be insufficient to provide adequate patient representative services based on program caseload and service costs. The Department of Finance shall not authorize an increase pursuant to this provision sooner than 30 days after notification in writing of the necessity thereof is provided to the Chairperson of the Joint Legislative Budget Committee and the chairpersons of the committees in each house of the Legislature that consider appropriations, or

not sooner than whatever lesser time after that notification the chairperson of the joint committee, or the chairperson's designee, may determine.

Background. Health and Safety Code Section 1418.8 sets forth procedures to be followed for skilled nursing facility (SNF) and intermediate care facility (ICF) residents who cannot make their own health care decisions and who do not have a legally authorized decision-maker, as an alternative to petitioning a court to appoint a decision-maker, or authorize a health care decision according to the Probate Code. The statute authorizes an interdisciplinary team -- consisting of the resident physician, a registered nurse responsible for the resident, other appropriate staff, and a patient representative -- to review and authorize medical treatment.

In *California Advocates for Nursing Home Residents (CANHR) v. Smith (2019),* the constitutionality of the statute was challenged. The Court upheld the constitutionality of the statute; however, the court required facilities to ensure that a patient representative is part of every interdisciplinary team even if no family member or friend of the patient is available to act in this role. An interdisciplinary team may act without a patient representative only in the instance of an "urgent medical emergency" affecting the patient. This exemption does not extend to necessary health care decisions in non-emergency circumstances.

If the patient lacks an available family member or friend, the facility must locate a person unaffiliated with the facility to act as a patient representative to use the interdisciplinary team process. If the facility is unable to locate a patient representative, the facility may not use the interdisciplinary team process and must instead petition a court to authorize health care decisions. Following the *CANHR v Smith* court ruling, facilities have not developed an organized process to designate unaffiliated patient representatives for otherwise unrepresented patients who lack decision-making capacity. CDA proposes to establish the Office of LTC Patient Representative to provide a uniform statewide approach to represent the interests of otherwise unrepresented patients. CDA proposes to fund this program using facility fees from the California Department of Public Health Licensing & Certification Fund, given the Court ruling imposed the responsibility of locating a patient representative on the facilities, not the state.

Staff Comment and Recommendation. Hold open.

Questions.

1. Advocates have expressed concerns that the Administration is proposing to fund the Office with facility licensing fees instead of General Fund. They believe that this may be a violation of the court ruling as skilled nursing facilities are precluded from funding the activities of patient representatives. Please respond to these claims.

Issue 5: Senate Budget Options - Aging Issues

The Subcommittee has asked the Legislative Analyst's Office to present the following proposals.

Senate Budget Option. The Senate is considering the following budget proposals:

- Eliminate the funding suspension in CDA senior nutrition programs and provide $35 million ongoing for those programs. This reflects a proposal put forward by the California Association of Area Agencies (C4A) heard at the Subcommittee's March 2, 2021 hearing. For details on the proposal, please refer to the March 2 hearing agenda.

- Eliminate the funding suspension for ADRCs and provide ongoing funding for the statewide ADRC network. This reflects a proposal put forward by the California Association of Area Agencies (C4A) heard at the Subcommittee's March 2, 2021 hearing. For details on the proposal, please refer to the March 2 hearing agenda.

- Provide ongoing funding to support the Dignity at Home Fall Prevention Program and make it permanent. This reflects a proposal put forward by the California Association of Area Agencies (C4A) heard at the Subcommittee's March 2, 2021 hearing. For details on the proposal, please refer to the March 2 hearing agenda.

- Provide one-time funding to bridge the digital divide and provide additional tablets and other devices to older Californians. This will build on CDA's current partnerships with AT&T and Google to provide tablets and smart speakers to older Californians who are low-income and live alone.

- Provide baseline ongoing funding for Area Agencies on Aging. This reflects a proposal put forward by the California Association of Area Agencies (C4A) heard at the Subcommittee's March 2, 2021 hearing. For details on the proposal, please refer to the March 2 hearing agenda.

Note that other aging issues are included in other departments. Those proposals (listed below) will be discussed at other Subcommittee hearings.

- Permanently restore the seven percent reduction to IHSS service hours.

- Incentivize counties to reach IHSS labor agreements.

- Simplify the CalFresh application process for seniors and the disabled.

Background. Over the past several years, the Senate and the Administration have taken an interest in aging issues. The Senate has implemented an "aging package" in the last two budget years that address issues of importance for aging Californians. Some of those funding proposals included increased funding for senior nutrition programs and a statewide ADRC network, increased supplemental payments for Multipurpose Senior Services Program (MSSP) providers, increased funding for Long-Term Care Ombudsman offices, and startup funding for an injury prevention and education program.

While the Legislature has made strides to address aging issues in California, the COVID-19 crisis has only highlighted the need for additional resources for the older population. The pandemic has laid bare the food insecurity among older adults. At the start of the pandemic Area Agencies on Aging (AAAs) shifted from providing congregate meals to home-delivered meals and meals for pick-up. In 2020, there were a record 27 million meals delivered to older Californians. This represents a 51% increase over 2019 numbers (17.8 million). While the state's recent progress in getting Californians vaccinated has hinted at a coming end to the pandemic it is likely that there will still be a need and desire for alternatives to congregate meals.

Access to reliable internet and digital devices have also been critical tools necessary to remain socially connected. To meet that need CDA has leveraged public-private partnerships with AT&T and Google to provide tablets and smart speakers to thousands of older Californians who are low income and live alone. Google has donated 8,500 smart speaker devices, which have been distributed to local AAAs and MSSP sites to distribute to their clients. CDA has also entered into an agreement with AT&T to purchase 4,000 iPad tablets that will be provided to AAAs to distribute to low-income older adults who live alone.

The Senate is considering the above budget options to build on current efforts at CDA by providing additional funding for senior nutrition programs, ADRCs, and AAs; and one-time funding to provide tablets and other devices to seniors to combat isolation and loneliness.

Staff Comment and Recommendation. Hold open.

Panel. The Subcommittee has requested the following panelist to provide comments on the above proposals.

- Victoria Jump, Director, Ventura County Area Agency on Aging

Questions.

For the Legislative Analyst's Office:

1. Please provide a brief overview of the proposals.

For Victoria Jump:

2. Please discuss the impact COVID-19 has had on the programs that the Area Agencies on Aging administer, and how the above proposals may help to address those issues at AAAs and ADRCs.

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 11, 2021
1:30 pm
State Capitol - Room 3191

Part A Agenda

Consultant: Renita Polk

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

ISSUES FOR VOTE ONLY

4170 DEPARTMENT OF AGING

Issue 1: Delay of Repeal of Funding for Aging and Disability Resource Connections (ADRCs) and Senior Nutrition Programs

Trailer Bill language – Governor's Budget. CDA proposes trailer bill language to delay the suspension of additional funding provided in the 2019 budget for ADRC programs and Older Americans Act senior nutrition programs until December 31, 2022. Rather than executing the suspension calculation this May (under current law), the Governor's budget proposes a new suspension calculation at May Revision in 2022. Specifically, the Governor proposes that the Legislature enact new suspension language that would give the Department of Finance (DOF) the authority to make this calculation again at the time of the May Revision in 2022.

This proposal was heard at the subcommittee's hearing on March 2, 2021.

Staff Comment and Recommendation – Modify. As with other issues proposed for suspension discussed in previous Subcommittee hearings, staff notes that the suspension language treats policies that are fundamentally ongoing as temporary and understates the true ongoing cost of the state's policy commitments. The suspension language creates uncertainty in these programs, creating uncertainty for the vulnerable individuals that these programs serve. Staff recommends the following alternative to the Administration's proposal:

- Adopt placeholder budget bill language to eliminate all program suspensions authorized in the Budget Act.

- Adopt placeholder trailer bill language to eliminate all program suspensions authorized in statute

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 2: Delay or Repeal of Program and Benefit Suspensions

Budget Bill Language and Trailer Bill Language – Governor's Budget. DHCS proposes provisional budget bill language and trailer bill language to delay or repeal program and benefit suspensions first adopted in the 2019 Budget Act. Specifically, the proposed language would: 1) delay or repeal suspensions for certain supplemental payments for Medi-Cal providers supported by Proposition 56 tobacco tax revenue; 2) delay suspension of certain optional Medi-Cal benefits; 3) delay suspension of provisional post-partum extension of Medi-Cal eligibility; and 4) repeal suspension of screening, brief intervention, and referral to treatment (SBIRT) for opioids and other drugs.

This proposal was heard at the subcommittee's hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Modify. While the Administration's proposed delay of the suspension of these critical programs would provide temporary respite from the threat to the health and well-being of program beneficiaries that these suspension represent, their continued existence in budget bill language and statute prevents the adoption of the type of provider behavior changes required to expand access to necessary care. As expanding access to care is one of the primary goals of the programs subject to suspension, maintaining these suspensions undermines these programs' effectiveness and reduces the effectiveness of a substantial investment of state resources. Subcommittee staff recommends the following alternative to the Administration's proposal:

- Adopt placeholder budget bill language to eliminate all program suspensions authorized in the Budget Act.

- Adopt placeholder trailer bill language to eliminate all program suspensions authorized in statute.

Issue 3: Expansion of Medi-Cal Eligibility Regardless of Immigration Status

Legislative Augmentation. The Governor's 2020-21 January budget included $80.5 million ($64.2 million General Fund) in 2020-21 to extend Medi-Cal eligibility for all individuals 65 and older regardless of immigration status, effective no sooner than January 1, 2021, including $5.9 million General Fund costs to the Department of Social Services for additional In-Home Supportive Services (IHSS) for this population. When fully implemented, this expansion of coverage would have resulted in annual costs of $350 million ($320 million General Fund), including $119.5 million of General Fund costs for IHSS.

Due to the estimated General Fund shortfall due to the COVID-19 pandemic, the 2020 Budget Act did not include the Governor's proposal to extend Medi-Cal eligibility to individuals 65 and older regardless of immigration status. However, the Legislature approved trailer bill language to prioritize full-scope Medi-Cal expansion to undocumented seniors in the upcoming budget if the Department of Finance determines there are sufficient General Fund revenues for that fiscal year and the ensuing three fiscal years to support the expansion.

Subcommittee Staff Comment and Recommendation—Augment. The trailer bill language approved by the Legislature in the 2020 Budget Act prioritized expanding full-scope Medi-Cal to undocumented seniors if sufficient General Fund revenues are available. The COVID-19 pandemic has made clear that when any California resident is denied access to health care, particularly California seniors, the health and well-being of all Californians can be put at risk. Subcommittee staff recommends the following actions:

- **Approve** expenditure authority of $84.5 million ($67.5 million General Fund and $17 million federal funds) for DHCS to expand full-scope Medi-Cal coverage to income-eligible individuals 65 years of age and older regardless of immigration status, beginning January 1, 2022.
- **Adopt placeholder trailer bill language** to do the following:

- Expand full-scope Medi-Cal coverage to income-eligible individuals 65 years of age and older regardless of immigration status, beginning January 1, 2022.
- Increase eligibility for full-scope Medi-Cal coverage for income-eligible individuals regardless of immigration status by one year of age every fiscal year, beginning with expansion to individuals age 26 in 2022-23.
- Require DHCS and the Department of Finance to provide, by January 10, 2022, a fiscal and programmatic plan for expanding full-scope Medi-Cal to the remaining population ages 26 to 64 regardless of immigration status, within the subsequent five fiscal years.

- **Hold open** consideration of expanding eligibility for full-scope Medi-Cal coverage for the remaining undocumented population, ages 26 to 64 in the 2021-22 fiscal year. Upon receipt of updated fiscal estimates after the release of the May Revision, the subcommittee may wish to consider additional coverage expansions for this population, if sufficient General Fund resources are available.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 4: Delay of Repeal of Funding for Specified Provider Rate Increases and the Uniform Holiday Schedule

Governor's Budget. DDS proposes to delay the suspension of additional funding provided in the 2019 and 2020 budgets for specified provider rate increases and the continued suspension of the Uniform Holiday Schedule until December 31, 2022. Rather than executing the suspension calculation this May (under current law), the Governor's budget proposes a new suspension calculation at May Revision in 2022. Specifically, the Governor proposes that the Legislature enact new suspension language that would give the Department of Finance (DOF) the authority to make this calculation again at the time of the May Revision in 2022.

This proposal was heard at the subcommittee's hearing on February 23, 2021.

Staff Comment and Recommendation – Modify. As with other issues proposed for suspension discussed in previous Subcommittee hearings, staff notes that the suspension language treats policies that are fundamentally ongoing as temporary and understates the true ongoing cost of the state's policy commitments. The suspension language creates uncertainty in these programs, creating uncertainty for the vulnerable individuals that the programs serve. Staff recommends the following alternative to the Administration's proposal:

- Adopt placeholder budget bill language to eliminate all program suspensions authorized in the Budget Act.

- Adopt placeholder trailer bill language to eliminate all program suspensions authorized in statute.

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 5: Delay of Repeal of Funding for Restoration of the Seven Percent Cut to IHSS Service Hours

Governor's Budget. CDSS proposes to delay the suspension of funding to restore the seven percent cut to IHSS service hours until December 31, 2022. Rather than executing the suspension calculation this May (under current law), the Governor's budget proposes a new suspension calculation at May Revision in 2022. Specifically, the Governor proposes that the Legislature enact new suspension language that would give the Department of Finance (DOF) the authority to make this calculation again at the time of the May Revision in 2022.

This proposal was heard at the subcommittee's hearing on March 2, 2021.

Staff Comment and Recommendation – Modify. As with other issues proposed for suspension discussed in previous Subcommittee hearings, staff notes that the suspension language treats policies that are fundamentally ongoing as temporary and understates the true ongoing cost of the state's policy commitments. The suspension language creates uncertainty in these programs, creating uncertainty for the vulnerable individuals that the programs serve. Staff recommends the following alternative to the Administration's proposal:

- Adopt placeholder budget bill language to eliminate all program suspensions authorized in the Budget Act.

- Adopt placeholder trailer bill language to eliminate all program suspensions authorized in statute.

- Adopt placeholder trailer bill language to permanently restore the seven percent reduction to In Home Supportive Services (IHSS) hours and repeal language allowing for the reduction currently in statute.

Issue 6: Delay of Repeal of Funding for Various Children's Programs

Governor's Budget. CDSS proposes to delay the suspension of funding provided in the 2019 Budget Act for the programs listed below until December 31, 2022. Rather than executing the suspension calculation this May (under current law), the Governor's budget proposes a new suspension calculation at May Revision in 2022. Specifically, the Governor proposes that the Legislature enact new suspension language that would give the Department of Finance (DOF) the authority to make this calculation again at the time of the May Revision in 2022.

The programs proposed for funding suspensions include:

- Family Urgent Response System
- Foster Family Agency Rate Increase
- Emergency Child Care Bridge Supplement

- Child Welfare - Public Health Nurse Early Intervention Program

Staff Comment and Recommendation – Modify. Staff recommends the following alternative to the Administration's proposal:

- Adopt placeholder budget bill language to eliminate all program suspensions authorized in the Budget Act.

- Adopt placeholder trailer bill language to eliminate all program suspensions authorized in statute.

ISSUES FOR DISCUSSION

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Spring BCP - Child Welfare Services – California Automated Response and Engagement System

Spring Finance Request. The Office of Systems Integration (OSI) requests $128.5 million ($68.1 million General Fund) for project resources in combined funding with the California Department of Social Services (CDSS) for 2021-22 to continue the development and implementation activities of the Child Welfare Services – California Automation Response and Engagement System (CWS-CARES).

Background. The current Child Welfare Services/Case Management System (CWS/CMS), which was initially implemented in 1997, is used by more than 20,000 county and CDSS workers to serve and protect the health and safety of children, youth, and families in California. The existing CWS/CMS is not compliant with federal and state laws, regulations, or policies. In November 2015, an agile procurement and development approach to iteratively develop and implement a new solution to replace the CWS/CMS was adopted. This was a custom development approach that required reassessment due to the length of time it was taking to build CWS-CARES.

In August 2018, the Child Welfare Digital Services (CWDS) began extensive research to identify ways to accelerate the development of the replacement system. The research resulted in a decision to change the current development approach to use a Platform-as-a-Service (PaaS), which would allow CWDS to focus on core business needs rather than platform development and maintenance within the infrastructure. In September 2019, the project received approval from the California Department of Technology (CDT) to use Salesforce as the project's PaaS. The research indicated that the development in Salesforce will yield better and faster results while retaining key principles foundational to success such as directly involving county partners, utilizing user-centered design, and configuring/developing in an agile, iterative way.

The CWS-CARES project focused on planning efforts during 2019-20 and is in the process of transitioning from planning to design, development and implementation (DD&I) in 2020-21. Additional funding for DD&I is required for 2021-22. As part of this process, the project has also submitted Special Project Report (SPR) #4 to CDT. The request for additional county and vendor resources will allow the CWS-CARES Project to align with the Salesforce and CDI configuration/development approach and support ongoing project efforts to replace the existing CWS/CMS. The additional funding will also enable the project to adhere to the agreements made regarding the CWS-CARES Path Forward document amongst the governance entities and state oversight.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Spring BCP – CWS-CARES Project Staff Resources

Spring Finance Request. The CDSS requests $1.3 million ($953,000 General Fund) per year for a five-year extension of eight existing limited-term positions. These positions are set to expire on June 30, 2021. The requested resources would extend the positions until June 30, 2026. Staff resources are needed to support the development and implementation of the Child Welfare Services - California Automated Response and Engagement System (CWS-CARES) and the continued planning, design, and development, transitioning into maintenance and operation.

Ba**ckground.** The staff resources were originally approved in 2013-14, and funding for these positions was extended to June 30, 2019 in the 2014 Budget Act. The 2019 Budget Act extended these positions for an additional two years until June 30, 2021. In November 2015, the CWS-CARES Project modified its procurement, design, development, and implementation approach after discussions with the state and federal control agencies. Rather than releasing a large multi-year request for proposal, estimated to cost several hundred million dollars, the CWS-CARES Project adopted a modular procurement approach coupled with agile design and development techniques to deliver the CWS-CARES Project incrementally. In August 2019, the CWS-CARES Project pivoted its approach and returned to the planning stage. The CWS-CARES Project is currently moving forward with a Customer Relationship Management platform service delivery model.

According to CDSS, the extension of the resources requested is necessary to support the development and implementation of the CWS-CARES. CDSS requires program staff that will work collaboratively with and support the work of the Office of Systems Integration (OSI) by providing necessary program information during user research, design, development and implementation, as well as ongoing Maintenance and Operations (M&O) activities. CDSS worked with the OSI to develop a staffing model to support OSI throughout the life of the CWS-CARES Project. The program staff resources are required to ensure that CDSS' expertise, needs, and input are integrated into all phases of the project.

Staff Comment and Recommendation. Hold open.

Questions.

1. What is the overall plan for the deployment of the different modulation and the timeline for the completed project?

2. Will permanent positions be needed to maintain and update the CWS-CARES project in the future?

Issue 2: Spring BCP – Statewide Verification Hub Staffing Resources

Spring Finance Request. The CDSS requests $5.3 million ($531,000 General Fund) in 2021-22, and $1.7 million ($169,000 General Fund) annually thereafter to support 9.5 positions and contracting services to continue the planning, design, development, and implementation of the Statewide Verification Hub (SVH).

Background. The California Health and Human Services (CHHS) Agency seeks to streamline and modernize the processes of obtaining required eligibility verifications for means-tested human services programs, improve accuracy of benefit calculation, improve client experience, enhance reporting capabilities, and simplify the verification process across departments and programs.

Current eligibility determinations for CalFresh, California Work Opportunity and Responsibility to Kids (CalWORKs), Early Learning Childcare (ELC) and Medi-Cal are made by county welfare departments or contracted entities at initial application, periodic reporting, and annual recertification/redetermination. Eligibility may also be reassessed during the certification period based on either client self reporting or other information received by the county or its designee, if a change in client circumstance is indicated. At initial application and recertification/redetermination, an eligibility determination for CalFresh, CalWORKs and Medi-Cal requires three key steps: application, interview, and verification. Under federal and state rules, all relevant programmatic eligibility information must be verified. According to CDSS, current methods for collecting verifications are time consuming and rely on data from multiple sources, some of which are outdated or difficult for the recipient and county to either access or obtain. Verifications may be obtained from disparate sources—including state and county data systems, federal data systems, the client themselves, and various third-party vendors. A single form of verification, such as periodic earned income, might be provided in a variety of potential formats— including a regular file, a paper pay document, or a scan or photo uploaded from a mobile device. This creates challenges both from a data management and storage perspective, as well as from perspective of the logistics for both obtaining and validating the information.

The CHHS Agency, along with the CDSS and the Department of Health Care Services (DHCS) recognize the challenges with both the electronic and paper processes currently used to complete the required verifications for CalFresh, CalWORKs, ELC and Medi-Cal. The SVH was developed to address the cumbersome process of mediating between structured and unstructured data, improve the integrity of the data used and retained, enhance reporting capabilities, reduce incidence of erroneous identity resolution, and reduce the quantity and dollar volume of over-issuance/overpayment claims. The creation of a centralized hub provides a solution that can be leveraged by multiple means-tested human services programs administered by CHHS. The vision of the SVH is as an agency-wide IT solution that will improve California families' access to services by streamlining and modernizing the process for required verifications for many CHHS means-tested programs, enhancing client access/experience, and providing real-time information on application progress, all while preserving Californians' privacy and security. The goal of this effort is to develop a human-centered solution, giving the client access to household, case or client historical verification information via a trusted, authenticated portal, and to ensure that the solution is made in a way that can be leveraged by other means-tested human services programs.

Staff Comment and Recommendation. Hold open.

Issue 3: Senate Budget Options – Aging Issues

Senate Budget Option. The Senate is considering the following proposals related to aging issues:

- Provide $150 million over three years for a pilot program that would afford operating subsidies to Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs) that serve residents who receive State Supplementary Program (SSP) payments. This budget proposal supports SB 648 (Hurtado).

- Maintain current IHSS collective bargaining mechanisms. The proposal would maintain two funding mechanisms (discussed below) that will help to make progress on IHSS collective bargaining. This reflects a proposal put forth by SEIU California, UDW/AFSCME Local 3930, the California Association of Counties, the California Association of Public Authorities, and other organizations heard during the Subcommittee's March 2, 2021 hearing. For more detail on this proposal, please refer to the March 2 hearing agenda.

- Fiscal penalty for IHSS counties failing to bargain in good faith. This reflects a proposal put forward by UDW/AFSCME 3930 and SEIU heard during the Subcommittee's March 2, 2021 hearing. For more detail on this proposal, please refer to the March 2 hearing agenda.

Note that other aging issues are included in other departments. Those other proposals include the ones listed below and will be discussed at other Subcommittee hearings.

- Eliminate the funding suspension in CDA senior nutrition programs and provide $35 million ongoing for those programs.

- Eliminate the funding suspension for ADRCs and provide ongoing funding for the statewide ADRC network.

- Provide ongoing funding to support the Dignity at Home Fall Prevention Program and make it permanent.

- Provide one-time funding to bridge the digital divide and provide additional tablets and other devices to older Californians.

- Provide baseline ongoing funding for Area Agencies on Aging.

- Expansion of CalAIM meal-related benefits.

ARF/RCFE Background. Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs), commonly referred to as board and care or assisted living facilities, are licensed by the DSS Community Care Licensing Division (CCLD). The facilities are typically privately operated and serve individuals with varying needs. How individuals pay for these facilities varies as do how much the facilities charge. Some individual's care is paid for through public assistance programs such as SSI/SSP. The state provides a supplement to SSI/SSP grants known as the Non-medical Out of Home Care (NMOHC) rate. This rate is intended to support SSI/SSP

recipients who require additional care. As of January 2021, the maximum SSI rate with the NMOHC supplement is $1,217.37 per month for an individual. $1,079.37 of that amount would go to the facility and the resident would keep the remainder. The amount paid to the facility is meant to cover a resident's room and board and overall care and supervision. Facilities are not permitted to charge individuals receiving SSI above the state-mandated rate. In past hearings, the Subcommittee has heard testimony that state-mandated rate is not sufficient for these facilities to maintain operations. The above proposal would provide operating subsidies to these facilities to help keep them in operation.

IHSS Collective Bargaining. Under current law, counties and the state share the nonfederal cost for locally negotiated increases to wages and health benefits for IHSS providers. Counties are responsible for 35 percent of the nonfederal share and the state participates in 65 percent of the nonfederal share of cost for increases up to the state participation cap, which is set at $1.10 above the state minimum wage. For increases above that amount, the county is responsible for 100 percent of the nonfederal share. However, there is a tool available, referred to as the ten percent over three years tool, that allows the county to receive state participation above the state participation cap. With this tool, the state will participate above the state participation cap at the 65 percent share of cost in a cumulative total of up to a 10 percent increase in the sum of the combined total of changes in wages or health benefits, or both, over a three-year period.

On January 1, 2022, current law will alter these funding mechanisms in a manner that will make it more difficult to make progress on IHSS collective bargaining. First, the sharing ratio will flip, with the county becoming responsible for 65 percent of the nonfederal share and the state covering 35 percent of the nonfederal share. Second, the ten percent over three years tool will no longer be available, as current law indicates that any use of this tool must begin prior to January 1, 2022. Maintaining the current tools will be essential for further progress in local bargaining over wage and benefit increases.

The 2019 Budget Act instituted a fiscal penalty on counties who failed to bargain in good faith. That penalty was a one-time withholding of 1991 Realignment funding equal to one percent of the county's 2018-19 IHSS MOE. Additionally, the budget enacted mandatory mediation and fact-finding provisions. All of these provisions expired on January 1, 2021. While there has been progress in achieving new contracts, many contracts will expire in 2021 and 2022. Without a fiscal penalty it is feared that it will be difficult to reach new contracts.

Staff Comment and Recommendation. Hold open.

The sustainability of ARFs and RCFEs has been a topic of concern within the Subcommittee, and the Legislature as a whole, over the past several years. There is a diminishing supply of ARFs and RCFEs that accept SSI/SSP recipients. Since 2019, the capacity at ARFs and RCFEs for SSI/SSP recipients has decreased by about 2,000. This loss of capacity has been attributed to the low SSI/SSP rate and increasing value of real estate, coupled with the other costs associated with operating 24-hour residential facilities. The shrinking capacity for SSI/SSP recipients, combined with California's homelessness problem and the overall effects of the COVID-19 pandemic raises concerns that this important housing option will disappear for thousands of needy Californians.

Panel. The Subcommittee has requested the following panelists to provide comments on these proposals.

- Leza Coleman, Executive Director, California Long-Term Care Ombudsman Association (CLTCOA)
- Justin Garrett, California State Association of Counties
- Beverly Yu, State Government Affairs Director, UDW/AFSCME Local 3930

Questions.

For Leza Coleman:

1. Please provide your perspective on how the proposal to provide operating subsidies to ARFs and RCFEs will impact SSI/SSP recipients.

For Justin Garrett:

2. Please discuss the how maintaining current collective bargaining mechanisms will impact progress on collective bargaining across the state.

For Beverly Yu:

3. Please discuss how enacting a fiscal penalty on counties will create progress on reaching collective bargaining contracts.

Issue 4: Spring BCP – Family First Prevention Services Act State-Level Resources

Spring Finance Request. The CDSS requests $3.2 million ($2.3 million General Fund) in 2021-22 and $2.6 million ($1.9 million General Fund) annually thereafter for seven permanent positions and contract funding to support California's compliance and participation in the prevention services program authorized by Part I of the federal Family First Prevention Services Act (FFPSA). The requested resources include four Associate Governmental Program Analysts (AGPAs), two Staff Services Managers I (SSM Is), one Attorney IV, and $1.4 million General Fund for 2021-22 ($970,000 General Fund ongoing) in contracted support.

Note that the January Governor's budget includes $42.7 million General Fund for the implementation of the federal FFPSA, which reflects an October 2021 implementation date. The budget also includes trailer bill language for this purpose.

Background. Historically, prevention services and programs have been significantly underfunded. Annually, through the Child Abuse Prevention and Treatment Act and the Preserving Safe and Stable Families program, CDSS and counties have less than $25 million available statewide to spend on prevention and early intervention services. When families come to the attention of Child Welfare Services, some counties are able to offer in-home Family Maintenance (FM) services aimed at keeping the child with the family and may also be offered services after Family Reunification as a support to ensure the safety of the child upon return to their family's care. The FM services can

mitigate the trauma that both children and parents experience when children are removed from their homes and placed into foster care. Counties' ability to offer these services is varied, and some have been unable to provide any type of FM services at all. The FFPSA provides an opportunity for California to expand on the efforts of current FM programs and establish a robust prevention program that includes multiple prevention strategies, adding critical components to the system of care.

Part I of the FFPSA provides an opportunity for participating Title IV-E agencies to draw down federal Title IV-E funds for prevention services aimed at keeping children and youth from entering or re-entering foster care. Eligible prevention services include qualifying substance abuse services, mental health services, and in-home parenting skills programs. Eligible programs must be trauma informed, evidence-based, and included in the state's five-year Prevention Plan which must be submitted and approved by the federal Administration for Children and Families (ACF) in order for county child welfare, probation, and Title IV-E Tribes (tribes with a Title IV-E agreement with the state) to participate in the program and draw down Title IV-E funds for prevention services.

The State's five-year Prevention Plan and the proposed prevention program it outlines must include the following details: the specific evidence-based, trauma-informed prevention programs and services to be utilized, including how the state selected the services; the services' target population(s); and whether the programs and services are promising, supported, or well supported, as defined. The requested positions will help to ensure compliance with these federal requirements. The state also requires expertise to convene decision-makers from system of care partners such as state departments, local education partners and to provide technical assistance to county child welfare agencies. Contracting funds are requested to hire vendors to establish quality improvement measures, develop curriculums, and evaluate the efficacy of the interventions.

Staff Comment and Recommendation. Hold open.

Questions.

1. How will the state's rollout plan affect counties that previously had a waiver to use IV-E funds for prevention services? Will they be able to maintain the level of prevention services that they have been able to provide in the past?

Issue 5A: Senate Budget Options – Strengthening the Safety Net (Child Welfare/Foster Care)

Senate Budget Option. The Senate is considering the following proposals to strengthen the safety net, relating to the child welfare and foster care systems:

- Provide funding for placements for high-needs youth across the state.
- Provide ongoing funding for county-administered child welfare prevention services. This reflects a proposal put forth by the County Welfare Directors Association and heard during the Subcommittee's February 16, 2021 hearing.

- Fund a pilot program to provide a universal basic income for transition-age youth. This proposal would fund SB 739 (Cortese).

- Approve funds to provide COVID relief for Short-term Residential Therapeutic Programs (STRTPs). This reflects a proposal put forth by the California Alliance of Child and Family Services and heard during the Subcommittee's February 16, 2021 hearing.

Background. In 2015, the Continuum of Care Reform (CCR), (Assembly Bill 403 (Chapter 773, Statutes of 2015)), provided the statutory framework to ensure services and supports are focused on maintaining stability for foster youth in a permanent home and reducing the use of congregate care facilities. While the state has implemented several reforms to avoid placing youth in restrictive environments and into family settings, there is still more that can be done to ensure that youth in the system receive the support that they need, and to prevent entry into the foster care system in the first place. Of particular concern are youth with high needs, whose needs are not being met within California. In December 2020, the department notified the Joint Legislative Budget Committee of its unanticipated need for additional funding due to the decertification of out-of-state facilities and the need to quickly relocate returning foster youth from out-of-state care. However, additional ongoing funding will likely be needed to serve these youth and youth with similar needs that may have been sent out of state in the future had the department not decertified all out-of-state facilities.

Staff Comment and Recommendation. Hold open.

Panel. The Subcommittee has requested the following panelist to provide comments on this issue.

- Jennifer Rodriguez, Executive Director, Youth Law Center

- Veronica Vierya, Former Foster Youth

Questions.

For Jennifer Rodriguez:

1. Please discuss investments that the state can make to better serve youth with specialized needs, such as youth who have previously been sent out-of-state for treatment, and prevent youth from entering the foster care system if it can be avoided.

For Former Foster Youth:

1. Please discuss the impact of having a basic income once exiting from the foster care system can have on former foster youth.

Issue 5B: Senate Budget Options – Strengthening the Safety Net (Food Assistance Programs)

Senate Budget Option. The Senate is considering the following proposals to strengthen the safety net, relating to food assistance:

- Provide additional support for food banks to meet increased needs due to the continued impacts of the COVID-19 pandemic. This reflects proposals put forth by the California Association of Food Banks and heard during the Subcommittee's February 9, 2021 hearing.

- Expand access to the California Food Assistance Program (CFAP) to service Californians regardless of immigration status. This proposal supports SB 464 (Hurtado) and was heard during the Subcommittee's February 9, 2021 hearing.

Background. Before the COVID-19 pandemic, millions of Californians (about 1 in 10) were experiencing food insecurity. The pandemic and resulting economic crisis are exacerbating hardship across the state. Despite recent federal and state interventions, recent data show that overall food insecurity has spiked to more than 25 percent of California households – that is approximately 10 million people since the COVID pandemic began. While some low-income Californians have been helped by federal relief programs and/or CalFresh, many immigrants have been left out of relief measures solely due to their immigration status. Undocumented immigrants, DACA recipients, Temporary Protected Status (TPS) holders, and certain visa holders are excluded from federal CalFresh and the state-funded California Food Assistance Program (CFAP). This exclusion forces immigrant households to make choices between buying groceries or covering the cost of rent, utilities, and other basic needs. Likewise, it limits excluded immigrants' and their children's ability to achieve economic security and mobility — deepening racial disparities and slowing our economy's recovery from this and future recessions. The exclusion of these immigrants from federal relief and CFAP has also put a strain on food banks, as that is one of the few places they can go to receive food assistance.

Staff Comment and Recommendation. Hold open.

Staff notes that the Supplemental Report of the 2018-19 budget required the CDSS to convene a stakeholder workgroup "to identify how the State and local entities can improve current programs and coordinate linkages to community services to strengthen California's food assistance safety net for all low-income Californians, and work to remove barriers that exclude immigrant Californians from the State's food assistance safety net." One of the workgroup's recommendations was to expand the CFAP to all, regardless of immigration status.

Panel. The Subcommittee has requested the following panelist to provide comments on this issue.

- Jared Call, Senior Advocate, Nourish California

Questions.

For Jared Call:

1. How has the pandemic increased food insecurity across the state?

2. What impact will this proposal have on increasing food security among immigrant, low-income Californians?

Issue 5C: Senate Budget Options – Strengthening the Safety Net (Cash Assistance Programs)

The Senate has asked the Legislative Analyst's Office to present the following proposal.

Senate Budget Option. The Senate is considering the following proposals to strengthen the safety net, relating to the state's cash assistance programs:

CalWORKs

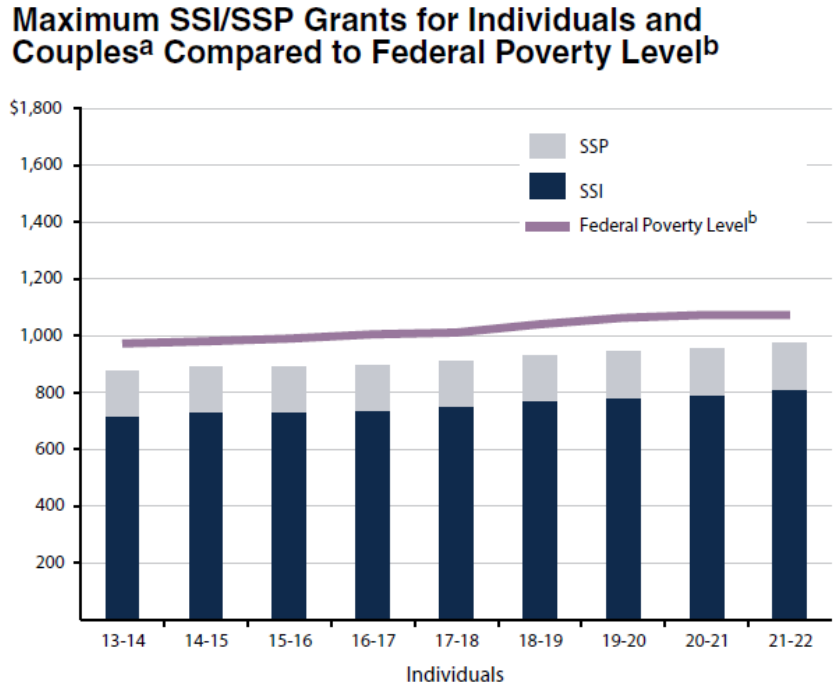
- Increase CalWORKs grants to take the final steps in meeting the longtime Senate priority of "no child in deep poverty." This proposal would increase CalWORKs grants to 50 percent of the Federal Poverty Level (FPL) for a family that is one person larger than the assistance unit size. Note that the Governor's budget proposes a 1.5 percent increase to CalWORKs grants. The proposal the Senate is considering would increase grants above what is proposed in the Governor's budget.

SSI/SSP

- Restore the Cost-of-Living Adjustment (COLA) and past cuts to the SSP program.

Background. The Senate has recognized the deep, devastating impact living in poverty can have on children and families. Poverty affects children in many ways. Children living in poverty not only experience hunger and instability but other less obvious effects such as behavioral problems and social and emotional development difficulties. As a result of that recognition, the Senate has committed to increasing grants for CalWORKs recipients so no child lives in deep poverty. The 2018 budget included language stating the intent of the Legislature to provide future grant increases so that grants are no less than 50 percent of the FPL.

Another state program that aims to address poverty is the State Supplementary Payment (SSP) program. The SSP is a supplement to the Supplemental Security Income (SSI) program administered by the federal government. Until 2011, the state provided a statutory Cost-of-Living Adjustment (COLA) for the SSP. As part of the 2016-17 budget package, the Legislature provided a one-time COLA of 2.76 percent on the SSP portion of the grant, the first since 2005. But the state has not provided a COLA for SSP since then. California has a high cost of living relative to other states. The SSP is supposed to keep elderly individuals and people with disabilities who receive SSI from falling into poverty. But cuts to the SSP and the repeal of the Cost of Living Adjustment (COLA) due to the last recession have pushed more than 1 million Californians into poverty. The graph below, provided by the LAO, shows that the maximum SSI/SSP grants for individuals are below the federal poverty level.



Staff Comment and Recommendation. Hold open.

Panel. The Subcommittee has requested the following panelist to provide comments on this issue.

- Mike Herald, Director of Policy Advocacy, Western Center on Law and Poverty

Questions.

For Mike Herald:

1. Please describe the impact of poverty in California, and how the above proposals will help to address poverty and its devastating effects.

Issue 6: Spring BCP – Community Care Expansion Program

Spring Finance Request. The CDSS requests three-year limited-term resources to administer the Community Care Expansion (CCE) program. The requested resources include $1.4 million General Fund in 2021-22, and $797,000 General Fund in 2022-23 and 2023-24. The requested funds would support two Associate Governmental Program Analysts, one Staff Services Manager I, one Staff Services Manager I Specialist, one Staff Services Manager II, and $500,000 in contract funding for technical assistance and evaluation services to support acquisition and rehabilitation of Adult Residential Facilities (RCFs) and Residential Care Facilities for the Elderly (RCFEs).

Background. The January Governor's budget proposed $250 million in one-time funding, over three years, to expand and preserve ARFs and RCFEs and Residential Care Facilities for the Chronically Ill (RCFCIs) via the CCE program. According to CDSS, the goals of the CCE are to create new assisted living settings that can serve people experiencing homelessness, with a focus on seniors and

those with behavioral health conditions, as well as to stabilize existing settings that serve people at risk of homelessness through capital investments and rehabilitation. The CCE will leverage significant investments by local governments to provide enhanced services in assisted living settings to meet the needs of this population.

To effectively manage the resources proposed in the Governor's budget, CDSS will be responsible for programmatic oversight, licensure of newly established facilities, and the overall administration of the program. To support these activities CDSS requests resources to administer the program from the $250 million funding proposal included in the 2021-22 Governor's Budget. CDSS requests contract funding of $500,000 for technical assistance and evaluation services. Technical assistance will support counties and tribes to develop gap analyses and implement successful capital fund disbursement infrastructure. Evaluation funding will support monitoring facility creation and preservation efforts.

In addition to the request for the Community Care Expansion Program, CDSS requests one three-year limited-term Staff Services Manager I-Specialist for the continued operation of the state's Project Roomkey and Rehousing Strategy. Project Roomkey was established in response to the COVID-19 pandemic to provide non-congregate shelter options such as hotels, motels, or self-contained trailers for people experiencing homelessness to protect human life and minimize strain on the capacity of the health care system. This role is needed to further lead the data collection efforts, which now include mandated data reporting on Rehousing efforts. In addition, technical assistance from the state is required for 55 counties and three tribes that are currently operating Project Roomkey sites. The requested resources will support programs in leveraging FEMA reimbursement; conducting statewide collaboration efforts to share best practices and emerging guidance with local partners; and responding to daily stakeholder requests, which include requests from the Governor's Office, advocates, and the media.

Staff Comment and Recommendation. Hold open.

Issue 7: Senate Budget Options – Housing

The Senate has asked the Legislative Analyst's Office to present the following proposal.

Senate Budget Option. The Senate is considering a proposal to provide one-time funding for a flexible funding pool to be used for county-administered housing programs. This reflects a proposal put forward by the County Welfare Directors Association heard in the Subcommittee's February 9, 2021 hearing.

Note that the Senate's broader Homelessness, Housing Affordability, and Homeownership proposals, of which the above proposal is a component, were discussed in Subcommittee No. 4.

Background. Homelessness continues to be one of the most growing and unremitting problems in California and has been exacerbated even further by the COVID-19 pandemic. There is a clear need for more resources, and a shift towards more preventative strategies and flexible uses of funding targeted towards the most vulnerable individuals in the state. Recent state budgets have provided local jurisdictions with historic levels of funding to address homelessness. Despite these

investments, the state's homelessness population has remained high. The Senate has proposed a $20 billion investment with a focus on supporting local governments, helping individuals transition from homelessness to permanent housing, and creating new housing units for homeless individuals. The above proposal is a component of that larger plan.

The CDSS administers various housing programs for populations that are homeless or at-risk of homelessness and that are served by programs such as Adult Protective Services, CalWORKs, Child Welfare Services and Foster Care, and others. These safety net programs serve some of the most vulnerable populations in California, an increasing number of whom are housing insecure and/or homeless and who are often left out of other, larger solutions related to housing and homelessness. The current CDSS-administered housing programs, while very successful, are limited in the services they can provide, and participants often have to already be homeless or about to be evicted in order to receive services. The proposal would allow counties to fund additional services such as assistance in obtaining or maintaining housing, working with landlords on housing availability, and legal assistance for individuals to fight illegal evictions.

The above proposal is meant to ensure that there is a targeted housing investment for low-income families, child-welfare involved families, older adults who have been abused, neglected or exploited, and single adults with disabilities, and that they are not left out of the very welcome, but more general, statewide solutions on homelessness and COVID-19.

Staff Comment and Recommendation. Hold open.

Panel. The Subcommittee has requested the following panelist to provide comments on this issue.

- Eileen Cubanski, Director of Budget and Fiscal Policy, County Welfare Directors Association

Questions.

For Eileen Cubanski:

1. Please describe the impact of this proposal on addressing homelessness among at-risk populations served by other county-administered welfare programs.

Issue 8: Spring BCP – Whole Child Integration and Data Development Support

Spring Finance Request. The CDSS requests $1.7 million General Fund in 2021-22 and $1.5 million annually thereafter to support nine positions to help implement the department's whole child approach to child care and development.

Background. The Early Childhood Development Act of 2020 transfers several childcare programs from the California Department of Education (CDE) to CDSS. This transfer supports the implementation of a high-quality, affordable, child care and development system designed to comprehensively and effectively serve children and families. Following enactment, CDSS and CDE have been involved in collaborative work and stakeholder engagement to support a smooth transfer

and to support the implementation of these goals. The Master Plan on Early Learning and Care (Master Plan) was also released on December 1, 2020.

The request for resources supports the integration of child care programs transferring from CDE into CDSS' existing programs and correlates with the objectives outlined in the Early Childhood Development Act of 2020 and the State's Master Plan on Early Learning and Care. The request includes the following positions within various divisions of CDSS:

- Community Care Licensing Division. The CDSS CCL Child Care Program requests one Staff Services Manager (SSM) I and four Associate Governmental Program Analysts (AGPAs), to establish the Whole Child Integration and Collaboration Unit. This Unit will work collaboratively with the new Child Care and Development Division, and the Research and Data Division to design, develop, and implement a shared vision of quality and equity across mixed delivery systems.

- Research Automation and Development Division. CDSS requests conversion of one SSM II Specialist to a permanent position. According to CDSS, there is an increased and ongoing need for dedicated resources to address program integrity requirements specific to child care and to provide oversight of all data management and IT system consolidation, coordination, and implementation. The SSM II Specialist will act as an implementation manager for child care and development programs, the Pre-School Development Grant Renewal (PDG-R), and child care program-related data management activities and technical systems and platform solutions.

- Legal Division. CDSS requests one Attorney IV in the Children and Community Care Licensing Policy Litigation Branch (CCCL) to provide legal services in support of the integration between Child Care and Development programs and Community Care Licensing. CDSS requests one Attorney III in the Information, Technology and Administrative Litigation Branch (ITAL), to provide guidance and advice on information technology and data initiatives, be responsible for advising on complex state and federal information security and privacy laws, and support the proper collection and distribution of data through the execution of Data Sharing Agreements. CDSS requests one AGPA in the Administrative Legal Services Branch to provide complex administrative support.

Staff Comment and Recommendation. Hold open.

Issue 9: Spring BCP – Child Care and Development Program Support

Spring Finance Request. The CDSS requests $9.2 million ($8.7 million General Fund) for 50 permanent positions to support the department's responsibilities, services, and systems for childcare programs. The department also requests authority for 20 positions associated with funding the move from the Department of Education (CDE) to CDSS.

Background. As discussed in previous issues, the Early Childhood Development Act of 2020 transfers several childcare programs from the CDE to CDSS. According to CDSS, the requested positions are necessary to support the successful transfer and administration of childcare programs,

as well as the transfer of staff, at CDSS. The transfer of the CDE staff to CDSS and the creation of the Child Care and Development Division will bring another 185 staff to CDSS.

Division/Unit	Number of positions	Purpose
Child Care and Development Division	18	Create a new division that will oversee 16 childcare and development programs.
Child and Adult Care Food Program	3	Program helps support access to nutritious meals
Legal Division	8	Support workload associated with the acquisition of responsibilities for more new programs and transferring staff.
Research Automation and Development Division	5	Support research and program integrity requirements.
Administration Division	9	Support fiscal workload associated with the transfer of staff and programs from CDE.
Health, Safety, and Security Team	7	Follow-up on workplace incident reports and take appropriate action.

As part of the proposed 2021-22 Governor's Budget, funding was included for 20 administrative positions, without corresponding position authority. The department requests position authority to align with the funding proposed in the 2021-22 Governor's Budget.

Staff Comment and Recommendation. Hold open.

PROPOSALS FOR INVESTMENT

The Subcommittee has received the following proposals for investment related to the child welfare programs within the DSS. Note that proposal sponsors provided all information below, aside from staff comments and recommendations. Staff recommends all proposals be held open.

1. Increased funding for 36 CalWORKs Indian Health Clinic Mental Health and Substance Abuse behavioral health program sites

Budget Issue. The California Rural Indian Health Board, Inc. (CRIHB) requests $3.6 million General Fund ongoing to support mental health and substance abuse services at Indian Health Clinics.

Background. The loss of funding during the recession of 2008-09 has caused progressively increasing damage to the program integrity due to the scope of mandated Memorandum of Understanding (MOU) activities, lack of administrative support, staff recruitment difficulties, and no cost of living adjustment in the past 13 years. The cost of housing alone has increased significantly statewide and qualified staff are difficult to retain. It is more urgent now for the CalWORKs IHC behavioral health program to have adequate funding to address the COVID-19 exacerbation of needs in Native American communities. This is caused by job losses, school closures, family stressors, isolation, food insecurity, and instability. The program must help to address the needs for mental health and substance abuse services and urgent referrals to meet the family's needs. According to CRIHB, providing adequate program funding to Indian Health Clinics necessary to execute the mandatory services required in the MOU. This will assist with supporting the program integrity reduced during the funding reduction of 2008-09.,

Staff Comment and Recommendation. Hold open.

The 2021 Governor's budget proposes $1.9 million to fund these services at 36 Indian Health Clinic sites.

2. Establishment of Equity Corps for COVID-19 Outreach and Recovery

Budget Issue. The Advancement Project California requests $300 million General Fund one-time to establish and fund an Equity Corps.

Background. The communities most impacted by COVID-19 are low-income communities of color across the state – primarily Black, Latinx, Pacific Islander, and Native and Indigenous communities. Even before the pandemic, many of them were already struggling with historical disinvestment from health infrastructure, displacement and housing instability, and an inherited unhealthy built environment. Community based organizations (CBOs) and county staff have been doing heroic work to support these communities by meeting their basic needs and fully participating in economic and political life while weathering the epidemic, complementing the state and local governments' efforts. However, much of this work is unfunded when many CBOs face financial challenges from the recession while increasing community needs push them to expand their support and services.

Equity Corps efforts would include providing vital public health information around ongoing case surges, vaccine access, and the reopening of schools and businesses, as well as connecting residents to resources to help them meet their basic needs through the end of the pandemic and the recovery. Besides supporting the hardest-hit communities as they recover and rebuild from the pandemic, this program would also create jobs for residents in these communities and ensure that resources are flowing directly to the communities where they can make the most significant difference.

Staff Comment and Recommendation. Hold open.

3. Resources for County Public Administrators, Public Guardians, and Public Conservators

Budget Issue. The California Association of Public Administrators, Public Guardians, and Public Conservators (CA|PA|PG|PC), the California State Association of Counties, and the County Welfare Directors Association of California request $120 million ongoing to support PA|PG|PC programs.

Background. PA|PG|PC programs are appointed by superior courts to serve adults in every California county who are unable to act in their own best interests as a result of serious mental illness, cognitive impairment, or death. Oftentimes, these individuals are referred while experiencing homelessness. Operating since the 1960s without any state or federal funding – but heavily impacted by legislative initiatives and court decisions – California's dedicated PA|PG|PC public servants are now stretched to the limit. For the past several years, PA|PG|PC programs have been operating at full capacity and are struggling to meet the growing needs of their communities. Currently, PA|PG|PC programs are short staffed by more than 50 percent, and target populations served by these programs have grown approximately 30 percent in just the last five years. While a majority of health and social services programs were realigned from the state to counties in either 1991 or 2011 (with dedicated statewide tax revenues and mandate protections), PA|PG|PC services were not included and so are supported entirely by county revenues. The requested $120 million ongoing in state resources would assist counties in caring for individuals who cannot care for themselves and are at-risk of victimization and personal harm.

Staff Comment and Recommendation. Hold open.

4. Investment for Statewide Diaper and Wipe Distribution

Budget Issue. SupplyBank.org requests $10 million General Fund one-time to expand the Diaper Bank Program statewide to serve the 50 counties not currently served by the program.

Background. Prior to the pandemic, an insufficient supply of diapers to keep babies clean and dry, afflicted one out of three mothers in the United States. Diapers for one child can cost up to $80 a month, making diapers the third or fourth greatest cost burden for many families on CalWORKs after rent, food and sometimes transportation. With a pre-pandemic average of 40,000 emergency room and inpatient visits related to diaper need annually in California, this issue causes severe health consequences for infants and toddlers and significant costs to the state. Diapers are also a requirement for most childcare providers, making diaper need a barrier to affordable childcare and thus employment.

The requested resources will build upon the existing Diaper Bank Program established by the Legislature in 2018 to provide a statewide reach through existing efforts in 50 counties administered by SupplyBank.Org and their partners. SupplyBank.Org currently has ongoing distributions of diapers and other materials in all counties as part of their response to COVID-19. Their pre-COVID model that would resume in conjunction with this program integrates the distribution of diapers and wipes into existing programs within each respective county's safety net.

Staff Comment and Recommendation. Hold open.

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 11, 2021
1:30 p.m.
State Capitol - Room 3191

Consultant: Scott Ogus

PART B

PUBLIC COMMENT

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Program Integrity Data Analytics

Budget Change Proposal – April Finance Letter. DHCS requests expenditure authority of $6.9 million ($1.1 million General Fund and $5.8 million federal funds) in 2021-22 to extend contract funding for the Medi-Cal Program Integrity Data Analytics service.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$1,130,000	$-
0890 – Federal Trust Fund	$5,755,000	$-
Total Funding Request:	**$6,885,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The DHCS Audits and Investigations (A&I) division is responsible for financial auditing and detection of fraud and abuse among providers of health care services to Medi-Cal beneficiaries. The mission of A&I's Medi-Cal Fraud Investigations Branch is to protect the fiscal integrity of California's publicly funded health care programs. Investigations Branch fraud investigators are sworn law enforcement officers and conduct criminal, administrative and civil investigations into various types of suspected Medi-Cal program fraud. This fraud may involve beneficiaries or providers of programs under the purview of DHCS, as well as the In-Home Supportive Services (IHSS) program administered by the Department of Social Services (DSS).

In 2010, the United States Congress required the federal Centers for Medicare and Medicaid Services (CMS) to implement a predictive analytic modeling system to detect fraud in the Medicare program. Based upon the successful implementation of this system for Medicare, CMS began encouraging state Medicaid programs to pursue new data analytics technologies, as well. In addition, the federal Patient Protection and Affordable Care Act (ACA) required Medicaid programs to implement new program integrity requirements to prevent, detect, and take enforcement action against fraud. According to DHCS, the traditional model of recoveries for overpayment or fraud and abuse is "pay and chase", in which efforts must be made to recoup overpayments identified after the payments have already been made. Data analytics are a strategy intended to provide front-end fraud prevention and program integrity.

In 2013, after news reports identified significant numbers of fraudulent providers in the Drug Medi-Cal system, A&I engaged in a comprehensive review of all Drug Medi-Cal providers. The Investigations Branch visited 497 facilities, suspended 87 providers, and sent 98 fraud referrals to the California Department of Justice resulting in criminal charges against 48 providers and 137 affiliated individuals. During its review of the Drug Medi-Cal program, DHCS complemented its field work with a short-term limited scope contract for enhanced data analytics services. According to DHCS, the data analytics tool identified many of the same suspect providers in a fraction of the time spent identifying fraudulent providers via labor intensive field visits.

The 2014 Budget Act authorized limited-term expenditure authority of $5 million ($1.3 million General Fund and $3.8 million federal funds) in 2014-15, $10 million ($2.5 million General Fund and $7.5 million

federal funds) in 2015-16 and 2016-17, and $5 million ($1.3 million General Fund and $3.8 million federal funds) in 2017-18 to secure a data analytics contractor to expand on the success of these activities experienced during the review of Drug Medi-Cal providers. However, due to procurement challenges, only a portion of the appropriated funds were used for a narrow pilot focused on Drug Medi-Cal and specialty mental health services claims. The investigative use of these tools occurs in a multi-disciplinary Special Investigations Unit within the Investigations Branch at A&I.

The 2018 Budget Act included expenditure authority of $9 million ($2.3 million General Fund and $6.8 million federal funds) in 2018-19 and up to $10 million ($2.5 million General Fund and $7.5 million federal funds) in 2019-20 to extend the data analytics contract for an additional two years.

Resource Request. DHCS requests expenditure authority of $6.9 million ($1.1 million General Fund and $5.8 million federal funds) in 2021-22 to extend contract funding for the Medi-Cal Program Integrity Data Analytics (MPIDA) service. According to DHCS, the MPIDA service provides the department with access to tools and data that increase the probability of identifying fraud, including a cloud-based interactive dashboard with geo-mapping capabilities, the ability to sort provider and beneficiary information based on fraud indicators, and data analytics tools to identify patterns of suspicious behavior based on historical data and changing behaviors. The MPIDA service also provides access to several proprietary databases to perform link analysis, which can identify a provider's known business associates to determine if there are warning signs of fraud, if other providers are engaged in similar fraudulent behavior, or if the fraudulent behavior is part of an organized scheme.

DHCS indicates the MPIDA service would be used to focus on pharmacy claims, as the Medi-Cal program transitions pharmacy benefits from the managed care to fee-for-service delivery system under Medi-Cal Rx. In concert with the Medi-Cal Rx vendor, DHCS indicates it would use the MPIDA tools to identify:

- High-risk prescribers
- Geospatial anomalies between beneficiary, prescriber, and pharmacy locations
- Maximum daily equivalent anomalies by prescriber, pharmacy, or beneficiary
- Overprescribing of high-risk drugs such as antipsychotics and opioids
- Counter indicated prescribing such as concurrent prescriptions of opioids and benzodiazepines or antipsychotics
- Billing for the maximum amount of refills
- Avoiding use of generics where appropriate
- Billing for brand name drugs while providing generics
- Short filling of prescriptions
- Receiving or reselling discounts without passing them along to Medi-Cal
- Prescriptions without an indicated Medi-Cal corresponding provider visit.

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

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

1. Please provide a brief overview of this proposal.

Issue 2: Interoperability Federal Final Rule Compliance

Budget Change Proposal – April Finance Letter. DHCS requests expenditure authority of $2.9 million ($713,000 General Fund and $2.1 million federal funds) in 2021-22 and $737,000 ($184,000 General Fund and $553,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to support compliance with federal interoperability and patient health information access rules.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$713,000	$184,000
0890 – Federal Trust Fund	$2,141,000	$553,000
Total Funding Request:	**$2,854,000**	**$737,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2022-23.

Background. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorized approximately $4.5 billion for California for both the Medicare and Medi-Cal electronic health records (EHR) incentive programs. Of the $4.5 billion for California, it is estimated that approximately $2 billion in incentive payments will be made to qualified Medi-Cal health care providers who adopt, implement, or upgrade and meaningfully use electronic health records in accordance with federal requirements. In addition to the efforts to encourage use of EHRs, the federal Centers for Medicare and Medicaid Services (CMS) has sought to promote and improve interoperability, allowing the exchange of health information between different systems. The Medi-Cal EHR program, now called the Medi-Cal Promoting Interoperability Program (PIP), has administered the ARRA HITECH program since 2009.

Although the ARRA HITECH programs and funding are scheduled to end in fall 2021, CMS continues to advance interoperability requirements, as well as patient access to health information. In May 2020, CMS finalized the Interoperability and Patient Access Final Rule (CMS-9115-F), which included the following new requirements for CMS-regulated health care payers, including Medi-Cal fee-for-service and managed care delivery systems:

- Patient Access Application Programming Interface – Payers are required to implement and maintain a secure application programming interface (API) that allows patients to easily access their claims and encounter information, including cost, as well as a defined subset of their clinical information through third-party applications of their choice.
- Provider Director API – Payers are required to make provider directory information publicly available via a standards-based API.
- Payer-to-Payer Data Exchange – Payers are required to exchange certain patient clinical data at the patient's request, allowing the patient to take their information with them as they transition between payers.
- Federal-State Data Exchanges for Dual-Eligibles – States are currently required to exchange enrollee data for individuals dually eligible for Medicare and Medicaid. The new rule requires data to be exchanged daily, rather than monthly.

- Public Reporting and Information Blocking – Defines and creates possible penalties and disincentives for information blocking by certain providers. CMS will report on providers that may be information blocking based on attestations in the Promoting Interoperability Program requirements. Public reporting of this information would allow patients to choose providers more likely to support electronic access to their health information.
- Digital Contact Information – Collects and reports data on providers who do not list or update digital contact information.

The 2015 Budget Act included five positions, funded by a 10 percent allocation from the Health Care Services Plan Fines and Penalties Fund and 90 percent from federal funds, to support ARRA HITECH implementation. As the ARRA HITECH funding is expiring, DHCS is seeking to extend these five positions to support the new interoperability requirements from the new federal rule.

Resource Request. DHCS requests expenditure authority of $2.9 million ($713,000 General Fund and $2.1 million federal funds) in 2021-22 and $737,000 ($184,000 General Fund and $553,000 federal funds) annually thereafter to support compliance with federal interoperability and patient health information access rules. In particular, DHCS reports the implementation of the patient access and provider directory APIs, as well as the public reporting and information blocking, are the most near-term priorities for the department and CMS. The federal rule requires the patient access and provider directory APIs to be implemented by January 1, 2021, and the public reporting and information blocking components targeted to early 2021. According to DHCS, the department will not meet these deadlines due to its focus on COVID-19 response efforts, but CMS has indicated it will work with states as long as they present clear approaches and adequate timelines for implementation. In addition, the digital contact information is required by early 2021 and the payer-to-payer data exchange by January 1, 2022. The specific positions and contract resources requested are as follows:

Health Information Management Division

- **One Staff Services Manager I** would lead a team of staff to plan and coordinate the business elements of the interoperability implementation, health information exchange, and clinical data exchange initiatives and programs.
- **One Staff Services Manager I Specialist** would act as lead business analyst, providing subject matter expertise regarding interoperability, health information exchange, and clinical data exchange to Medi-Cal programs, Medi-Cal managed care plans, and others.
- **One Research Scientist III** position would develop metrics, specifications, and data files based on incoming clinical data collected and stored in department data resources.
- **One Associate Governmental Program Analyst** (**AGPA)** would function as a business analyst, writing required state and federal documents, leading tests to confirm system readiness for data exchange, performing assessments to confirm data is exchanged in a secure and sustainable manner, reviewing system requirements documents align with regulatory requirements and internal policies, and acting as liaison for various entities involved in health information exchange.
- **One AGPA** would act as a project support technician, reviewing program and plan readiness and performance, processing invoices, creating and submitting performance reports, assisting in the development of an interoperability and clinical data exchange roadmap, and acting as an interoperability and clinical data exchange liaison for internal entities.

Contracting Resources

- **Lead Interoperability Business Analyst Contract** – DHCS requests expenditure authority of $250,000 ($63,000 General Fund and $187,000 federal funds) in 2021-22. This contract would provide leadership and specialized subject-matter expertise for all business analysis, policy, process, and change activities related to interoperability compliance.
- **Interoperability Compliance Business Analysis Team** – DHCS requests expenditure authority of $400,000 ($100,000 General Fund and $300,000 federal funds) in 2021-22. This contract would provide two staff to perform business analysis functions with specialized knowledge of and experience with federal interoperability compliance. This team would conduct gap analysis, requirements gathering, market research, and business rules elicitation.
- **Interoperability Compliance Change Management and Business Process Design Team** – DHCS requests expenditure authority of $400,000 ($100,000 General Fund and $300,000 federal funds) in 2021-22. This contract would provide two staff to perform change management and business process evaluation functions, including verifying both systems and staff are prepared to achieve the required outcomes as effectively and efficiently as possible.
- **Lead Interoperability Technical Team** – DHCS requests $1.3 million ($313,000 General Fund and $937,000 federal funds) in 2021-22. This contract would provide five staff to support technical leadership and specialized subject matter expertise for the overall technical planning effort, including potential prototyping and concept development.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Managed Care Plan Statewide Procurement

Budget Change Proposal – April Finance Letter. DHCS requests 11 positions and expenditure authority of $2.7 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22, $2.5 million ($1.3 million General Fund and $1.3 million federal funds) in 2022-23 through 2024-25, and $1.6 million ($777,000 General Fund and $777,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to support the statewide Medi-Cal managed care program re-procurement effort.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$1,336,000	$1,255,000
0890 – Federal Trust Fund	$1,336,000	$1,255,000
Total Funding Request:	**$2,672,000**	**$2,510,000**
Total Requested Positions:	**11.0**	**11.0**

* Additional fiscal year resources requested: 2023-24 through 2024-25: $2,510,000, 2025-26 and ongoing: $1,554,000.

Background. The managed care model of health care service delivery in California began in the 1970s with legislation that culminated in passage of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). In addition to regulatory oversight of the commercial managed care market, the Knox-Keene Act authorized the state to license health maintenance organizations and pre-paid health plans to enroll Medi-Cal beneficiaries. Beginning in 1981, the state began licensing different models of managed care delivery for Medi-Cal beneficiaries in different counties. Today, there are four primary models of managed care delivery in the Medi-Cal program:

- *County Organized Health Systems* – In 1982, the Legislature authorized the creation of three county organized health systems (COHS), which are county-administered managed care plans. Santa Barbara and San Mateo Counties were the first COHS plans to enroll beneficiaries (a COHS was planned in Monterey, but was never implemented), while Congress approved three additional COHS (Santa Cruz, Solano, and Orange) counties in 1990. The authorization for COHS requires that they be an independent, public entity and that they meet the regulatory requirements of the state's Knox-Keene Act. However, they need not obtain a license under the Knox-Keene Act, as they are specifically exempted. There are currently twenty-two counties in the COHS model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo. Eight of these counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were part of the expansion of Medi-Cal to rural counties described below (see *Expansion to Rural Counties*, below). Beneficiaries in these counties receive services through Partnership Health Plan of California.

- *Geographic Managed Care* – In 1992, the department designated Sacramento County as a geographic managed care (GMC) county, which allowed many plans to operate within the county to provide services to Medi-Cal beneficiaries. In 1998, San Diego also became a GMC county, and both counties currently contract with several commercial health plans with the goal of providing more choice to beneficiaries. As these plans are commercial plans, they are required to

be licensed under the Knox-Keene Act. Sacramento and San Diego remain the only two GMC counties in the state.

- *Two Plan Model* – In 1995, as part of a significant expansion of Medi-Cal managed care, twelve counties were designated to participate in a new Two Plan Model for managed care delivery. Under this model, one county-developed plan, a local initiative, offers services alongside a commercial plan. Both plans are required to be licensed under the Knox-Keene Act. There are currently fourteen Two Plan Model counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Los Angeles' local initiative, L.A. Care, subcontracts with several other smaller managed care plans to provide services to Medi-Cal beneficiaries.

- *Regional Model* – AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the expansion of Medi-Cal managed care into the twenty-eight rural counties not previously operating managed care plans. These counties phased in between November 2013 and December 2014. 8 counties transitioned into the COHS model, while twenty counties transitioned into a new regional model, including: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra, Sutter, Tehama, Tuolumne, and Yuba. Beneficiaries in these counties (except San Benito and Imperial) receive services through either Anthem Blue Cross, or California Health and Wellness. Beneficiaries in San Benito County receive services through either Anthem Blue Cross, or fee-for-service Medi-Cal, while beneficiaries in Imperial County receive services through either California Health and Wellness or Molina Health Systems.

Procurement of Commercial Plans. According to DHCS, during the decades-long expansion of Medi-Cal managed care, the department has not engaged in a re-procurement process for the commercial plans that operate in the 36 counties operating under the two plan model, geographic managed care model, and the non-COHS regional model (including Imperial and San Benito counties). DHCS began its re-procurement process with a Request for Information (RFI) in fall 2020. The department expects to release a Request for Proposal (RFP) before the end of 2021, with a potential implementation date of January 2024.

According to DHCS, the re-procurement and the consequent changes in contracting relationships between the department and commercial Medi-Cal managed care plans would align with the goals of the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, focusing on quality outcomes, reducing disparities, increasing access to care and care coordination, and driving delivery system transformation through value-based initiatives, modernization of systems, and payment reform.

Staffing and Resource Request. DHCS requests 11 positions and expenditure authority of $2.7 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22, $2.5 million ($1.3 million General Fund and $1.3 million federal funds) in 2022-23 through 2024-25, and $1.6 million ($777,000 General Fund and $777,000 federal funds) annually thereafter to support the statewide Medi-Cal managed care program re-procurement effort. After release of the RFP in late 2021, DHCS expects a need for staff and resources to identify and build evaluation criteria for quality outcomes and disparities measures, to identify and review plan readiness deliverables and tools, and to transition activities for counties changing from one plan or model type to another. The specific requested staff and resources by division are as follows:

Managed Care Operations Division – Five positions and resources equivalent to two positions

- **One Staff Services Manager II** position would supervise and direct activities of analytical staff overseeing the re-procurement efforts, including the development of templates, standards, the plan termination process and post-termination reporting, as well as serving as the division subject matter expert on re-procurement, scheduling and facilitating webinar meetings with branch and management staff.
- **Two Health Program Specialist I (HPS I)** positions would lead procurement and readiness activities, create evaluation and qualification tools, evaluate and score managed care plan proposals, create readiness tools, and oversee the termination process for plans not selected to continue. These positions would continue beyond the readiness phase to support policy changes, confirm transfer of information to associate level staff, lead future implementation of service or benefit changes, assist on higher level review of deliverables and submissions, and make recommendations on approvals and process improvements.
- **Two Associate Governmental Program Analysts (AGPA)** would assist with evaluating and scoring managed care plan proposals, review readiness deliverables, and oversee termination deliverables for plans not selected to continue. These positions would continue beyond the readiness phase to support policy changes, secure transfer of information, provide technical assistance to plans to fulfill contractual obligations, and coordinate with CMS and other stakeholders.
- Four year resources equivalent to **two AGPAs** would develop evaluation criteria, review tools, oversee readiness activities, schedule and facilitate workgroup meetings, and ensure coordination among stakeholders. These positions would also be members of the workgroup to evaluate and score plan RFPs.

Managed Care Quality and Monitoring Division – Six positions and resources equivalent to five positions

Program Monitoring and Compliance Branch

- **One HPS I** position would focus on certifying and ensuring procured plans meet network certification requirements, and developing enhanced monitoring tools and compliance measures to establish adequate contract oversight.
- Four year resources equivalent to **one HPS I** would lead, oversee, and monitor compliance with network certification and delegated entity compliance with network certification.
- **One AGPA** in the Compliance Unit would oversee health plan compliance with monitoring and oversight of delegated entities, serve as lead over enhanced monitoring requirements, develop reference materials, monitoring tools, validation surveys, and review criteria to be utilized to verify compliance.
- Four year resources equivalent to **one AGPA** in the Network Adequacy Unit would monitor utilization and compliance with network adequacy standards, monitor managed care plan compliance with network and delegated entity certification requirements through data analysis, validation studies, contract review, and continual oversight.

Quality and Medical Policy Branch

- **One Health Program Specialist II** position would help develop enhanced monitoring tools and compliance measures to ensure adequate contract oversight, and would be focused on efforts aimed at strengthening the quality of preventative services offered through Medi-Cal.
- **One HPS I** would develop contract language, execute contract amendments or policy letters relating to community engagement requirements, provide 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.
- Four year resources equivalent to **one HPS I** would support the RFP process, designing and operationalizing new requirements and regulations related to department-offered quality incentives and value-based payments, and ongoing monitoring of Medi-Cal managed care plans.

Data Analytics Branch

- Four year resources equivalent to **two Research Data Specialist I** positions would provide technical assistance for new and existing managed care plans, oversee and coordinate encounter and provider data readiness testing, closeout activities of encounter and provider data submission, collaborate with clinical and technical staff to develop, implement, maintain, monitor and dispense RFP related complex coding policies and guidance, and support the data components for RFP data completeness.
- Four year resources equivalent to **one Research Data Analyst II** position would review and provide technical assistance for new and existing managed care plans, oversee and coordinate encounter and provider data system readiness and closeout activities, and prepare datasets related to ongoing monitoring, report reconciliation, and evaluation measures.

Utilization and External Relations Branch

- **One HPS I** would assist in the development and dissemination of policy changes and updates to managed care plans, engage with health plan associations and stakeholders to facilitate policy decisions.

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

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

1. Please provide a brief overview of this proposal.

2. Please briefly describe the timeline of the re-procurement process.

3. Please provide some examples of the types of new requirements DHCS intends to incorporate in new managed care contracts, particularly for quality and outcomes, reducing disparities, improving access to care, and care coordination.

Issue 4: Provider Application and Verification for Enrollment (PAVE)

Budget Change Proposal – April Finance Letter. DHCS requests expenditure authority of $7.2 million ($1.8 million General Fund and $5.4 million federal funds) in 2021-22 to support enhancements to the Provider Application and Validation for Enrollment (PAVE) system.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$1,792,000	$-
0890 – Federal Trust Fund	$5,376,000	$-
Total Funding Request:	**$7,168,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The DHCS Provider Enrollment Division (PED) is responsible for the enrollment and re-enrollment of fee-for-service health care service providers into the Medi-Cal program. According to DHCS, there are approximately 182,000 Medi-Cal providers who serve the needs of Medi-Cal beneficiaries. Since September 2018, PED has utilized the Provider Application and Validation for Enrollment (PAVE) enrollment portal to automate the work of processing provider enrollment and re-enrollment applications.

PAVE is a commercial software as a solution vendor application that is used to process and track provider enrollment for most Medi-Cal providers. PAVE provides a secure, web-based portal for providers to submit their applications and maintain, up-to-date information. DHCS also uses PAVE to establish and monitor ongoing compliance with enrollment requirements by Medi-Cal providers. According to DHCS, PAVE is currently used for the following provider types: ambulatory surgical clinics, audiologists, blood banks, certified acupuncturists, certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, chiropractors, clinical laboratories, diabetes prevention, dispensing opticians, Drug Medi-Cal clinics, transportation, hearing aid dispensers, licensed clinical social workers, licensed marriage and family therapists, licensed midwives, occupational therapists, ocularists, optometrists, orthotists, out of state hospitals, pharmacies, physical therapists, physician assistants, physicians, podiatrists, portable imaging, prosthetists, psychologists, respiratory care practitioners, speech language pathologists, and tribal health services.

DHCS intends to expand the use of PAVE to other provider types, including providers in the Family Planning Access, Care, and Treatment (Family PACT) program; Diabetes Prevention Program (DPP) providers, and dental providers. In addition, DHCS intends to make program integrity enhancements to the provider enrollment process to collect information regarding affiliations with other providers that may have been sanctioned in Medicare or other Medicaid programs.

Resource Request. DHCS requests expenditure authority of $7.2 million ($1.8 million General Fund and $5.4 million federal funds) in 2021-22 to support these enhancements to PAVE system. Specifically, these contract resources would support DHCS' work with its existing software as a solution vendor to implement change requests for the following PAVE enhancements:

- **Diabetes Prevention Program (DPP)** – Between July 1, 2021, and September 30, 2021, DHCS would enable PAVE to accommodate existing providers to submit a supplemental application to include DPP as a service. According to DHCS, there are currently 6,124 enrolled pharmacies that would be eligible to add DPP services. Newly enrolling pharmacies would also be eligible to include DPP as part of the enrollment application.
- **Program Integrity Enhancements** – Between July 1, 2021, and September 30, 2021, DHCS would enhance PAVE to facilitate new federal affiliate disclosure requirements by modifying application packages on the PAVE portal.
- **Family PACT Providers** – Between July 1, 2021, and December 31, 2021, DHCS would implement a consolidated process to allow the department's Office of Family Planning (OFP) to review and approve Family PACT provider applications after the provider is enrolled into the fee-for-service Medi-Cal program. The new process would eliminate the need for Family PACT providers to send a hard copy application to OFP for Family PACT enrollment by allowing OFP to use its own processing queues in PAVE to review and approve applications.
- **Dental Providers** – Between July 1, 2021, and June 30, 2022, DHCS would remove the paper applications and manual processes for dental provider applications.

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Local Educational Agencies Medi-Cal Billing Option Program Expansion

Budget Change Proposal – April Finance Letter. DHCS requests eight positions and expenditure authority of $2.2 million ($1.1 million General Fund and $1.1 million federal funds) in 2021-22 and 2022-23, and $1.2 million ($583,000 General Fund and $583,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to expand and improve the delivery of school-based health care, including contract resources to help implement expansion of the Local Educational Agencies Billing Option Program (LEA BOP).

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$1,119,000	$1,083,000
0890 – Federal Trust Fund	$1,119,000	$1,083,000
Total Funding Request:	**$2,238,000**	**$2,166,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional fiscal year resources requested – 2023-24 and ongoing: $1,166,000.

Background. DHCS administers the Local Educational Agencies Billing Option Program (LEA BOP), a school-based federal reimbursement and certified public expenditure program. LEA BOP provides reimbursement for approved Medi-Cal services to local educational agencies, such as school districts, county offices of education, charter schools, community college districts, California State University, and University of California campuses. To be eligible for reimbursement, services must be medically necessary, provided by a qualified health service practitioner to a Medi-Cal enrolled student, and provided under an individualized education plan (IEP) or individualized family service plan.

Schools are federally obligated under the Individuals with Disabilities Education Act (IDEA) to provide every child with a disability with a free and appropriate public education (FAPE) through an individualized education program (IEP). A child's IEP outlines the special education and related services necessary to enable the child to make educational progress. Many of these services, such as physical therapy, are covered under Medi-Cal's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit and eligible for federal matching funds LEAs are Medi-Cal providers. LEAs are obligated under the IDEA to find students who are in need of services and provide those services under the IDEA. The IDEA FAPE requirement obligates LEAs to pay for any services required as part of a student's IEP.

Expansion of LEA BOP. In April 2020, the federal Centers for Medicare and Medicaid Services (CMS) approved three primary changes to LEA BOP, retroactive to July 1, 2015: 1) incorporation of a new time survey methodology into the cost settlement process, 2) adding new service practitioners and new services eligible for Medi-Cal reimbursement under LEA BOP, and 3) expansion of the population covered under LEA BOP to include Medi-Cal beneficiaries outside of special education. According to DHCS, since the expansion of LEA BOP, LEAs have increasingly asked the department to provide more technical assistance, trainings, and guidance for successful administration and reimbursement under the program.

School-Based Medi-Cal Administrative Activities. In addition to reimbursement under LEA BOP, LEAs are eligible for reimbursement under the School-Based Medi-Cal Administrative Activities (SMAA) program. The SMAA program authorizes governmental entities to submit claims and receive reimbursement for activities that constitute administration of the Medi-Cal program. These activities

include referring students and families for Medi-Cal eligibility determinations, providing health care information, referring, coordinating and monitoring health care services, and coordinating services between agencies. LEAs are reimbursed in the SMAA program by determining the amount of time school staff spend performing SMAA functions using an approved time survey methodology. The time survey results are then used to calculate the percentage of school costs that can be claimed under SMAA.

SB 75 Requires Coordination Between Agencies to Improve Federal Reimbursement. SB 75 (Committee on Budget and Fiscal Review), Chapter 51, Statutes of 2019, requires DHCS and the California Department of Education (CDE) to jointly improve the coordination and access to available federal funds through the LEA BOP, the SMAA program, and medically necessary EPSDT benefits. The bill requires DHCS and CDE to create workgroups that include representatives from local educational agencies, appropriate county agencies, regional centers, and legislative staff. On or before October 1, 2021, the workgroups will provide the relevant policy committees and budget subcommittees of the Legislature and the Department of Finance with recommendations for program requirements and support services needed for the LEA BOP, the SMAA program, and medically necessary federal EPSDT benefits to guarantee ease of use and access for LEAs.

Staffing and Resource Request. DHCS requests eight positions and expenditure authority of $2.2 million ($1.1 million General Fund and $1.1 million federal funds) in 2021-22 and 2022-23, and $1.2 million ($583,000 General Fund and $583,000 federal funds) annually thereafter to expand and improve the delivery of school-based health care, including contract resources to help implement expansion of the Local Educational Agencies Billing Option Program (LEA BOP). Specifically, the positions and contract resources requested by division are as follows:

Local Government Financing Division – seven positions and $1 million contract resources for two years

- **One Staff Services Manager I** position would oversee unit staff; give final approval for research and analysis of federal and state law, regulations, legislation, issue memos, correspondence, policies analysis and state plan amendments; develop, procure, and managed the outreach campaign contract; provide guidance and oversight to the contractors to ensure all guidelines are being met; and coordinate between the contractor, stakeholders, and DHCS staff to develop a sound outreach methodology.
- **One Research Data Analyst II** position would conduct extensive research and analysis of erroneous payment corrections to guarantee claims are properly adjudicated for federal reimbursement; research, implement, and maintain the cost allocation methodology to allow LEA BOP and the SMAA program to properly report and claim costs associated with administrative activities and direct medical services; implement new procedure codes to verify compliance with federal requirements; analyze trends and utilization variances that will determine growth and evaluate the expansion of new services; examine technological alternatives to improve access to care and increase claiming for LEAs; act as program liaison with the fiscal intermediary to initiate, recommend, resolve, and implement claims processing updates or changes; conduct data runs and reports of paid claims data; enroll LEA providers as Medi-Cal providers; coordinate with the Medi-Cal payment systems and stakeholders on provider manual changes and policy updates; develop and maintain databases to capture, compile, and integrate necessary program data, spreadsheets, and other instruments to oversee the LEA BOP; develop program models to establish statewide

distribution of program information, updates, and legislative bill analyses; and develop financial or policy impacts on the program.

- **Five Associate Governmental Program Analysts** would work in cooperation with local partners and stakeholders to perform research, planning, public communication, policy formulation and analysis, and program evaluation; research and analyze federal and state laws and regulations to develop policy standards; perform ongoing program evaluations to certify statewide compliance with federal and state laws and regulations; develop contract language and procure the contract for the outreach campaign; oversee contract through assignment review, monthly invoices, and collaborate through weekly meetings and monthly status reports; train to conduct outreach activities once the contract expires; develop proposals and other documentation to recommend program changes or resolve complex policy issues; act as program liaison to state and local stakeholders; develop program models to establish statewide distribution of program information, updates, and legislative bill analyses; and develop financial or policy impacts on the program; and develop legislative or state plan amendment proposals.

- **Outreach Campaign Contract** – DHCS requests expenditure authority of $1 million ($500,000 General Fund and $500,000 federal funds) in 2021-22 and 2022-23 to support an outreach campaign contract. The contractor would be selected in consultation with CDE and the executive director of the State Board of Education, and would have experience successfully working with education entities. The contractor would develop, implement, and manage an outreach campaign for the LEA BOP, including: 1) designing an outreach methodology that meets the needs of the LEAs; 2) training and developing DHCS staff on how to maintain outreach after the contract expires; and 3) developing a five-year outreach plan with targeted goals and strategies.

Office of Legal Services – One position

- **One Attorney III** position would provide counsel support including technical assistance for matters related to the procurement and administration of LEA BOP contracts, regulation development, bill analysis, enforcement actions, sanctions, appeals, Public Record Act requests, program policy development and other legal matters. This position would also: 1) research and prepare extensive legal opinions related to complex statutory and regulatory interpretation, contract interpretation, program administration, and related disputes as required for compliance with California's Medicaid State Plan and relevant federal and state laws; 2) give ongoing legal advice for responses to community, stakeholder, LEA, county and federal inquiries; 3) draft, review, and analyze legislation, regulations, policy, procedures, and other departmental guidance; 4) provide legal research, advice, and support with the development of policies, information notices, protocols, forms, and template; and 5) provide legal assistance with drafting new regulations and review and amend the California Medicaid State Plan.

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

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

1. Please provide a brief overview of this proposal.

Issue 6: Office of Medicare Innovation and Integration

Budget Change Proposal – April Finance Letter. DHCS requests four positions and expenditure authority of $602,000 ($452,000 General Fund and $150,000 federal funds) in 2021-22, and $566,000 ($425,000 General Fund and $141,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to establish a new Office of Medicare Innovation and Integration, which would provide focused leadership and expertise to lead innovative models for Medicare beneficiaries in California, including Medicare-only and individuals dually eligible for Medicare and Medi-Cal.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$452,000	$452,000
0890 – Federal Trust Fund	$150,000	$141,000
Total Funding Request:	**$602,000**	**$566,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and resources ongoing after 2022-23.

Background. In January 2021, the Administration published its Master Plan for Aging (MPA), which outlines five goals and twenty-three strategies to prepare the state for significant demographic changes in the years ahead, including the growth of the population of Californians 60 years of age and older to 10.8 million people by 2030. The Administration intends for the MPA to serve as a blueprint for state government, local communities, private organizations, and philanthropy to build environments that promote an age-friendly California. The five goals include: 1) Housing for All Ages and Stages; 2) Health Reimagined; 3) Inclusion and Equity, Not Isolation; 4) Caregiving That Works; and 5) Affording Aging.

The MPA identified that long-term services and supports (LTSS) may be out of reach for some middle income Medicare beneficiaries who are not eligible for Medi-Cal and do not have the resources to pay for these services out of pocket. This lack of access to LTSS places these beneficiaries at greater risk of having unmet LTSS needs, as well as greater risk of institutionalization. The second goal of the MPA, Health Reimagined, included several proposed initiatives for 2021-22, including: 1) plan and develop innovative models to increase access to LTSS for Medicare beneficiaries; and 2) plan and develop innovative models to increase access to LTSS and integrated health care for individuals dually eligible for Medicare and Medi-Cal by implementing statewide managed LTSS and dual eligible special needs plan (D-SNP) structure, in partnership with stakeholders.

Staffing and Resource Request. DHCS requests four positions and expenditure authority of $602,000 ($452,000 General Fund and $150,000 federal funds) in 2021-22, and $566,000 ($425,000 General Fund and $141,000 federal funds) annually thereafter to establish a new Office of Medicare Innovation and Integration, which would provide focused leadership and expertise to lead innovative models for Medicare beneficiaries in California, including Medicare-only and individuals dually eligible for Medicare and Medi-Cal. The new office would support the goals of the MPA within DHCS, and would provide recommendations for the Director and State Medicaid Director, and represent DHCS with CMS and other external partners. The office would explore and develop person-centered, effective and efficient strategies to deliver services, including:

- Build off lessons learned from the Coordinate Care Initiative demonstration to inform the D-SNP transition in the California Advancing and Innovating in Medi-Cal (CalAIM) initiative, and other approaches for integrated service delivery for California's dually eligible population.

- Identify best practices and build partnerships across health care, housing, and community-based providers to leverage the strengths of each sector in developing integrated, coordinated systems of care.

- Coordinate with DHCS divisions and across California Health and Human Services Agency departments that provide LTSS to dually eligible beneficiaries so that services are more coordinated and efficient.

- Develop targeted demonstration programs intended to reach special populations with complex care needs.

- Explore the feasibility of an Integrated Care at Home Demonstration in California, expanding opportunities for the provision of non-medical benefits into Medicare Advantage plans in California. Evaluate the costs and outcomes of specific non-medical benefits to guide California Medicare Advantage plans to provide the most beneficial services to Medicare beneficiaries.

- Review models to provide and improve care planning to patients and families with Alzheimer's and related dementias.

- Work with federal partners to explore broadening the approach to LTSS financing, including mechanisms that promote inclusion of LTSS benefits in Medicare and the private Medicare insurance market.

- Convene California's Medicare Advantage plans to define a strategy to integrate chronic care benefits into their plans and gain their commitment to a timeline to implement that strategy.

- Explore opportunities to enable Medigap carriers and Medicare Accountable Care Organizations to offer complementary products to cover LTSS services.

- In partnership with CMS, explore development of community-based integrated care models for Medicare beneficiaries utilizing Medicare waivers and demonstration authorities through Program of All-Inclusive Care for the Elderly (PACE) organizations, Federally Qualified Health Centers, and other provider-based risk-bearing entities.

- Explore shared savings opportunities for state-federal partnerships.

- Partner with federal, state, and local organizations to address caregiver needs.

- Partner with CMS, the California Department of Aging, and local Health Insurance Counseling and Advocacy Program (HICAP) agencies on Medicare enrollment issues.

- Develop and promote strategies to address emerging issues.

For support of the new office, DHCS is requesting the following positions:

- **One Deputy Director** would be reclassified from the existing Associate Director for Policy position to lead the new office.

- **One Staff Services Manager II** position would coordinate with external stakeholders to develop policies and initiatives, and provide leadership and subject matter expertise on dual eligible and Medicare topics within DHCS and with other state departments. This position would also coordinate with other staff on data and fiscal analysis of dual eligible and Medicare-only beneficiaries, as well as research federal and state laws and regulations, and market conditions for Medicare Advantage plans in California.

- **One Health Program Specialist I** position and **one Associate Governmental Program Analyst** would perform policy analyses and document development, issue tracking, stakeholder engagement, and coordination with internal DHCS divisions and other state departments.

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

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

1. Please provide a brief overview of this proposal.

2. Would the new office publish its recommendations to DHCS leadership on achieving the goals outlined in this proposal and in the Master Plan for Aging? Does DHCS intend for this office to be a resource for DHCS leadership exclusively, or for the general public?

3. Can you provide examples of the types of projects on which the office would be expected to begin work in its first few years?

Issue 7: Behavioral Health Quality Improvement Program

Budget Change Proposal and Budget Bill Language– April Finance Letter. DHCS requests expenditure authority of $940,000 ($470,000 General Fund and $470,000 federal funds) in 2021-22, and $913,000 ($457,000 General Fund and $456,000 federal funds) in 2022-23. If approved, these resources would allow DHCS to assist county behavioral health programs to prepare for opportunities and program requirements through the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. DHCS is also requesting budget bill language authorizing distribution and administration of local assistance funds for this purpose.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$470,000	$457,000
0890 – Federal Trust Fund	$470,000	$456,000
Total Funding Request:	**$940,000**	**$913,000**
Total Requested Positions:	**0.0**	**0.0**

Background. During the fall of 2019, the Administration released a comprehensive proposal to transform the delivery system of physical, behavioral, and oral health care services in the Medi-Cal program, known as the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. Due to the COVID-19 pandemic, the Administration delayed implementation of CalAIM in the 2020-21 fiscal year. In 2021, the Governor's January budget includes funding and proposed trailer bill language to commence a comprehensive effort to transform the Medi-Cal program. CalAIM is an ambitious effort to incorporate evidence-based investments in prevention, case management, and non-traditional services into the Medi-Cal program. Many of these investments were piloted during the state's most recent 1115 Waiver, Medi-Cal 2020, and the Administration is seeking to incorporate these programs into existing Medi-Cal delivery systems on a more consistent, statewide basis. CalAIM also seeks to reform payment structures for Medi-Cal managed care plans and county behavioral health programs to streamline rate-setting and to reduce documentation and auditing workload for plans and their network providers. Other components of CalAIM include changes to populations and services that would be delivered in the fee-for-service or managed care system, continuation of certain dental services piloted in the Dental Transformation Initiative, statewide incorporation of long-term services and supports as a mandatory managed care benefit, seeking a federal waiver to allow Medi-Cal services to be provided in an Institute for Mental Disease (IMD), and testing full integration of physical, behavioral, and oral health service delivery under a single contracted entity.

Behavioral Health Payment Reform. Under CalAIM, DHCS proposes to reform behavioral health payment methodologies in a multi-step process from the current cost-based reimbursement process to a rate-based and value-based structure using intergovernmental transfers to fund the non-federal share of services. The first step in the process would transition behavioral health services from the current claims coding system, Healthcare Common Procedure Coding System (HCPCS) Level II, to HCPCS Level I. According to DHCS, this transition would allow for more granular claiming and reporting of services provided, as well as more accurate reimbursements. This transition would occur no sooner than July 1, 2022.

DHCS expects that, concurrent with the transition to HCPCS Level I, DHCS would transition to a rate-setting process for behavioral health services by peer groups of counties with similar costs of doing business. The non-federal share of rates would be provided by counties via intergovernmental transfer (IGT), rather than the current, cost-based certified public expenditure (CPE) process. DHCS would make annual updates to established rates to ensure reimbursement reflects the costs of providing services. DHCS would, at first, make payments to counties on a monthly basis, and would eventually transition to a quarterly payment schedule.

Medical Necessity Criteria Reforms. Under CalAIM, DHCS proposes to modify the existing medical necessity criteria for behavioral health services to ensure behavioral health needs are being addressed and guided to the most appropriate delivery system as well as provide appropriate reimbursement to counties. The proposed changes would separate the concept of eligibility for services from that of medical necessity, allow counties to provide services to meet a beneficiary's behavioral health needs prior to diagnosis of a covered condition, clarify that treatment in the presence of a co-occurring substance use disorder is appropriate and reimbursable when medical necessity is met, implement a standardized screening tool to facilitate accurate determinations of which delivery system (specialty mental health, Medi-Cal managed care, or Medi-Cal fee-for-service) is most appropriate for care, implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system in which they seek care, and make other revisions and technical corrections. These changes would ensure that eligibility criteria, largely being driven by level of impairment as well as diagnosis or a set of factors across the bio-psycho-social continuum, would be the driving factor for determining the delivery system in which a beneficiary should receive services. DHCS proposes to make these changes effective January 1, 2022.

Behavioral Health Quality Improvement Program. The Governor's January budget also included $21.8 million General Fund for a two-year Behavioral Health Quality Improvement Program (BH-QIP) to provide incentives to county behavioral health programs to make the critical changes necessary to successfully implement CalAIM, including:

- Transition from HCPCS Level II to HCPCS Level I
- Update county information technology (IT) systems for changes to medical necessity criteria
- Incorporate managed care and other utilization data from DHCS into county IT systems
- Automate data reporting

According to DHCS, the two-year incentive program would be allocated to counties based on a formula balancing both equality and equity, as well as a framework based on meeting planning, infrastructure, reporting, and outcomes milestones.

Resource Request. DHCS requests expenditure authority of $940,000 ($470,000 General Fund and $470,000 federal funds) in 2021-22, and $913,000 ($457,000 General Fund and $456,000 federal funds) in 2022-23, to assist county behavioral health programs to prepare for opportunities and program requirements through the California Advancing and Innovating in Medi-Cal (CalAIM) initiative and the BH-QIP. These two-year resources, equivalent to three positions, would be responsible for designing the program, determining payment methodologies, managing implementation processes, distributing awards, setting measures and reporting benchmarks, monitoring progress, providing counties with technical assistance, and adapting the program based on lessons learned. Specifically, these resources would support the following position equivalents and contract resources in the following divisions:

Local Government Financing Division – Two-year resources equivalent to one position

- Two-year resources equivalent to o**ne Associate Governmental Program Analyst (AGPA)** would develop minimum county standards for progress in implementing the HCPCS transition, provide training and technical assistance to counties, analyze and monitor fiscal data and reports, review county plans for the HCPCS transition, serve as fiscal liaison to facilitate processing and flow of incentive payments to counties.

Community Services Division – Two-year resources equivalent to one position

- Two-year resources equivalent to **one Research Data Specialist II** position would review and assess county data systems and capabilities to report behavioral health performance and outcome measures, assess county capacity to support automated reporting, review and assess county capabilities to integrate managed care and behavioral health utilization data, develop guidance for plans for secure exchange of protected health information, provide technical assistance for data collection, analysis, and reporting, establish metrics for analyzing integrated managed care and behavioral health data, collaborate with other department divisions to set benchmarks and monitor and evaluate county progress.

Medi-Cal Behavioral Health Division – Two-year resources equivalent to one position

- Two-year resources equivalent to **one Health Program Specialist I** position would collaborate with other department divisions to develop and implement the incentive payment program, review and monitor county progress reports, provide technical assistance to counties, and develop quality measures that may be used for value-based incentive payments.

In addition to these position equivalents, DHCS requests expenditure authority of $500,000 ($250,000 General Fund and $250,000 federal funds) in 2021-22 and 2022-23 to support a contractor to identify county strengths, opportunities for improvement, actionable items, recommendations on implementation deficiencies, as well as training and technical assistance related to data collection and reporting, quality improvement, and administer implementation evaluations.

Budget Bill Language Request. DHCS also request budget bill language to implement the BH-QIP. Specifically, this language would add a provision to Item 4260-101-0001 that would allocate $21.8 million of local assistance funding for BH-QIP and authorize DHCS to determine the methodology and distribution of the funds to county behavioral health programs. The proposed language would also ensure federal funds are not jeopardized, allow implementation without regulatory action, and provide certain contract exemptions.

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

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

1. Please provide a brief overview of this proposal.

Issue 8: Behavioral Health Continuum Infrastructure Program

Budget Change Proposal and Budget Bill Language – April Finance Letter. DHCS requests General Fund expenditure authority of $2.2 million in 2021-22, 2022-23, and 2023-24. If approved, these resources would support administration of the Behavioral Health Continuum Infrastructure Program, proposed in the Governor's January budget. DHCS is also requesting budget bill language authorizing distribution and administration of local assistance funds for this purpose.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$2,191,000	$2,155,000
Total Funding Request:	**$2,191,000**	**$2,155,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24: $2,155,000

Background. The Governor's January budget includes General Fund expenditure authority of $750 million in 2021-22 for DHCS to implement the Behavioral Health Continuum Infrastructure Program, a competitive grant program for counties for the acquisition and rehabilitation of real estate assets to expand the community behavioral health continuum. Specifically, these resources would support the addition of at least 5,000 beds, units, or rooms, including the following:

- **Treatment facilities** including crisis intervention and stabilization, crisis residential, residential treatment, day rehabilitation, day treatment intensive or partial hospitalization with housing supports
- **Housing facilities** including adult and senior care facilities, room and board with intensive outpatient services, and peer respite and shared housing. These facilities would include intensive wrap-around supports, such as enhanced care management, in-lieu-of services, and county behavioral health services.

The grant program would allow facilities to be directly operated by counties, or operated through a contract with qualified nonprofit providers. Counties would be required to provide a 25 percent match of local funds, which may include property, land, or philanthropic donations.

Resource Request. DHCS requests General Fund expenditure authority of $2.2 million in 2021-22, 2022-23, and 2023-24 to support administration of the Behavioral Health Continuum Infrastructure Program, proposed in the Governor's January budget. These resources would support the equivalent of four positions, as well as contract resources to provide training and technical assistance to counties on real estate acquisition and rehabilitation, to conduct outreach and education activities, and to develop and manage the contracting process. Specifically, DHCS requests the following position equivalents and contract resources in the following divisions:

Community Services Division – Three-year resources equivalent to three positions

- Three-year resources equivalent to **three Associate Governmental Program Analysts** would develop and implement communications and feedback mechanisms with county and tribal partners, provide technical assistance to potential applicants, monitor expenditures and local

matching funds, oversee and monitor grantees, review grantee progress reports, create a process and monitor activities to verify that federal financial participation is not jeopardized, track the progress and completion of beds, units, and service facilities.

Office of Legal Services – Three-year resources equivalent to one position

- Three-year resources equivalent to **one Attorney IV** position would perform legal research, analysis, and drafting of legal opinions and technical language for the program; respond to questions from various stakeholders; provide creative solutions to complex, novel or sensitive proposals across various legal subject matter areas; research and provide legal advice and input; and opine on matters in the three delivery systems for behavioral health services in Medi-Cal.

In addition to these position equivalents, DHCS is requesting General Fund expenditure authority of $1.5 million in 2021-22, 2022-23, and 2023-24 to support two administrative consulting contracts:

- DHCS requests General Fund expenditure authority of $1 million for three years to support an administrative consultant contract that would: 1) assist DHCS in the review of county and tribal applications; 2) provide comprehensive technical assistance and training regarding real estate and infrastructure implementation; 3) develop and execute contracts and award grant monies to tribal governments and counties; 4) provide payment to grantees for completed milestones; 5) provide oversight to ensure all land acquisition and real estate documents are secured and provided; 6) provide annual quality assurance review of awardees; and 7) develop and implement training and educational materials.

- DHCS request General Fund expenditure authority of $500,000 for three years to support a second administrative consultant contract that would: 1) perform outreach to eligible organizations, facilitate meetings with local entities, providers, and other stakeholders; 2) assist counties and tribes in preparing and completing the application; 3) assist grantees with challenges to land acquisition or other project issues; 4) subcontract with a tribal entity or subject matter experts with tribal experience to provide insight, training, and technical assistance for tribal grantees; 5) develop and deliver training and technical assistance on various real estate topics; and 6) collect and aggregate submitted quarterly reports into a comprehensive quarterly reports and a final report.

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

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

1. Please provide a brief overview of this proposal.

Issue 9: Conforming and Technical Adjustments

Budget Change Proposals and Technical Adjustments – April Finance Letter. DHCS is requesting positions and expenditure authority related to its portion of two joint budget change proposals, as well as two technical adjustments. These changes are as follows:

- State Verification Hub Staff and Technical Resources – DHCS requests one position and annual expenditure authority of $998,000 ($499,000 General Fund and $499,000 federal funds) to support development and implementation of the Statewide Verification Hub, a centralized client eligibility verification system for public assistance programs. These position and resources are part of a joint April Finance Letter submitted by the Department of Social Services (see related issue in Part A of the subcommittee's agenda under Department of Social Services: *Issue 2: Spring BCP – Statewide Verification Hub Staffing Resources*)

- Annual Health Care Service Plan Health Equity and Quality Reviews – DHCS 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 the Department of Managed Health Care (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 are part of a joint April Finance Letter submitted by DMHC. (see related issue heard by the subcommittee during its May 4th hearing under DMHC: *Issue 1: Annual Health Care Service Plan Health Equity and Quality Reviews*)

- Equity Dashboard – DHCS requests reduction in expenditure authority of $117,000 ($59,000 General Fund and $58,000 federal funds) to align workload funding with the positions in the Administration's Equity Dashboard proposal. This proposal was heard during the subcommittee's February 5th hearing.

- Medi-Cal Enterprise System Modernization – DHCS requests a reduction in General Fund expenditure authority of $1.8 million and an increase in federal fund expenditure authority of $1.8 million to update the funding split in the Administration's Medi-Cal Enterprise System Modernization proposal. This proposal was heard during the subcommittee's February 19th hearing.

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

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

1. Please provide a brief overview of the DHCS-related components of the two joint April Finance Letter proposals with DSS and DMHC.

2. Please provide a brief overview of the two technical adjustments.

Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEES NO. 1 and 3 Agenda

Subcommittee No. 1 - Education
Senator John Laird, Chair
Senator Dave Min
Senator Rosilicie Ochoa Bogh

Subcommittee No. 3 – Health and Human Services
Senator Susan Talamantes Eggman, Ph.D., Chair
Senator Melissa Melendez
Senator Richard Pan, M.D.

Thursday, May 13, 2021
10:00 a.m., or upon adjournment of session
State Capitol - Room 4203

Consultants: Elisa Wynne and Scott Ogus

PUBLIC COMMENT

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

6100 CALIFORNIA DEPARTMENT OF EDUCATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Child Care Overview, Priorities and Stakeholder Perspectives

Panel I:
- Sara Cortez, Legislative Analyst's Office

Panel II:
- Christina Figueroa, Parent
- Lily Marquez, Parent

Panel III:
- Donna Sneeringer, Chief Strategy Officer, Child Care Resource Center
- Nina Buthee, Executive Director, Every Child California
- Keisha Nzewi, Director of Public Policy, California Child Care Resource and Referral Network
- Donise Keller, Child Care Provider
- Angie Garling, Vice President, Early Care are Education, Low Income Investment Fund

Background

Generally, programs in the early care and education system have two objectives: to support parental work participation and to support child development. Children, from birth to age five, are cared for and instructed in child care programs, State Preschool, transitional kindergarten, and the federal Head Start program.

The administration of child care programs is currently in transition as SB 98 (Committee on Budget and Fiscal Review), Chapter 24, Statutes of 2020, established the Early Childhood Development Act to transfer the administrative responsibility of all state child care programs, with the exception of the California State Preschool Program, from the Department of Education (CDE) to the Department of Social Services (DSS), commencing July 1, 2021.

Child Care. California provides child care subsidies to some low-income families, including families participating in CalWORKs. Families who have participated in CalWORKs are statutorily guaranteed child care during "Stage One" (when a family first enters CalWORKs) and "Stage Two" (once a county deems a family "stable", defined differently by county). In the past, the state has funded "Stage Three" (two years after a family stops receiving cash aid) entirely while it is not a statutorily guaranteed entitlement program. Families remain in Stage Three until their income surpasses a specified threshold or their child ages out of the program. For low-income families who do not participate in CalWORKs, the state prioritizes based on income, with lowest-income families served first. To qualify for subsidized child care: (1) parents demonstrate need for care (parents working, or participating in an education or training program); (2) family income must be below 85 percent of the most recent state median income (SMI) calculation; and (3) children must be under the age of 13.

California State Preschool Program. State Preschool provides both part-day and full-day services with developmentally-appropriate curriculum, and the programs are administered by local educational

agencies (LEAs), colleges, community-action agencies, and private nonprofits. State preschool can be offered at a child care center, a family child care network home, a school district, or a county office of education (COE). The State Preschool program serves eligible three- and four-year old children, with priority given to four-year olds whose family is either on aid, is income eligible (family income may not exceed 85 percent of the SMI), is homeless, or the child is a recipient of protective services or has been identified as being abused, neglected, or exploited, or at risk of being abused, neglected or exploited.

Transitional Kindergarten. SB 1381 (Simitian), Chapter 705, Statutes of 2010, enacted the "Kindergarten Readiness Act" and established the transitional kindergarten program, beginning in 2012-13, for children who turn five between September 1 and December 1. Each elementary or unified school district must offer developmentally-appropriate transitional kindergarten and kindergarten for all eligible children, regardless of family income. Transitional kindergarten is funded through an LEA's Local Control Funding Formula allocation. LEAs may enroll children in transitional kindergarten that do not meet the age criteria if they will turn five by the end of the school year, however, these students will not generate state funding until they turn five.

State Child Care and Preschool Programs Source: Legislative Analyst's Office

Program	Description
CalWORKs Child Care	
Stage 1	Child care becomes available when a participant enters the CalWORKs program.
Stage 2	Families transition to Stage 2 child care when the county welfare department deems them stable.
Stage 3	Families transition to Stage 3 child care two years after they stop receiving cash aid. Families remain in Stage 3 until the child ages out (at 13 years old) or they exceed the income-eligibility cap.
Non-CalWORKs Child Care	
General Child Care	Program for other low-income, working families.
Alternative Payment	Another program for low-income, working families.
Migrant Child Care	Program for migrant children from low-income, working families.
Care for Children with Severe Disabilities	Program for children with severe disabilities living in the Bay Area.
Preschool	
State Preschool	Part-day, part-year program for low-income families. Full-day, full-year program for low-income, working families.
Transitional Kindergarten	Part-year program for children who turn five between September 2 and December 2. May run part day or full day.

Funding. California provides child care and development programs through vouchers and contracts.

- **Vouchers.** The three stages of CalWORKs child care and the Alternative Payment Program are reimbursed through vouchers. Parents are offered vouchers to purchase care from licensed or license-exempt caregivers, such as friends or relatives who provide in-home care. Families can also use these vouchers at any licensed child care provider in the state, and the value of child care vouchers is capped. The state will only pay up to the regional market rate (RMR) — a different amount in each county and based on regional surveys of the cost of child care. The RMR is currently set to the 75th percentile of the 2016 RMR survey. If a family chooses a child care provider who charges more than the maximum amount of the voucher, then a family must pay the difference, called a co-payment. Typically, a Title 22 program – referring to the state Title 22 health and safety regulations that a licensed provider must meet — serves families who receive vouchers. The Department of Social Services (DSS) funds CalWORKs Stage One, and county welfare departments locally administer the program. The California Department of Education (CDE) funds the remaining voucher programs, which are administered locally by Alternative Payment (AP) agencies statewide. Alternative Payment agencies (APs), which issue vouchers to eligible families, are paid through the "administrative rate," which provides them with 17.5 percent of total contract amounts.

- **Contracts.** Providers of General Child Care, Migrant Child Care, and State Preschool – known as Title 5 programs for their compliance with Title 5 of the California Code of Regulations — must meet additional requirements, such as development assessments for children, rating scales, and staff development. Title 5 programs contract with, and receive payments directly from, CDE. These programs receive the same reimbursement rate (depending on the age of the child), no matter where in the state the program is located. The rate is increased by a stautory adjustment factor for infants, toddlers, children with exceptional needs, severe disabilities, cases of neglect, and English learners. The current standard reimbursement rate (SRR) is $49.54 per child per day of enrollment for General Child Care and $49.85 for State Preschool. All Title 5 programs also operate through family child care home education networks, which serve children in those programs through family child care homes that are members of the network.

For license-exempt care, reimbursement rates are set at seventy percent of the regional reimbursement rate established for family child care homes, except for hourly rates, which are set by dividing the weekly rate by 45 hours, to arrive at a rate that can in some cases be around 25 percent of the family child care home hourly rate.

Child care and early childhood education programs are generally capped programs, meaning that funding is provided for a fixed amount of slots or vouchers, not for every qualifying family or child. The exception is the CalWORKs child care program (Stages One and Two), which are entitlement programs in statute.

Subsidized child care programs are funded by a combination of non-Proposition 98 state General Fund and federal funds. Until the 2011-12 fiscal year, the majority of these programs were funded from within the Proposition 98 guarantee for K-14 education. In 2012, funding for state preschool and the General Child Care Programs were consolidated; all funding for the part-day/part-year state preschool was budgeted under the state preschool program, which is funded from within the Proposition 98 guarantee.

For LEA-run preschool, wrap-around care to provide a full day of care for working parents is provided with Proposition 98 funding, while non-LEA state preschool providers received General Fund through the General Child Care program to support wrap-around care. The 2019-20 Budget Act changed this structure and funded all non-LEA state preschool and wrap care with non-Proposition 98 and retained LEA state preschool and wrap care within Proposition 98.

California also receives funding from the federal Child Care and Development Fund (CCDF), which is comprised of federal funding for child care under the Child Care and Development Block Grant (CCDBG) Act and the Social Security Act and from federal TANF funds.

Collective Bargaining. In 2019, Governor Newsom signed legislation granting collective-bargaining rights to child care providers in California allowing them to negotiate with the state over matters related to the recruitment, retention, and training of family childcare providers. CalHR is currently negotiating with Child Care Providers United - California (CCPU) to establish a Master Contract Agreement. The CCPU represents both voucher and direct contract providers that are family child care homes, or license-exempt home providers.

Pandemic Impacts and Response:

The pandemic has affected child care providers and families. The COVID-19 emergency, has placed increased fiscal pressure on child care providers. The Center for the Study of Child Care Employment conducted a survey of 953 California child care providers at the end of June 2020. The vast majority of child care providers reported they were serving fewer children compared to before the pandemic and 77 percent of open providers reported they experienced a loss of income from families. Providers are also reporting higher costs. Of open providers, 80 percent reported higher costs for cleaning, sanitation, and personal protective equipment. Families receiving child care also have been affected, particularly due to school and child care closures that have required families to find new child care arrangements.

The LAO has provided the following table that shows an estimate of providers that remain open, and those that are closed permanently or temporarily and reflects both private and subsidized providers. This would not reflect license exempt providers and is a point-in-time snapshot.

Community Care Licensing - Child Care Licenses and Closures

As of March 31, 2021

	Small Family Homes	Large Family Homes	Child Care Centers	Total
Open and Operating[a]				
Facilities	12,875	11,263	10,525	34,663
Slots	102,536	156,748	575,117	834,401
Temporarily Closed				
Facilities	1,352	960	4,267	6,579
Slots	10,736	13,342	224,016	248,094
Permanently Closed Since March 2020				
Facilities	2,194	902	605	3,701
Slots	17,438	12,528	27,428	57,394

a) Represents licenses that are not inactive or temporarily closed.

Governor's Budget Proposal:

The Governor's Budget includes the following adjustments and proposals:

- **Non-CalWORKs Child Care.** The proposed budget includes $19.9 million for a 1.5 percent COLA adjustment for non-CalWORKs child care. The proposed budget also includes an increase of $21.5 million ongoing in 2020-21 and an additional $44 million ongoing for 4,700 additional Alternate Payment Program slots due to updated Proposition 64 cannabis tax revenues.

- **CalWORKs Child Care.** The proposed budget includes several adjustments to reflect changes in the CalWORKs child care caseload and cost of care for a net decrease of $141 million, reflecting a $62 million decrease in Stage 1, a $112 million decrease in Stage 2, and a $33 million increase in Stage 3.

- **COVID-19 Related Support.** The proposed budget includes $55 million one-time General Fund to support child care providers' and families' needs as a result of the pandemic.

Federal Stimulus Funds for Child Care

The Legislative Analyst's Office provided the following information on available federal funds in their recent blog post: *Overview of Federal Relief for K-12 Education and Child Care.*

Since March 2020, the federal government has passed three relief packages that assist child care providers in their response to the coronavirus disease 2019 (COVID-19) pandemic.

- ***Coronavirus Aid, Relief, and Economic Security (CARES) Act.*** Signed into law on March 27, 2020, the CARES Act provided $3.5 billion for child care programs. The legislation also established the Coronavirus Relief Fund (CRF), which can be used by states for a variety of activities that address the COVID-19 public health emergency. (California allocated a portion of its CRF funding to child care.)

- ***Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA)***. Signed into law on December 27, 2020, the CRRSAA provided $10 billion for child care. The CRRSAA made some minor changes to allowable uses, but generally had similar rules for child care funds were to be spent.

- ***American Rescue Plan (ARP).*** The ARP was signed into law on March 11, 2021 and provides the largest round of funding, $39.6 billion for child care.

Overview of Federal COVID-19 Relief Funding for Child Care

California Allocations (In Millions)

	CARES Act	CRRSAA	ARP	Totals
Supplemental CCDBG	$350	$964	$1,443	$2,758
Child Care Stabilization	—	—	2,313	2,313
Child Care Entitlement (LAO estimate)	—	—	63	63
Totals	$350	$964	$3,820	$5,134

COVID-19 = coronavirus disease 2019; CARES = Coronavirus Aid, Relief, and Economic Security; CRRSAA= Coronavirus Response and Relief Supplemental Appropriations Act; and CCDBG = Child Care and Development Block Grant.

- ***California to Receive a Combined $2.8 Billion in Supplemental Child Care and Development Block Grant (CCDBG) Funding.*** The federal government provided a total of $28.5 billion in federal relief through supplemental CCDBG funds. California received a combined $2.8 billion in supplemental CCDBG funds from the three relief packages. All the supplemental CCDBG provided through the three relief packages can be used for child care assistance to essential workers. Supplemental CCDBG provided through the CARES Act and CRRSAA can also be used to support child care providers. For CARES Act and CRRSAA, supplemental CCDBG must be committed by September 30, 2022 and expended by September 30, 2023. For ARP, funds must be committed by September 30, 2023 and expended by September 30, 2024.

- ***State Has Appropriated $882 Million of Relief Funds for Child Care.*** The state appropriated all of its $460 million in CARES Act funding through a variety of spending actions in 2020 and 2021. CARES Act funding for child care includes $350 million of supplemental CCDBG as well as $110 million in CRF. The Legislature also passed Chapter 6 of 2021 (AB 82, Ting), which appropriated $402 million of the $964 million in supplemental CCDBG the state received through the CRRSAA. The administration subsequently submitted a budget revision to use $20 million of the CRRSAA funds to address a budget shortfall associated with providing voucher providers with reimbursement flexibility. The figure below describes how the state used these one-time federal relief funds in more detail. A total of $542 million in CRRSAA and $1.4 billion in ARP supplemental CCDBG funds remain available.

How the State Has Spent One-Time Federal Relief Funding for Child Care
(In Millions)

Activity	Description	CARES Act	CRRSAA	Total
Alternative Payment Voucher Slots	Provided $50 million one time in 2019-20 and $294 million one time in 2020-21. Funds are intended to provide temporary child care until June 30, 2022.	$188	$156	$344
Voucher Stipends	Stipends to voucher providers based on the number of subsidized children enrolled.	31	244	275
Voucher Reimbursement Flexibility	In 2020-21, voucher provider payments are based on a child's authorized hours of care instead of the amount of care used. This holds voucher providers harmless if a child temporarily does not attend child care.	63	20	83
Family Fees	From September 2020 through June 2021, the state has waived family fees for families not receiving in-person care.	50	—	50
Cleaning Supplies and Protective Equipment	The state provided funds for gloves, face coverings, cleaning supplies, and labor costs associated with cleaning child care facilities.	50	—	50
Voucher Paid Operation Days	Provides an additional 30 paid non-operation days. Funds used so child could attend another provider while the original provider is closed.	40	—	40
School Aged Care	Funds are to cover the additional cost of providing care to school-aged children. During the school year, school-aged children typically receive care before and/or after school. As schools in most of the state remain closed, many school-aged children participating in distance learning also are receiving care from a child care provider during the school day.	38	—	38

State Administration	Provides funds to CDE and DSS for administrative costs.	—	2	2
Totals		$460	$422	$882

California Anticipated to Receive an Additional $2.4 Billion for Child Care From ARP. Of this amount, $2.3 billion is child care stabilization funding. The state is to provide grants to child care providers to pay for costs such as payroll, rent, and cleaning supplies. The ARP also includes ongoing child care entitlement funding, which we estimate would provide an additional $63 million for subsidized child care programs. For entitlement funds, the state must commit by the end of the fiscal year and expend by the end of the second fiscal year. The Legislature has not yet appropriated any of these funds.

Senate Priorities

In April of 2021, the Senate Democratic Caucus released: *Senate Democrats Budget Priorities for 2021-22 and Beyond,* which included broad outlines for budget priorities. Universal access to Early Care and Education for ages 0-3 is a top priority for the Senate Democrats, including making progress on the following:

- Make a significant investment (up to 200,000) in additional childcare slots for working families as next step toward universal access for ages 0 to 3.
- Establish and support childcare worker apprenticeship/training programs.
- Reduce costs to working families by reducing/eliminating family fees.
- Increase provider reimbursement rates to achieve a livable wage for childcare workers.
- Stabilize and retain providers as the state emerges from the pandemic.
- Support providers that have remained open during the pandemic by continuing hold harmless policies.
- Provide one-time funds to help providers who have closed to re-open or those who are open to expand.
- Retain essential worker families in the child care system.

Suggested Questions:

- What are the investments needed to re-open or open new child care homes and centers? What barriers exist now and prior to the pandemic for providers wanting to expand or open for child care?
- With the significant amount of one-time funds, what uses should the Legislature consider prioritizing? What investments need ongoing funds?

- What steps can the state take to grow the child care workforce?

- As the Legislature considers additional slots, what types of slots make the most sense for immediate and long-term expansion? What type of capacity is in the existing system to absorb an increase in slots, and where does capacity need to be increased before additional slots are added?

- What needs of parents are not currently being met? How can the state help to ensure that parents can find the care they need?

- What policies adopted during the pandemic need to be retained over the short or long-term?

Staff Recommendation:

Information Only

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
6100 CALIFORNIA DEPARTMENT OF EDUCATION

Issue 1: Student Behavioral Health Proposals

Package of School-Based Behavioral Health Proposals in January Budget. The Governor's January budget includes three proposals to address school-based behavioral health:

1) Mental Health Services Oversight and Accountability Commission – The budget includes expenditure authority from the Mental Health Services Fund of $25 million in 2021-22 to expand the Mental Health Student Services Act Partnership Grant Program, which facilitates partnerships between county mental health plans and schools to provide mental health services to students.
2) Department of Health Care Services – The budget includes expenditure authority of $400 million ($200 million General Fund and $200 million federal funds) to support an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services.
3) K-12 Schools Proposition 98 Funding – The budget includes General Fund expenditure authority from Proposition 98 education funds to support innovative partnerships with county behavioral health to support student mental health services. The funding would be provided to local education agencies to match funding in county Mental Health Services Act spending plans dedicated to the mental health needs of students.

Background - Mental Health Funding for Local Educational Agencies (LEAs). LEAs do not currently have significant sources of funding dedicated for supporting the mental health of students within their Proposition 98 allocations. For students with mental health needs who qualify for special education and have an Individualized Education Plan (IEP) that requires services, LEAs may use their special education funding to provide these services. Of the total amount of funds available to LEAs for special education, approximately $152 million was set aside each year as Educationally-Related Mental Health Services (ERMHS) funds, restricted to education-related mental health services that are included in IEPs. Recently, the state expanded the allowable use of ERMHS funds to include mental health services for all students beginning in the 2020-21 fiscal year. However, given that the costs for special education services generally exceed the amount of categorical funds provided for this purpose, this expansion of the use of mental health funding will not create a significant expansion of mental health services for the general student population. There have also been smaller efforts to create mental health resources for LEAs, particularly around suicide prevention. LEAs may use their general operations funds to provide services to students, including mental health or wellness services, and these expenditures have been an allowable use of recent pandemic relief funds.

Mental Health Student Services Act. The 2019 Budget Act included expenditure authority from the Mental Health Services Fund of $50 million in 2019-20 and $10 million annually thereafter for the Mental Health Student Services Act (MHSSA), a competitive grant program to establish mental health partnerships between county mental health or behavioral health departments and school districts, charter

schools, and county offices of education. These partnerships support: (1) services provided on school campuses; (2) suicide prevention; (3) drop-out prevention; (4) outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), and youth who have been expelled or suspended from school; (5) placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services; and (6) other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth.

Prior to the MHSSA, SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, known as the Investment in Mental Health Wellness Act, included expenditure authority from the Mental Health Services Fund of $32 million annually for MHSOAC to support counties to increase capacity for client assistance and services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams. In 2018-19 the expenditure authority was reduced to $20 million annually. According to MHSOAC, since 2017-18, 50 percent of the funding has been allocated to programs dedicated to children and youth aged 21 and under, and approximately $20 million was allocated for four School-County Collaboration Triage grants to: 1) provide school-based crisis intervention services for children experiencing or at risk of experiencing a mental health crisis and their families or caregivers; and 2) supporting the development of partnerships between behavioral health departments and educational entities. Humboldt County, Placer County, Tulare County Office of Education, and a joint powers authority in San Bernardino County were awarded $5.3 million annually over four years in this program. MHSOAC also awarded grants for school-based triage programs in Berkeley, Humboldt, Riverside, Sacramento, and San Luis Obispo.

Building on the partnership model in the triage grant program, MHSSA supports partnerships between county behavioral health programs and educational entities. Combining the $50 million allocation in 2019-20 with the annual $10 million allocations for the subsequent three fiscal years, MHSOAC allocated a total of $75 million over four years for funding of the MHSSA Partnership Grant Program. The funding was made available in two categories: 1) $45 million for counties with existing school mental health partnerships, and 2) $30 million for counties developing new or emerging partnerships. Within each category, funding was made available based on the population size of a county with a total of six grants at $2.5 million each made available to small counties (less than or equal to 200,000 population), six grants at $4 million each made available to medium counties (between 200,000 and 750,000 population), and six grants at $6 million each made available to large counties (greater than 750,000 population).

According to MHSOAC, 38 counties submitted applications for funding. 20 counties with existing partnerships submitted applications and 10 received awards. 18 counties developing new or emerging partnerships submitted applications and eight received awards. The counties that submitted applications in each category and their award status are as follows:

County	Size	Existing or New	Awarded
Amador	Small	New	NO
Calaveras	Small	New	YES

Contra Costa	Large	New	NO
Fresno	Large	Existing	YES
Glenn	Small	Existing	NO
Humboldt	Small	Existing	YES
Imperial	Small	New	NO
Kern	Large	Existing	YES
Lake	Small	Existing	NO
Los Angeles	Large	Existing	NO
Madera	Small	New	YES
Marin	Medium	Existing	NO
Mariposa	Small	Existing	NO
Mendocino	Small	Existing	YES
Monterey	Medium	Existing	NO
Nevada	Small	New	NO
Orange	Large	Existing	YES
Placer	Medium	Existing	YES
Riverside	Large	New	NO
Sacramento	Large	Existing	NO
San Bernardino	Large	Existing	NO
San Diego	Large	Existing	NO
San Francisco	Large	Existing	NO
San Luis Obispo	Medium	Existing	YES
San Mateo	Large	New	YES
Santa Barbara	Medium	New	YES
Santa Clara	Large	New	YES
Santa Cruz	Medium	New	NO
Shasta	Small	New	NO
Solano	Medium	Existing	YES
Sonoma	Medium	New	NO
Sutter-Yuba	Small	New	NO
Tehama	Small	New	YES
Trinity-Modoc	Small	New	YES
Tulare	Medium	Existing	YES
Tuolomne	Small	New	NO
Ventura	Large	Existing	YES
Yolo	Medium	New	YES

According to MHSOAC, only 18 awards were made due to funding constraints. MHSOAC estimates approximately $80.5 million would be required to fund all 38 grant applications for school-mental health partnerships, $45.5 million with existing partnerships and $35 million for new and emerging partnerships.

MHSOAC Proposal – Increased Access to Student Behavioral Health Services

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
3085 – Mental Health Services Fund	$25,000,000	$-
Total Funding Request:	**$25,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Budget Change Proposal – Governor's Budget. MHSOAC requests expenditure authority from the Mental Health Services Fund of $25 million in 2021-22 to expand the MHSSA Partnership Grant Program to additional counties. In an October 2020 report, MHSOAC documented the expanding need for school mental health services, highlighting the following research findings:

- One in three high school students report feeling chronically sad and hopeless – including more than half of LGBTQ students.
- One in six high school students report having considered suicide in the past year – including one in three LGBTQ students.
- 50 to 75 percent of students with mental health needs do not receive needed care.
- Racial, ethnic, and cultural disparities concentrate the risk factors, prevalence rates and service gaps in low-income communities of color.

In addition, public health interventions related to the COVID-19 pandemic including stay-at-home orders and school closures have led to social isolation and economic disruption that cause additional stress and anxiety, particularly for school-aged children. As the state considers relaxing public health interventions in the coming months, in particular the reopening of schools, there is likely to be a significant unmet need for behavioral health services on school campuses as the accumulated trauma of the pandemic among school-aged children interfaces with the reintegration of these children into routine social interactions with peers and educators.

DHCS Proposal – Increased Access to Student Behavioral Health Services

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$194,493,000	$-
0890 – Federal Trust Fund	$194,493,000	$-
Total Funding Request:	**$388,986,000**	**$-**

Program Funding Request Summary – Budget Change Proposal		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$5,507,000	$-
0890 – Federal Trust Fund	$5,507,000	$
Total Funding Request:	**$11,014,000**	**$**
Total Requested Positions:	**0.0**	**0.0**

Local Assistance – Governor's Budget. DHCS requests expenditure authority of $389 million ($194.5 million General Fund and $194.5 million federal funds) in 2021-22 to implement an incentive program through Medi-Cal managed care plans, in coordination with county behavioral health departments and schools, to build infrastructure, partnerships, and capacity statewide to increase the number of students receiving preventive and early intervention behavioral health services. The incentive payments would support the following interventions:

- Local planning efforts to review existing plans and documents that articulate student needs; compile data; map existing behavioral health resources; identify gaps, disparities, and inequities; convene stakeholders; and develop a framework for a robust and coordinated system of social, emotional, and behavioral health supports for students. These planning efforts would include Medi-Cal managed care plans, county behavioral health departments, schools, and other key local stakeholders.
- Execution of contracts between schools, Medi-Cal managed care plans, and county behavioral health departments to provide preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers. Incentives would be provided for reaching threshold levels of school participation and for three-way contracts between the schools, behavioral health departments and Medi-Cal managed care plans.
- Development of behavioral health wellness programs, including Mental Health First Aid or Social and Emotional Learning.
- Expand the workforce using community health workers or peers to expand the surveillance and early intervention of behavioral health issues in school-aged children.
- Increase behavioral health telehealth services in schools, including access to equipment and space
- Implement adverse childhood experience (ACE) screenings and referral processes in schools
- Implement a school suicide prevention strategy
- Implement culturally appropriate and community-defined interventions and systems for behavioral health services in schools to close health equity gaps.
- Increase prenatal and postpartum access to behavioral health for teen parents
- Improve public reporting of performance and outcomes for behavioral health access and quality
- Increase access to substance use disorder prevention, early intervention and treatment
- Provide care teams to conduct outreach, engagement, and home visits, as well as linkage to social services to address non-clinical needs

Budget Change Proposal – Governor's Budget. DHCS also requests expenditure authority of $11 million ($5.5 million General Fund and $5.5 million federal funds) in 2021-22 to support implementation workload for the student behavioral health incentive program, including capitated rate development, local government financing, and managed care operations and monitoring.

Proposition 98 Proposal – Funding for Student Mental Health

Proposition 98 Proposal – Governor's Budget. The budget provides $25 million ongoing Proposition 98 General Fund to fund partnerships with county behavioral health to support student mental health services. Funds would be provided as competitive grants to LEAs to match, on a 1:1 basis, proposed county expenditures for children's mental health services, as specified in a county's three-year program

and expenditure plan or annual update prepared pursuant to Section 5847 of the Welfare and Institutions Code from their share of the MHSF.

LEA applicants must provide a plan that describes the following:

- The need for mental health services at the local educational agency as well as potential gaps in local service connections.
- That plans address the mental health needs of enrolled students in kindergarten through grade 12 in a manner consistent with a whole child approach, including but not limited to the following:
  - Professional development for educators to identify early warning signs and risk factors for students in need of mental health supports.
  - Establishment or expansion of mental health and counseling staff available in schools.
  - Development of peer support networks, and other activities that promote students' sense of connectedness and belonging to a school community.
  - Development of partnerships with community organizations, including health and mental health service providers, with an emphasis on those that serve at risk student groups.
  - Development of resources and supports for family engagement.
  - Resources that address the acute and chronic mental health support needs in communities experiencing ongoing natural disasters and systemic violence.
- A proposal for how the funds will be used to expand a county's children's mental health services project and meet data collection and reporting requirements required of Mental Health Services Act three-year program plans.

Funds would be awarded for up to a three year term, with the Superintendent of Public Instruction (SPI) to review the grantee and determine renewal at the end of the grant period. The SPI shall determine the amount of grants.

Stakeholder Feedback and Proposals for Investment

In response to the Administration's proposals to improve access to behavioral health services for students, stakeholders have submitted feedback on these proposals, as well as alternative proposals for investment.

Local Health Plans of California Feedback. The Local Health Plans of California (LHPC), which represent the majority of Medi-Cal managed care plans in the state, have submitted feedback to DHCS regarding their proposal to support access to behavioral health services for students. In their letter, LHPC recommends that the first year of the program focus on technical assistance and the support needed to conduct needs assessments or gap analyses, determine what approaches or contracting arrangements will best meet those needs, and develop project plans which include specific milestones. DHCS identifies local planning efforts as an example of an activity that would be eligible for incentives. However, LHPC believes this should be the starting point for most partnerships or projects proposed under the incentive program. While projects should have the flexibility to implement sooner than program year two depending on readiness and whether there is an existing understanding of gaps or needs, LHPC anticipates LEAs, county mental health plans, and Medi-Cal managed care plans will generally need the first year for planning given the preliminary activities outlined below.

County Behavioral Health Directors Association Feedback. The County Behavioral Health Directors Association (CBHDA), which represents county mental health and substance use disorder programs, has submitted feedback to DHCS regarding their proposal, as well. According to their letter, CBHDA strongly supports the Administration's intent of increasing behavioral health services in schools in a manner that recognizes the extensive school-based behavioral health services currently provided by county behavioral health agencies and agency-contracted community-based organizations. CBHDA and its members believe that coordination across these respective systems and identification of high-risk children and youth through school-based partnerships will enable the provision of necessary behavioral health services. In addition, CBHDA urges structuring the proposal to acknowledge the Medi-Cal plans, including county behavioral health plans, with established partnerships and programs in local schools in directing resources under this proposal, including direction of incentive payments and the three-way partnerships among schools, managed care plans, and county behavioral health plans, outlined in the Administration's proposal. These collaborations are especially important as mental health needs of children and youth rise due to the impacts of the COVID-19 pandemic, and as demand for these services surges, it will be especially important to ensure all Medi-Cal children receive early intervention for mental health needs. CBHDA indicates it has provided the Administration with a list of additional activities that should be eligible for incentive funds, such as funding to ensure school sites have an appropriate location to provide behavioral health services, a consistent barrier to providing school-based mental health services.

Coalition Support for Increasing MHSSA Funding. A coalition of 28 organizations including Children Now, CBHDA, the Children's Partnership, the Sacramento County Office of Education, the California Pan-Ethnic Health Network, and the California Children's Hospital Association request total expenditure authority of $80.5 million in 2021-22 to provide additional grants for partnerships between schools and county mental health programs to provide mental health services to students. According to the coalition, MHSOAC's current initiative through the MHSSA is a key investment in school mental health. While the Governor's budget proposes an investment of $25 million in MHSSA, the amount proposed is not enough to fully meet the demand for funding across the state to support student mental health through school-county partnerships.

The goals of school-county partnerships are to prevent student mental health concerns from becoming severe and disabling; increase timely access to services; participate in outreach to recognize early signs; reduce stigma; reduce discrimination; and prevent negative outcomes. In 2019-20, MHSOAC was able to fund 18 of 38 school-county partnership applicants. The remaining unfunded 20 applications represent turn-key partnerships ready for implementation. Once funded, schools in the remaining unfunded counties could begin providing much needed supports to school age children. Given the increased emotional pressure the COVID-19 pandemic has placed on students, the coalition requests to fund MHSSA at $80.5 million for the 2021-22 budget year, the level that is required to ensure students have access to school-based mental health services, quickly.

Panel Discussion. The two subcommittees have requested the following panelists to discuss options for improving the Administration's proposals for improving access to behavioral health services for students:

- Linnea Koopmans, Acting CEO, Local Health Plans of California
- Elia Gallardo, Director of Government Affairs, County Behavioral Health Directors Association

- Lishaun Francis, Associate Director – Health Collaborations, Children Now
- Dr. Erin M. Simon, Asst Superintendent-School Support Services, Long Beach Unified School District

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 two subcommittees have requested MHSOAC, DHCS, and panelists to respond to the following questions:

DHCS:

1. Please provide a brief update of changes to the DHCS student behavioral health proposal, if any, and any additional guidance provided to stakeholder regarding the program's proposed operation.

2. Please provide a brief overview of the federal regulations that authorize the capitation payment structure proposed to support these interventions. Under these regulations, would the state be permitted to impose minimum requirements on Medi-Cal managed care plans as a condition of receipt of the incentive payments?

MHSOAC:

1. Please describe the cost of supporting the unsuccessful applications submitted to the commission for MHSSA funding of school-mental health partnerships?

2. Are there opportunities within the existing grantees, or the unsuccessful grantees proposals, to make additional progress, were more funding made available?

3. What is MHSOAC's assessment of the reasons more counties did not apply for MHSSA funding?

4. How quickly could the interventions to support the behavioral health needs of students included in the existing and unsuccessful MHSSA proposals be implemented if additional funding was adopted in the budget?

PANELISTS

Local Health Plans of California:

1. Please describe how local health plans see their role in increasing student access to behavioral health services.

2. How do local health plans currently coordinate with county behavioral health programs and schools to provide the full continuum of Medi-Cal behavioral health benefits to students and youth/

3. What changes or improvements to the DHCS proposal do local health plans believe would improve the delivery of services and encourage better coordination between plans, county behavioral health programs and schools?

4. Are there currently barriers to contracting with school-based providers for behavioral health services? How could the state help establish the appropriate reimbursement relationships with school-based providers to ensure students have access to the full continuum of behavioral health services?

County Behavioral Health Directors Association:

1. Please describe how county behavioral health programs currently work with schools to provide behavioral health services to students.

2. How are the providers of these services reimbursed? Are they part of the behavioral health plans' provider networks?

3. Please describe how MHSSA grantees are using school-mental health partnership funds. What types of infrastructure, staff, or other resources are partnerships building with these funds?

4. What changes or improvements to the DHCS proposal would help behavioral health programs partner with Medi-Cal managed care plans and schools to provide a full continuum of services to students?

5. What strategies could three-way partnerships employ to ensure seamless delivery of behavioral health services to students, regardless of the acuity of the diagnosis and the responsible entity (e.g. managed care or county plan)?

Children Now:

1. Please describe the coalition proposal to fully fund MHSSA school-mental health partnerships.

2. How would this funding help deploy behavioral health resources to schools in time for the next school year?

3. What additional investments should the state consider to help provide behavioral health services to students on- and off-campus?

Long Beach Unified School District:

1. Please describe how the school district currently assists students in receiving access to mental health services.

2. How does the school district work with the county office of behavioral health or other health providers in ensuring care for students?

3. How does the school district determine students in need of services?

4. Is the school district part of an MHSSA school-mental health partnership?

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Technical Adjustments

Technical Adjustments – April Finance Letter. MHSOAC requests extension of the liquidation period for two previously approved augmentations of expenditure authority:

- County Mental Health Innovation Planning – MHSOAC requests budget bill language to extend the period to liquidate $400,000 from the Mental Health Services Fund, previously authorized in the 2018 and 2019 Budget Acts. The 2018 and 2019 Budget Acts included a total of $5 million from the Mental Health Services Fund to support contract costs for technical assistance to counties to develop plans for expenditures of Proposition 63 dollars allocated for innovative programs. According to MHSOAC, delays in finalizing a subcontract resulted in the need for an additional year to liquidate the expenditure and finalize the subcontract.
- Triage Personnel Grant Program – MHSOAC requests budget bill language to extend the period to liquidate $5.9 million from the Mental Health Services Fund, previously authorized in the 2018 Budget Act. These resources were authorized to support the Triage Personnel Grant Program, which provides competitive grants to counties to support crisis services for individuals with mental health needs. According to MHSOAC, grantees require additional time to complete work delayed by the COVID-19 pandemic, including difficulty hiring and retaining staff, challenges accessing and engaging clients using remote telecommunications platforms, and finalizing subcontract.

The requested budget bill language for both technical adjustments would be as follows:

> 4560-494—Reappropriation, Mental Health Oversight and Accountability Commission. Notwithstanding any other law, the period to liquidate encumbrances of the following citations is extended as specified below.
>
> 3085—Mental Health Services Fund
>
> (1) $400,000 in Item 4560-001-3085, Budget Act of 2018. Available for liquidation until June 30, 2022.
> (2) $5,900,000 in Item 4560-101-3085, Budget Act of 2018. Available for liquidation until June 30, 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 MHSOAC to respond to the following:

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

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 18, 2021
1:30 p.m.
State Capitol - Room 3191

PART A

Consultant: Scott Ogus

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

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Office of Youth and Community Restoration (Issue 039-MR)

Budget Change Proposal - May Revision Adjustment. CHHSA requests 14 positions and General Fund expenditure authority of $4.2 million in 2021-22 and $4.1 million annually thereafter. If approved, these positions and resources would augment CHHSA's January budget proposal to establish and operate the Office of Youth and Community Restoration (OYCR), as part of the proposed realignment of youthful offenders to local jurisdictions. The combined proposals request 33 positions and General Fund expenditure authority of $7.6 million in 2021-22 and $7.2 million annually thereafter.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$4,167,000	$4,113,000
Total Funding Request:	**$4,167,000**	**$4,113,000**
Total Positions Requested:	**14.0**	**14.0**

* Positions and resources ongoing after 2022-23.

Background. Senate Bill (SB) 823 (Committee on Budget and Fiscal Review), Chapter 337, Statutes of 2020, repealed previous provisions that would have created the Department of Youth and Community Restoration and the provisions that would have transferred the responsibilities of the Division of Juvenile Justice (DJJ) within the California Department of Corrections and Rehabilitation (CDCR) to CHHS. Instead, SB 823 established the OYCR within CHHS, effective July 1, 2021. SB 823 directed the juvenile justice subcommittee of the Children Welfare Council to advise and provide recommendations to the OYCR related to the policies, programs, and approaches that improve youth outcomes, reduce youth detention, and reduce recidivism. The OYCR will provide staffing support to elicit, examine, and operationalize the expertise of subcommittee members.

Moving the DJJ under CHHS was intended to align the rehabilitative mission of the state's juvenile justice system with trauma-informed and developmentally appropriate services supported by programs overseen by the state's Health and Human Services Agency. The transition of justice-involved youth being served in local communities will promote trauma-responsive, culturally informed services for youth involved in the juvenile justice system that supports the youths' successful transition into adulthood and help them become responsible, thriving, and engaged members of their communities.

Staff Comment and Recommendation – Hold Open.

In previous hearings of both Subcommittees No. 3 and 5 concerns regarding the level of staffing in the OYCR and independence of the Ombudsperson were expressed. The requested resources appear to address those concerns by moving the Ombudsperson into its own unit and providing additional staff. However, the Subcommittee may want to consider language detailing the authorities and responsibilities of the Ombudsperson in more detail, perhaps modeled after other existing Ombudspersons for the foster care system and the long-term care system. Current statute does not provide the OYCR Ombudsperson the same authority as other Ombudspersons. For example, statute does not specifically allow the Ombudsperson access to copies of records that they may need to investigate complaints – one of the duties of the Ombudsperson outlined in current statute.

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

1. Please provide a brief overview of this proposal.

Issue 2: Children and Youth Behavioral Health Initiative (Issues 043-MR and 044-MR)

Budget Change Proposal - May Revision. CHHSA requests one position and expenditure authority from the Coronavirus Fiscal Recovery Fund (CFRF) of $35.1 million in 2021-22, $20.1 million in 2022-23, General Fund expenditure authority of $100,000 in 2023-24, and $10.1 million annually thereafter. If approved, these resources would support the following two components of the Administration's Children and Youth Behavioral Health Initiative:

- Public Education and Change Campaign – The Office of the Surgeon General within CHHSA requests one position and expenditure authority from the CFRF of $25.1 million in 2021-22, $100,000 in 2022-23, and General Fund expenditure authority of $100,000 annually thereafter to support a public awareness campaign to address adverse childhood experiences (ACEs) and toxic stress, as well as to provide trauma-informed training for educators.

- Coordination, Subject Matter Expertise, and Evaluation – CHHSA requests expenditure authority from the CFRF of $10 million in 2021-22, $20 million in 2022-23, and General Fund expenditure authority of $10 million annually beginning in 2024-25 to provide cross-department coordination, convene and engage with stakeholders, draft and run procurement for services including subject matter experts, and commission an initiative-wide independent evaluator for all program components.

Program Funding Request Summary – Public Education and Change Campaign		
Fund Source	**2021-22**	**2022-23***
8506 – Coronavirus Fiscal Recovery Fund	$25,100,000	$100,000
Total Funding Request:	**$25,100,000**	**$100,000**
Total Positions Requested:	**1.0**	**1.0**

* Positions and resources ongoing after 2022-23, shifting to General Fund in 2023-24.

Program Funding Request Summary – Coordination, Subject Matter Expertise, and Evaluation		
Fund Source	**2021-22**	**2022-23***
8506 – Coronavirus Fiscal Recovery Fund	$10,000,000	$20,000,000
Total Funding Request:	**$10,000,000**	**$20,000,000**
Total Positions Requested:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2024-25 and ongoing: $10,000,000 General Fund.

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

- California Health and Human Services Agency (CHHSA) – CHHSA requests expenditure authority from the CFRF of $10 million in 2021-22, $20 million in 2022-23, and General Fund expenditure authority of $10 million annually beginning in 2024-25 to provide cross-department coordination, convene and engage with stakeholders, draft and run procurement for services including subject matter experts, and commission an initiative-wide independent evaluator for all program components.
- Office of the Surgeon General (OSG) - The Office of the Surgeon General within CHHSA requests one position and expenditure authority from the CFRF of $25.1 million in 2021-22, $100,000 in 2022-23, and General Fund expenditure authority of $100,000 annually thereafter to support a public awareness campaign to address adverse childhood experiences (ACEs) and toxic stress, as well as to provide trauma-informed training for educators.
- Office of Statewide Health Planning and Development (OSHPD) – OSHPD requests expenditure authority from the CFRF of $700 million in 2021-22, and General Fund expenditure authority of $125 million in 2022-23 and $75 million in 2023-24 to support workforce, education, and training efforts. Specifically, these funds would support: 1) expanding training capacity for psychiatry and social workers, 2) creating a school behavioral health coach and counselor workforce, 3) developing the substance use disorder workforce, 4) building the behavioral health workforce pipeline, 5) establishing "earn and learn" apprenticeship models, 6) enhancing training to serve justice- and system-involved youth, 7) expanding behavioral health training for primary care providers, 8) expanding peer personnel training and placement programs, and 9) augmenting existing OSHPD workforce programs for behavioral health disciplines.
- Department of Managed Health Care (DMHC) – DMHC is requesting trailer bill language to require Knox-Keene licensed health care service plans to reimburse behavioral health services provided in school settings for plan members, regardless of whether the provider is part of the plan's contracted provider network. The Department of Health Care Services would establish a statewide reimbursement schedule that would govern payment for behavioral health services by health care service plans in the school setting, unless the provider was under contract with the plan.
- Department of Health Care Services (DHCS) – DHCS requests 78 positions and expenditure authority from the CFRF of $22 million in 2021-22, $24 million in 2022-23, and expenditure authority of $12 million ($6 million General Fund and $6 million federal funds) annually beginning in 2024-25 to implement a Behavioral Health Service Virtual Platform, school-linked behavioral health services, plan offered behavioral health services, and to expand the continuum of behavioral health treatment resources.
- Department of Public Health (DPH) – DPH requests ten positions and expenditure authority from the CFRF of $5 million in 2021-22, General Fund expenditure authority of $50 million in 2022-23, $40 million in 2024-25, and $5 million annually thereafter to implement and build an effective public education and change campaign around behavioral health to: 1) promote general public acceptance and awareness, 2) partner with community leaders for culturally specific campaigns, and 3) empower youth to co-design the campaign.

Office of Surgeon General – ACEs, Toxic Stress, and Trauma-Informed Public Awareness Campaign and Training. As part of the Administration's California Children and Youth Behavioral Health Initiative, the Office of Surgeon General (OSG) proposes the following expenditures:

- Public Awareness Campaign on ACEs and Toxic Stress - $24 million in 2021-22 would support OSG to engage leading experts and consultants to develop content and messaging for a public

awareness campaign on ACEs and toxic stress, which would include the latest evidence on trauma-informed and trauma-sensitive responses. This proposal is similar to a proposal by OSG in the 2020 Governor's January budget that was withdrawn due to the pandemic-induced General Fund deficit.

- Trauma-Informed Training for Educators - $1 million in 2021-22 would support OSG to engage leading experts and consultants to develop a curriculum of trauma-informed training specific to the education sector. The training would include the standardized language, guidelines, and current scientific evidence to focus on mitigating the long-term harms of COVID-19, ACEs, and toxic stress. The training would be accredited by OSG and be made available statewide.
- State Operations – **One Information Officer**, supported by $100,000 annually would respond to media inquiries, provide interview preparation, manage speaker presentation, provide presentation preparation, provide audio/visual support, write news releases or op-eds, and provide general communication support.

California Health and Human Services Agency - Coordination, Subject Matter Expertise, and Evaluation. As part of the Administration's California Children and Youth Behavioral Health Initiative, CHHSA requests contract resources of $10 million in 2021-22, $20 million in 2022-23, and $10 million annually beginning in 2024-25 to support the following activities:

- Behavioral Health Panel – CHHSA would procure a wide range of subject matter expertise to advise and guide the initiative through a policy and program behavioral health panel. The panel would advise on the content and focus of a commissioned independent evaluation of the initiative, and may be called upon for technical assistance by other departments implementing the initiative.
- Youth Advisory Board – CHHSA would establish a youth advisory board overseeing and steering the initiative, including advising on the appropriate use of technology platforms and other aspects of the initiative.
- Coordination Across Departments – CHHSA would provide multi-system coordination, particularly between the education and behavioral health systems, as well as between public and commercial health plans and providers.
- Independent Evaluation – CHHSA would engage a consultant to produce an independent, multi-year evaluation to identify best and emerging practices, and inform future policy and program work.

Staff Comment and Recommendation – Hold Open.

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

1. Please provide a brief overview of all of the components of the California Children and Youth Behavioral Health Initiative.

2. Please provide a brief overview of the Office of Surgeon General's Public Awareness and Change Campaign portion of the proposal.

3. Please provide a brief overview of CHHSA's portion of the proposal for coordination, subject matter expertise, and evaluation.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Song-Brown Health Care Workforce Program Augmentation (Issue 114-MR)

Budget Change Proposal and Budget Bill Language - May Revision. OSHPD requests General Fund expenditure authority of $50 million in 2021-22. If approved, these resources would allow OSHPD to provide additional awards to support and sustain new primary care residency programs through the Song-Brown Health Care Workforce Training Program. OSHPD also requests provisional budget bill language to specifically allocate these funds for new residency programs.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$50,000,000	$-
Total Funding Request:	**$50,000,000**	**$-**

Background. The Song-Brown Health Care Workforce Training Act (Song-Brown Program) was established in 1973 to increase the number of family physicians to provide needed medical services to the people of California. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas and provides financial support to family medicine, internal medicine, OB/GYN, and pediatric residency programs, as well as family nurse practitioner, physician assistant, and registered nurse education programs throughout California. The Song-Brown program is aided by the California Healthcare Workforce Policy Commission (CHWPC), a 15-member citizen advisory board that provides expert guidance and statewide perspectives on health professional education issues, reviews applications, and recommends contract awards. OSHPD, as part of its proposed recast and reorganization into the Department of Health Care Access and Information (HCAI), proposes to transition the CHWPC to the California Health Workforce Education and Training Council, which will combine oversight of the Song-Brown Program with programs being transitioned from the Health Professions Education Foundation. This proposal was heard during the subcommittee's hearing on May 4th, 2021.

The 2017 Budget Act authorized $33.3 million annually over three years for augmentation of health care workforce initiatives at OSHPD. In the 2020 Budget Act, this allocation was extended permanently. The $33.3 million annual allocation provides up to $18.7 million for existing primary care residency slots, up to $3.3 million for new primary care residency slots at existing residency programs, up to $5.7 million for primary care residency slots at teaching health centers, up to $3.3 million for newly accredited primary care residency programs, up to $333,000 for the State Loan Repayment Program, and up to $2 million for OSHPD state operations costs. Unspent funds in each of these categories from prior years are available for expenditure for the subsequent five fiscal years. For example unspent funds from 2017-18 are available until June 30, 2023, and unspent funds from 2018-19 are available until June 30, 2024. According to OSHPD, the Song-Brown program awarded the following in 2020-21:

1) *Existing Primary Care Residency Slots* – $19.4 million to support 155 existing residency slots
2) *New Primary Care Residency Programs* - $4 million to support six new programs.
3) *Teaching Health Centers (THC)* - $8.5 million to support 50 residency slots at existing THCs
4) *New Primary Care Residency Slots at Existing Programs* - $3.9 million to support 13 new residency slots in existing programs

In 2019, the California Future Health Workforce Commission submitted a report, titled *Meeting the Demand for Health: Final Report of the California Future Health Workforce Commission*, which focuses on addressing California's looming health workforce shortage. According to the report, California is projected to have a shortage of 4,103 primary care clinicians by 2030.

Resource Request. OSHPD requests General Fund expenditure authority of $50 million in 2021-22 to provide additional awards to support and sustain new primary care residency programs through the Song Brown Program. According to OSHPD, the institutional award size is based upon providing up to $800,000 to support the costs for a new primary care residency program to receive accreditation. OSHPD expects to provide 10 program awards annually between 2021-22 and 2026-27.

OSHPD also requests provisional budget bill language to specifically allocate these funds for new residency programs. The language would amend provision 3 of Item 4140-101-0001, as follows:

> 4140-101-0001
>
> 3. Of the funds appropriated in this item, up to $18,667,000 is available to fund grant awards for existing primary care residency slots, up to $3,333,000 is available to fund new primary care residency slots at existing residency programs, and up to $5,667,000 is available to fund primary care residency slots for existing teaching health centers under the Song-Brown Health Care Workforce Training Act (Article 1 (commencing with Section 128200) of Chapter 4 of Part 3 of Division 107 of the Health and Safety Code). Of the funds appropriated in this item, up to $3,333,000 is available to fund newly accredited primary care residency programs and, as of June 30, 2023 2022, unspent amounts may be redirected to fund new residency slots at existing programs if newly accredited primary care residency programs have not been established. ***Of the funds appropriated in the item, $50,000,000 is available to fund new primary care residency programs.*** Of the funds appropriated in this item, up to $333,000 is available for the State Loan Repayment Program.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 2: Geriatric Care Workforce Programs (Issue 113-MR)

Budget Change Proposal and Budget Bill Language - May Revision Adjustment. OSHPD requests General Fund expenditure authority of $5 million in 2021-22. If approved, these resources would allow OSHPD to increase its allocation to support geriatric workforce programs, originally proposed in the January budget. The combined allocation from both requests would be $8 million, $7.9 million for support of the programs, and $150,000 for administration. OSHPD also requests to amend the previously requested provisional budget bill language to reflect the combined funding request.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$5,000,000	$-
Total Funding Request:	**$5,000,000**	**$-**

Background. In January 2021, the Administration released its Master Plan for Aging (MPA), a comprehensive framework for supporting aging Californians. According to the MPA, the increasing number of older adults living longer requires California to develop a larger and more diverse pool of health care workers with expertise and experience in geriatric medicine, including dementia care, behavioral health, palliative care, and the ability to work in interdisciplinary teams. Among the recommendations contained within the MPA is an expansion of training opportunities for geriatricians, gerontologists, as well as nurses and social workers with geriatric training.

OSHPD administers programs designed to increase access to healthcare to underserved populations and provide a culturally competent healthcare workforce. These programs award scholarships and loan repayments to aspiring health professionals and graduate students who agree to provide direct patient care in medically underserved areas for one to four years. According to OSHPD, its existing workforce programs administered by the Healthcare Workforce Development Division (HWDD), and Health Professions Education Foundation (HPEF) train health care professionals that include geriatric providers. In particular, OSHPD reports geriatric providers participate in the Health Careers Training Program Mini Grants, the State Loan Repayment Program, and the six scholarship and six loan repayment programs in the HPEF.

Augmentation to January Budget Request. In the Governor's January budget, OSHPD requested General Fund expenditure authority of $3 million in 2021-22, with $2.9 million allocated to local assistance and $150,000 allocated to state operations. The local assistance resources would support scholarships and loan repayments for geriatric care providers through existing health care workforce development programs in HWDD and HPEF. According to OSHPD, expanding funding for existing programs would enable the state to leverage these programs' infrastructure to quickly increase awards to geriatric providers. If this funding is approved, OSHPD expects to be able to support 17 additional workforce awards annually, including ten loan repayment awards, two scholarships, and five career pipeline grants.

In the May Revision, OSHPD requests additional General Fund expenditure authority in 2021-22 of $5 million to augment its January budget request. The combined request would provide $7.9 million for scholarship and loan repayments for geriatric providers. The state operations allocation would remain at $150,000.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Children and Youth Behavioral Health Initiative (Issue 115-MR)

Budget Change Proposal - May Revision. OSHPD requests expenditure authority from the Coronavirus Fiscal Recovery Fund (CFRF) of $700 million in 2021-22, General Fund expenditure authority of $125 million in 2022-23, and General Fund expenditure authority of $75 million in 2023-24. If approved, these resources would support behavioral health workforce, education, and training through OSHPD's existing programs, as well as the development of new programs.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	**$-**	**$125,000,000**
8506 – Coronavirus Fiscal Recovery Fund	$700,000,000	$-
Total Funding Request:	**$700,000,000**	**$125,000,000**

***** Additional fiscal year resources requested: 2023-24: $75,000,000.

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

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

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

Office of Statewide Health Planning and Development – Workforce, Education and Training. As part of the Administration's California Children and Youth Behavioral Health Initiative, OSHPD requests expenditure authority from the CFRF of $700 million in 2021-22, and General Fund expenditure authority of $125 million in 2022-23 and $75 million in 2023-24 to support workforce, education, and training efforts. Specifically, these funds would support the following programs:

- Expand Training Capacity for Psychiatry and Social Workers - $71.5 million over two years would support expanding training capacity for child and adolescent psychiatry, public mental health nurse practitioners, and social workers. These resources would build on existing programs, such as the Psychiatric Education Capacity Expansion program, and would add new programs that train non-prescribing clinicians, child and adolescent social workers, and child welfare workers.
- School Behavioral Health Coaches and Counselors - $427 million over two years would support training programs for behavioral health counselors and coaches to provide a variety of interventions on school campuses. According to OSHPD, these counselors and coaches would improve health outcomes by enhancing the ability of educators to improve educational outcomes, as well as a central component of establishing community schools as centers of wellness.
- Substance Use Disorder Workforce - $76 million over two years would support development of a new substance use disorder (SUD) workforce framework and plan focused on: 1) expanding knowledge of existing licensed behavioral health clinicians to provide age-appropriate SUD treatment, 2) providing financial support for high school graduates or community college students to obtain an undergraduate social work degree to begin an SUD career serving youth and families, 3) developing an SUD career ladder for existing SUD counselors including financial support, 4) establishing and supporting programs to help registered SUD counselors become certified and train in age-appropriate treatment, and 5) developing SUD educational capacity programs.
- Behavioral Health Workforce Pipeline - $24 million over two years would build on OSHPD's existing programs, such as the Mini-Grants program, to support career exploration in behavioral health disciplines. OSHPD would also support programs to provide mentorship, as well as

academic, career, and psychosocial support to prepare students from underrepresented and low-income background for behavioral health careers.

- "Earn and Learn" Apprenticeship Models - $9.5 million over two years would support "Earn and Learn" models that provide tuition support and on-the-job training at a behavioral health provider organization while an individual attends a post-secondary education program or completes training. The employer would provide a position for the graduate and there would be a period of service obligation. The program would provide financial support to the employer to mentor and supervise the students.
- Training to Serve Justice- and System-involved Youth - $9.5 million over two years would support enhanced training to existing and new staff across the child welfare, education, and probation sectors on effective behavioral health strategies with justice- and system-involved youth.
- Behavioral Health Training for Primary Care Providers - $9.5 million over two years would support an increase in funding for the Train New Trainers Psychiatry Fellowship Scholarship, previously approved in the 2019 Budget Act, which provides training to primary care staff to directly serve, rather than refer, for moderate behavioral health conditions. The current program would be expanded to include pediatricians and other child or young adult providers.
- Peer Personnel Training and Placement Programs - $28.5 million over two years would support expansion of OSHPD's Peer Personnel Training and Placement Program, which trains and places peer personnel in positions throughout the public mental health system.
- Existing Behavioral Health Workforce Programs - $199.5 million over two years would support OSHPD's existing loan repayment, stipend, and scholarship programs for behavioral health disciplines.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of OSHPD's workforce development proposals as part of the California Children and Youth Behavioral Health Initiative.

Issue 4: Miscellaneous Technical Adjustments

Budget Bill Language - May Revision. OSHPD requests budget bill language for two technical adjustments:

- OSHPD requests elimination of Item 4140-011-0121 to withdraw a proposed $40 million one-time loan from the Hospital Building Fund to the General Fund proposed in the January budget. According to OSHPD, given the state's improved fiscal condition, this loan is no longer necessary.

- OSHPD requests budget bill language to extend the period to liquidate encumbrances from allocations to the Steven M. Thompson Corps Loan Repayment Program, originally authorized in the 2019 Budget Act. According to OSHPD, this extension is needed to allow program grantees additional time to fulfill their respective service grant agreements.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Mental Health Student Services Act Partnership Grant Program Augmentation

Budget Change Proposal – May Revision Adjustment. MHSOAC requests expenditure authority from the Mental Health Services Fund of $30 million in 2021-22. If approved, these resources would allow MHSOAC to augment its proposed expansion of the Mental Health Student Services Act Partnership Grant Program proposed in the January budget. The combined allocation for these two proposals would be $50 million for the grant program and $5 million for administration.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
3085 – Mental Health Services Fund	$30,000,000	$-
Total Funding Request:	**$30,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. The 2019 Budget Act included expenditure authority from the Mental Health Services Fund of $50 million in 2019-20 and $10 million annually thereafter for the Mental Health Student Services Act (MHSSA), a competitive grant program to establish mental health partnerships between county mental health or behavioral health departments and school districts, charter schools, and county offices of education. These partnerships support: (1) services provided on school campuses; (2) suicide prevention; (3) drop-out prevention; (4) outreach to high-risk youth and young adults, including, but not limited to, foster youth, youth who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ), and youth who have been expelled or suspended from school; (5) placement assistance and development of a service plan that can be sustained over time for students in need of ongoing services; and (6) other prevention, early intervention, and direct services, including, but not limited to, hiring qualified mental health personnel, professional development for school staff on trauma-informed and evidence-based mental health practices, and other strategies that respond to the mental health needs of children and youth.

Combining the $50 million allocation in 2019-20 with the annual $10 million allocations for the subsequent three fiscal years, MHSOAC allocated a total of $75 million over four years for funding of the MHSSA Partnership Grant Program. The funding was made available in two categories: 1) $45 million for counties with existing school mental health partnerships, and 2) $30 million for counties developing new or emerging partnerships. Within each category, funding was made available based on the population size of a county with a total of six grants at $2.5 million each made available to small counties (less than or equal to 200,000 population), six grants at $4 million each made available to medium counties (between 200,000 and 750,000 population), and six grants at $6 million each made available to large counties (greater than 750,000 population).

According to MHSOAC, only 18 awards were made due to funding constraints. MHSOAC estimates approximately $80.5 million would be required to fund all 38 grant applications for school-mental health partnerships, $45.5 million with existing partnerships and $35 million for new and emerging partnerships.

Augmentation to January Budget Request. In the Governor's January budget, MHSOAC requested expenditure authority from the Mental Health Services Fund of $25 million in 2021-22 to expand the MHSSA Partnership Grant Program to additional counties. In the May Revision, MHSOAC requests additional expenditure authority from the Mental Health Services Fund of $30 million in 2021-22 to further expand the MHSSA Partnership Grant Program. Of the $30 million, $5 million would be allocated to administration of the program. If both requests are approved, the combined allocation for the grant program would be $50 million.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. How many additional previously unfunded grants could be funded with the combined $50 million allocation?

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

Issue 1: Advanced Premium Assistance Subsidy Program Reduction

General Fund Reduction – May Revision. Covered California requests a reduction in General Fund expenditure authority of $405.6 million in 2021-22 to reflect savings in the state premium affordability subsidy program resulting from more generous federal premium subsidies authorized by the American Rescue Plan.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	($405,647,000)	$-
Total Funding Request:	**($405,647,000)**	**$-**

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

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

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

May Revision Proposes to Revert State Subsidy Funding to the General Fund. Covered California requests a reduction in General Fund expenditure authority of $405.6 million in 2021-22 to reflect savings in the state premium affordability subsidy program resulting from more generous federal premium subsidies authorized by the American Rescue Plan. In addition, Covered California is reflecting a General Fund savings in 2020-21 of $272.2 million as a result of the federal subsidy program. The combined amount over two fiscal years previously allocated to improve health care premium affordability assistance would be $677.9 million.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. The 2019 Budget Act included resources to improve health coverage affordability for consumers for three years. Please explain why these resources are not being reallocated to further improve health coverage affordability beyond the new federal subsidies.

Issue 2: One-Dollar Premium Subsidy Program

Budget Change Proposal and Trailer Bill Language– May Revision. Covered California requests General Fund expenditure authority of $20 million annually. If approved, these resources would allow Covered California to subsidize the one dollar per month premium required for the cost of providing abortion services, for which federal funding is prohibited. Covered California also requests trailer bill language to implement the one dollar premium subsidy program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$20,000,000	$20,000,000
Total Funding Request:	**$20,000,000**	**$20,000,000**

* Resources ongoing after 2022-23.

Background. Section 1303 of the federal Patient Protection and Affordable Care Act (ACA) prohibits the use of certain federal funds to pay for coverage of abortions by Qualified Health Plans offering coverage in health benefit exchanges, including state-based exchanges such as Covered California. Section 1303 requires plans to charge and collect at least one dollar per enrollee per month for coverage of such abortion services. As a result, Covered California enrollees that would receive federal or state subsidies that would combine to reduce premium costs to zero, instead have to arrange to pay one dollar per month.

The availability of zero dollar premiums to exchange beneficiaries could significantly improve enrollment, particularly among individuals with incomes between 150 and 200 percent of the federal poverty level (FPL), as well as facilitate other coverage reforms, such as seamless transitions between Medi-Cal and zero dollar premium plans and strategies to prevent coverage lapses due to non-payment of premiums. A recent study in Health Affairs[1] suggested the availability of zero dollar premiums could improve enrollment for individuals between 150 and 200 percent of the FPL by as much as 14 percent. This "zero price effect" suggests a substantially larger enrollment effect from reducing the last dollar of premiums from one dollar to zero, compared to the effect from reducing a larger premium by one dollar.

One-Dollar Premium Subsidy Program. Covered California requests General Fund expenditure authority of $20 million annually to subsidize the one dollar per month premium required for the cost of providing abortion services, for which federal funding is prohibited. This premium subsidy program would be implemented for the 2022 coverage year. Covered California also requests trailer bill language to implement the one dollar premium subsidy program. According to Covered California, approval of this proposal would allow auto-enrollment into zero-dollar coverage of individuals who are no longer eligible for Medi-Cal, but are below 150 percent of the FPL, or otherwise eligible for zero-dollar coverage.

[1] Drake C., Anderson D. "Terminating Cost-Saring Reduction Subsidy Payments: The Impact of Marketplace Zero-Dollar Premiums on Enrollment". Health Affairs. January 2020.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Health Care Affordability Reserve Fund

Budget Change Proposal and Trailer Bill Language– May Revision. Covered California requests trailer bill language to establish the Health Care Affordability Reserve Fund. In addition, Covered California requests a one-time transfer of General Fund of $333.4 million for the purpose of future health care affordability measures.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$333,439,000	$-
Total Funding Request:	**$333,439,000**	**$-**

Background. In addition to the state subsidy program to improve health coverage affordability, the 2019 Budget Act included trailer bill language to implement a penalty on individuals that fail to maintain minimum essential coverage during a coverage year, to encourage enrollment in the absence of the federal individual mandate penalty. The minimum penalty is $695 for adults in a household and $347.50 for each child. The revenue from the penalty offsets General Fund expenditures for the state subsidy program. In the May Revision, Covered California is proposing to revert the allocations to the state subsidy program authorized in the 2019 Budget Act to the state's General Fund, due to the implementation of more generous federal subsidies through the American Rescue Plan through the 2022 coverage year.

Health Care Affordability Reserve Fund. Covered California proposes trailer bill language to establish the Health Care Affordability Reserve Fund, as well as a transfer of General Fund resources of $333.4 million. According to the Administration, the individual mandate penalty is estimated to result in General Fund revenue of $353.4 million in 2020-21 and 2021-22 as a result of individuals failing to enroll in health coverage. The $333.4 million proposed transfer to the fund represents this revenue, reduced by the $20 million May Revision budget request for a one dollar premium subsidy program. The Administration indicates this reserve fund would provide available resources to support state subsidies if the more generous federal subsidies are not extended beyond the 2022 coverage year, or if the state implements future health care affordability measures.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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 18, 2021
1:30 pm
State Capitol - Room 3191

Part B Agenda

Consultants: Renita Polk and Elisa Wynne

ISSUES FOR DISCUSSION

PUBLIC COMMENT

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

ISSUES FOR DISCUSSION

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: May Revision Overview - CalWORKs

May Revision. The May Revision proposes $6.7 billion total funding in 2021-22 for CalWORKs. The caseload is projected to increase to a monthly average of 358,110 cases. Additional budget adjustments relating to the CalWORKs program include:

- CalWORKs Grant Increases. An increase of 5.3 percent, beginning on October 1, 2021, to maximum aid payments funded by the Child Poverty and Family Supplemental Support Subaccount.

- CalWORKs Single Allocation (Issue 192). The 2021-22 total Single Allocation is proposed at $2.1 billion total funds. The May Revision also proposes to move the Stage One Child Care component ($362.4 million) out of the Single Allocation beginning in 2021-22. With this component removed, the Single Allocation representing only the Employment Services, Eligibility, and Cal-Learn components includes $1.7 billion total funds in 2021-22. The May Revision also includes a request for provisional language to revert $250 million appropriated in 2019 for the Single Allocation.

- COVID-19 Overpayment Collections Relief (Issue 168). An increase of $2 million ($1.5 million federal funds and $450,000 General Fund) to provide collection relief for non-fraudulent overpayment claims related to the benefit months of April 2020 through June 2022 or the end of the Public Health Emergency, whichever is sooner. This also requires statutory changes.

- Family Reunification (Issue 167). An increase of $9 million to provide an additional six months of cash aid and services, to parents whose children have been removed from the home by child welfare services and placed in out-of-home care and who would not otherwise qualify for CalWORKs. The continuation of aid and services will promote prevention of foster care placement or reunification of families connected to the CalWORKs program. The Administration has indicated that trailer bill language will accompany this proposal. Language was not available at the time of the writing of this agenda.

- CalWORKs Indian Health Clinics (Issue 165). An increase of $3.9 million ongoing to restore 2009 funding levels.

- Federal Pandemic Emergency Assistance Fund (Issue 166). An increase of $202.6 million to provide a one-time cash-aid payment of $640 to CalWORKs families. The Administration has indicated that trailer bill language will accompany this proposal. Language was not available at the time of the writing of this agenda.

- Time on Aid Provisional Language. The addition of provisional language to extend the pause of the CalWORKs 48 month time clock until DSS is able to implement the 60 month time clock (May 2022) is requested. The language is necessary to implement the Time on Aid proposal included in the Governor's January budget.

Questions.

1. Please provide a brief overview of major changes proposed in the May Revision in the CalWORKs program.

2. At what percentage of the federal poverty level will grants be with the additional grant increases proposed in the May Revision? Will these grant increases meet the longtime Senate priority of reaching 50 percent of the federal poverty level for the assistance unit plus one?

Staff Recommendation. Hold open**.**

Issue 2: May Revision Overview – Housing and Homelessness Programs

May Revision. The May Revision proposes a one-time, $3.4 billion multi-year investment to support the expansion of the department's various housing and homeless assistance programs. Investments include:

- CalWORKs Housing Support Program (HSP) (Issue 164). $570 million in 2021-22 and 2022-23 to address the immediate housing needs of families experiencing homelessness in the CalWORKs program to help them obtain and keep permanent housing. This investment will be available for expenditure over multiple years and is supported by $250 million in early reversion funds allocated to the CalWORKs Single Allocation in 2019-20. The May Revision includes trailer bill language regarding all county letter authority for the program. Language was not available at the time of the writing of this agenda.

  The HSP's current funding allocation is $95 million annually.

- Bringing Families Home (BFH) (Issue 172). $280 million General Fund in 2021-22 and 2022-23 to help reduce the number of families in the child welfare system experiencing homelessness, to increase family reunification, and to prevent foster care placements. The Administration has indicated that it is working on trailer bill language associated with this program. Language was not available at the time of the writing of this agenda.

  The 2019 Budget Act included a one-time allocation of $25 million General Fund for BFH. The program requires a dollar-for-dollar grantee match, bringing current total funding to $50 million over a three year period ending in June 2022.

- Housing and Disability Advocacy Program (HDAP) (Issue 154). $175 million General Fund one-time to be spent over four years to support the provision of outreach, case

management, disability benefit advocacy services, and housing assistance to individuals in need. The HDAP is designed to assist homeless people stabilize in permanent housing while also advocating for disability benefits. The Administration has indicated that it is working on trailer bill language associated with this program. Language was not available at the time of the writing of this agenda. The CDSS also requests provisional language to allow the reappropriation of unexpended funds for the HDAP appropriated in the 2020 budget.

The HDAP's current funding allocation is $25 million annually.

- Home Safe Program (Issue 155). $100 million General Fund one-time to be spent over two years to support homelessness assistance and prevention services for older and dependent adults experience or at risk of abuse and neglect.

  The 2018 Budget Act included an allocation of $15 million General Fund one-time for Home Safe. The program requires a dollar-for-dollar grantee match, bringing current total funding to $30 million, ending in June 2021.

- Project Roomkey (Issue 156). $150 million one-time to provide funding to counties and tribes operating Project Roomkey non-congregate sheltering and rehousing efforts out of Project Roomkey. Funding may be used for non-congregate sheltering for people experiencing homelessness or for rehousing out of Project Roomkey.

- Community Care Expansion Program (Issue 182). $497.5 million ($450 American Rescue Act funds and $47.5 million General Fund) in 2021-22 and $500 million General Fund in 2022-23 to fund the acquisition, construction, and/or rehabilitation of adult and senior care facilities in support of individuals and families that are homeless or at risk of homelessness. The Administration has indicated that the funds will be granted to counties and tribes and then awarder to facility operators by the county/tribe. Trailer bill language is associated with this proposal but was not available at the time of the writing of the agenda.

Questions.

1. Please provide a brief overview of major changes proposed in the May Revision to the department's housing and homelessness programs.

2. Is there a time by which the American Rescue Act funds must be used?

Staff Comment and Recommendation. Hold open**.**

The May Revision proposes significant investments in the department's housing and homelessness programs, several fold higher than current program funding. While additional funding is important to address barriers to obtaining housing and staying housed, there are additional considerations to think about when deliberating the proposed investments. Some of the above programs require a local match in order to receive funding. The subcommittee should consider whether local entities will have the resources to provide a match to the significantly increased funding level. The

subcommittee must also consider the time frame within which the federal funds must be spent and whether there is capacity to spend those funds within that amount of time.

Issue 3: May Revision Overview - Automation Programs

May Revision. The May Revision includes the following investments for the department's automation programs:

- CalFresh Notice of Denial or Pending Status (Issue 179). $1.3 million ($650,000 General Fund) in automation funding to update the Notice of Denial or Pending Status (CF 377.1A) form. This form is used by counties to notify households of their application status at initial application. The current form is not compliant with federal policy.

- Translations for CalSAWS Consolidated Portal and Mobile Functionality (Issue 183). $1 million General Fund one-time for translations work needed for the CalSAWS project.

- Enterprise Data Infrastructure (Issue 187). $3 million General Fund to improve the efficiency and effectiveness of data acquisition and processing operations. The funding will be used for the procurement of new integration and data warehouse platforms and to expand current innovative technologies across the department.

- Child Welfare Services/Case Management System (CWS/CMS) Data Cleanup (Issue 181). $1.5 million ($583,000 General Fund) for counties to support CWS/CMS data clean-up activities to remove duplicate data in the system.

- CWS/CMS Migration (Issue 180). $5.7 million ($1.2 million General Fund) to migrate the existing platform so it can be supported by Microsoft and International Business Machines (IBM). The current platform is no longer supported by Microsoft.

- Revised CWS-CARES Cost Estimate. (Issue 169). An increase of $39.4 million General Fund and $31.8 million federal funds one-time to reflect revised costs for the CWS-CARES system. Provisional language to clarify total project costs is also requested. Expenditure of these funds is dependent upon Department of Technology approval of project documents.

Questions.

1. Please provide a brief overview of major changes proposed in the May Revision to the department's automation programs.

Staff Recommendation. Hold open**.**

Issue 4: May Revision Overview – Supplemental Security Income/State Supplemental Payment (SSI/SSP)

May Revision. The May Revision includes a total of $9.7 billion ($2.7 billion General Fund) for the SSI/SSP program. The May Revision includes $66.3 million General Fund in 2021-22, and $131.5 million ongoing to increase SSP, Cash Assistance Program for Immigrants (CAPI), and California Veterans Cash Benefit payments for individuals (Issue 151 in DSS Finance Letter). This also includes $500,000 in SAWS automation costs. The Administration has indicated that trailer bill language will accompany this proposal. Language was not available at the time of the writing of this agenda.

Background. Grant levels for SSI/SSP are determined by both the federal government and the state. The federal government, which funds the SSI portion of the grant, is statutorily required to provide an annual cost-of-living-adjustment (COLA) each January. The state has full discretion over whether and how to provide increases to the SSP portion of the grant. Until 2011, the state had a statutory COLA.

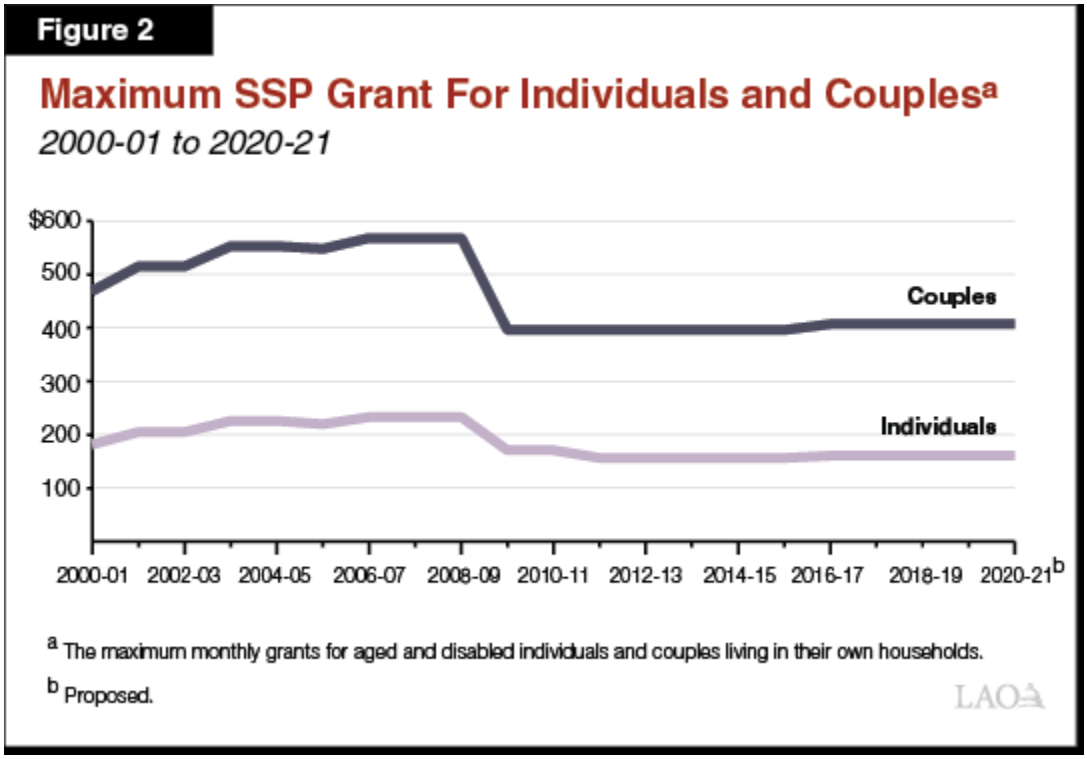
The state is required to maintain SSP monthly grant levels at or above the levels in place in March 1983 ($156.40 for SSP individual grants and $396.20 for SSP couple grants) in order to receive federal Medicaid funding. Beginning in 2008-09 and during times of budget constraints, the state incrementally decreased SSP grants for individuals and couples until they reached these minimum levels. Since these reductions, SSP grants for individuals and couples have only been increased once in 2016-17 when the budget provided a COLA of 2.76 percent on the SSP grant.

Questions.

1. Please provide a brief overview of the changes proposed in the May Revision for the SSI/SSP program.

Staff Comment and Recommendation. Hold open**.**

The proposed budget would raise grants to 2011 levels, which was after many of the major Great Recession cuts. On January 1, 2009, the SSP grant for an individual was $233. A series of reductions made between 2009 and 2011 reduced SSP grants to the minimum level allowed by law to maintain federal funding ($156.40). Currently, the SSP grant for an individual is $160.72. The May Revision proposal would increase SSP grants to $170.36, far lower than the $233 provided before major recession cuts and when grants were at their highest levels. The graph below, provided by the Legislative Analyst's Office, shows that grants were at their highest in 2008-09, and the proposed grant increases would bring payments to what they were after the greatest reductions made before 2011. The May Revision proposal is an important step but not a complete restoration of SSP grants to the levels that they were at prior to the last recession and to the levels that older adults and people with disabilities need. The Senate Build Back Boldly plan included a full restoration of past reductions to the SSP grant, bringing grants back to 2009 levels.



Issue 5: May Revision Overview – In-Home Supportive Services (IHSS)

May Revision. The May Revision includes a total of $17.2 billion ($5.5 billion General Fund) for the IHSS program. Additionally, it includes the following budget adjustments relating to the IHSS program:

- Elimination of Suspension Language for the IHSS Seven Percent Reduction. Provisional language to strike out suspension language related to the reduction in IHSS service hours is requested.

  Note that the subcommittee took action on May 11, 2011 to strike out this language, as well as to repeal statute implementing the seven percent reduction.

- IHSS State and County Sharing Ratio (Issue 152). $203.8 million ($57.3 million General Fund) to maintain the state and county share of the non-federal costs at the traditional 65 percent state and 35 percent county levels, as well as the ten percent county options, discussed in previous subcommittee hearings.

- Permanent Provider Backup System. $12.9 million ($5.8 million General Fund) for 2021-22 and $17 million ($7.5 million General Fund) for 2022-23. This funding will support the permanent establishment of a backup provider system that includes a wage differential to serve severely impaired IHSS recipients when their regular provider is unavailable. For the wage differential, the Independent Provider Mode back-up providers will receive a $2.00

wage differential and Contract Mode back-up providers will receive the wage reflected in the contract between the county and the agency providing the services.

- Long-Term Care Career Pathways (Issue 150). $200 million General Fund one-time to incentivize, support, and fund career pathways for IHSS providers, allowing workers to build their experience to obtain a higher level job in the home care and/or health industry. Provisional language is also requested to implement this proposal.

- Trailer Bill Language – Electronic Visit Verification (EVV) Guiding Principles. The May Revision includes trailer bill language on EVV guiding principles to align with federal requirements for the EVV system.

- Trailer Bill Language – IHSS Medi-Cal Residual Conformity. The May Revision includes trailer bill language clarifying eligibility rules for IHSS recipients that are also on Medi-Cal.

Questions.

1. Please provide a brief overview of major changes proposed in the May Revision to the IHSS program.

2. Does the Administration proposal to eliminate the suspension language for the IHSS seven percent service hour reduction also include the repeal of statute enacting the original seven percent reduction?

3. Is the proposal to maintain the 65 percent state and 35 percent county sharing ratio and the ten percent over three years option an ongoing proposal or is it only for a limited time?

4. Please provide additional detail on how the funding to support long-term career pathways will be used and how this program will be rolled out.

5. What is the reasoning for limiting the permanent backup provider system to severely impaired IHSS recipients?

Staff Comment and Recommendation. Hold open**.**

Staff notes that the funding for a permanent backup provider system is limited to severely impaired IHSS recipients. The current COVID emergency backup system is available to all IHSS recipients. The subcommittee may wish to inquire as to the reasoning for limited the permanent system to severely impaired recipients.

Issue 6: May Revision Overview – Children and Family Services

May Revision. The May Revision proposes a total of $9.2 billion ($921.4 million General Fund) for children and family services, including the following:

- Addressing Complex Care Needs/Reducing Out-of-State Placements (Issue 175). $42.1 million ($39.2 million General Fund) for System of Care activities to meet the immediate needs of foster youth with acute and complex needs, including youth that returned from out-of-state group home placements. These funds will help develop a more comprehensive continuum of care and support activities. The Administration has indicated that trailer bill language will accompany this proposal. Language was not available at the time of the writing of this agenda.

- Family First Prevention Services Act (FFPSA) (Issue 173). $148.9 million ($122.5 million General Fund) one-time for a three-year block grant to support counties in their implementation of the Part I prevention services of the FFPSA. The May Revision also includes additional program funding made available through the federal American Rescue Plan Act (ARPA): $12 million for the Child Abuse Prevention and Treatment Act, $29 million for Community-Based Child Abuse Prevention, and $7.8 million for Promoting Safe and Stable Families. These funds will be combined with the funding for FFPSA to support a comprehensive Child and Family Well-Being System.

  To apply for the General Fund block grant, counties will be required to develop a comprehensive Child and Family Well-Being System Prevention Plan for submittal to DSS for approval. The plan must describe primary and secondary prevention strategies and how the strategies will impact outcomes, specifically prevention of recurrence of child maltreatment and re-entry into the system. The Administration has indicated that trailer bill language will accompany this proposal. Language was not available at the time of the writing of this agenda.

- Continuum of Care Reform (CCR) Reconciliation (Issue 170). $7.1 million one-time for eligible CCR reconciliation administrative costs, which include expenditures for Child and Family Teams for 2018-19. Total county administrative expenditures exceed the amount that was budgeted for CCR administrative costs for 2018-19.

- Placement Prior to Approval (Issue 177). An increase of $12.9 million ($9.8 million General Fund) to provide emergency caregiver support for resource families pending approval for 120 days up to 365 days with good cause. The Administration proposes total funding of $32.4 million ($24.5 million General Fund) for this purpose.

- Stipend for Tribal Social Work Students (Issue 174). $4.2 million ($3 million General Fund) one-time, available over three years, to provide stipends and scholarships to Native American students pursuing a Master of Social Work degree who have committed to practicing in public child welfare for tribal or county social services.

- Child and Adolescent Needs and Strengths (CANS) Assessment Workload (Issue 171). An increase of $3.4 million General Fund in 2021-22 for county workload associated with the implementation of the CANS assessment tool.

- Federal Flexibilities for Former Nonminor Dependents 21 and older. Amendments to provisional language needed to comply with COVID-19 federal flexibilities related to the voluntary reentry into extended foster care for a nonminor dependent that exited extended foster care between January 27, 2020 and April 17, 2020 are requested.

- Elimination of Suspension Language. Provisional language to strike out suspension language for the Family Urgent Response System (FURS), Foster Family Agency Social Worker Rate Increase, Emergency Child Care Bridge Program Augmentation, and the Public Health Nurse Early Intervention Program. Reappropriation language for the Emergency Child Care Bridge program and the FURS is also requested.

  Note that the subcommittee took action to strike out this suspension language at its May 11, 2021 hearing.

Questions.

1. Please provide a brief overview of major changes proposed in the May Revision for children and family services.

2. Is the funding to address complex needs intended to be an ongoing investment? If not, over how many years is this funding intended to be used? Please provide some examples of the support activities that may be implemented with this funding to address the complex needs of youth involved in the system.

3. Is the Administration and/or counties planning to review cases of youth that were placed out of state to determine what services they needed that were not available in California to see if there are commonalities among those cases and to direct how the proposed funding will be used?

4. Is the additional funding to provide emergency caregiver support for resource families only for the budget year?

Staff Comment and Recommendation. Hold open**.**

As discussed during this subcommittee's May 6, 2021 hearing, the CDSS has recently decertified out-of-state facilities, halted admissions of California youth to out-of-state facilities, and returned all youth that were placed out-of-state back to California. While these steps as well as the funding proposed in the May Revision are important, there not a prohibition on youth being sent to other out-of-state facilities in the future. In addition to providing additional funding to build up supports and services for youth with complex needs in California the Legislature may want to consider prohibiting California youth from being sent out-of-state in the future. The subcommittee may also

want to consider setting aside a portion of funds as a flexible funding pool for unfunded/unavailable needs identified by foster youth.

The budget has provided funding for caregiver payments prior to placement approval beyond 120 days for several years. There has been a longstanding goal to approve these placements within 90 days but it is still a struggle to meet that deadline. Considering the delay in reaching that timeline and the delays that the recent pandemic has caused, the subcommittee may want to consider extending these payments past 120 days for more than the 2021-22 fiscal year.

Issue 7: May Revision Overview – Immigrant Integration Services

May Revision. The May Revision proposes the below funding for immigrant integration services:

- Support for Unaccompanied Undocumented Minors (Issue 158). $20 million General Fund one-time time to provide additional support for Unaccompanied Undocumented Minors (UUMS) through Opportunities for Youth pilot project, the UUM legal services, and state operations. It is also requested that provisional language be added to identify funding is allocated for these purposes.

- Rapid Response Funding (Issue 157). $100 million General Fund one-time in 2021-22 for the Rapid Response Program. The program provides funds to entities that provide critical services such as shelter, food, and emergency medical care to immigrants and immigrant families during times of need, particularly when federal funding is not available. Provisional language to allow the reappropriation of unexpended funds appropriated in the 2020 Budget Act is also requested.

- Migrant Border Arrival Support. Half-year costs of $8 million General Fund in 2020-21 to provide non-congregate shelter and support services to arriving immigrants at the Southern California border. Services will support the orderly entrance of migrant populations who need shelter and COVID-19 screening prior to travelling to their final destination or require shelter to quarantine after testing positive for COVID-19 or exposure to COVID-19.

- Deferred Action for Childhood Arrivals (DACA) and Naturalization Filing Fees (Issue 189). $25 million General Fund one-time million to provide funding for immigration services for work on behalf of clients involved in, applying for, or subject to, federal DACA status. This includes filing fees and naturalization. Provisional language is also associated with this request.

Questions.

1. Please provide a brief overview of major changes proposed in the May Revision for immigrant integration services.

Staff Recommendation. Hold open**.**

Issue 8: May Revision Overview – Child Care

May Revision. The May Revision proposes the below funding for child care services:

- Additional Child Care Slots. With the addition of 100,000 subsidized child care slots, the May Revision proposes the largest expansion of this kind. Of the total, approximately 63,000 will be Alternative Payment Vouchers, 1,300 Migrant Child Care slots, and will be 500 emergency bridge slots that begin October 1, 2021 and the remaining 42,000 slots are General Child Care and begin April 1, 2022.

- Proposition 64 Cannabis Funded Slots. Updated Proposition 64 cannabis tax revenues will provide an additional $83 million for child care slots in 2021-22 and ongoing. These funds will provide for an additional 6,500 new child care slots.

- Infrastructure Facilities. $250 million one-time federal American Rescue Plan Act of 2021 (ARPA) funds to provide infrastructure grants for the acquisition, construction, development, and renovation of child care facilities focusing on desert areas to be spent through September 30, 2024.

- Child Care Resource and Referral Programs. $10 million ARPA funds to support continued Resource and Referral partnerships to strengthen their role serving as intermediaries to develop new child care facilities and capacity, and to streamline and improve data collection processes.

- Quality Improvement. $20 million for a multi-year effort to strengthen existing quality improvement supports and systems. DSS will engage with stakeholders to inform policy-setting and program design with a focus on addressing inequities. Quality projects funded by the federal Child Care and Development Fund (CCDF) will transfer to DSS as part of the child care and development transition without any immediate changes.

- State Operations. The May Revision shifts $31.7 million ($0.9 million General Fund) and 185.7 positions from the California Department of Education (CDE) to the DSS to administer child care, and nutrition programs. Additionally, to continue to support this transition, additional state operations resources of $10.9 million ($10.4 million General Fund) and 79 positions to provide adequate infrastructure to support the system, program enhancements, and a whole-child/whole-family approach to child care integration and data development are proposed.

- Local Assistance. $3 billion ($1.5 billion General Fund) and shifts the following programs to DSS, including: General Child Care, Alternate Payment Programs, CalWORKs Stage 2 & Stage 3, Resource & Referral Programs, Migrant Child Care Program, Severely Disabled Program, California Child Care Initiative, Quality Improvement Activities, Local Planning Councils, and Child and Adult Care Food Program.

- Direct Deposit. $6 million to modernize payment options to child care and development

contractors through the option of direct deposit.

- Child Care Data Landscape. $4.8 million General Fund to support planning and initial implementation for the design of a child care data system to meet the needs of families and the workforce. This proposed data system aligns with the Master Plan for Early Learning and Care and would strengthen the administrative processes used for data collection. DSS will build on prior efforts and engage stakeholders in the design.

Questions.

1. Please provide a brief overview of major changes proposed in the May Revision for child care.

2. What amount of federal funds are expended for the additional slots and are these ongoing child care slots?

3. How will the infrastructure funds be distributed? Are funds available within this proposal across the system, for small family child care providers as well as larger center-based providers? How will projects be prioritized?

4. When does DSS anticipate direct deposit will become an option for child care providers?

5. How will the child care Data System align with the child care data efforts at the Department of Education and the Cradle to Career Data system? What are the anticipated functionalities of the data system, what is the total cost, and when is the expected completion date?

Staff Comment and Recommendation. Hold open**.**

The increase of 100,000 slots in child care is a historic one-year investment in child care access. However, the pandemic has highlighted the importance of access to quality, affordable child care, especially for our state's low income working families, many of whom are essential workers. Those employees staffing child care centers, that remained open and provided care during the pandemic while most schools and many workplaces are closed, are also clearly essential workers, supporting the economy before, during and after the pandemic. The subcommittee may want to consider additional investments in child care provider rates to ensure providers are available to support new investments of slots and to recognize and respect the vital work that child care employees do for California's children every day.

Several items highlighted in the Senate's Build Back Boldly budget plan are not included in the May Revision. In addition to rate reform, the plan called for up to 200,000 additional slots, and additional investments in child care workforce training, ensuring that essential workers who had temporary care vouchers during the pandemic are retained in the system, and other ongoing stabilization measures for providers. Finally staff notes that significant ongoing funds are provided for Transitional Kindergarten (TK) in the May Revision, without a plan in place to stabilize the state preschool system. While TK provides educational benefits for all children, regardless of

income, it may not meet the needs of our most vulnerable families who need year round child care that includes kindergarten preparation, but with hours and access that match families' work schedules.

Issue 9: May Revision Overview – Child Care Pandemic Relief

Pandemic Relief Package to Support Early Learning and Care Workforce. The May Revision proposes $579 million in one-time Coronavirus Response and Relief Supplemental Appropriations (CRRSA) funds. The pandemic relief package includes:

- A tiered licensed provider one-time stipend based on licensing capacity of between $3,500 to $6,500.
- A third round of per-child stipends for subsidized child care and preschool providers. Stipends will be $600 per child and costs a total of $206 million.
- Family fee waivers for eligible families beginning July 1, 2021 through June 30, 2022.
- $25 million one-time CRRSA funds available through September 30, 2023, for the expansion of the California Child Care Initiative Project to target areas such as child care deserts and building capacity of new licensed family child care homes.
- $10.6 million one-time CRRSA funds available through September 30, 2023 for early childhood mental health consultation. This investment will expand the California Inclusion and Behavior Consultation project which offers support to child care programs and providers on such topics as children's social emotional development, trauma-informed practices and health and safety for the wellbeing of children and families impacted by the pandemic and beyond.
- Sixteen non-operational days for providers accepting vouchers that have to close due to COVID-related reasons beginning July 1, 2021, through June 30, 2022.
- Continued hold harmless funding for child care providers that contract directly with the state and provider reimbursement at a child's maximum certified level of need for all providers accepting vouchers through June 30, 2022.

Background. The pandemic has affected child care providers and families. The COVID-19 emergency, has placed increased fiscal pressure on child care providers. Providers are serving fewer children and reporting higher costs. Of open providers, 80 percent reported higher costs for cleaning, sanitation, and personal protective equipment. Families receiving child care also have been affected, particularly due to school and child care closures that have required families to find new child care arrangements. During the pandemic, multiple short-term actions were taken through the beginning of 2021 as follows:

Pandemic-Related Child Care Actions

(In Millions)

Policy	Description	Total
Alternative Payment Voucher Slots for Essential Workers	Provided $50 million one time in 2019-20 to provide temporary vouchers and $47 million ongoing federal funds in 2020-21 to transition families to permanent vouchers. Provided an additional $138 million on a one-time basis for 2020-21.	$235
Voucher Reimbursement Flexibility	In 2020-21, voucher-provider payments are based on a child's authorized hours of care instead of the amount of care used. This holds voucher providers harmless if a child temporarily does not attend child care.	63
Family Fees	From April 2020 through August 2020, the state temporarily waived family fees for those receiving subsidized care. From September 2020 through June 2021, the state has waived family fees for families not receiving in-person care.	62
Cleaning Supplies and Protective Equipment	The state provided funds for gloves, face coverings, cleaning supplies, and labor costs associated with cleaning child care facilities.	50
Voucher Paid Operation Days	Provides an additional 14 paid non-operation days. Funds used so child can attend another provider while the original provider is closed.	40
School-Aged Care	Funds were to cover the additional cost of providing care to school-aged children. During the school year, school-aged children would typically receive care before and/or after school. As schools in most of the state remain closed, many school-aged children participating in distance learning also are receiving care from a child care provider during the school day.	38
Voucher Stipends	Stipends to voucher providers based on the number of subsidized children enrolled.	31
Direct Contract Reimbursement Flexibility	Direct contract providers were provided reimbursement flexibility in 2020-21. To receive this flexibility, providers must have opened to begin the school year or have been closed due to local or state public health guidance. Providers also must provide distance learning services to children enrolled in its programs and submit a distance learning plan to CDE. For providers that meet these	—

	conditions, reimbursement will be the lesser of their contract amount or program costs. Typically, provider reimbursement is also generally based on the attendance of eligible children.	
Attendance Record Requirements	Trailer legislation allows voucher providers to submit attendance records during 2020-21 without a parent signature if the parent is unable to sign due to the COVID-19 pandemic. Typically, providers are required to submit attendance records with a parent signature to receive reimbursement.	—
Total		$518

Source: Legislative Analyst's Office

With the recent passage of H.R. 133 in December 2020, the Coronavirus Response and Relief Supplemental Appropriations Act, the state received an additional $964 million in supplemental CCDBG funds. Early actions have already been taken to shore up the child care system, totaling approximately $400.3 million of these new funds, as follows:

- $244 million for stipends for child care providers (including State Preschool) that accept state subsidies. Stipends will be $525 per eligible enrolled child.

- $80 million to provide more than 8,000 children of essential workers access to subsidized child care, through June 30, 2022.

- $76 million to extend the care of children on temporary subsidies through June 30, 2022.

- $250,000 for administrative costs to ensure expedient allocation of funding and slots to providers and families.

- An increase in paid non-operational days for child care providers that accept state vouchers, from 24 to 40 days. These additional days will allow providers that experience multiple closures due to COVID-19 to better sustain their business during these difficult times and protect the fragile statewide system of care. These additional non-operational days will be paid for with unused child care funds provided in the 2020 Budget Act.

Questions.

1. Please provide a brief overview of major changes proposed in the May Revision to provide pandemic relief for child care providers.

2. Combined with the investments made in the previous item, how much in federal stimulus funding remains available for allocation?

Staff Recommendation: Hold open**.**

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.

Thursday, May 20, 2021
10 a.m. or Upon Adjournment of Floor Session
State Capitol - Room 4203

Part A Agenda

Consultant: Renita Polk

ISSUES FOR DISCUSSION

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

ISSUES FOR DISCUSSION

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Spring BCP – Deaf Community

Spring Finance Request. The DDS requests $2.4 million ($1.6 million General Fund) for 21 regional center coordinators to support the expansion of deaf service resources, provide training and expertise to regional center staff, and coordinate with the department on statewide efforts. The DDS also requests $197,000 ($158,000 General Fund) for one Career Executive Assignment level position to provide statewide leadership and subject matter expertise on the provision of services and supports for individuals who are deaf and have intellectual or developmental disabilities.

Background. For several years, the department has been addressing service equity issues that exist within the developmental services system, with a focus on learning how to serve diverse populations within the service system with cultural and linguistic sensitivity. To that end, the department recognizes the need to evaluate supports for individuals who are deaf and have developmental disabilities and work with regional centers to identify and develop resources to provide improved services and supports. Approximately 14,300 individuals served within the system have moderate to profound hearing loss with about 510 of those individuals reportedly using American Sign Language (ASL) as their primary means of communication.

The current service delivery system is not nimble at identifying the unique cultural needs of individuals who are deaf. Factors that must be considered when serving this population include the availability of deaf service coordinators, adequate training of service coordinators, availability of ASL interpreters with experience in developmental disabilities, effective assessment of the need for individual service planning, and availability of providers with experience working with individuals who have developmental disabilities and who are deaf. The proposed position will be responsible for the department's statewide efforts to provide culturally and linguistically sensitive services and supports to individuals who are deaf and have developmental disabilities. The specialist will also consult on innovative methods of service delivery and recommend solutions to improve services and supports for the targeted population, including those with the most challenging service needs. Additionally, the specialist will provide subject matter expertise, technical assistance, participate on external panels and committees, and interface with the regional center coordinators included in this request.

The proposed regional center coordinators will serve as a regional center's point person and subject matter expert on the provision of services to the deaf and hard of hearing community. Proposed duties of the regional center coordinator will include: liaising and partnering with generic agencies that provide services for individuals who are deaf and hard of hearing to expand the regional center's resource pool; and serving as the resource person for regional center staff who provide service coordination to individuals who are deaf and hard of hearing, among other duties.

Staff Recommendation. Hold open.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)
5160 DEPARTMENT OF REHABILITATION (DOR)

Issue 2: May Revision BCP – Disability Employment Grant

May Revision. The DOR and DDS jointly request $20 million General Fund ($10 million for each department) one time, to be spent over three years, to create a grant program to incentivize private entities to develop internship programs for individuals with physical disabilities. Provisional language is also requested to extend the encumbrance period and expedite contracts to establish the new program.

Background. DOR works in partnership with its constituents, community, other state departments, and federal entities, to provide services and advocacy resulting in employment, independent living, and equality for individuals with disabilities. The department administers the largest Vocational Rehabilitation and Independent Living programs in the country with over 100,000 Californians served per year. DDS provides services and supports to more than 350,000 individuals with intellectual and developmental disabilities (I/DD) and their families through a statewide system of 21 regional centers (RCs) under contract with the department. In 2013, California established an Employment First Policy, making opportunities for competitive integrated employment the highest priority for working-age individuals with I/DD.

The COVID-19 pandemic has caused a rise in unemployment, particularly among people with disabilities. According to the Society for Human Resources Management, close to one million workers with disabilities in the United States have lost their jobs since the COVID outbreak was declared a pandemic by the World Health Organization in March 2020. In 2020, only 13.51% of RC consumers received wages, according to the RC data dashboard available on the DDS website. The proposed grant program would help to address these inequities and increase the employment of Californians with disabilities.

This proposal will consist of three parts:

1. $2 million for DOR to initiate a targeted marketing campaign through general and social media to encourage the recruitment and employment of individuals with disabilities. The campaign would increase awareness of the talent pool represented by individuals with disabilities. Funds would also be awarded to chambers of commerce or trade organizations to establish a business champions campaign to formally recognize and promote employers who lead in providing internships and hiring individuals with disabilities.
2. $8 million for DOR to incentivize employers to hire individuals with disabilities through technical assistance and one-time grants to make workplaces accessible, develop industry-recognized work-based learning opportunities, and support training for managers and human resources professionals. The DOR proposes to work with the Society for Human Resource Management and community colleges to create training on strategies to recruit, screen, and hire individuals with disabilities, as well as establish a learning and training program for individuals with disabilities leading to employment.

3. $10 million for DDS to expand current efforts to achieve increased competitive integrated employment opportunities, to include targeted technical assistance, local collaboration with community colleges, small business associations and chambers of commerce, and other targeted pathways leading to meeting established targets set through input and discussions with the Developmental Services Task Force.

Questions.

1. Please provide an overview of the May Revision proposal.

2. How do the efforts described in this proposal differ from current efforts to increase employment opportunities at both the DOR and DDS?

Staff Recommendation. Hold open**.**

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

Issue 3: Overview of May Revision

May Revision. The DDS requests the following budget adjustments in the May Revision, not discussed in other agenda items:

- COVID-19 Response. An increase of $257 million ($152.2 million General Fund) for ongoing response to COVID-19. Costs reflect the projected impacts on Regional Center (RC) services and surge sites at Fairview and Porterville Developmental Centers to serve consumers diagnosed with, exposed to, or at high risk of COVID-19.

- Self-Determination Supports (Issue 055-MR). An increase of $10.3 million ($6.8 million General Fund) to improve consumer onboarding into the Self-Determination Program, to include: participant choice specialists, intensive transition support services, and regional center training. Beginning in 2024-25, ongoing costs decrease to $3.1 million. The Administration has indicated that trailer bill language will accompany this proposal. The language was not available at the time this agenda was written.

- Implicit Bias Training (Issue 058-MR). An increase of $700,000 ($553,000 General Fund) to support implicit bias training for regional center personnel and contractors involved in Lanterman Act eligibility determinations. Trailer bill language is associated with this proposal.

- Lanterman Act Provisional Eligibility (Issue 060-MR). An increase of $23.8 million General Fund ongoing to support regional center operations and purchase of services to provide provisional eligibility for children ages three and four to reduce the likelihood of children experiencing delays in receiving services, which can lead to long-term impacts

and a need for more intensive services and supports. Trailer bill language is associated with this proposal.

- Competitive Integrated Employment and Paid Internship Program. A proposed change in statute to increase the number of incentive payments for longer-term employment and provide additional incentives to help with COVID-19 recovery and funding to support paid internship development. No increased costs are associated with this proposal. The language was not available at the time this agenda was written.

- Enhanced Caseload Ratios for Consumers with Low to No Purchase of Services (Issue 056). An increase of $12.8 million ($10 million General Fund) ongoing to enhance case management for consumers with low or no purchase of services, improving access to and utilization of needed supports.

- Emergency Preparedness Resources (Issue 059-MR). An increase of $4.3 million General Fund in 2021-22 and $200,000 ongoing to update emergency preparedness materials and to distribute batteries, generators, and emergency go-bags to consumers living independently. The ongoing funding is to support regional center emergency preparedness training and community outreach.

- Bilingual Staff Differential (Issue 061-MR). An increase of $3.6 million ($2.2 million General Fund) for the establishment of a verification process for bilingual competency and provides a differential to increase the availability of staff who are bi/multi-lingual. Trailer bill language is associated with this proposal. Trailer bill language is associated with this proposal.

- Systemic, Therapeutic, Assessment, Resources, and Treatment (START) Teams (Issue 071-MR). An increase of $5.7 million ($4 million General Fund) for five additional START teams. The January Governor's Budget proposed an additional four teams. Approval of both proposals would increase the number of START teams in the budget year to nine.

- One-Time Deferred Maintenance (Issue 072-MR). A one-time increase of $5 million General Fund to support deferred maintenance projects at the state-operated Porterville Developmental Center and Fairview Developmental Center. The DDS also requests provisional language to extend the encumbrance and expenditure period to June 30, 2022.

- Home and Community-Based Services (HCBS). Language is requested to change the date for provider compliance with HCBS regulations from March 17, 2022, to March 17, 2023.

- Supplemental Individuals with Disabilities Education Act Funding (Issue 076-BBA). An increase of $24.5 million from the federal American Rescue Plan Act funding. The DDS also requests provisional language to authorize transfers between programs.

- Elimination of Supplemental Provider Rate Increase Suspension and Uniform Holiday Schedule (Issue 064 and 065-MR). Provisional language is requested to reflect the

elimination of program funding suspensions proposed in the Governor's budget. The subcommittee took action at its May 11, 2021 hearing to eliminate these suspensions.

- Early Start Outreach to Tribal Communities (Issue 054-MR). An increase of $500,000 General Fund ongoing to conduct outreach to tribal communities to improve awareness of early intervention programs, including Early Start.

Questions.

1. Please provide a brief overview of the department's major May Revision proposals.

2. Please provide more detail on the proposed Self-Determination supports. Will the proposed funding help to provide consistency across RCs in program implementation?

3. The May Revision includes funding for provisional Lanterman Act eligibility for children ages 3 and 4 that previously received Early Start services. What is the estimated number of children who may benefit from this proposal?

Staff Recommendation. Hold open**.**

Issue 4: May Revision BCP and TBL – Performance Incentive Program (Issue 074-MR)

May Revision. The DDS requests $5.6 million ($4 million General Fund) in 2021-22 to establish a performance-based incentives funding program. Beginning in 2022-23, ongoing costs increase to $89.3 million ($61 million General Fund). DDS also requests trailer bill language to implement this proposal.

Costs in 2021-22 will support the initial infrastructure needed to prepare for program implementation in 2022-23. These initial costs could include additional staffing and exploration of new data collection systems/tools.

Background. DDS, with input from the Developmental Services Task Force (DS Task Force), began work on the development and achievement of measurable enhanced performance objectives and outcomes in 2019-20. As with other initiatives, DDS needed to pause in response to the COVID19 pandemic. According to DDS, during the past year, stakeholders have continued to express the need to improve satisfaction with, value, and adaptability of regional center services for individuals with intellectual and developmental disabilities and their families. Through discussions among stakeholders, the DS Task Force, DDS leadership, and regional center representatives, the system is prepared to identify performance indicators and targets that can be consistently applied across all regional centers. In response to the pandemic, data was used to inform decisions and monitor progress during the past year. Going forward, the department and regional centers can continue to demonstrate their capabilities in using data to identify needs and inform changes in policy or operations.

This request would require DDS and regional centers to work with stakeholders on the development of standard performance indicators to incentivize high-quality regional center operations, with the priority of reducing caseload ratios. According to DDS, prioritization will allow service coordinators to improve person-centered planning with consumers and their families, reduce inequity of service delivery, build community partnerships, and improve outcomes for individuals with intellectual and developmental disabilities.

Questions.

1. The department has indicated that its proposed performance incentive program will prioritize the reduction of caseload ratios. How does the department propose to ensure that Regional Centers struggling with high caseloads can achieve the performance incentive marks needed to receive additional caseworker dollars?

2. The Administration has indicated that it will use data to identify performance indicators and targets for the proposed program. What are some of the specific data measures the department will use to identify these targets?

Staff Comment and Recommendation. Hold open**.**

The Administration has indicated that this proposal will prioritize the reduction of caseload ratios at RCs. Statute and federal agreements require average service coordinator to consumer ratios to be at 1:62 to 1:66, depending on specified consumers at each regional center. The average statewide ratio is currently 1:75. Staff notes that stakeholders, including SEIU and the Association of Regional Center Agencies (ARCA), have requested funding of $59 million General Fund to hire service coordinators at RCs to meet statutory caseload ratio targets. This request was heard at the subcommittee's February 23, 2021 hearing. The subcommittee may want to inquire as to why the Administration chose to put forward this new program to address caseload, instead of proposing funding for RCs to hire additional service coordinators to come into alignment with those requirements.

Staff also notes that trailer bill language accompanies this request. While the Administration intends to prioritize the reduction of caseload ratios with this proposal, the trailer bill language makes no mention of that prioritization. If the subcommittee takes action to approve this proposal, staff suggests the subcommittee consider adopting language that identifies the prioritization of reducing caseload ratios in the trailer bill.

Issue 5: May Revision TBL – Direct Service Professional (DSP) Workforce Training and Development (Issue 057-MR)

May Revision. The DDS requests $4.3 million ($2.9 million General Fund) to implement a tiered training and certification program for direct service professionals tied to wage differentials. Funding increases to $51 million in 2023-24 and annually thereafter. Trailer bill language is associated with this proposal.

Background. Direct service professionals (DSPs) are critical to the provision of services and supports to individuals with intellectual and developmental disabilities (I/DD). To stabilize and diversify the workforce and reduce turnover, the May Revision includes funding to establish a training and certification program for direct service professionals tied to wage differentials. The program aims to professionalize and diversify the workforce. The training and certification program would include progressively higher wages for DSPs who complete additional training. The program aims to promote improved consumer access to a more skilled workforce, which will foster improved consumer outcomes while having a positive effect on DSP turnover. The change allows providers to secure quality job-specific training to DSPs across the state through a standardized training curriculum. Supporting employers as well as individual employees to advance their training will increase professionalism and competence.

Questions.

1. What is the expected timeline to implement this program? If funding is provided in the 2021-22 budget, when can the Legislature expect to see the program up and running?

2. Does the department plan to create the training curriculum, or utilize an existing curriculum? Are there existing curriculums that can be used for this training?

3. How does the department envision this program will be rolled out?

Staff Comment and Recommendation. Hold open**.**

At its May 6, 2021, hearing the subcommittee discussed various budget options it was considering for inclusion in the budget. One of those proposals was the development of a training and certification program for DSPs. While the May Revision aligns with those Senate priorities there are still many questions to be answered around how the program will be set up and designed. Trailer bill language on the proposal includes Legislative findings and declarations but does not provide much detail on program design other than to identify specific topics that the training shall include.

4700 DEPARTMENT OF COMMUNITY SERVICES AND DEVELOPMENT (CSD)

Issue 1: Overview of May Revision

May Revision. The CSD requests the following budget adjustments in the May Revision:

- Low-Income Home Energy Assistance Program (LIHEAP) (Issue 024-MR). $203.6 million one-time in federal American Rescue Plan Act funds for the LIHEAP. The program assists low-income families in managing costs associated with home energy bills, energy crises, weatherization, and energy-related minor home repairs. The department also requests trailer bill language to allow for full utilization and rapid distribution of the federal funds.

- Low-Income Household Water Assistance Program Grant (Issue 026-MR). $90 million one-time in federal funds to provide low-income water arrearage assistance. The department also requests trailer bill language allowing for the development and implementation of the program.

- California Arrearage Payment Program (CAPP) (Issue 028-MR). $1 billion one-time in American Rescue Plan Act funds to cover low-income utility payment arrearages. $6.5 million will be used for state operations and the remaining $993.5 million will be used for local assistance.

Background. CSD reduces poverty for Californians by leading the development and coordination of effective and innovative programs for low-income Californians. CSD administers local community services and energy assistance programs through a network of community-based organizations and non-profit regional administrators to deliver services to low-income families, individuals, and communities to help them achieve economic security and a higher quality of life.

The COVID-19 pandemic and measures taken to limit its spread resulted in significant job loss, financial downturn, and business interruption. The economic consequences of stay-at-home orders and precautionary quarantine measures instituted not only increased home energy consumption for many California households but impacted many Californians' ability to pay their home energy bills. Consequently, millions of low-income Californians have fallen behind on their energy bills due to financial hardship related to the COVID-19 pandemic. Temporary moratoriums on utility disconnection provided vital short-term protection for customers. However, with moratoriums soon to expire, many low-income Californians will struggle to manage the financial burden of repaying past due balances and risk losing home energy services. Data from the California Public Utilities Commission, through March 2021, indicate 3.14 million customers are in arrears for a total amount of $1.33 billion. Of that total, over 1.48 million are low-income customers with a total arrearage of $607 million.

Questions.

1. Please provide an overview of the department's May Revision proposals.

2. The trailer bill language associated with the development of the Low-Income Household Water Assistance Program allows the department develop a state plan, requirements, and guidelines for the program without taking regulatory action. What is the rationale for this exemption from developing regulations?

Staff Comment and Recommendation. Hold open.

The proposed trailer bill language associated with the water assistance program exempts the department from developing regulations to implement the program. The subcommittee may want to consider adopting changes to the language to keep the Legislature notified of the program design plan prior to implementation.

4170 CALIFORNIA DEPARTMENT OF AGING (CDA)

Issue 1: May Revision BCP – Community Based Adult Services Certification Workload (Issue 045-MR)

May Revision. The CDA requests $1.9 million ($773,000 General Fund) in 2021-22 and $2.4 million ($946,000 General Fund) ongoing to support ten new positions to address existing certification and recertification backlogs and to increase capacity for growth in the number of CBAS providers.

Background. The CBAS program provides community-based day health services to older and younger adults with chronic medical, cognitive, or behavioral health conditions and/or disabilities who are at risk of needing institutional care. The CBAS program is an alternative to institutional care for Medi-Cal beneficiaries who meet the eligibility criteria and, with the aid of appropriate health, rehabilitative, personal care, and social services, can remain in their homes. The CDA certifies licensed Adult Day Health Care Centers as Medi-Cal CBAS providers.

Approximately half of all CBAS providers must undergo certification renewal and an onsite survey each year. CDA must also monitor provider compliance with the California Medi-Cal 2020 Waiver Requirements, the federal Affordable Care Act, and Home and Community-Based Services requirements, to ensure the state's compliance with these Medicaid waiver requirements. The workload associated with these requirements has proven to be greater than originally estimated and continues to impact CDA's ability to meet requirements for timely CBAS provider recertification. According to CDA, the resources requested will help CDA conduct timely and repeated follow-up monitoring visits to ensure that appropriate corrective actions are taken to keep participants safe while still maintaining its annual recertification scheduled visits. These positions will support (1) increasing the completion of onsite recertification monitoring to the mandated levels; (2) processing new provider applications and conducting on-site CBAS initial certification; (3) and taking appropriate action when providers are out of compliance with program standards and requirements and/or suspected of Medi-Cal fraud.

Questions.

1. Please provide a brief overview of the proposal.

Staff Recommendation. Hold open.

Issue 2: May Revision BCP – CalFresh Expansion Older Adult Outreach (Issue 044-MR)

May Revision. The CDA requests $2 million ($1.1 million General Fund) and two positions in 2021-22 and ongoing to support CalFresh expansion outreach.

Background. The CalFresh program provides monthly benefits to low-income households to assist with food purchases. Beginning June 1, 2019, recipients of Supplemental Security Income

(SSI) and State Supplementary Payments (SSP) were made eligible for CalFresh. It is estimated that statewide 213,000 SSI/SSP recipients remain eligible for CalFresh. Of these SSI/SSP recipients, approximately 60 percent, or 127,800, are over 60 years of age and could benefit from outreach and assistance in enrolling in CalFresh to receive food benefits.

The 2018 Budget Act provided one-time funding to support the implementation of the CalFresh expansion to SSI/SSP recipients across multiple state departments. The CDA received one-time funding of $2 million in 2019-20 for that purpose. With these funds, 25 Area Agencies on Aging (AAAs) participated in CalFresh outreach and application assistance and six AAAs participated in outreach-only during the 12-month contract period. The AAAs assisted 5,974 older adults to apply for CalFresh and 4,272 older adults now receive CalFresh benefits due to the AAA's involvement in this program.

CDA requests to resume administering the program at the same funding levels as 2019-20 when the program was initially implemented. To effectively administer the program, CDA requests one Health Program Specialist position and one Associate Governmental Program Analyst position to oversee the requirements of the CalFresh Expansion program. Duties of the positions include monitoring grant administrative activities, training, maintaining ongoing communication with the AAAs for guidance and technical assistance, reviewing AAA's monthly data reporting, preparing quarterly reports for CDSS, participating in contractor meetings and stakeholder calls, and fiscal management including review of expenditures, and review and approval of program budgets, closeouts, and equipment requests.

Questions.

1. Please provide an overview of the May Revision proposal.

Staff Comment and Recommendation. Hold open.

This subcommittee has had many discussions about food insecurity, particularly among seniors in California. The above proposal would help more seniors access the CalFresh program and needed food benefits. The proposal also aligns with the Senate's priorities to ensure all Californians have access to food.

Issue 3: May Revision BCP – Older Adults' Recovery and Resilience (Issue 049-MR)

May Revision. The CDA requests $106 million General Fund one-time to be spent over three years to strengthen older adults' recovery and resilience from the isolation and health impacts from staying at home during the COVID-19 pandemic. The request also includes provisional language to administer the funding and limited-term resources equivalent to 16 positions to oversee and lead programs at the state level. In anticipation of program ramp-up, CDA plans to recruit ten positions in 2021-22 and six positions in 2022-23. These resources represent a 5.7 percent state administrative cost for the total $106 million in funding.

Background. The pandemic has hit older adults, people with disabilities, their families, and caregivers hard, leaving many of them isolated, home-bound, and with limited resources for the last eighteen months. California's older adult population was the first demographic to be asked to stay-at-home, due to their high risk of death from COVID-19. Since that population has been home for over a year, the need for services that are specific to isolation, health, and well-being at home has increased. The investments that are proposed in this request target both isolation and health needs which will support older adults' recovery and resilience as they are vaccinated and begin to reengage with in-person community activities and services. The table below shows the funding breakdown between CDA programs.

Proposed Program Funding
(Millions of Dollars, Onetime over Three Years)

Program	Funding
Senior Nutrition	$20.7
Senior Legal Services	$20
Fall Prevention and Home Modification	$10
Digital Connections	$17
Senior Employment Opportunities	$17
Aging and Disability Resource Connections	$9.4
Behavioral Health Friendship Line	$2.1
Family Caregiving Support	$2.8
Elder Abuse Prevention Council	$1.0
State Operations	$6.0
TOTAL	**$106**

CDA will monitor the utilization of these programs and local needs and may redistribute funding between programs during the three years using the Control Section 26 process when applicable. CDA also requests provisional authority to be able to work with AAAs, local governments, and local non-profit and community-based organizations to effectively administer these programs based on local capacity.

Questions.

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

2. What is the expected impact of the proposed funding for digital connections? How many additional California seniors will be able to receive devices and other services with this additional funding?

3. The department proposes to provide $2.8 million for family caregiving support. Will the department collaborate with Caregiver Resources Centers, funded through the Department of Health Care Services, to provide these supports?

Staff Comment and Recommendation. Hold open.

Staff notes that several proposals in the May Revision align with budget options discussed by the subcommittee at its May 6, 2021 hearing. The importance of providing additional funding for senior nutrition, Aging and Disability Resource Connections, and digital connections were highlighted during that hearing. In addition, the COVID-19 crisis has underlined the need for additional resources for older Californians. With the projected budget surplus the subcommittee may want to consider providing even more resources for the above programs, as the senior population is only projected to grow in coming years and COVID-19 has unmasked overwhelming need among this population.

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.

Thursday, May 20, 2021
10:00 a.m., or upon adjournment of session
State Capitol - Room 4203

PART B

Consultant: Scott Ogus

PUBLIC COMMENT

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

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: Language Access Services (Issue 045-MR)

Budget Change Proposal and Budget Bill Language - May Revision. CHHSA requests General Fund expenditure authority of $20 million in 2021-22. If approved, these resources would allow CHHSA to improve and deliver language access services across the spectrum of health and human services programs. CHHSA also requests provisional budget bill language to allow encumbrance or expenditure of this funding until June 30, 2024.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$20,000,000	$-
Total Funding Request:	**$20,000,000**	**$-**
Total Positions Requested:	**0.0**	**0.0**

Background. According to CHHSA, more than a quarter of Californians are foreign born, and more than ten percent of the state's population speaks English "not well" or "not at all". Access to accurate, timely, and understandable information is critical for these communities, and existing laws, policies, and practices, including interpretation and translation services provided by state health and human services departments, have made progress in responding to this need. However, the pandemic and its disproportionate impact on already marginalized communities have highlighted the need for a comprehensive language access approach, which is a critical component of advancing health equity and improving outcomes for all Californians.

As part of the January budget, CHHSA requested two limited-term positions and General Fund expenditure authority of $307,000 in 2021-22 and 2022-23 to develop and implement an agency-wide language access policy and protocol framework that considers legal compliance; operational aspects of translation and interpretation; bilingual staff testing, classification, and related human resources requirements; and engagement with community stakeholders and partners.

In the May Revision, CHHSA requests General Fund expenditure authority of $20 million in 2021-22 to build on its January proposal to: 1) consolidate its existing contract work on language access; 2) provide dedicated staff to large, medium, and small health and human services departments to support language access efforts; and 3) provide resources for the provision of language access services. These resources would support the equivalent of 22 positions, primarily at the Department of Social Services, with one position each at the Department of Public Health and the Department of Health Care Services. These position equivalents would perform the following workload:

- Identification of vital documents and website content for translation, as well as points of public contact in need of oral and sign language interpretation services.
- Periodic language needs assessments to determine threshold languages for document translation.
- Coordination and streamlining of interpretation and translation services.
- Implementation of quality control measures to ensure the accuracy, readability, and cultural appropriateness of translations.

- Ongoing stakeholder engagement to ensure continuous improvement of language and communication access.

In addition, CHHSA requests budget bill language to allow encumbrance or expenditure of these funds until June 30, 2024.

Staff Comment and Recommendation – Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please describe how CHHSA would deploy language access services under this proposal.

Issue 2: Health Information Exchange Leadership (Issue 048-MR)

Budget Change Proposal and Budget Bill Language – May Revision. CHHSA requests General Fund expenditure authority of $2.5 million in 2021-22. If approved, these resources would allow CHHSA to lead efforts and stakeholder engagement in building out health information exchanges. CHHSA also requests provisional budget bill language to allow encumbrance or expenditure of this funding until June 30, 2023.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$2,500,000	$-
Total Funding Request:	**$2,500,000**	**$-**
Total Positions Requested:	**0.0**	**0.0**

Background. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorized approximately $4.5 billion for California for both the Medicare and Medi-Cal electronic health records (EHR) incentive programs. Of the $4.5 billion for California, it is estimated that approximately $2 billion in incentive payments will be made to qualified Medi-Cal health care providers who adopt, implement, or upgrade and meaningfully use electronic health records in accordance with federal requirements. In addition to efforts to encourage use of EHRs, the federal Centers for Medicare and Medicaid Services (CMS) has sought to promote and improve interoperability, allowing the exchange of health information between different systems.

According to the Office of the National Coordinator for Health Information Technology, health information exchanges (HIEs) allow doctors, nurses, pharmacists, other health care providers, and patients to appropriately access and share a patient's vital medical information electronically. CHHSA reports the ARRA HITECH funding allowed the state to make significant progress in adoption of EHRs, a necessary step to initiate large scale health information exchange. CHHSA, through its proposed Center for Data Insights and Innovation, proposes to accelerate the exchange of data among entities and providers in both the public and private sector to deliver person-centered, data-driven programs and services that improve outcomes. In addition, CHHSA intends to integrate social services data with the existing health data available through health information exchanges.

Resource Request. CHHSA requests General Fund expenditure authority of $2.5 million in 2021-22, available until June 30, 2023, to lead efforts and stakeholder engagement in building out health information exchanges. These resources would support the equivalent of three positions and contract resources, as follows:

- Resources equivalent to **one Career Executive Assignment (CEA)** would provide leadership on health and social services data among agency departments and offices, develop standards and identify best practices for information exchange, serve as a single point of contact for stakeholders for interoperability initiatives, and serve as the State Health Information Technology Coordinator to represent California with the federal Office of the National Coordinator for Health Information Technology and other federal partners.

- Resources equivalent to **one Attorney** would provide expertise in relevant state and federal laws and regulations, experience with health information exchanges, and experience with California privacy laws in public health and social services. The attorney would also develop standards, regulations, and policy guidance to agency and department staff.
- Resources equivalent to **one Staff Services Manager II** would provide oversight, management, planning and organizational activities for all stakeholder meetings and workgroups, support the Advisory Committee, and provide support to other projects including contract management and reporting.

- $1.4 million for contract resources would support the following subject matter experts consultants:

    - Project Management – The project manager would have experience with health information exchanges, as well as facilitation and collaboration with both public and private entities in the healthcare field.
    - Meetings, Events, and Logistics – Professional event and logistics services would set up workgroup, stakeholder, and Advisory committee meetings and logistics.
    - Subject Matter Experts – Subject matter experts would be provided in health information exchange standards, interoperability and information blocking, and data linkage and attribution.

Staff Comment and Recommendation – Hold Open.

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

1. Please provide a brief overview of this proposal.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Increased Emergency Preparedness and Response Capacity (Issue 030-MR)

Budget Change Proposal – May Revision. EMSA requests 14 positions and General Fund expenditure authority of $8.5 million annually. If approved, these positions and resources would allow EMSA to maintain and store critical equipment and medical supplies acquired during the pandemic, and provide resources for the Operations Center, for exercises, and for training.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$8,495,000	$8,495,000
Total Funding Request:	**$8,495,000**	**$8,495,000**
Total Requested Positions:	**14.0**	**14.0**

* Positions and resources ongoing after 2022-23.

Background. EMSA is the lead state agency responsible for coordinating medical response to disasters and provides medical resources at the request of local governments in accordance with the medical and health disaster response system. This role includes identifying, coordinating, acquiring, and deploying medical supplies, personnel, and equipment to ensure critical medical needs are met. EMSA also is responsible for statewide patient movement coordination activities.

According to EMSA, recent pandemic and wildfire response activities revealed critical gaps in its response capabilities. During the last year, EMSA was supporting 17 different missions simultaneously, including federal medical stations, alternate care sites, long-term care facilities, and support for multiple warehouses, the Departmental Operations Center, the Medical Health Coordination Center, and the State Operations Center.

Staffing and Resource Request. EMSA requests 14 positions and General Fund expenditure authority of $8.5 million annually to maintain and store critical equipment and medical supplies acquired during the pandemic, and provide resources for the Operations Center, for exercises, and for training. Specifically, these resources would be allocated as follows:

- Staffing Resources – 14 positions and $2.5 million in the Response Resource Unit, the Plans and Training Unit, and Bio-Medical Support Resource Unit would support the following critical duties:
    - Manage three warehouses
    - Support receiving, servicing, storing, and deploying millions of supply and equipment items, including 15,000 ventilators and other biomedical equipment
    - Provide leadership at multiple EMSA treatment sites simultaneously during a disaster response
    - Support local Emergency Operations Centers and field operations during disasters
    - Conduct training exercise for response partners
    - Support expanded Mobile Medical Assets Program
    - Statewide support for local disaster preparedness, response, mitigation, and recovery planning.

- Facilities - $3.1 million would support the continued use of three additional warehouses leased during the pandemic to store ventilators, oxygen concentrators, and other COVID-19 patient interface devices and supplies.

- Bio-medical Equipment Maintenance - $2 million would allow maintenance of all new medical equipment according to the unique service schedules and requirements of each device.

- Exercise and Training - $324,000 would support training and exercises for medical personnel.

- Departmental Operations Center - $250,000 would support a build-out of the center to meet current industry standards, including the purchase of multimedia equipment, projectors, screens, network equipment, computers, communications equipment, software, and furniture.

- Response Caches - $250,000 would support caches of equipment to allow simultaneous deployment of multiple medical teams.

- Emergency Response Vehicle Fleet - $101,000 would support lease of 10 additional response vehicles to aid in personnel deployment.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 2: Medical Surge Staffing Program (Issue 031-MR)

Budget Change Proposal – May Revision. EMSA requests six positions and General Fund expenditure authority of $1.4 million annually. If approved, these positions and resources would support recruitment, on-boarding, and program management of the California Health Corps Program, California Medical Assistance Teams Program, and the Disaster Healthcare Volunteers/Medical Reserve Corps Program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$1,414,000	$1,414,000
Total Funding Request:	**$1,414,000**	**$1,414,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2022-23.

Background. EMSA is the lead agency responsible for coordinating California's medical response to disasters, providing medical resources such as medical personnel to local governments in support of their disaster response. EMSA administers and deploys medical staffing through the following programs:

- California Medical Assistance Teams – state-coordinated, rapidly deployed teams of health care and support professionals for use in catastrophic and other local emergency or potential emergency events.
- Disaster Healthcare Volunteer Program – a statewide registry that registers and credentials health professionals who may wish to volunteer during a disaster including doctors, nurses, paramedics, dentists, or mental health practitioners.
- California Health Corps – a volunteer registry of health care professionals implemented through executive order in response to a need for surge capacity during the pandemic.

Staffing and Resource Request. EMSA requests six positions and General Fund expenditure authority of $1.4 million annually to support recruitment, on-boarding, and program management of the California Health Corps Program, California Medical Assistance Teams Program, and the Disaster Healthcare Volunteers/Medical Reserve Corps Program. According to EMSA, there has been a shortage of permanent personnel to implement and manage these programs during the COVID-19 response. The six positions would be allocated as follows:

- **One Program Manager I** position would provide oversight and management of the California Health Corps, provide guidance to program staff, assign and review staff work, oversee the development of procedures and desk manuals, facilitate implementation of new program procedures, research and resolve issues related to rules and requirements, analyze processes, assist in development and usage of databases, and make recommendations to improve the program.
- **Three Senior Emergency Service Coordinators** would each be assigned to one of the California Office of Emergency Services (CalOES) administrative regions to develop, implement, maintain and evaluate medical surge staffing mobilization processes and deployment procedures, and assist in Medical surge staffing Initiative response plans and exercise programs.

- **One Information Technology Specialist I** position would provide oversight and management of the Medical surge Staffing Deployment System, provide secondary support to the Disaster Healthcare Volunteers system, and develop and maintain system exercise programs and trainings for internal and external partners.
- **One Information Technology Specialist II** position would serve as a solution architect for the Medical Surge staffing deployment and tracking system.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Human Resources Workload Support (Issue 032-MR)

Budget Change Proposal – May Revision. EMSA requests 5 positions and General Fund expenditure authority of $851,000 annually. If approved, these positions and resources would support the Human Resources Unit to address workload associated with routine and emergency response personnel functions.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$851,000	$851,000
Total Funding Request:	**$851,000**	**$851,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and resources ongoing after 2022-23.

Background. According to EMSA, its non-emergency staffing levels as of January 1, 2021, include 79 permanent positions, as well as 17 temporary blanket and retired annuitant positions for a total of 96 positions. EMSA's human resources unit currently consists of one Staff Services Manager (SSM) I Specialist, an Office Technician (OT), and two retired annuitants (RA) who currently support the department's workforce during normal operations and emergency response missions. EMSA also reports that its staffing levels generally increase dramatically during a state emergency, depending on the level of medical response needed.

Staffing and Resource Request. EMSA requests five positions and General Fund expenditure authority of $851,000 annually to provide administrative support services to the Human Resources Division to address mission critical workload associated with routine and emergency response personnel services functions. These additional resources would play a key strategic role in managing EMSA staff and workplace culture and environment and enhance EMSA's ability to ensure hiring is timely, personnel actions are completed, performance management goals are attained, legal mandates regarding employment laws are met, employee development is championed and sustained, and EMSA's management team is supported and able to ensure staff are productive and empowered to do their best. The specific positions requested are as follows:

- **One Staff Services Manager III** would develop, provide, and direct the uniform implementation of departmental policies and procedures impacting human resources operations and be responsible for planning, organizing, directing, and coordinating the operation of all human resources functions.
- **One Staff Services Manager I** would supervise and direct the daily activities of the division and serve as a subject matter expert in personnel services, classification and pay, workforce planning, succession planning, recruitment and selection, training, employee health and wellness, and worker's compensation.
- **Three Associate Governmental Program Analysts** would promote and be accountable for providing personnel support, customer satisfaction, and quality services and would provide recommendations and changes that promote innovative solutions to meet customer needs in accordance with established policies and procedures.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 4: Statewide Emergency Medical Services Data Solution (Issue 045-MR)

Budget Change Proposal – May Revision. EMSA requests 2 positions and General Fund expenditure authority of $10 million in 2021-22. If approved, these positions and resources would support planning and readiness activities to establish a statewide emergency services data infrastructure that strengthens real-time information sharing and data analytics for state and local governments, emergency medical services providers, and health care providers.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$10,000,000	$-
Total Funding Request:	**$10,000,000**	**$-**
Total Requested Positions:	**2.0**	**2.0**

* Positions ongoing after 2022-23.

Background. Data related to the provision of emergency medical services (EMS) in California is currently recorded in Prehospital Care Reporting (PCR) software by prehospital care personnel, such as paramedics and emergency medical technicians (EMTs). EMS providers transfer this data to one of the 33 local EMS agencies (LEMSAs). According to EMSA, wile this data can be used to plan and improve services by LEMSAs, it does not provide the ability to compare, benchmark, or integrate with like provider agencies or the statewide system for performance improvement.

EMSA provides funding to the Inland Counties EMS Agency to collect pre-hospital and trauma data in the California EMS Information System (CEMSIS), which collects voluntary data from 32 of 33 LEMSAs statewide. CEMSIS provides participating LEMSAs access to aggregate statewide data submitted to the CEMSIS data system and is a tool for local EMS system quality improvement, improved EMS system management, and a limited benchmarking against and compliance with existing EMS national standards. EMSA reports this data is not available in real-time for state policymakers and managers, leaving the state without complete or timely information on the EMS system.

Staffing and Resource Request. EMSA requests 2 positions and General Fund expenditure authority of $10 million in 2021-22 to support planning and readiness activities to establish a statewide emergency services data infrastructure that strengthens real-time information sharing and data analytics for state and local governments, emergency medical services providers, and health care providers. Specifically, EMSA is requesting the following:

- Changes to Existing Systems - $7.6 million would onboard additional LEMSAs to the existing systems and connect all health information exchanges and health information organizations to EMS data. EMSA would award up to nine grants to connect and onboard interoperable systems and prioritize awarding grants to counties that have not already implemented these systems.
- New Statewide Data Hub - $2.4 million would support a one-year planning period to begin the process of merging CEMSIS with its Health Information Technology for EMS system into a statewide data hub. Included in this request is support for the equivalent of **two Information Technology Specialist** positions to support the project as it progresses through the California Department of Technology's Project Approval Lifecycle (PAL) process.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 5: COVID-19 Statewide Response Expenditures (Issue 038-MR)

Budget Change Proposal – May Revision Adjustment. EMSA requests General Fund expenditure authority of $17 million in 2021-22. If approved, these positions and resources would allow EMSA to continue its support for medical staffing, ambulance transportation services, and related support costs.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$16,956,000	$-
Total Funding Request:	**$16,956,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. During the COVID-19 pandemic, the Administration augmented expenditure authority for EMSA through a variety of Executive Orders, provisional language, budget control sections, and transfers from the Disaster Response-Emergency Operations Account (DREOA). In addition, a variety of federal funding streams have supported the pandemic response including reimbursements from the Federal Emergency Management Agency (FEMA) and direct categorical funding from Congressional relief packages.

SB 89 General Fund Allocation for 2019-20. SB 89 (Committee on Budget and Fiscal Review), Chapter 2, Statutes of 2020, appropriated up to $1 billion of General Fund expenditure authority to any item for any purpose related to the Governor's declaration of a state of emergency related to the coronavirus pandemic. SB 89 required the Department of Finance to notify the Joint Legislative Budget Committee (JLBC) 72 hours prior to any expenditures made pursuant to this authority. EMSA received the following augmentations under SB 89:

- Ventilator Supply - $8.6 million (Item 4120-001-0001) to support the purchase of new ventilators, the refurbishment of ventilators already possessed by the state, and the purchase of intravenous fusion pumps. JLBC was notified of this expenditure on March 20, 2020.
- Medical Transportation - $2 million (Item 4120-001-0001) for a contract with American Medical Response to provide patient transportation and stand-by services. JLBC was notified of this expenditure on March 20, 2020.

Disaster Response-Emergency Operations Account (DREOA). Government Code Section 8690.6 established the Disaster Response-Emergency Operations Account (DREOA) within the Special Fund for Economic Uncertainties (SFEU) and authorizes DREOA funds, upon allocation by the Director of Finance, to be transferred to state agencies for disaster response operation costs incurred as a result of a proclamation by the Governor of a state of emergency. EMSA received a total augmentation of General Fund expenditure authority of $30.9 million from two allocations of funds from DREOA in 2019-20, and $53.3 million from five allocations of funds from DREOA in 2020-21.

The EMSA response activities supported by SB 89 and DREOA funding in 2019-20 and 2020-21 are as follows:

- **Ambulance Transport** – $25.7 million for provision of patient transportation, medical staffing, and stand by services at various medical sites.
- **Ventilators** – $23.9 million for purchase of new ventilators, refurbishment of existing ventilators already possessed by the state, and ventilator certification.
- **Bio-Medical Equipment** – $3.4 million for purchase of medical equipment needed to assess patients with acute respiratory distress, cardiac monitors, and defibrillators.
- **California Medical Assistance Teams (CalMAT) Personnel** – $24.2 million to support staff costs for CalMAT personnel deployments at various locations and alternate care sites.
- **CalMAT Support** – $1.1 million for purchase of CalMAT equipment and supplies to support field medical and alternate care sites.
- **EMSA Infrastructure** – $9.1 million for staffing, equipment, supplies, and services to support the infrastructure needs of EMSA during the pandemic.
- **EMSA Overtime** – $936,000 for EMSA staff overtime expenses incurred while deploying to field medical sites and staffing various operational centers, including the State Operations Center (SOC), the Departmental Operations Center (DOC), and the Medical and Health Coordination Center (MHCC).
- **Health Corps Personnel** – $3.4 million for staff costs for Health Corps personnel deployments at various locations and alternate care sites.
- **Health Corps Support** – $50,000 for purchase of equipment, supplies, and services to support the infrastructure needs of the Health Corps.
- **Medical Supplies** – $1.1 million for purchase and replenishment of medical supplies required at alternate care sites.
- **Personal Protective Equipment** – $108,000 for purchase of equipment to minimize exposure to COVID-19.
- **Travel Expenses (EMSA and CalMAT Staff)** – $2 million for travel, airfare, per diem, hotel, and care rental expenses for deployed staff in the field and to meet DOC operational needs

Control Section 11.91 Provides COVID-19 Support to Multiple Departments. The January budget includes Control Section 11.91, which provides support to several different departments, including EMSA, for continued COVID-19 direct response expenditures. EMSA is requesting General Fund expenditure authority of $17 million in 2021-22 for continued medical staffing, ambulance transportation services, and related support costs.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Local Assistance Estimate – May Revision Update

Medi-Cal Local Assistance Estimate - May Revision Update. The May 2021 Medi-Cal Local Assistance Estimate includes $115.6 billion ($21.5 billion General Fund, $79 billion federal funds, and $15.1 billion special funds and reimbursements) for expenditures in 2020-21, and $123.8 billion ($27.6 billion General Fund, $83.8 billion federal funds, and $12.4 billion special funds and reimbursements) for expenditures in 2021-22. These figures represent a decrease in estimated General Fund expenditures in the Medi-Cal program of $991.1 million in 2020-21 and $792.5 million in 2021-22 compared to the Governor's January budget.

Caseload. In 2020-21, the May Revision assumes annual Medi-Cal caseload of 13.6 million, a decrease of approximately 372,000 or 2.7 percent compared to assumptions in the Governor's January budget. In 2021-22, the May Revision assumes annual Medi-Cal caseload of 14.5 million, a decrease of approximately 1.1 million or 7.1 percent compared to assumptions in the Governor's January budget and an increase of 6.6 percent compared to the revised caseload estimate for 2020-21. The decrease in estimated caseload is primarily due to lower than expected enrollment impacts from the COVID-19 pandemic, offset by additional enrollment related to the federal continuous coverage requirement during the pandemic.

May Revision Local Assistance Adjustments. The Administration requests the following adjustments to reflect caseload and miscellaneous adjustments not attributable to other significant adjustments:

- Item 4260-101-0001 be increased by $642,395,000 and reimbursements be increased by $146,251,000
- Item 4260-101-0232 be increased by $20,692,000
- Item 4260-101-0233 be increased by $5,759,000
- Item 4260-101-0236 be increased by $16,693,000
- Item 4260-101-0890 be increased by $2,840,960,000
- Item 4260-101-3168 be increased by $905,000
- Item 4260-101-3305 be increased by $240,691,000
- Item 4260-101-3375 be decreased by $615,000
- Item 4260-102-0001 be decreased by $7,433,000
- Item 4260-102-0890 be decreased by $1,381,000
- Item 4260-103-3305 be decreased by $4,896,000
- Item 4260-106-0890 be increased by $5,556,000
- Item 4260-113-0001 be increased by $47,326,000
- Item 4260-113-0890 be increased by $96,858,000
- Item 4260-117-0001 be decreased by $5,000
- Item 4260-117-0890 be decreased by $59,000

Medi-Cal Local Assistance Funding Summary 2020-21 Comparison to January Budget			
Fiscal Year:	**2020-21**	**2020-21**	**Jan-May**
Benefits			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$21,334,400,000	$20,777,035,000	($567,365,000)
Federal Funds	$75,062,886,000	$74,665,303,000	($397,583,000)
Special Funds/Reimbursements	$16,346,719,000	$ 15,053,592,000	($1,293,127,000)
Total Expenditures	**$112,754,005,000**	**$110,495,930,000**	**($1,293,127,000)**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$1,002,510,000	$584,930,000	($417,580,000)
Federal Funds	$3,700,064,000	$4,096,862,000	$396,798,000)
Special Funds and Reimbursements	$9,698,000	$22,813,000	$13,115,000
Total Expenditures	**$4,712,272,000**	**$4,704,605,000**	**($7,667,000)**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$124,477,000	$118,290,000	($6,187,000)
Federal Funds	$260,491,000	$256,194,000	($4,297,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$384,968,000**	**$374,484,000**	**($10,484,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$22,471,387,000	$21,480,255,000	($991,132,000)
Federal Funds	$79,023,441,000	$79,018,359,000	($5,082,000)
Special Funds and Reimbursements	$16,356,417,000	$15,076,405,000	($1,280,012,000)
Total Expenditures	**$117,851,245,000**	**$115,575,019,000**	**($2,276,226,000)**

Medi-Cal Local Assistance Funding Summary 2021-22 Comparison to January Budget			
Fiscal Year:	**2021-22**	**2021-22**	**Jan-May**
Benefits			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$27,622,057,000	$26,575,162,000	($1,046,895,000)
Federal Funds	$77,513,294,000	$79,195,085,000	$1,681,791,000
Special Funds/Reimbursements	$12,013,747,000	$12,368,260,000	$354,513,000
Total Expenditures	**$117,149,098,000**	**$118,138,507,000**	**$989,409,000**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$633,742,000	$879,710,000	$245,968,000
Federal Funds	$3,922,743,000	$4,303,412,000	$380,669,000
Special Funds and Reimbursements	$5,269,000	$18,186,000	$12,917,000
Total Expenditures	**$4,561,754,000**	**$5,201,308,000**	**$639,554,000**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$144,153,000	$152,628,000	$8,475,000
Federal Funds	$319,600,000	$274,039,000	($45,561,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$463,753,000**	**$426,667,000**	**($37,086,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$28,399,952,000	$27,607,500,000	($792,452,000)
Federal Funds	$81,755,637,000	$83,772,536,000	$2,016,899,000
Special Funds and Reimbursements	$12,019,016,000	$12,386,446,000	$367,430,000
Total Expenditures	**$122,174,605,000**	**$123,766,482,000**	**$1,591,877,000**

Significant General Fund Changes. The May 2021 Medi-Cal Local Assistance Estimate includes the following significant General Fund changes:

Medi-Cal Unanticipated 2020-21 Savings — The May Revision estimates Medi‑Cal 2020-21 General Fund savings has increased by $991.1 million compared to the Governor's January budget, for a total of General Fund savings of $2.1 billion compared to the 2020 Budget Act. According to the Administration, this increase in savings is primarily attributable to the following factors: 1) Timing of Federal Deferrals ($541 million savings), 2) Adjustments to state-only claiming amounts ($520 million savings), 3) Lower than expected COVID-19 impacts ($435 million savings), 4) Accelerated designated

state health program claims ($112 million savings), 5) Delay in Medi-Cal Rx implementation ($47 million savings).

These savings are offset by the following costs in 2020-21: 1) Removal of caseload impacts due to minimum wage increases ($33 million cost), 2) Delay of pharmacy retroactive adjustments ($49 million cost), 3) Shift of audit settlement payment timing ($62 million cost), 4) Delay of federal Disproportionate Share Hospital (DSH) payment reduction ($79 million cost), 5) Reduced transfer of long-term care quality assurance fee to General Fund ($118 million cost), 6) Creation of a reserve in the Medi-Cal Drug Rebate Fund ($222 million cost), and 7) other factors ($101 million cost).

Children and Youth Behavioral Health Initiative — The May Revision includes $528 million from the federal Coronavirus Fiscal Recovery Fund (CFRF) in 2021-22 to support the Children and Youth Behavioral Health Initiative, a multi-departmental effort to improve behavioral health services for children and youth up to age 25. The Medi-Cal changes related to this initiative are as follows:

- Statewide Behavioral Health Services and Supports Virtual Platform - $83 million CFRF would support a business services bender to implement an all payer behavioral health direct service and supports virtual platform to be integrated with screening, community-based care, and app-based support services.
- Capacity and Infrastructure Grants for Behavioral Health Services in Schools - $100 million CFRF would support grants for increased capacity and infrastructure for behavioral health services in schools.
- Continuing CalHOPE Student Support - $45 million CFRF would support the CalHOPE Student Support program, which provides training to give teachers and staff the skills to prepare a healthy learning environment for children, to be able to easily identify signs of stress and poor functioning, provide support for children and youth, and refer to more intensive services where needed.
- Grants for Age-Appropriate and Evidence-Based Behavioral Health Programs for Children and Youth - $10 million CFRF would support evidence-based interventions proven to improve outcomes for children and youth.
- Additional Investment in Continuum of Care Infrastructure - $2.5 billion ($1.9 billion General Fund and $530 million CFRF) over multiple years would support competitive grants for qualified entities to construct, acquire, and rehabilitate real estate assets to expand the continuum of behavioral health services.
- Provider Training - $50 million CFRF would support pediatric, primary care, and other health care provider training in 2022-23.
- Dyadic Services - $200 million ($100 million General Fund) would support a new statewide benefit that provides integrated physical and behavioral health screening and service to the whole family.

Full-Scope Medi-Cal Expansion for Undocumented Seniors 60 and Over – The May Revision includes $68 million ($50 million General Fund) to expand full-scope Medi-Cal for undocumented seniors age 60 and over beginning May 1, 2022.

New Medi-Cal Benefits – Doulas and Community Health Workers. – The May Revision includes $402,584 ($152,043 General Fund) to add doula services as a benefit in Medi-Cal. The May Revision also includes $16 million ($6 million General Fund) to add community health workers services as a benefit in Medi-Cal.

California Advancing and Innovating in Medi-Cal (CalAIM) Changes – The May Revision includes $509 million ($139 million General Fund) for three changes to the Administration's CalAIM proposal:

- Medi-Cal Population Health Management – The May Revision includes $300 million ($30 million General Fund) for a business solution to bring together administrative and clinical data and other information from DHCS, Medi-Cal managed care plans, counties, providers, beneficiaries, and other partners to support the delivery of care for Medi-Cal beneficiaries.
- Providing Access and Transforming Health (PATH) – The May Revision includes $200 million ($100 million General Fund) for PATH, a multiyear effort to shift delivery systems and advance the coordination and delivery of quality care services, particularly for justice-involved individuals.
- Medically Tailored Meals Pilot Program Augmentation – The May Revision includes $9.3 million General Fund to expand the medically tailored meals pilot to a broader population.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the significant caseload and expenditure changes in the May 2021 Medi-Cal Estimate.

Issue 2: Family Health Estimate – May Revision Update

Family Health Local Assistance Funding Summary 2020-21 Comparison to January Budget			
Fiscal Year:	**2020-21**	**2020-21**	**Jan-May**
California Children's Services (CCS)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$96,679,000	$95,460,000	($1,219,000)
Federal Funds	$39,519,000	$-	($39,519,000)
Special Funds/Reimbursements	$12,664,000	$5,992,000	($6,672,000)
County Funds [non-add]	[$80,243,000]	[$78,450,000]	[($1,793,000)]
Total CCS Expenditures	**$148,862,000**	**$142,484,000**	**($6,378,000)**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$70,007,000	$56,224,000	($13,783,000)
Special Funds and Reimbursements	$70,390,000	$76,668,000	$77,000
Total GHPP Expenditures	**$140,397,000**	**$132,892,000**	**($7,505,000)**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$15,182,000	$9,718,000	($5,464,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$42,814,000**	**$37,350,000**	**($5,464,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$181,868,000	$161,402,000	($20,466,000)
Federal Funds	$44,647,000	$5,128,000	($39,519,000)
Special Funds and Reimbursements	$105,558,000	$105,164,000	($394,000)
County Funds [non-add]	[$80,243,000]	[$78,450,000]	[($1,793,000)]
Total Family Health Expenditures	**$332,073,000**	**$312,726,000**	**($19,347,000)**

Family Health Local Assistance Funding Summary 2021-22 Comparison to January Budget			
Fiscal Year:	**2021-22**	**2021-22**	**Jan-May**
California Children's Services (CCS)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$78,514,000	$80,366,000	$1,852,000
Special Funds/Reimbursements	$3,992,000	$3,992,000	$-

County Funds [non-add]	[$81,696,000]	[$83,493,000]	[$1,797,000]
Total CCS Expenditures	**$82,506,000**	**$84,358,000**	**$1,852,000**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$114,380,000	$119,636,000	$5,256,000
Special Funds and Reimbursements	$25,026,000	$17,951,000	($7,075,000)
Total GHPP Expenditures	**$139,406,000**	**$137,567,000**	**($1,819,000)**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$19,387,000	$16,805,000	($3,582,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$47,019,000**	**$44,437,000**	**($2,582,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$212,281,000	$216,807,000	$4,526,000
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$51,522,000	$44,447,000	($7,075,000)
County Funds [non-add]	[$81,696,000]	[$83,493,000]	[$1,797,000]
Total Family Health Expenditures	**$268,931,000**	**$266,382,000**	**($2,549,000)**

Family Health Estimate – May Revision Update. The May 2021 Family Health Local Assistance Estimate includes $312.7 million ($161.4 million General Fund, $5.1 million federal funds, and $105.2 million special funds and reimbursements) for expenditures in 2020-21, and $266.4 million ($216.8 million General Fund, $5.1 million federal funds, and $44.4 million special funds and reimbursements) for expenditures in 2021-22. These figures represent a decrease in estimated General Fund expenditures of $20.5 million in 2020-21 and an increase of $4.5 million in 2021-22 compared to the January budget. These changes are primarily attributed to changes in caseload and other miscellaneous adjustments.
The May Revision caseload estimates for Family Health programs are as follows:

- **California Children's Services (CCS) Caseload Estimate**
  Medi-Cal: The May Revision estimates Medi-Cal CCS caseload of 171,061 in 2020-21, an increase of 2,615 or 1.6 percent, compared to the January budget. The May Revision estimates Medi-Cal CCS caseload of 168,980 in 2021-22, an increase of 440 or 0.3 percent, compared to the January budget, and a decrease of 2,081 or 1.2 percent, compared to the revised 2020-21 estimate.
  State-Only: The May Revision estimates state-only CCS caseload of 12,569 in 2020-21, a decrease of 2,002 or 13.7 percent, compared to the January budget. The May Revision estimates state-only CCS caseload of 14,601 in 2021-22, an increase of 30 or 0.2 percent, compared to the January budget, and an increase of 2,032 or 16.2 percent, compared to the revised 2020-21 estimate.

- **Genetically Handicapped Persons Program (GHPP) Caseload Estimate**
  The May Revision estimates state-only GHPP caseload of 598 in 2020-21, a decrease of 62 or 9.4 percent, compared to the January budget. The May Revision estimates state-only GHPP caseload of 670 in 2021-22, an increase of 2 or 0.3 percent, compared to the January budget, and an increase of 72 or 12.7 percent, compared to the revised 2020-21 estimate.

- **Every Woman Counts (EWC) Program Caseload Estimate**
  The May Revision estimates EWC caseload of 21,409 in 2020-21, a decrease of 3,510 or 14.1 percent compared to the January budget. The May Revision estimates EWC caseload of 24,602 in 2021-22, a decrease of 2,823 or 10.3 percent compared to the January budget, and an increase of 3,193 or 14.9 percent compared to the revised 2018-19 estimate.

May Revision Local Assistance Adjustments. The Administration requests the following adjustments to reflect caseload and miscellaneous adjustments:

- Item 4260-111-0001 be increased by $7,108,000 and reimbursements be increased by $77,000
- Item 4260-114-0001 be decreased by $2,582,000

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the caseload and expenditure changes in the May 2021 Family Health Estimate.

Issue 3: Maternal Health Investments – Postpartum Coverage Extension and Doula Benefit

Local Assistance - May Revision. DHCS requests expenditure authority of $90.5 million ($25.3 million General Fund and $25.3 million federal funds) to extend Medi-Cal eligibility from 60 days to 12 months for most postpartum individuals as part of the federal American Rescue Plan.

DHCS also requests expenditure authority of $402,000 ($152,000 General Fund and $251,000 federal funds) to provide doula services as a covered benefit in the Medi-Cal program.

Program Funding Request Summary – Postpartum Coverage Extension		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$45,273,000	$45,273,000
0890 – Federal Trust Fund	$45,273,000	$45,273,000
Total Funding Request:	**$90,546,000**	**$90,546,000**

* Resources ongoing after 2022-23.

Program Funding Request Summary – Doula Benefit		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$152,040	$208,850
0890 – Federal Trust Fund	$250,540	$344,150
Total Funding Request:	**$402,600**	**$553,000**

* Resources ongoing after 2022-23.

Background – Postpartum Coverage Extension. Medi-Cal offers coverage for pregnancy and pregnancy-related services to certain individuals up to 322 percent of the federal poverty level, without regard to immigration status. Previously, coverage for postpartum services for individuals not otherwise eligible for Medi-Cal services was only available for 60 days after delivery. The 2019 Budget Act authorized expansion of coverage for postpartum Medi-Cal coverage from 60 days to 12 months if the individual was diagnosed with a mental health condition. Because federal matching funds were not available for this extension, the program had been funded exclusively with state General Fund.

The federal American Rescue Plan authorizes states to receive federal matching funds for expansion of pregnancy-related services for 12 months after the last day of their pregnancy. DHCS requests expenditure authority of $90.5 million ($25.3 million General Fund and $25.3 million federal funds) to implement this provision of the American Rescue Plan.

Background – Doula Benefit. Doulas are trained professionals who provide continuous physical, emotional, and information support to a mother before, during, and shortly after childbirth to help her achieve the healthiest, most satisfying experience possible. According to DHCS, research suggests that doula services may result in avoidance of high-cost preterm births and cesarean deliveries, as well as other positive health outcomes.

DHCS requests expenditure authority of $402,000 ($152,000 General Fund and $251,000 federal funds) to provide doula services as a covered benefit in the Medi-Cal program. The standard doula benefit in Medi-Cal would include maternity and labor support visits, which could be at the beneficiary's home, or part of a beneficiary's office visit, and during delivery.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposals.

Issue 4: Full-Scope Medi-Cal Coverage for Undocumented Seniors 60 and Over

Local Assistance and Trailer Bill Language Proposal – May Revision. DHCS requests expenditure authority of $68 million ($50 million General Fund and $18.5 million federal funds) to expand full-scope Medi-Cal benefits to adults 60 years of age or older, regardless of immigration status. DHCS also requests trailer bill language to implement the expansion of coverage, beginning May 1, 2022.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$49,569,000	$-
0890 – Federal Trust Fund	$18,471,000	$-
Total Funding Request:	**$68,040,000**	**$-**

* No fiscal details provided for 2022-23 and beyond.

Background. California provides restricted-scope Medi-Cal coverage, such as emergency and pregnancy-related services, to income eligible adults who are 19 years or older without, or unable to verify, satisfactory immigration status. The 2015 Budget Act expanded full-scope Medi-Cal coverage to income-eligible children, and the 2019 Budget Act expanded coverage to young adults up to age 26.

DHCS requests expenditure authority of $68 million ($50 million General Fund and $18.5 million federal funds) to expand full-scope Medi-Cal benefits to adults 60 years of age or older, regardless of immigration status, beginning May 1, 2022. The full-scope of Medi-Cal benefits would include coverage for eligible in-home supportive services (IHSS). Funding for the non-federal share of IHSS benefits would be supported in the Department of Social Services budget. For 2021-22, no IHSS cost are assumed for this population.

DHCS also requests trailer bill language to implement this expansion of coverage, beginning May 1, 2022.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 5: Children and Youth Behavioral Health Initiative

Budget Change Proposal – May Revision. DHCS requests 78 positions and expenditure authority from the Coronavirus Fiscal Recovery Fund (CFRF) of $250 million in 2021-22, expenditure authority of $1.5 billion ($125 million General Fund and $1.3 billion CFRF and $100 million federal funds) in 2022-23, with a total five-year expenditure authority of $3 billion ($890.2 million General Fund, $1.5 billion CFRF, and $529.5 million federal funds) . If approved, these resources would allow DHCS to implement a Behavioral Health Service Virtual Platform, school-linked behavioral health services, plan offered behavioral health services, and to expand the continuum of behavioral health treatment resources.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$-	$125,000,000
0890 – Federal Trust Fund	$-	$100,000,000
8506 – Coronavirus Fiscal Recovery Fund	$250,000,000	$1,280,000,000
Total Funding Request:	**$250,000,000**	**$125,000,000**
Total Requested Positions:	**78.0**	**78.0**

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

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

establishing "earn and learn" apprenticeship models, 6) enhancing training to serve justice- and system-involved youth, 7) expanding behavioral health training for primary care providers, 8) expanding peer personnel training and placement programs, and 9) augmenting existing OSHPD workforce programs for behavioral health disciplines.

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

Department of Health Care Services – Behavioral Health Services and Supports Virtual Platform. Over five years, DHCS is requesting $634.7 million from General Fund, CFRF, and federal funds, to support implementation of a behavioral health service virtual platform to be integrated with screening, clinic-based care and app-based support services. The platform would support automated assessments and screenings, self-monitoring tools, and new tools to help families navigate how to access help regardless of payer source. The platform would be build out from the department's existing CalHOPE program, a crisis counseling program that included a media campaign, web-based resources and services, a 24 hour warm line and student support.

Department of Health Care Services – School-Linked Behavioral Health Services. Over five years, DHCS is requesting $550 million to support direct incentive payments to counties, tribal entities, schools, Local Education Agencies (LEAs), school districts, health care service plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers to build infrastructure for ongoing behavioral health prevention and treatment services on or around school campuses. These funds would also expand access to behavioral health school counselors, peer supports, behavioral health coaches, build a statewide community-based organization network, and connect plans, counties, community-based organizations, and schools via data sharing systems.

Department of Health Care Services – Investment in Age-Appropriate Evidence-Based Behavioral Health Programs. Over five years, DHCS is requesting $429 million to support statewide scaling and spread of evidence-based interventions proven to improve outcomes for children and youth with or at high risk for mental health conditions, with a particular focus on young people experiencing their first break or first episode of psychosis, or developing a substance use disorder.

Department of Health Care Services – Behavioral Health Continuum Infrastructure. Over five years, DHCS is requesting an additional $245 million for the behavioral health continuum infrastructure grant program, dedicated to adding child or adolescent beds to existing facilities, adding new facilities or new crisis mobile services.

Department of Health Care Services – Dyadic Services. Over five years, DHCS is requesting $800 million ($400 million General Fund and $400 million federal funds) to support dyadic services in Medi-Cal, beginning July 1, 2022. Dyadic services are based on the Healthy Steps model of care, an integrated behavioral health care model in which health care is delivered in the context of the caregiver and family, so that families are screened for behavioral health problems, interpersonal safety, tobacco and substance misuse and social determinants of health such as food insecurity and housing instability.

Department of Health Care Services – Pediatric, Primary Care and Other Healthcare Providers. Over five years, DHCS is requesting $165 million to provide opportunities for primary care and other health care providers to access culturally proficient education and training on behavioral health and suicide prevention.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 6: Behavioral Health Continuum Infrastructure Expansion

Local Assistance, Budget Change Proposal, and Trailer Bill Language. DHCS requests expenditure authority of $981 million ($681 million General Fund and $300 million Coronavirus Fiscal Recovery Fund) in 2021-22, with a total of $2.3 billion ($1.8 billion General Fund and $518.5 million Coronavirus Fiscal Recovery Fund) over multiple fiscal years. If approved, these resources would support competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources.

DHCS also requests $22.5 million ($12.5 million General Fund and $10 million Coronavirus Fiscal Recovery Fund) in 2021-22 and $62.8 million ($61.3 million General Fund and $1.5 million Coronavirus Fiscal Recovery Fund) in 2022-23. If approved, these resources would support limited-term staff and contractors to administer the behavioral health continuum infrastructure program.

DHCS also requests trailer bill language to implement the program.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**Multi-year total**
0001 – General Fund	$680,999,000	$1,800,000,000
8506 – Coronavirus Fiscal Recovery Fund	$300,000,000	$518,500,000
Total Funding Request:	**$980,999,000**	**$2,318,500,000**

Program Funding Request Summary – Budget Change Proposal		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$12,500,000	$61,250,000
8506 – Coronavirus Fiscal Recovery Fund	$10,000,000	$1,500,000
Total Funding Request:	**$22,500,000**	**$62,750,000**

Background. The Governor's January budget included $750 million in local assistance grants to qualified entities to efficiently and cost-effectively construct, acquire, and rehabilitate real estate assets. The May Revision would build upon the Governor's Budget proposal and would allow California to expand the community continuum of behavioral health treatment facilities, allowing individuals to live and be treated in a stable environment which leads to better health and behavioral health outcomes. This would include the addition of approximately 15,000 beds, units, or rooms to expand such capacity.

Funding could be used to expand capacity for the following types of facilities: crisis intervention, stabilization and crisis residential; residential treatment; day rehabilitation; day treatment intensive or partial hospitalization with housing supports; adult residential care facilities or board and care facilities; room and board with intensive outpatient services; peer respite and shared housing; locked and unlocked forensic facilities; community-based outpatient and behavioral health wellness services; and a full continuum of care focused on individuals 25 years and younger. According to DHCS, at least $242.3 million would be provided for individuals 25 years and younger, while at least $237.5 million would be targeted to address individuals found or at-risk of being found incompetent to stand trial.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 7: Support for Public Hospital System

Local Assistance – May Revision. DHCS requests expenditure authority from the Coronavirus Fiscal Recovery Fund of $300 million in 2021-22. If approved, these resources would allow DHCS to support public hospitals and health care systems' unreimbursed costs associated with providing care to Medi-Cal beneficiaries during the pandemic.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
8506 – Coronavirus Fiscal Recovery Fund	$300,000,000	$-
Total Funding Request:	**$300,000,000**	**$-**

Background. According to DHCS, during the pandemic, designated public hospitals have been integral to the public health response effort, including efforts to increase surge capacity, rapidly expand and deploy testing, assist in development and distribution of vaccines, and serve vulnerable populations and communities of color.

DHCS requests expenditure authority from the Coronavirus Fiscal Recovery Fund of $300 million in 2021-22 to support direct grants to designated public hospitals in support of their health care expenditures.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Why did DHCS utilize Coronavirus Fiscal Recovery Funds for this purpose, rather than General Fund, which could draw down federal matching funds in Medi-Cal?

Issue 8: California Advancing and Innovating in Medi-Cal (CalAIM) – May Revision Adjustments

Budget Change Proposal, Local Assistance, and Trailer Bill Language – May Revision. DHCS requests several changes related to its California Advancing and Innovating in Medi-Cal (CalAIM) initiative.

- Population Health Management Service – DHCS requests expenditure authority of $15 million ($1.5 million General Fund and $13.5 million federal funds) in 2021-22, 2022-23, and 2023-24 to administer a Population Health Management service, to utilize administrative and clinical data as part of CalAIM efforts proposed in the Governor's January budget.
- Medi-Cal Providing Access and Transforming Health (PATH) – DHCS requests expenditure authority of $200 million ($100 million General Fund and $100 million federal funds) to build capacity for effective pre-release care for justice-involved populations to enable coordination with justice agencies and Medi-Cal coverage of services 30 days prior to release.
- Medically Tailored Meal Pilot Extension – DHCS requests General Fund expenditure authority of $9.3 million in 2021-22 to support expansion of the medically tailored meal pilot to additional covered conditions and additional counties.
- Behavioral Health Quality Improvement Program – DHCS requests trailer bill language to implement the Behavioral Health Quality Improvement Program to replace budget bill language proposed in the January budget.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposals.

Issue 9: Eliminate Rate Freeze for ICF-DD and Pediatric Subacute Facilities

Local Assistance – May Revision. DHCS requests expenditure authority of $24.4 million ($11.1 million General Fund and $13.3 million federal funds), and $26.7 million ($12.1 million General Fund and $14.5 million federal funds) annually thereafter to eliminate the rate freeze for intermediate care facilities-developmental disabilities (ICF-DDs) and free-standing pediatric subacute facilities.

Program Funding Request Summary – ICF-DDs		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$8,778,000	$9,576,000
0890 – Federal Trust Fund	$10,464,000	$11,416,000
Total Funding Request:	**$19,242,000**	**$20,992,000**

***** Resources ongoing after 2022-23.

Program Funding Request Summary – Pediatric Subacute Facilities		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$2,328,000	$2,540,000
0890 – Federal Trust Fund	$2,873,000	$3,133,000
Total Funding Request:	**$5,201,000**	**$5,673,000**

***** Resources ongoing after 2022-23.

Background. Prior to 2009, Medi-Cal rates for ICF-DDs and free-standing pediatric subacute facilities were adjusted after completion of an annual rate study for specified provider types. ABX4 5 (Evans) Chapter 5, Statutes of 2009, Fourth Extraordinary Session, froze rates for 2009-10 and every year thereafter at the 2008-09 levels. Effective June 1, 2011, AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, required DHCS to freeze rates and reduce payments by up to 10 percent for the facilities enjoined from the original rate freeze, which was required by ABX4 5 and included ICF-DD and free-standing pediatric subacute facilities. The federal Centers for Medicare and Medicaid Services approved the implementation of the rate freeze and a reduction of payments by 10 percent.

DHCS requests expenditure authority of $24.4 million ($11.1 million General Fund and $13.3 million federal funds), and $26.7 million ($12.1 million General Fund and $14.5 million federal funds) annually thereafter to eliminate the rate freeze for intermediate care facilities-developmental disabilities (ICF-DDs) and free-standing pediatric subacute facilities.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 10: Audio-Only Telehealth

Trailer Bill Language – May Revision. DHCS requests trailer bill language to establish a rate for audio-only telehealth services at 65 percent of the fee-for-service rate, and a comparable alternative to the prospective payment system (PPS) rates for clinics to maintain an incentive for in-person care.

Background. In response to the pandemic emergency, DHCS provided broad flexibilities for the delivery of Medi-Cal services through telehealth, telephonic/audio only, and other virtual communication modalities. According to DHCS, providing these telehealth flexibilities proved to be critically important during a time when in-person care put beneficiaries at risk of exposure to COVID-19. DHCS is proposing to allow additional Medi-Cal benefits and services to be provided via telehealth across all delivery systems when clinically appropriate.

Temporary Flexibilities During Pandemic Emergency. DHCS implemented the following temporary policy changes during the pandemic emergency, related to telehealth:

- Expanded ability for providers to render all applicable services that can be appropriately provided via telehealth modalities, including home- and community-based services, Local Education Agency, and Targeted Case Management services.
- Allowed most telehealth modalities to be provided for new and established patients.
- Allowed many covered services to be provided via telephone/audio-only for the first time.
- Allowed payment parity between services provided in-person face-to-face, by synchronous telehealth, and by telephonic/audio only when the services met the requirements of the billing code by various provider types, including federally qualified health centers (FQHCs) and rural health centers (RHCs).
- Waived site limitations for providers and patients of FQHCs and RHCs
- Allowed expanded access to telehealth through non-public technology platforms, based on a federal exemption to Health Insurance Portability and Accountability Act (HIPAA) requirements.

According to DHCS, the availability and need for telehealth has led to a significantly wider adoption of the use of these modalities for service delivery. Providers have become familiar with delivering services via telehealth and receiving reimbursement for telehealth services.

January Budget Proposed Extension of Certain Telehealth Flexibilities. In the Governor's January budget, DHCS proposed trailer bill language to allow the delivery of certain Medi-Cal benefits, under specified circumstances, via telehealth, telephonic/audio-only, remote patient monitoring, and other virtual communication modalities. Specifically, DHCS proposed the following permanent flexibilities, contingent on federal approval:

- Allow an FQHC or RHC to establish new patients, within its federally designated service area, through synchronous telehealth only.
- Permanently remove the site limitations on the provision of services by FQHCs and RHCs.
- Expand synchronous and asynchronous telehealth services to home- and community-based services waivers, the Targeted Case Management (TCM) Program, and the Local Education Agency Billing Option Program (LEA-BOP).
- Add synchronous telehealth and telephonic/audio-only services to State Plan Drug Medi-Cal.

- Require payment parity between in-person face-to-face visits and synchronous telehealth modalities only.
- Expand use of clinically appropriate telephonic/audio-only, other virtual communication, and remote patient monitoring for established patients, subject to a separate fee schedule and not billable by FQHCs or RHCs.
- Provides that the TCM Program and LEA BOP will follow traditional certified public expenditure reimbursement methodologies when rendering services via telehealth.

Trailer Bill Language Proposal – Audio-Only Visits. In its January budget proposal, DHCS did not propose to extend the following telehealth flexibilities implemented during the pandemic emergency:

- Telephonic/audio-only modalities as a billable visit for FQHCs or RHCs
- Telephonic/audio-only modalities to establish a new patient
- Payment parity for telephonic/audio-only modalities and virtual communications
- Various flexibilities for Tribal 638 clinics.

In the May Revision, DHCS requests trailer bill language to establish a rate for audio-only telehealth services at 65 percent of the fee-for-service rate, and a comparable alternative to the prospective payment system (PPS) rates for clinics to maintain an incentive for in-person care.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 11: Medication Therapy Management Program

Local Assistance – May Revision. DHCS requests expenditure authority of $12.6 million ($4.4 million General Fund and $8.2 million federal funds) in 2021-22 and $13.5 million ($4.7 million General Fund and $8.8 million federal funds) annually thereafter to provide medication management payments to Medi-Cal enrolled pharmacies that provide specialized services to high-risk and medically complex populations.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$4,418,830	$4,736,150
0890 – Federal Trust Fund	$8,176,670	$8,763,850
Total Funding Request:	**$12,595,500**	**$13,500,000**

***** Resources ongoing after 2022-23.

Background. According to DHCS, following implementation of the new Actual Acquisition Cost (AAC) pharmacy reimbursement methodology, independent pharmacy providers and the California Pharmacists Association (CPhA) notified the department that the new reimbursement methodology could cause certain pharmacies to cease providing specialized medication management services. These specialized services are designed to ensure at-risk populations remain adherent and compliant with their drug treatment regimens. Characteristics of the at-risk population receiving medication management services may include homelessness, mental illness, or history of non-compliance or non-adherence with medications.

DHCS authorized a survey to determine acquisition costs and identify specialized services provided by those pharmacies in the dispensing of specific drugs. The survey confirmed the AAC methodology resulted in a potential for beneficiary access issues with respect to certain drugs, while being an appropriate reimbursement methodology overall. The drug therapy categories surveyed were identified through direct communications from Medi-Cal providers to the Department, including reports from stakeholders and CPhA.

Medication Therapy Management Program. DHCS requests expenditure authority of $12.6 million ($4.4 million General Fund and $8.2 million federal funds) in 2021-22 and $13.5 million ($4.7 million General Fund and $8.8 million federal funds) annually thereafter to provide medication management payments to Medi-Cal enrolled pharmacies that provide specialized services to high-risk and medically complex populations. DHCS would implement a separate reimbursement methodology for fee-for-service pharmacy services provided in conjunction with certain complex chronic and medical conditions such as serious mental illness, human immunodeficiency virus, hepatitis C virus, cancer, cystic fibrosis and other genetic diseases, multiple sclerosis, hemophilia, cardiovascular diseases, lung and respiratory diseases, nervous system disorders, chronic kidney disease, Alzheimer's disease or other dementia, end-stage renal disease, osteoporosis, and diabetes. Medi-Cal providers would be required to enter into a contract with the department to provide these services, according to requirements and guidelines outlined in the contract. DHCS estimates each beneficiary would receive an average of six therapy sessions annually and each provider would be able to accommodate approximately 30 total beneficiaries at any point in time.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 12: Community Health Workers Benefit

Local Assistance and Trailer Bill Language – May Revision. DHCS requests expenditure authority of $16.3 million ($6.2 million General Fund and $10.2 million federal funds) annually to support reimbursement for community health workers to provide clinically appropriate Medi-Cal covered benefits and services in both the fee-for-service and managed care delivery systems.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$6,154,300	$6,154,300
0890 – Federal Trust Fund	$10,168,700	$10,168,700
Total Funding Request:	**$16,323,000**	**$16,323,000**

***** Resources ongoing after 2022-23.

Background. Community health workers (CHWs) are skilled and trained health educators who work directly with individuals who may have difficulty understanding or interacting with providers due to cultural or language barriers. CHWs can assist those individuals by helping them navigate the relationship with their health care providers, assist them in accessing health care services, and provide key linkages with other similar and related community-based resources.

Community Health Workers Benefit. DHCS requests expenditure authority of $16.3 million ($6.2 million General Fund and $10.2 million federal funds) annually to support reimbursement for community health workers to provide clinically appropriate Medi-Cal covered benefits and services in both the fee-for-service and managed care delivery systems, effective January 1, 2022. According to DHCS, CHWs would provide services under the supervision of a licensed, enrolled Medi-Cal provider

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 13: San Mateo County Dental Integration Pilot

Local Assistance – May Revision. DHCS requests expenditure authority of $697,000 ($280,950 General Fund and $416,050 federal funds) annually to implement a dental integration pilot program in San Mateo County.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$280,950	$280,950
0890 – Federal Trust Fund	$416,050	$416,050
Total Funding Request:	**$697,000**	**$697,000**

***** Resources ongoing after 2022-23.

Background. The 2018 Budget Act authorized a pilot project to integrate dental services into managed care in San Mateo County. Health Plan of San Mateo (HPSM), which is a county organized health system, will establish a dental provider network and reimburse providers of dental services for Medi-Cal beneficiaries in the county. Under the budget authority, HPSM would receive an enhanced, at-risk capitation payment to account for the additional dental services provided.

DHCS requests expenditure authority of $697,000 ($280,950 General Fund and $416,050 federal funds) annually to transition dental benefits for enrollees in HPSM from the fee-for-service delivery system to the plan, effective January 1, 2022. The department would also contract for an evaluation of the pilot program, using funding provided by HPSM, to be completed and published no later than December 31 of the sixth fiscal year the pilot is in operation.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Senate Budget and Fiscal Review—Nancy Skinner, Chair

SUBCOMMITTEE NO. 3 Agenda

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

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

Consultant: Scott Ogus

PUBLIC COMMENT

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

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Children and Youth Behavioral Health Initiative

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

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

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

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

***** Savings ongoing after 2022-23.

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 6: COVID-19 Pandemic Response

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 7: Federal Grant Authority

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

Epidemiology and Laboratory Capacity

Item 4265-001-0001

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

American Rescue Plan

Item 4265-001-0890

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

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

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

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

Item 4265-111-0890

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 8: Pandemic Response Review

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

Issue 9: Children and Youth Behavioral Health Initiative

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

Issue 11: Miscellaneous Technical Adjustments

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

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

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

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

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

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

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

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

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

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

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

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

Item 4265-001-0001

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

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

  Item 4265-001-0001

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

4440 DEPARTMENT OF STATE HOSPITALS

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

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

The five state hospitals operated by DSH are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DSH-Patton Unit U-06	July 2021	May 2022

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

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

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

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

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

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

- Atascadero – 112.0 positions have shifted of 132.0 proposed

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: CONREP – Mobile FACT Team

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

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

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

* Resources ongoing after 2022-23.

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 4: Community Based Restoration Program Expansion

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

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

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

***** Positions and resources ongoing after 2022-23.

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 9: Statewide Integrated Health Care Provider Network

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

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

***** Resources ongoing after 2022-23.

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 10: One-Time Deferred Maintenance Allocation - Adjustment

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 11: Non-Restorable Incompetent to Stand Trial Patients

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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.

Wednesday, May 26, 2021
1:30p.m.
State Capitol – Senate Chamber

PART A

Consultant: Scott Ogus

PUBLIC COMMENT

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

VOTE ONLY CALENDAR - INDEX

0530 California Health and Human Services Agency					
4260 Department of Health Care Services					
4300 Department of Developmental Services					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**
1	Electronic Visit Verification Phase II	$5,754	$25,824	0.0	AAB and Adopt Placeholder TBL
0530 California Health and Human Services Agency					
4300 Department of Developmental Services					
4440 Department of State Hospitals					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**
2	Relocation to the Clifford L. Allenby Building Phase 3	$744,000	$0	0.0	AAB
0530 California Health and Human Services Agency					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**
3	California Affordable Drug Manufacturing Act Implementation (SB 852)	$2,197	$0	1.0	AAB
4	Healthy California for All Commission Reappropriation	$2,500	$0	0.0	AAB
5	Health Information Exchange Leadership	$2,500	$0	0.0	AAB
4120 Emergency Medical Services Authority					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**
6	Regional Disaster Medical Health Response	$365	$0	0.0	AAB
7	Office of Legislative, Regulatory and External Affairs and Legal Unit	$286	$0	2.0	AAB

8	Community Paramedicine or Triage to Alternate Destination (AB 1544)	$768	$0	2.0	AAB
9	Increased Emergency Preparedness and Response Capacity	$8,495	$0	14.0	AAB
10	Medical Surge Staffing Program	$1,414	$0	6.0	AAB
11	Human Resources Workload Support	$851	$0	5.0	AAB
12	Statewide Emergency Medical Services Data Solution	$10,000	$0	2.0	AAB
4140 Office of Statewide Health Planning and Development					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**
13	Administrative Support Services	$0	$0	0.0	AAB
14	Reimbursements for Health Care Payments Data Program	$0	$5,009	0.0	AAB
15	SB 17 Attorney Fees	$0	$457	0.0	AAB
16	Alzheimer's/Geriatric Health Care Workforce Development	$0	$8,000	0.0	AAB
17	Reappropriations and Other Technical Adjustments	$0	$0	0.0	AAB
18	Miscellaneous Technical Adjustments	$0	$0	0.0	AAB
19	Song-Brown Healthcare Workforce Program Augmentation	$50,000	$0	0.0	AAB
4150 Department of Managed Health Care					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**
20	Health Coverage: Mental Health or Substance Use Disorders (SB 855)	$0	$1,500	5.0	AAB
21	Risk-Based or Global Risk Provider Arrangement Pilots (AB 1124)	$0	$413	0.0	AAB
4150 Department of Managed Health Care					
4260 Department of Health Care Services					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**

22	Annual Health Care Service Plan Equity and Quality Reviews	$0	$952	2.5	AAB and Adopt Modified Placeholder TBL to clarify regulatory implementation

4260 Department of Health Care Services

(dollars in thousands) (AAB=approve as budgeted)

Issue #	Subject	GF	OF	Pos.	Staff Recommendation and Comments
23	Medi-Cal Local Assistance Estimate	$254,996	-$5,729,059	0.0	Approve the balance of Estimate, with any changes necessary to conform to other actions that have been, or will be, taken.
24	Family Health Estimate	-$14,607	-$153,823	0.0	Approve the balance of Estimate, with any changes necessary to conform to other actions that have been, or will be, taken.
25	AB 1705 Ground Emergency Medical Transportation Public Provider	$0	$715	5.0	AAB
26	New/Restored Benefits: CGM and OTC Acetaminophen and Cough/Cold	$1,556	$3,334	0.0	AAB and Adopt Placeholder TBL
27	California Community Transitions (SB 214)	$432	$0	0.0	AAB and Adopt Placeholder TBL
28	Medi-Cal Enterprise System Modernization	$2,228	$20,051	0.0	AAB
29	Coordination of Benefits and Post-Payment Recovery	$0	$0	0.0	AAB and Adopt Placeholder TBL

30	Limited-Term Positions - Extension or Conversion to Permanent	$6,257	$11,224	62.5	AAB
31	Mental Health Services Act Flexibilities	$0	$0	0.0	AAB and Adopt Placeholder TBL
32	Behavioral Health Plan 274 Expansion Project	$108	$972	0.0	AAB
33	Mental Health Services Assisted Outpatient Treatment (AB 1976)	$288	$0	0.0	AAB
34	Substance Use Disorder Recovery Residences (SB 406)	$594	$0	4.0	AAB
35	California Advancing and Innovating in Medi-Cal State Operations	$11,041	$12,819	69.0	AAB
36	Medi-Cal Screening for Misuse of Opioids and Other Drugs	$0	$0	0.0	AAB and Adopt Placeholder TBL
37	Medi-Cal Program Integrity Data Analytics	$1,130	$5,755	0.0	AAB
38	Interoperability Federal Final Rule Compliance	$713	$2,141	0.0	AAB
39	Managed Care Plan Statewide Procurement	$1,336	$1,336	11.0	AAB
40	Provider Application and Validation for Enrollment (PAVE)	$1,792	$5,376	0.0	AAB
41	Local Educational Agencies Billing Option Program Expansion	$1,119	$1,119	8.0	AAB
42	Office of Medicare Innovation and Integration	$452	$150	4.0	AAB and Adopt Modified Placeholder TBL to define functions of Office
43	Behavioral Health Quality Improvement Program	$470	$470	0.0	AAB
44	Maternal Mental Health Investments - Postpartum Coverage and Doulas	$45,425	$45,524	0.0	AAB and Adopt Placeholder TBL
45	Support for Public Hospital System	$0	$300,000	0.0	AAB
46	Eliminate Rate Freeze for Pediatric Subacute Facilities	$2,328	$2,873	0.0	AAB and Adopt Placeholder TBL

47	Telehealth Services and Audio-Only Telehealth	$0	$0	0.0	Reject and Adopt Modified Placeholder TBL consistent with AB 32 (Aguiar-Curry)
48	Medication Therapy Management Program	$4,418	$8,177	0.0	AAB and Adopt Placeholder TBL
49	Community Health Workers Benefit	$6,154	$10,169	0.0	AAB
50	San Mateo Dental Integration Pilot Program	$281	$416	0.0	AAB
51	Miscellaneous Technical Adjustments - Behavioral Health and Prop 56	$0	$0	0.0	AAB
52	Medically Tailored Meals Expansion	$9,300	$0	0.0	AAB and Adopt Modified Placeholder TBL to more clearly define the administration of the one-time program.
53	Full-Scope Medi-Cal Coverage for Undocumented Seniors 60 and Over	$49,569	$18,471	0.0	Modify to expand to 50 and older and Adopt Modified Placeholder TBL consistent with this expansion
4265 Department of Public Health					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**
54	Adjustment to Support Infectious Disease Modeling	$450	$0	0.0	AAB
55	AIDS Drug Assistance Program (ADAP) Estimate	$0	$51,199	0.0	AAB
56	Center for Health Care Quality Estimate	$0	$394,000	1456.3	AAB
57	Health Care and Essential Workers: PPE (SB 275)	$0	$164	1.0	AAB
58	Skilled Nursing Facility Staffing Requirements Compliance (AB 81)	$0	$939	6.0	AAB

59	Timely Investigation of Caregivers	$0	$1,028	7.0	AAB
60	Medical Breach Enforcement Section Expansion	$0	$2,616	17.0	AAB
61	COVID-19 Workplace Outbreak Reporting (AB 685)	$677	$0	3.0	AAB
62	Support for Alzheimer's Disease Awareness, Research, and Training	$24,500	$0	0.0	AAB
63	Women Infant, and Children (WIC) Program Estimate	$0	$229,415	0.0	AAB
64	Books for Low-Income Children	$5,000	$0	0.0	AAB
65	Genetic Disease Screening Program (GDSP) Estimate	$0	-$1,871	0.0	AAB
66	Improving the California Prenatal Screening Program	$0	$4,349	3.0	AAB
67	Cosmetic Fragrance and Flavor Ingredient Right to Know Act (SB 312)	$26	$0	0.0	AAB
68	Rescind Rh Disease Reporting Requirement - Trailer Bill Language	$0	$0	0.0	AAB and Adopt Placeholder TBL
69	Federal Grant Authority	$0	$0	0.0	AAB
70	COVID-19 Pandemic Response External Challenges	$6,000	$0	0.0	AAB
71	Expansion of Pre-Exposure Prophylaxis Assistance Program	$0	$0	0.0	AAB and Adopt Placeholder TBL
72	Miscellaneous Technical Adjustments	$0	$20,612	0.0	AAB and Adopt Placeholder TBL

4440 Department of State Hospitals

(dollars in thousands) (AAB=approve as budgeted)

Issue #	Subject	GF	OF	Pos.	Staff Recommendation and Comments
73	State Hospitals Program and Caseload Updates	$55,775	$0	86.8	AAB
74	IST Diversion Program Expansion and Reappropriation	$47,584	$0	3.0	AAB and Adopt Placeholder TBL
75	Los Angeles Community-Based Restoration Program Expansion	$32,833	$0	5.5	AAB
76	CONREP Non-SVP Mobile FACT Team	$9,667	$0	2.0	AAB
77	Technical Budget Adjustment - Various Programs	$0	$0	0.0	AAB
78	Protected Health Information Permanent Implementation	$986	$0	8.0	AAB

79	Increased Court Appearances and Public Records Act Requests	$777	$0	5.5	AAB
80	Patient Education	$352	$0	3.0	AAB
81	Medical and Pharmaceutical Billing System	$794	$0	1.0	AAB
82	Skilled Nursing Facility Infection Preventionists (AB 2644)	$350	$0	2.0	AAB
83	One-Time Deferred Maintenance Allocation	$100,000	$0	0.0	AAB
84	Metropolitan - Consolidation of Police Operations (Capital Outlay)	$0	$22,024	0.0	AAB
85	Coalinga - Hydronic Loop Replacement (Capital Outlay)	$27,459	$0	0.0	AAB
86	Statewide - Enhanced Treatment Units (Capital Outlay)	$3,792	$0	0.0	AAB
87	COVID-19 Workers Compensation Claims (SB 1129)	$16,489	$0	7.0	AAB
88	Reevaluation Services for Felony Incompetent to Stand Trial Patients	$12,729	$0	15.5	AAB and Adopt Placeholder TBL
89	Statewide Integrated Health Care Provider Network	$6,346	$0	6.0	AAB
90	Non-Restorable Incompetent to Stand Trial Patients	$0	$0	0.0	AAB and Adopt Placeholder TBL
91	Increased Investigation Workload	$337	$0	0.0	AAB
92	Statewide Ligature Risk Special Repair Funding	$0	$0	0.0	AAB
93	Atascadero - Potable Water Booster Pump Reappropriation (Capital Outlay)	$0	$0	0.0	AAB
4560 Mental Health Services Oversight and Accountability Commission					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**
94	Technical Adjustments - MHSF Liquidation Extension	$0	$0	0.0	AAB
4800 California Health Benefits Exchange (Covered California)					
(dollars in thousands) (AAB=approve as budgeted)					
Issue #	**Subject**	**GF**	**OF**	**Pos.**	**Staff Recommendation and Comments**

95	Hospital Discharge Data Sharing	$0	$0	0.0	AAB and Adopt Placeholder TBL
96	One-Dollar Premium Subsidy Program	$0	$0	0.0	AAB and Adopt Placeholder TBL

VOTE ONLY CALENDAR - NARRATIVES

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES
4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Electronic Visit Verification Phase II

Budget Change Proposal – Governor's Budget. The Office of Systems Integration (OSI), the Department of Health Care Services (DHCS), the Department of Public Health (DPH), and the Department of Developmental Services (DDS) request total expenditure authority of $24.1 million ($5.8 million General Fund and $18.3 million federal funds) in 2021-22. If approved, these resources would continue the multi-departmental planning effort for the second phase (Phase II) of implementation of Electronic Visit Verification for personal care services and home health care services, including completion of activities required by the Department of Technology's Project Approval Lifecycle (PAL) Stage Gate requirements and the federal Advanced Planning Document (APD) process.

Program Funding Request Summary (CHHSA-OSI)		
Fund Source	**2021-22***	**2022-23**
9745 – CHHS Automation Fund	$21,234,000	$-
Total Funding Request:	**$21,234,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

***** Transfers from other Departments (included below): DHCS: $10,617,000; DDS: $10,617,000

Program Funding Request Summary (DHCS)		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$1,832,000	$-
0890 – Federal Trust Fund	$18,312,000	$-
Total Funding Request:	**$20,144,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Program Funding Request Summary (DDS)		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$3,922,000	$-
0995 – Reimbursements*	$7,512,000	$-
Total Funding Request:	**$11,434,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

***** Reimbursements are the result of federal matching funds transferred from DHCS and are included in the total $18,312,000 attributed to the DHCS request.

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and Adopt Placeholder Trailer Bill Language consistent with the Administration's proposal.

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4300 DEPARTMENT OF DEVELOPMENTAL SERVICES
4440 DEPARTMENT OF STATE HOSPITALS

Issue 2: 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.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 3: California Affordable Drug Manufacturing Act Implementation (SB 852)

Budget Change Proposal – Governor's Budget. CHHSA requests one position and General Fund expenditure authority of $2.2 million in 2021-22, and $184,000 annually thereafter. If approved, these resources would allow CHHSA to conduct research and analysis to support implementation of SB 852 (Pan), Chapter 207, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$2,197,000	$184,000
Total Funding Request:	**$2,197,000**	**$184,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 4: Healthy California for All Commission Reappropriation

Reappropriation Budget Bill Language – Governor's Budget. CHHSA requests reappropriation of General Fund expenditure authority of up to $2.5 million, previously authorized in the 2019 Budget Act, to support the Healthy California for All Commission.

Program Funding Request Summary		
Fund Source	**2021-22***	**2022-23**
0001 – General Fund	$2,500,000	$-
Total Funding Request:	**$2,500,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* Reappropriation of expenditure authority from 2019 Budget Act, available for encumbrance and expenditure until June 30, 2022.

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 5: Health Information Exchange Leadership

Budget Change Proposal and Budget Bill Language – May Revision. CHHSA requests General Fund expenditure authority of $2.5 million in 2021-22. If approved, these resources would allow CHHSA to lead efforts and stakeholder engagement in building out health information exchanges. CHHSA also requests provisional budget bill language to allow encumbrance or expenditure of this funding until June 30, 2023.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$2,500,000	$-
Total Funding Request:	**$2,500,000**	**$-**
Total Positions Requested:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Staff Comment and Recommendation – Approve as budgeted.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 6: Regional Disaster Medical Health Response (RDMHS) Local Assistance

Budget Change Proposal – Governor's Budget. EMSA requests General Fund expenditure authority of $365,000 annually. If approved, these resources would allow EMSA to improve regional disaster medical and health mitigation, preparedness, response and recovery by funding three additional local Regional Disaster Medical Health Specialists (RDMHS) in three California Office of Emergency Services (CalOES) Mutual Aid Regions.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$365,000	$365,000
Total Funding Request:	**$365,000**	**$365,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation— Approve as budgeted.

Issue 7: Office of Legislative, Regulatory and External Affairs and Legal Unit

Budget Change Proposal – Governor's Budget. EMSA requests two positions and General Fund expenditure authority of $286,000 annually. If approved, these resources would allow EMSA to address increased workload within the Office of Legislative, Regulatory, and External Affairs (LEA) and the Legal Unit.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$286,000	$286,000
Total Funding Request:	**$286,000**	**$286,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 8: Community Paramedicine or Triage to Alternative Destination Act of 2020 (AB 1544)

Budget Change Proposal – Governor's Budget. EMSA requests two positions and General Fund expenditure authority of $768,000 in 2021-22 and three positions and General Fund expenditure authority of $789,000 in 2022-23 and 2023-24. If approved, these positions and resources would allow EMSA to

implement community paramedicine projects for local EMS agencies, pursuant to the requirements of AB 1544 (Gipson), Chapter 138, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$768,000	$789,000
Total Funding Request:	**$768,000**	**$789,000**
Total Requested Positions:	**2.0**	**3.0**

* Additional fiscal year resources requested – 2023-24: $789,000

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation— Approve as budgeted.

Issue 9: Increased Emergency Preparedness and Response Capacity

Budget Change Proposal – May Revision. EMSA requests 14 positions and General Fund expenditure authority of $8.5 million annually. If approved, these positions and resources would allow EMSA to maintain and store critical equipment and medical supplies acquired during the pandemic, and provide resources for the Operations Center, for exercises, and for training.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$8,495,000	$8,495,000
Total Funding Request:	**$8,495,000**	**$8,495,000**
Total Requested Positions:	**14.0**	**14.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 10: Medical Surge Staffing Program

Budget Change Proposal – May Revision. EMSA requests six positions and General Fund expenditure authority of $1.4 million annually. If approved, these positions and resources would support recruitment, on-boarding, and program management of the California Health Corps Program, California Medical Assistance Teams Program, and the Disaster Healthcare Volunteers/Medical Reserve Corps Program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$1,414,000	$1,414,000
Total Funding Request:	**$1,414,000**	**$1,414,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 11: Human Resources Workload Support

Budget Change Proposal – May Revision. EMSA requests 5 positions and General Fund expenditure authority of $851,000 annually. If approved, these positions and resources would support the Human Resources Unit to address workload associated with routine and emergency response personnel functions.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$851,000	$851,000
Total Funding Request:	**$851,000**	**$851,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 12: Statewide Emergency Medical Services Data Solution

Budget Change Proposal – May Revision. EMSA requests 2 positions and General Fund expenditure authority of $10 million in 2021-22. If approved, these positions and resources would support planning and readiness activities to establish a statewide emergency services data infrastructure that strengthens real-time information sharing and data analytics for state and local governments, emergency medical services providers, and health care providers.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$10,000,000	$-
Total Funding Request:	**$10,000,000**	**$-**
Total Requested Positions:	**2.0**	**2.0**

* Positions ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 13: Administrative Support Services

Budget Change Proposal – Governor's Budget. OSHPD requests a net-zero adjustment of expenditure authority between four special funds. If approved, this adjustment would allow OSHPD to better support administrative services related to accounting and human resources.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0121 – Hospital Building Fund	$6,000	$6,000
0143 – CA Health Data and Planning Fund	$31,000	$31,000
0518 – Health Facility Construction Loan Ins. Fund	($41,000)	($41,000)
3085 – Mental Health Services Fund	$4,000	$4,000
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* Expenditure authority changes ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted

Issue 14: Reimbursements for Health Care Payments Data Program

Budget Change Proposal – Governor's Budget. OSHPD requests expenditure authority from reimbursements of $5 million in 2021-22, $5.3 million in 2022-23, $4.7 million in 2023-24, and $4.7 million in 2024-25. If approved, these resources would allow OSHPD to use federal funds to support the Health Care Payments Data System through the end of the California Department of Technology's Project Approval Lifecycle process.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0995 – Reimbursements	$5,009,000	$5,316,000
Total Funding Request:	**$5,009,000**	**$5,316,000**
Total Requested Positions:	**0.0**	**1.0**

* Additional fiscal year resources requested: 2023-24: $4,736,000, 2024-25: $4,743,000.

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 15: SB 17 Attorney Fees

Budget Change Proposal and Budget Bill Language – Governor's Budget. OSHPD requests expenditure authority from the California Health Data and Planning Fund of $457,000 in 2021-22 and $567,000 in 2022-23. If approved, these resources would allow OSHPD to support attorney fees from the state Office of the Attorney General for legal services associated with challenges to California's drug price transparency law, SB 17 (Hernandez), Chapter 603, Statutes of 2017. OSHPD also proposes provisional budget bill language to provide increased expenditure authority in the event the attorney fees exceed the amount in this budget request.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0143 – CA Health Data and Planning Fund	$457,000	$567,000
Total Funding Request:	**$457,000**	**$567,000**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 16: Alzheimer's/Geriatric Health Care Workforce Development

Budget Change Proposal and Budget Bill Language– Governor's Budget and May Revision. OSHPD requests General Fund expenditure authority of $8 million in 2021-22. If approved, these resources would allow OSHPD to support geriatric care providers through its existing health care workforce development programs. OSHPD also proposes provisional budget bill language to authorize availability of state operations funding for encumbrance and expenditure through June 30, 2023.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$8,000,000	$-
Total Funding Request:	**$8,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearings on February 5th, 2021, and May 18th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 17: 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. 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. 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.

This issue was heard by the subcommittee at its hearing on May 4th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 18: Miscellaneous Technical Adjustments

Budget Bill Language - May Revision. OSHPD requests budget bill language for two technical adjustments:

- OSHPD requests elimination of Item 4140-011-0121 to withdraw a proposed $40 million one-time loan from the Hospital Building Fund to the General Fund proposed in the January budget. According to OSHPD, given the state's improved fiscal condition, this loan is no longer necessary.

- OSHPD requests budget bill language to extend the period to liquidate encumbrances from allocations to the Steven M. Thompson Corps Loan Repayment Program, originally authorized in the 2019 Budget

Act. According to OSHPD, this extension is needed to allow program grantees additional time to fulfill their respective service grant agreements.

This issue was heard by the subcommittee at its hearing on May 18th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 19: Song-Brown Health Care Workforce Program Augmentation

Budget Change Proposal and Budget Bill Language - May Revision. OSHPD requests General Fund expenditure authority of $50 million in 2021-22. If approved, these resources would allow OSHPD to provide additional awards to support and sustain new primary care residency programs through the Song-Brown Health Care Workforce Training Program. OSHPD also requests provisional budget bill language to specifically allocate these funds for new residency programs.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$50,000,000	$-
Total Funding Request:	**$50,000,000**	**$-**

This issue was heard by the subcommittee at its hearing on May 18th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 20: Health Coverage: Mental Health or Substance Use Disorders (SB 855)

Budget Change Proposal – Governor's Budget. DMHC requests five positions and expenditure authority from the Managed Care Fund of $1.5 million in 2021-22, and 5.5 positions and $1.3 million annually thereafter. If approved, these positions and resources would allow DMHC to enforce mental health and substance use disorder treatment coverage mandates on health plans pursuant to SB 855 (Wiener), Chapter 151, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0933 – Managed Care Fund	$1,500,000	$1,345,000
Total Funding Request:	**$1,500,000**	**$1,345,000**
Total Requested Positions:	**5.0**	**5.5**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 21: Risk-Based or Global Risk Provider Arrangement Pilots (AB 1124)

Budget Change Proposal – Governor's Budget. DMHC requests expenditure authority from the Managed Care Fund of $413,000 in 2021-22, $401,000 in 2022-23 through 2024-25, $322,000 in 2025-26, and $342,000 in 2026-27. If approved, these resources would allow DMHC to create two pilot programs to permit a qualifying voluntary employees' beneficiary association (VEBA) or trust fund to enter into capitation payment agreements with qualified providers while being exempt from licensure under the Knox-Keene Health Care Service Plan Act of 1975 for no more than four years, pursuant to AB 1124 (Maienschein), Chapter 266, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0933 – Managed Care Fund	$413,000	$401,000
Total Funding Request:	**$413,000**	**$401,000**
Total Requested Positions:	**0.0**	**0.5**

* Additional fiscal year resources requested – 2023-24 to 2024-25: $401,000, 2025-26: $322,000, 2026-27: $342,000.

This issue was heard by the subcommittee at its hearing on February 5th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 22: 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.

This issue was heard by the subcommittee at its hearings on May 4th, 2021, and May 11th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Modified Placeholder Trailer Bill Language** to clarify regulatory implementation.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 23: Medi-Cal Local Assistance Estimate

Medi-Cal Local Assistance Estimate - May Revision Update. The May 2021 Medi-Cal Local Assistance Estimate includes $115.6 billion ($21.5 billion General Fund, $79 billion federal funds, and $15.1 billion special funds and reimbursements) for expenditures in 2020-21, and $123.8 billion ($27.6 billion General Fund, $83.8 billion federal funds, and $12.4 billion special funds and reimbursements) for expenditures in 2021-22. These figures represent a decrease in estimated General Fund expenditures in the Medi-Cal program of $991.1 million in 2020-21 and $792.5 million in 2021-22 compared to the Governor's January budget.

Medi-Cal Local Assistance Funding Summary 2020-21 Comparison to January Budget			
Fiscal Year:	**2020-21**	**2020-21**	**Jan-May**
Benefits			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$21,334,400,000	$20,777,035,000	($567,365,000)
Federal Funds	$75,062,886,000	$74,665,303,000	($397,583,000)
Special Funds/Reimbursements	$16,346,719,000	$ 15,053,592,000	($1,293,127,000)
Total Expenditures	**$112,754,005,000**	**$110,495,930,000**	**($1,293,127,000)**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$1,002,510,000	$584,930,000	($417,580,000)
Federal Funds	$3,700,064,000	$4,096,862,000	$396,798,000)
Special Funds and Reimbursements	$9,698,000	$22,813,000	$13,115,000
Total Expenditures	**$4,712,272,000**	**$4,704,605,000**	**($7,667,000)**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$124,477,000	$118,290,000	($6,187,000)
Federal Funds	$260,491,000	$256,194,000	($4,297,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$384,968,000**	**$374,484,000**	**($10,484,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$22,471,387,000	$21,480,255,000	($991,132,000)
Federal Funds	$79,023,441,000	$79,018,359,000	($5,082,000)
Special Funds and Reimbursements	$16,356,417,000	$15,076,405,000	($1,280,012,000)
Total Expenditures	**$117,851,245,000**	**$115,575,019,000**	**($2,276,226,000)**

Medi-Cal Local Assistance Funding Summary 2021-22 Comparison to January Budget			
Fiscal Year:	**2021-22**	**2021-22**	**Jan-May**
Benefits			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$27,622,057,000	$26,575,162,000	($1,046,895,000)
Federal Funds	$77,513,294,000	$79,195,085,000	$1,681,791,000
Special Funds/Reimbursements	$12,013,747,000	$12,368,260,000	$354,513,000
Total Expenditures	**$117,149,098,000**	**$118,138,507,000**	**$989,409,000**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$633,742,000	$879,710,000	$245,968,000
Federal Funds	$3,922,743,000	$4,303,412,000	$380,669,000
Special Funds and Reimbursements	$5,269,000	$18,186,000	$12,917,000
Total Expenditures	**$4,561,754,000**	**$5,201,308,000**	**$639,554,000**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$144,153,000	$152,628,000	$8,475,000
Federal Funds	$319,600,000	$274,039,000	($45,561,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$463,753,000**	**$426,667,000**	**($37,086,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$28,399,952,000	$27,607,500,000	($792,452,000)
Federal Funds	$81,755,637,000	$83,772,536,000	$2,016,899,000
Special Funds and Reimbursements	$12,019,016,000	$12,386,446,000	$367,430,000
Total Expenditures	**$122,174,605,000**	**$123,766,482,000**	**$1,591,877,000**

This issue was heard by the subcommittee at its hearings on February 19th, 2021, and May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve the balance of Estimate, with any changes necessary to conform to other actions that have been, or will be, taken.

Issue 24: Family Health Estimate

Family Health Estimate – May Revision Update. The May 2021 Family Health Local Assistance Estimate includes $312.7 million ($161.4 million General Fund, $5.1 million federal funds, and $105.2 million special funds and reimbursements) for expenditures in 2020-21, and $266.4 million ($216.8 million General Fund, $5.1 million federal funds, and $44.4 million special funds and reimbursements) for expenditures in 2021-22. These figures represent a decrease in estimated General Fund expenditures

of $20.5 million in 2020-21 and an increase of $4.5 million in 2021-22 compared to the January budget. These changes are primarily attributed to changes in caseload and other miscellaneous adjustments.

Family Health Local Assistance Funding Summary 2020-21 Comparison to January Budget			
Fiscal Year:	**2020-21**	**2020-21**	**Jan-May**
California Children's Services (CCS)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$96,679,000	$95,460,000	($1,219,000)
Federal Funds	$39,519,000	$-	($39,519,000)
Special Funds/Reimbursements	$12,664,000	$5,992,000	($6,672,000)
County Funds [non-add]	[$80,243,000]	[$78,450,000]	[($1,793,000)]
Total CCS Expenditures	**$148,862,000**	**$142,484,000**	**($6,378,000)**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$70,007,000	$56,224,000	($13,783,000)
Special Funds and Reimbursements	$70,390,000	$76,668,000	$77,000
Total GHPP Expenditures	**$140,397,000**	**$132,892,000**	**($7,505,000)**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$15,182,000	$9,718,000	($5,464,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$42,814,000**	**$37,350,000**	**($5,464,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$181,868,000	$161,402,000	($20,466,000)
Federal Funds	$44,647,000	$5,128,000	($39,519,000)
Special Funds and Reimbursements	$105,558,000	$105,164,000	($394,000)
County Funds [non-add]	[$80,243,000]	[$78,450,000]	[($1,793,000)]
Total Family Health Expenditures	**$332,073,000**	**$312,726,000**	**($19,347,000)**

Family Health Local Assistance Funding Summary 2021-22 Comparison to January Budget			
Fiscal Year:	**2021-22**	**2021-22**	**Jan-May**
California Children's Services (CCS)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$78,514,000	$80,366,000	$1,852,000
Special Funds/Reimbursements	$3,992,000	$3,992,000	$-
County Funds [non-add]	[$81,696,000]	[$83,493,000]	[$1,797,000]
Total CCS Expenditures	**$82,506,000**	**$84,358,000**	**$1,852,000**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$114,380,000	$119,636,000	$5,256,000
Special Funds and Reimbursements	$25,026,000	$17,951,000	($7,075,000)
Total GHPP Expenditures	**$139,406,000**	**$137,567,000**	**($1,819,000)**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$19,387,000	$16,805,000	($3,582,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$47,019,000**	**$44,437,000**	**($2,582,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$212,281,000	$216,807,000	$4,526,000
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$51,522,000	$44,447,000	($7,075,000)
County Funds [non-add]	[$81,696,000]	[$83,493,000]	[$1,797,000]
Total Family Health Expenditures	**$268,931,000**	**$266,382,000**	**($2,549,000)**

This issue was heard by the subcommittee at its hearings on February 19th, 2021, and May 20th, 2021.

Subcommittee Staff Comment and Recommendation— Approve the balance of Estimate, with any changes necessary to conform to other actions that have been, or will be, taken.

Issue 25: AB 1705 Ground Emergency Medical Transportation Public Provider IGT Program

Budget Change Proposal – Governor's Budget. DHCS requests five positions and expenditure authority of $715,000 ($358,000 federal funds and $357,000 reimbursements) in 2021-22, and $670,000 ($335,000 federal funds and $335,000 reimbursements) annually thereafter. If approved, these positions and resources would allow DHCS to implement a new Ground Emergency Medical Transportation

(GEMT) Public Provider Intergovernmental Transfer (IGT) program, pursuant to AB 1705 (Bonta), Chapter 544, Statutes of 2019.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0890 – Federal Trust Fund	$358,000	$335,000
0995 – Reimbursements	$357,000	$335,000
Total Funding Request:	**$715,000**	**$670,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 26: New/Restored Benefits: CGM and OTC Acetaminophen, and Cough/Cold Products

Local Assistance and Trailer Bill Language– Governor's Budget. DHCS requests expenditure authority of $10.9 million ($3.8 million General Fund and $7.1 million federal funds) to add continuous glucose monitoring (CGM) systems as a Medi-Cal benefit for beneficiaries with Type 1 diabetes. In addition, DHCS proposes trailer bill language to restore over-the-counter acetaminophen and cough and cold products as Medi-Cal benefits. DHCS expects a reduction in annual Medi-Cal expenditures of $21 million ($7.8 million General Fund and $13.2 million federal funds) due to the replacement of more costly opioids, prescription pain relievers, and other prescription cough treatments with these less costly over-the-counter options.

Program Funding Request Summary – Local Assistance Funding (CGM)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$-	$3,797,000
0890 – Federal Trust Fund	$-	$7,144,000
Total Funding Request:	**$-**	**$10,941,000**

Program Funding Request Summary – Local Assistance Funding (Acetaminophen)		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	($7,761,000)	($7,777,000)
0890 – Federal Trust Fund	($13,197,000)	($13,223,000)
Total Funding Request:	**($20,958,000)**	**($21,000,000)**

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 27: California Community Transitions (SB 214)

Budget Change Proposal – Governor's Budget. DHCS requests General Fund expenditure authority of $432,000 in 2021-22 and $405,000 in 2022-23 and 2023-24. If approved, these resources would allow DHCS to implement and operate a temporary, state-funded California Community Transitions (CCT) program, pursuant to the requirements of SB 214 (Dodd), Chapter 300, Statutes of 2020.

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

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$432,000	$405,000
Total Funding Request:	**$432,000**	**$405,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24: $405,000.

This issue was heard by the subcommittee at its hearings on February 19th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 28: Medi-Cal Enterprise System Modernization

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority of $22.3 million ($4 million General Fund and $18.3 million federal funds) in 2021-22 and $1.3 million ($128,000 General Fund and $1.1 million federal funds) in 2022-23 to continue support of critical information technology modernization efforts.

Budget Change Proposal – May Revision Adjustment. DHCS requests a reduction in General Fund expenditure authority of $1.8 million and an increase in federal fund expenditure authority of $1.8 million to update the funding split in the Administration's Medi-Cal Enterprise System Modernization proposal. This proposal was heard during the subcommittee's February 19th hearing.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$2,228,000	$128,000
0890 – Federal Trust Fund	$20,051,000	$1,147,000
Total Funding Request:	**$22,279,000**	**$1,275,000**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearings on February 19th, 2021, and May 11th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 29: Coordination of Benefits and Post-Payment Recovery

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to clarify requirements for third-party commercial health insurance carriers to share data with the department of post-payment recovery and coordination of benefits.

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 30: Limited-Term Positions – Extension or Conversion to Permanent

Budget Change Proposals – Governor's Budget. DHCS requests expenditure authority of $8.7 million ($3.1 million General Fund and $5.6 million federal funds) in 2021-22, $1.5 million ($222,000 General Fund and $1.3 million federal funds) in 2022-23, $1.3 million ($132,000 General Fund and $1.1 million federal funds) in 2023-24 and 2024-25, and General Fund expenditure authority of $132,000 in 2025-26. If approved, these resources would allow DHCS to extend previously approved limited-term resources equivalent to 38 positions for workload in various programs.

DHCS also requests 62.5 positions and expenditure authority of $9.5 million ($3.2 million General Fund, $5.6 million federal funds, and $676,000 Hospital Quality Assurance Revenue Fund) annually. If approved, these positions and resources would allow DHCS to address ongoing workload in various programs.

Program Funding Request Summary – Extension of Limited-Term Positions		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$3,081,000	$222,000
0890 – Federal Trust Fund	$5,621,000	$1,322,000
Total Funding Request:	**$8,702,000**	**$1,544,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24 and 2024-25: $1,262,000; 2025-26: $132,000.

Program Funding Request Summary – Conversion of Limited-Term Positions to Permanent		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$3,176,000	$3,176,000
0890 – Federal Trust Fund	$5,603,000	$5,603,000
0890 – Federal Trust Fund	$676,000	$676,000
Total Funding Request:	**$9,455,000**	**$9,455,000**
Total Requested Positions:	**62.5**	**62.5**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 31: Mental Health Services Act Flexibilities

Trailer Bill Language – Governor's Budget. DHCS proposes trailer bill language to extend county flexibility for expenditures of Mental Health Services Act funding for behavioral health services by one year, until July 1, 2022. These flexibilities were originally authorized until July 1, 2021, pursuant to AB 81 (Committee on Budget), Chapter 13, Statutes of 2020.

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 32: Behavioral Health 274 Expansion Project

Budget Change Proposal – Governor's Budget. DHCS requests expenditure authority of $1.1 million ($108,000 General Fund and $972,000 federal funds) in 2021-22 and 2022-23 to support contract costs for technical assistance to counties during the expansion of standardized format, content, and data transmission of health provider directories for county behavioral health programs.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$108,000	$108,000
0890 – Federal Trust Fund	$972,000	$972,000
Total Funding Request:	**$1,080,000**	**$1,080,000**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 33: Mental Health Services Assisted Outpatient Treatment (AB 1976)

Budget Change Proposal – Governor's Budget. DHCS requests General Fund expenditure authority of $288,000 in 2021-22 and $270,000 in 2022-23 and 2023-24. If approved, these resources would allow DHCS to implement and report on additional Assisted Outpatient Treatment (AOT) programs, pursuant to AB 1976 (Eggman), Chapter 140, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$288,000	$270,000
Total Funding Request:	**$288,000**	**$270,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested – 2023-24: $270,000.

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 34: Substance Use Disorder Recovery Residences (SB 406)

Budget Change Proposal – Governor's Budget. DHCS requests four positions and General Fund expenditure authority of $594,000 in 2021-22 and $558,000 annually thereafter. If approved, these positions and resources would allow DHCS to investigate and take enforcement action against substance use disorder recovery residences providing unallowable, unlicensed health care services, pursuant to the provisions of SB 406 (Pan), Chapter 302, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$594,000	$558,000
Total Funding Request:	**$594,000**	**$558,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 35: California Advancing and Innovating in Medi-Cal (CalAIM) – State Operations

Budget Change Proposal – Governor's Budget. DHCS requests 69 positions and expenditure authority of $23.9 million ($11 million general Fund and $12.8 million federal funds) in 2021-22, 84 positions and expenditure authority of $28.2 million ($13.2 million General Fund and $15 million federal funds) in 2022-23, $25.2 million ($12 million General Fund and $13.2 million federal funds) in 2023-24, $23.9 million ($11.6 million General Fund and $12.3 million federal funds) in 2024-25, and $20.3 million ($9.8 million General Fund and $10.5 million federal funds) in 2025-26. If approved, these positions and resources would support the state operations costs of implementing the CalAIM initiative.

Program Funding Request Summary – Budget Change Proposal		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$11,041,000	$13,230,000
0890 – Federal Trust Fund	$12,819,000	$14,960,000
Total Funding Request:	**$23,860,000**	**$28,190,000**
Total Requested Positions:	**69.0**	**84.0**

* Additional fiscal year resources requested – 2023-24: $25,193,000; 2024-25: $23,927,000; 2025-26: $20,250,000

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 36: Medi-Cal Screening for Misuse of Opioids and Other Drugs

Local Assistance and Trailer Bill Language – May Revision Adjustment. DHCS requests expenditure authority of $3 million ($563,000 General Fund and $1 million federal funds) in 2020-21 and $1.7 million ($1.1 million General Fund and $1.1 million federal funds) in 2021-22 for the expansion of SBIRT. DHCS also requests trailer bill language to implement the expansion.

SB 78 (Committee on Budget and Fiscal Review), Chapter 38, Statutes of 2019, directed DHCS to seek federal approval to expand the Medi-Cal benefit for screening, brief intervention, and referral to treatment (SBIRT) to include screening for overuse of opioids and other illicit drugs such as heroin and methamphetamine. Effective June 9, 2020, the United States Preventive Services Task Force (USPSTF) assigned a "B" rating to SBIRT screening for opioids and other illicit drugs for adults ages 18 and older. The California Medicaid State Plan requires mandatory coverage of any benefit recommended by the USPSTF.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$1,098,710	$1,098,710
0890 – Federal Trust Fund	$1,941,440	$1,941,440
Total Funding Request:	**$3,040,100**	**$3,040,100**

* Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 19th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 37: Medi-Cal Program Integrity Data Analytics

Budget Change Proposal – April Finance Letter. DHCS requests expenditure authority of $6.9 million ($1.1 million General Fund and $5.8 million federal funds) in 2021-22 to extend contract funding for the Medi-Cal Program Integrity Data Analytics service.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$1,130,000	$-
0890 – Federal Trust Fund	$5,755,000	$-
Total Funding Request:	**$6,885,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearing on May 11th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 38: Interoperability Federal Final Rule Compliance

Budget Change Proposal – April Finance Letter. DHCS requests expenditure authority of $2.9 million ($713,000 General Fund and $2.1 million federal funds) in 2021-22 and $737,000 ($184,000 General Fund and $553,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to support compliance with federal interoperability and patient health information access rules.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$713,000	$184,000
0890 – Federal Trust Fund	$2,141,000	$553,000
Total Funding Request:	**$2,854,000**	**$737,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 11th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 39: Managed Care Plan Statewide Procurement

Budget Change Proposal – April Finance Letter. DHCS requests 11 positions and expenditure authority of $2.7 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22, $2.5 million ($1.3 million General Fund and $1.3 million federal funds) in 2022-23 through 2024-25, and $1.6 million ($777,000 General Fund and $777,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to support the statewide Medi-Cal managed care program re-procurement effort.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$1,336,000	$1,255,000
0890 – Federal Trust Fund	$1,336,000	$1,255,000
Total Funding Request:	**$2,672,000**	**$2,510,000**
Total Requested Positions:	**11.0**	**11.0**

* Additional fiscal year resources requested: 2023-24 through 2024-25: $2,510,000, 2025-26 and ongoing: $1,554,000.

This issue was heard by the subcommittee at its hearing on May 11th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 40: Provider Application and Verification for Enrollment (PAVE)

Budget Change Proposal – April Finance Letter. DHCS requests expenditure authority of $7.2 million ($1.8 million General Fund and $5.4 million federal funds) in 2021-22 to support enhancements to the Provider Application and Validation for Enrollment (PAVE) system.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$1,792,000	$-
0890 – Federal Trust Fund	$5,376,000	$-
Total Funding Request:	**$7,168,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearing on May 11th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 41: Local Educational Agencies Medi-Cal Billing Option Program Expansion

Budget Change Proposal – April Finance Letter. DHCS requests eight positions and expenditure authority of $2.2 million ($1.1 million General Fund and $1.1 million federal funds) in 2021-22 and 2022-23, and $1.2 million ($583,000 General Fund and $583,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to expand and improve the delivery of school-based health care, including contract resources to help implement expansion of the Local Educational Agencies Billing Option Program (LEA BOP).

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$1,119,000	$1,083,000
0890 – Federal Trust Fund	$1,119,000	$1,083,000
Total Funding Request:	**$2,238,000**	**$2,166,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional fiscal year resources requested – 2023-24 and ongoing: $1,166,000.

This issue was heard by the subcommittee at its hearing on May 11th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 42: Office of Medicare Innovation and Integration

Budget Change Proposal – April Finance Letter. DHCS requests four positions and expenditure authority of $602,000 ($452,000 General Fund and $150,000 federal funds) in 2021-22, and $566,000 ($425,000 General Fund and $141,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to establish a new Office of Medicare Innovation and Integration, which

would provide focused leadership and expertise to lead innovative models for Medicare beneficiaries in California, including Medicare-only and individuals dually eligible for Medicare and Medi-Cal.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$452,000	$452,000
0890 – Federal Trust Fund	$150,000	$141,000
Total Funding Request:	**$602,000**	**$566,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 11th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Modified Placeholder Trailer Bill Language** to define the functions of the Office.

Issue 43: Behavioral Health Quality Improvement Program

Budget Change Proposal and Budget Bill Language– April Finance Letter. DHCS requests expenditure authority of $940,000 ($470,000 General Fund and $470,000 federal funds) in 2021-22, and $913,000 ($457,000 General Fund and $456,000 federal funds) in 2022-23. If approved, these resources would allow DHCS to assist county behavioral health programs to prepare for opportunities and program requirements through the California Advancing and Innovating in Medi-Cal (CalAIM) initiative. DHCS is also requesting budget bill language authorizing distribution and administration of local assistance funds for this purpose.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$470,000	$457,000
0890 – Federal Trust Fund	$470,000	$456,000
Total Funding Request:	**$940,000**	**$913,000**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearing on May 11th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 44: Maternal Health Investments – Postpartum Coverage Extension and Doula Benefit

Local Assistance and Trailer Bill Language - May Revision. DHCS requests expenditure authority of $90.5 million ($25.3 million General Fund and $25.3 million federal funds) to extend Medi-Cal eligibility from 60 days to 12 months for most postpartum individuals as part of the federal American Rescue Plan. DHCS also requests trailer bill language to implement the extension of eligibility.

DHCS also requests expenditure authority of $402,000 ($152,000 General Fund and $251,000 federal funds) to provide doula services as a covered benefit in the Medi-Cal program.

Program Funding Request Summary – Postpartum Coverage Extension		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$45,273,000	$45,273,000
0890 – Federal Trust Fund	$45,273,000	$45,273,000
Total Funding Request:	**$90,546,000**	**$90,546,000**

* Resources ongoing after 2022-23.

Program Funding Request Summary – Doula Benefit		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$152,040	$208,850
0890 – Federal Trust Fund	$250,540	$344,150
Total Funding Request:	**$402,600**	**$553,000**

* Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 45: Support for Public Hospital System

Local Assistance – May Revision. DHCS requests expenditure authority from the Coronavirus Fiscal Recovery Fund of $300 million in 2021-22. If approved, these resources would allow DHCS to support public hospitals and health care systems' unreimbursed costs associated with providing care to Medi-Cal beneficiaries during the pandemic.

Program Funding Request Summary – Local Assistance		
Fund Source	**2021-22**	**2022-23**
8506 – Coronavirus Fiscal Recovery Fund	$300,000,000	$-
Total Funding Request:	**$300,000,000**	**$-**

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 46: Eliminate Rate Freeze for Pediatric Subacute Facilities

Local Assistance and Trailer Bill Language – May Revision. DHCS requests expenditure authority of $5.2 million ($2.3 million General Fund and $2.9 million federal funds), and $5.7 million ($2.5 million General Fund and $3.1 million federal funds) annually thereafter to eliminate the rate freeze for free-standing pediatric subacute facilities. DHCS also requests trailer bill language to implement these changes.

Program Funding Request Summary – Pediatric Subacute Facilities		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$2,328,000	$2,540,000
0890 – Federal Trust Fund	$2,873,000	$3,133,000
Total Funding Request:	**$5,201,000**	**$5,673,000**

***** Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 47: Telehealth Services and Audio-Only Telehealth

Trailer Bill Language – Governor's Budget and May Revision. DHCS requests trailer bill language to extend permanent flexibilities for the delivery of certain Medi-Cal benefits through telehealth, telephonic/audio-only, remote patient monitoring, and other virtual communication modalities.

DHCS also requests trailer bill language to establish a rate for audio-only telehealth services at 65 percent of the fee-for-service rate, and a comparable alternative to the prospective payment system (PPS) rates for clinics to maintain an incentive for in-person care.

This issue was heard by the subcommittee at its hearings on February 19th, 2021, and May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Reject and **Adopt Modified Placeholder Trailer Bill Language** to align with the provisions of AB 32 (Aguiar-Curry), pending in the current legislative session.

Issue 48: Medication Therapy Management Program

Local Assistance – May Revision. DHCS requests expenditure authority of $12.6 million ($4.4 million General Fund and $8.2 million federal funds) in 2021-22 and $13.5 million ($4.7 million General Fund and $8.8 million federal funds) annually thereafter to provide medication management payments to Medi-Cal enrolled pharmacies that provide specialized services to high-risk and medically complex populations.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$4,418,830	$4,736,150
0890 – Federal Trust Fund	$8,176,670	$8,763,850
Total Funding Request:	**$12,595,500**	**$13,500,000**

***** Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 49: Community Health Workers Benefit

Local Assistance – May Revision. DHCS requests expenditure authority of $16.3 million ($6.2 million General Fund and $10.2 million federal funds) annually to support reimbursement for community health workers to provide clinically appropriate Medi-Cal covered benefits and services in both the fee-for-service and managed care delivery systems.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$6,154,300	$6,154,300
0890 – Federal Trust Fund	$10,168,700	$10,168,700
Total Funding Request:	**$16,323,000**	**$16,323,000**

***** Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 50: San Mateo County Dental Integration Pilot

Local Assistance – May Revision. DHCS requests expenditure authority of $697,000 ($280,950 General Fund and $416,050 federal funds) annually to implement a dental integration pilot program in San Mateo County.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$280,950	$280,950
0890 – Federal Trust Fund	$416,050	$416,050
Total Funding Request:	**$697,000**	**$697,000**

***** Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 51: Miscellaneous Technical Adjustments – Behavioral Health and Prop 56 Loan Repayment

Miscellaneous Technical Adjustment – May Revision. DHCS requests federal fund expenditure authority of $138 million in Item 4260-115-0890 and $335 million in Item 4260-116-0890 to support federal grant funds received for mental health and substance use disorder services.

Miscellaneous Technical Adjustment – May Revision. DHCS requests expenditure authority from Proposition 56 tobacco tax revenue of $2 million in 2021-22 to reflect additional funds available for the Proposition 56 Loan Repayment Program based on past-year and estimated current-year expenditures.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 52: Medically Tailored Meals Expansion

Local Assistance – May Revision. DHCS requests General Fund expenditure authority of $9.3 million to continue providing medically tailored meals, and to cover additional health conditions, as part of an expansion of the pilot program and a bridge to availability of these benefits in the California Advancing and Innovating in Medi-Cal (CalAIM) program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$9,300,000	$-
Total Funding Request:	**$9,300,000**	**$-**

This issue was heard by the subcommittee at its hearing on May 20th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Modified Placeholder Trailer Bill Language** to more clearly define the administration of the one-time program.

Issue 53: Full-Scope Medi-Cal Coverage for Undocumented Seniors 60 and Over

Local Assistance and Trailer Bill Language Proposal – May Revision. DHCS requests expenditure authority of $68 million ($50 million General Fund and $18.5 million federal funds) to expand full-scope Medi-Cal benefits to adults 60 years of age or older, regardless of immigration status. DHCS also requests trailer bill language to implement the expansion of coverage, beginning May 1, 2022.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$49,569,000	$-
0890 – Federal Trust Fund	$18,471,000	$-
Total Funding Request:	**$68,040,000**	**$-**

* No fiscal details provided for 2022-23 and beyond.

Subcommittee Staff Comment and Recommendation—Modify the Administration's proposal to instead expand full-scope Medi-Cal benefits to adults 50 and older, regardless of immigration status, beginning May 1, 2022**. Adopt Modified Placeholder Trailer Bill Language** consistent with this modification.

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Issue 54: Adjustment to Support Infectious Disease Modeling

Budget Change Proposal – Governor's Budget. DPH requests General Fund expenditure authority of $450,000 in 2021-22, available for encumbrance or expenditure until June 30, 2023. If approved, these resources would support infectious disease modeling activities to inform public health emergency decision-making.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$450,000	$-
Total Funding Request:	**$450,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearing on February 12th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 55: AIDS Drug Assistance Program (ADAP) Estimate

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

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

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

This issue was heard by the subcommittee at its hearings on February 12th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 56: Center for Health Care Quality Estimate

Center for Health Care Quality Program Estimate – Governor's Budget and May Revision Adjustments. The budget includes expenditure authority for the Center for Health Care Quality of $341.9 million ($4.3 million General Fund, $100.4 million federal funds, and $240.2 million special funds and reimbursements) in 2020-21, a decrease of $6.1 million compared to the 2020 Budget Act, and $394 million ($4.3 million General Fund, $104 million federal funds, and $285.7 million special funds and reimbursements) in 2021-22, an increase of $52.1 million compared to the revised 2020-21 budget. According to DPH, the increase in 2021-22 is attributed to increased costs for the third year of the department's contract with Los Angeles County, implementation of a centralized application unit, legislatively mandated requirements related to personal protective equipment stockpiles for healthcare employers, staffing compliance oversight for skilled nursing facilities, and investigation of complaints against caregivers, as well as receipt of federal grant awards.

CHCQ Funding Summary, May 2021 Estimate		
Fund Source	**2020-21**	**2021-22**
0001 – General Fund	$4,296,000	$4,296,000
0890 – Federal Trust Fund	$100,430,000	$103,995,000
0942 – Special Deposit Fund		
Internal Departmental Quality Improvement Account	$3,600,000	$3,600,000
State Health Facilities Citation Penalty Account	$2,144,000	$2,144,000
Federal Health Facilities Citation Penalty Account	$9,873,000	$9,873,000
0995 – Reimbursements	$12,134,000	$12,914,000
3098 – Licensing and Certification Program Fund	$212,458,000	$257,178,000
Total CHCQ Funding	**$341,935,000**	**$394,000,000**
Total CHCQ Positions	**1425.3**	**1456.3**

This issue was heard by the subcommittee at its hearing on February 12th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 57: Health Care and Essential Workers: Personal Protective Equipment (SB 275)

Budget Change Proposal – Governor's Budget. DPH requests one position and expenditure authority from the Licensing and Certification Fund of $164,000 annually. If approved, this position and resources would allow DPH to establish regulations for a personal protective equipment (PPE) stockpile by health care employers, pursuant to the requirements of SB 275 (Pan), Chapter 301, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$164,000	$164,000
Total Funding Request:	**$164,000**	**$164,000**

Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 12th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 58: Skilled Nursing Facility Staffing Requirements Compliance (AB 81)

Budget Change Proposal – Governor's Budget. DPH requests six positions and expenditure authority from the Licensing and Certification Fund of $939,000 annually. If approved, these positions and resources would allow DPH to enforce skilled nursing facility compliance with staffing requirements, impose penalties, and manage disputes and appeals, pursuant to the requirements of AB 81 (Committee on Budget), Chapter 13, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$939,000	$939,000
Total Funding Request:	**$939,000**	**$939,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 12th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 59: Timely Investigation of Caregivers

Budget Change Proposal – Governor's Budget. DPH requests seven positions and expenditure authority from the Licensing and Certification Fund of $1 million annually. If approved, these positions and resources would allow DPH to improve the timeliness of investigations of complaints against caregivers.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$1,000,000	$1,000,000
Total Funding Request:	**$1,000,000**	**$1,000,000**
Total Requested Positions:	**7.0**	**7.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 12th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 60: Medical Breach Enforcement Section Expansion

Budget Change Proposal – Governor's Budget. DPH requests 17 positions and expenditure authority from the Licensing and Certification Fund of $2.6 million annually. If approved, these positions and resources would allow DPH to expand its Medical Breach Enforcement Section, which investigates complaints and administers penalties against individuals and health care providers for breaches of medical privacy.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
3098 – Licensing and Certification Fund	$2,616,000	$2,616,000
Total Funding Request:	**$2,616,000**	**$2,616,000**
Total Requested Positions:	**17.0**	**17.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 12th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 61: COVID-19 Workplace Outbreak Reporting (AB 685)

Budget Change Proposal – Governor's Budget. DPH requests three positions and General Fund expenditure authority of $677,225 annually. If approved, these positions and resources would allow DPH to create a new program to manage COVID-19 workplace outbreak reporting, pursuant to the requirements of AB 685 (Reyes), Chapter 84, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$677,225	$677,225
Total Funding Request:	**$677,225**	**$677,225**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 12th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 62: Support for Alzheimer's Disease Awareness, Research, and Training

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

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$24,500,000	$-
Total Funding Request:	**$24,500,000**	**$-**
Total Positions Requested:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearings on February 12th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 63: Women, Infants, and Children (WIC) Program Estimate

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

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

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

This issue was heard by the subcommittee at its hearings on February 12th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 64: Books for Low-Income Children

Budget Change Proposal – Governor's Budget and April Finance Letter. DPH requests General Fund expenditure authority of $5 million in 2021-22. If approved, these resources would allow DPH to support an early childhood literacy program for participants in the Women, Infants, and Children (WIC) program.

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

This issue was heard by the subcommittee at its hearing on February 12th, 2021, and May 4th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 65: Genetic Disease Screening Program (GDSP) Estimate

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

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

Genetic Disease Screening Program 2021-22 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0203 – Genetic Disease Testing Fund		
State Operations:	$33,322,000	$33,322,000

Local Assistance:	$111,939,000	$112,333,000
Total GDSP Funding	**$145,261,000**	**$145,655,000**

This issue was heard by the subcommittee at its hearings on February 12th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 66: Improving the California Prenatal Screening Program

Budget Change Proposal – Governor's Budget. DPH requests three positions and expenditure authority from the Genetic Disease Testing Fund of $4.3 million ($449,000 for state operations and $3.9 million for local assistance) in 2021-22, and $20.6 million ($449,000 for state operations and $20.2 million for local assistance) annually thereafter. If approved, these positions and resources would allow DPH to meet current standards of care and improve the screening process for the California Prenatal Screening Program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0203 – Genetic Disease Testing Fund	$4,349,000	$20,649,000
Total Funding Request:	**$4,349,000**	**$20,649,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 12th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 67: 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.

This issue was heard by the subcommittee at its hearing on May 4th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 68: Rescind Rh Disease Reporting Requirement – Trailer Bill Language Proposal

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

This issue was heard by the subcommittee at its hearing on May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal**.**

Issue 69: Federal Grant Authority

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

This issue was heard by the subcommittee at its hearing on May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 70: COVID-19 Pandemic Response External Challenges

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

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

This issue was heard by the subcommittee at its hearing on May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 71: Expansion of Pre-Exposure Prophylaxis Assistance Program

Trailer Bill Language - Expansion of PrEP-AP Program. The 2018 Budget Act included expenditure authority from the ADAP Rebate Fund of $2 million annually to expand eligibility for the PrEP-AP program including: 1) allowing PrEP medication for insured clients without requiring use of a manufacturer's assistance program, 2) payment for post-exposure prophylaxis (PEP) costs, 3) payment for PrEP and PEP starter packs, regardless of whether PrEP-AP eligibility requirements are met, 4) PrEP-AP access for individuals 12 years of age and older, 5) the ability to consider insured individuals as

uninsured for confidentiality or safety reasons, 6) provision of up to 28 days of PEP medication for victims of sexual assault regardless of whether eligibility requirements are met, and 7) payment of insurance premiums for PrEP-AP clients if it would result in cost-savings to the state. The 2020 Budget Act included trailer bill language to allow provision of up to 30 days of PrEP and PEP for all clients, due to the minimum supply provided by the manufacturer. In the May Revision, DPH is requesting trailer bill language to allow individuals to be eligible for PrEP-AP if these medications have been prescribed, dispensed or otherwise furnished.

This issue was heard by the subcommittee at its hearing on May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 72: Miscellaneous Technical Adjustments

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

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

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

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

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

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

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

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

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

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

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

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

  Item 4265-001-0001

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

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

  Item 4265-001-0001

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

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

This issue was heard by the subcommittee at its hearing on May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal**.**

4440 DEPARTMENT OF STATE HOSPITALS

Issue 73: State Hospitals Program and Caseload Updates

Program and Caseload Updates – May Revision. DSH requests resources to support the following program and caseload updates in its May Revision Budget Estimate.

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

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

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

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

Program Update – Enhanced Treatment Program (ETP) Staffing. In the January budget, DSH estimated a reduction of 30.1 positions and General Fund savings of $4.7 million in 2020-21 and 11.6 positions and $1.8 million in 2021-22 due to delayed completion of Enhanced Treatment Program (ETP) units at Atascadero and Patton State Hospitals. In the May Revision, DSH estimates an additional reduction of 23 positions and General Fund savings of $3.7 million in 2020-21, a reduction of 8.2 positions and General Fund expenditure authority of $329,000 in 2021-22, and General Fund expenditure authority of $1.1 million annually thereafter. These changes are due to additional delays at Atascadero.

AB 1340 (Achadjian), Chapter 718, Statutes of 2014, authorized DSH to establish an ETP pilot project to expand the range of clinical treatment options for patients determined to be at the highest risk of dangerous behavior or violence against other patients or hospital staff and cannot be safely treated in a standard treatment environment. According to DSH, the risk of violence against other patients or hospital staff

imposes both a threat to health and safety, as well as a barrier to the effective treatment of other patients who may fear for their physical safety in a standard treatment environment with a potentially violent patient. The pilot project period extends approximately five years from the first patient admitted to the ETP and imposes certain requirements on admission and treatment within an ETP.

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

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

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

Units/Hospital	Construction Initiated (Scheduled)	Construction Completion (Scheduled)
DSH-Atascadero Unit 29	September 24, 2018	December 2020
DSH-Atascadero Unit 33	July 2021	February 2022
DSH-Atascadero Unit 34	July 2021	February 2022
DSH-Patton Unit U-06	July 2021	May 2022

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

The Vocational Rehabilitation Program serves as a therapeutic program to provide a range of vocational skills and therapeutic interventions for patients, including the development of social, occupational, life, and career skills, and confidence. Patients are paid an hourly wage for the work performed in the following

jobs: custodial, kitchen worker, product assembler, laundry attendant, landscaper, painter, plumbing, barber, horticulture, multimedia production, peer mentor, office clerk, and repair technician.
The 2019 Budget Act included $3.2 million annually to implement a uniform wage structure for the DSH Vocational Rehabilitation Program, paying participants at the federal minimum wage. DSH estimates of General Fund savings in 2020-21 are due to the reduction in referrals to the program, as well as restrictions on patient work due to COVID-19.

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

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

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

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

- Atascadero – 112.0 positions have shifted of 132.0 proposed
- Coalinga – 55.0 positions shifted out of 76.1 proposed
- Patton – 27.4 positions shifted out of 27.4 proposed
- Metropolitan – Gain of 142.5 positions once proposed shifts are complete
- Napa – Gain of 93.0 positions once proposed shifts are complete

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

Program Update – Workforce Development for Psychiatric Residency Programs and Psychiatric Technicians. In the January budget, DSH estimated General Fund savings of $425,000 in 2020-21 related

to delays in workforce development programs for psychiatry residents, nursing staff, and psychiatric technicians. In the May Revision, DSH estimates a reduction of 1.2 position and General Fund savings of $203,000 in 2020-21 and $40,000 annually thereafter due to additional hiring delays.

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

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

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

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

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

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

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

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

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

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

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

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

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

Caseload Update – Forensic CONREP: Sexually Violent Predator (SVP) Program. Beginning in 1996, Sexually Violent Predators (SVP) were added to the CONREP population and are conditionally released to their county of domicile by court order with sufficient funding to provide treatment and supervision services. According to DSH, the CONREP-SVP program offers patients direct access to an array of mental health services with a forensic focus, as well as regularly scheduled sex offender risk assessments, polygraph testing, and review of Global Position System (GPS) data and surveillance. DSH estimates a total caseload of 29 SVPs will be conditionally released into the community by June 30, 2022. Currently, there are 18 current participants in the CONREP-SVP program and 11 individuals with court-approved petitions for release into the program who are awaiting placement.

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

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

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

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

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

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

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

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

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

This issue was heard by the subcommittee at its hearings on February 26th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 74: Incompetent to Stand Trial (IST) Diversion Program Expansion and Reappropriation

Local Assistance, Reappropriation, and Trailer Bill Language – May Revision. DSH requests three positions and General Fund expenditure authority of $47.6 million in 2021-22 and $1.2 million in 2022-23. If approved, these positions and resources would allow DSH to expand its community-based diversion program for individuals with potential to be determined incompetent to stand trial on felony charges.

DSH also requests reappropriation of up to $8 million of General Fund expenditure authority previously authorized in the 2018 Budget Act. If approved, this reappropriation would allow DSH to provide additional funding to county diversion programs until June 30, 2020, and to liquidate all funding to counties through June 30, 2024.

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

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$47,584,000	$1,230,000
Total Funding Request:	**$47,584,000**	**$1,230,000**

This issue was heard by the subcommittee at its hearings on February 26th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 75: Los Angeles Community-Based Restoration Program Expansion

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

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

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$32,833,000	$59,833,000
Total Funding Request:	**$32,833,000**	**$59,833,000**
Total Positions Requested:	**4.5**	**4.5**

***** Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearings on February 26th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 76: Conditional Release Program – Mobile Forensic Assertive Community Treatment Team

Local Assistance – Governor's Budget. DSH requests two positions and General Fund expenditure authority of $5.6 million in 2021-22 and $8 million annually thereafter. If approved, these positions and resources would allow DSH to implement a mobile treatment team for CONREP services based on the forensic assertive community treatment (FACT) model of care.

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

Program Funding Request Summary – Local Assistance Funding Adjustment		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$9,667,000	$14,257,000
Total Funding Request:	**$9,667,000**	**$14,257,000**

* Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearings on February 26th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 77: Technical Budget Adjustment – Various Programs

Technical Adjustment – Governor's Budget. DSH requests a net-zero adjustment of positions and expenditure authority between programs to reflect current allocations and anticipated expenditures.

Program Funding Request Summary – Local Assistance Funding		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$-	$-
Total Funding Request:	**$-**	**$-**

* Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 26th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 78: Protected Health Information Permanent Implementation

Budget Change Proposal – Governor's Budget. DSH requests General Fund expenditure authority of $986,000 in 2021-22 and 2022-23. If approved, these resources would allow DSH to continue processing of invoices and payments from external medical providers containing protected health information and consolidating financial operations into a single budget unit.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$986,000	$986,000
Total Funding Request:	**$986,000**	**$986,000**
Total Positions Requested:	**8.0**	**8.0**

This issue was heard by the subcommittee at its hearing on February 26th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 79: Increased Court Appearances and Public Records Act Requests

Budget Change Proposal – Governor's Budget. DSH requests General Fund expenditure authority of $777,000 in 2021-22 and 2022-23. If approved, these resources would allow DSH to address an increase in workload for attorneys that are required to appear for court hearings and for responding to Public Records Act requests.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$777,000	$777,000
Total Funding Request:	**$777,000**	**$777,000**
Total Positions Requested:	**5.5**	**5.5**

This issue was heard by the subcommittee at its hearing on February 26th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 80: Patient Education

Budget Change Proposal – Governor's Budget. DSH requests three positions and General Fund expenditure authority of $352,000 annually. If approved, these positions and resources would allow DSH to expand patient education services at Coalinga State Hospital to align with those offered at other State Hospitals.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$352,000	$352,000
Total Funding Request:	**$352,000**	**$352,000**
Total Positions Requested:	**3.0**	**3.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 26th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 81: Medical and Pharmaceutical Billing System

Budget Change Proposal – Governor's Budget. DSH requests one position and General Fund expenditure authority of $794,000 in 2021-22 and $774,000 in 2022-23, 2023-24, and 2024-25. If approved, these position and resources would allow DSH to enhance system functionality for its Cost Recovery System to capture, bill, and recover eligible patient costs of care reimbursements.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$794,000	$774,000
Total Funding Request:	**$794,000**	**$774,000**
Total Positions Requested:	**1.0**	**1.0**

* Position and resources ongoing through 2024-25.

This issue was heard by the subcommittee at its hearing on February 26th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 82: Skilled Nursing Facility Infection Preventionists (AB 2644)

Budget Change Proposal – Governor's Budget. DSH requests two positions and General Fund expenditure authority of $350,000 annually to support infection preventionists at skilled nursing facilities operated at Metropolitan and Napa State Hospitals, pursuant to the requirements of AB 2644 (Wood), Chapter 287, Statutes of 2020.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$350,000	$350,000
Total Funding Request:	**$350,000**	**$350,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on February 26th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 83: One-Time Deferred Maintenance Allocation

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

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

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$100,000,000	$-
Total Funding Request:	**$100,000,000**	**$-**
Total Positions Requested:	**0.0**	**0.0**

This issue was heard by the subcommittee at its hearings on February 26th, 2021, and May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 84: Metropolitan – Consolidation of Police Operations (Capital Outlay)

Capital Outlay Budget Change Proposal – Governor's Budget. DSH requests expenditure authority from the Public Buildings Construction Fund of $22 million for the construction phase of the consolidation of police operations at Metropolitan State Hospital.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0660 – Public Buildings Construction Fund	$22,024,000	$-
Total Funding Request:	**$22,024,000**	**$-**

This issue was heard by the subcommittee at its hearing on February 26th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 85: Coalinga – Hydronic Loop Replacement (Capital Outlay)

Capital Outlay Budget Change Proposal – Governor's Budget. In the January budget, DSH requested General Fund expenditure authority of $50.5 million for the construction phase of a hydronic loop replacement at Coalinga State Hospital.

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	$27,459,000	$-
Total Funding Request:	**$27,459,000**	**$-**

This issue was heard by the subcommittee at its hearings on February 26th, 2021, and May 4th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 86: Statewide – Enhanced Treatment Units (Capital Outlay)

Capital Outlay Budget Change Proposal – Governor's Budget. DSH requests General Fund expenditure authority of $3.8 million to support increased construction costs for Enhanced Treatment Units at Atascadero and Patton State Hospitals.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$3,792,000	$-
Total Funding Request:	**$3,792,000**	**$-**

This issue was heard by the subcommittee at its hearing on February 26th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 87: COVID-19 Workers Compensation Claims (SB 1129)

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

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

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

This issue was heard by the subcommittee at its hearing on May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 88: Reevaluation Services for Felony Incompetent to Stand Trial Patients

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

Program Funding Request Summary

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

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

This issue was heard by the subcommittee at its hearing on May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 89: Statewide Integrated Health Care Provider Network

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

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

***** Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 90: Non-Restorable Incompetent to Stand Trial Patients

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

This issue was heard by the subcommittee at its hearing on May 24th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 91: 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.

This issue was heard by the subcommittee at its hearing on May 4th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 92: 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.

This issue was heard by the subcommittee at its hearing on May 4th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

Issue 93: 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**

This issue was heard by the subcommittee at its hearing on May 4th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 94: Technical Adjustments – MHSF Liquidation Extension

Technical Adjustments – April Finance Letter. MHSOAC requests extension of the liquidation period for two previously approved augmentations of expenditure authority:

- County Mental Health Innovation Planning – MHSOAC requests budget bill language to extend the period to liquidate $400,000 from the Mental Health Services Fund, previously authorized in the 2018 and 2019 Budget Acts. The 2018 and 2019 Budget Acts included a total of $5 million from the Mental Health Services Fund to support contract costs for technical assistance to counties to develop plans for expenditures of Proposition 63 dollars allocated for innovative programs. According to MHSOAC, delays in finalizing a subcontract resulted in the need for an additional year to liquidate the expenditure and finalize the subcontract.
- Triage Personnel Grant Program – MHSOAC requests budget bill language to extend the period to liquidate $5.9 million from the Mental Health Services Fund, previously authorized in the 2018 Budget Act. These resources were authorized to support the Triage Personnel Grant Program, which provides competitive grants to counties to support crisis services for individuals with mental health needs. According to MHSOAC, grantees require additional time to complete work delayed by the COVID-19 pandemic, including difficulty hiring and retaining staff, challenges accessing and engaging clients using remote telecommunications platforms, and finalizing subcontract.

This issue was heard by the subcommittee at its hearing on May 13th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted.

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

Issue 95: 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.

This issue was heard by the subcommittee at its hearing on May 4th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

Issue 96: One-Dollar Premium Subsidy Program

Budget Change Proposal and Trailer Bill Language– May Revision. Covered California requests General Fund expenditure authority of $20 million annually. If approved, these resources would allow Covered California to subsidize the one dollar per month premium required for the cost of providing abortion services, for which federal funding is prohibited. Covered California also requests trailer bill language to implement the one dollar premium subsidy program.

Program Funding Request Summary		
Fund Source	**2021-22**	**2022-23***
0001 – General Fund	$20,000,000	$20,000,000
Total Funding Request:	**$20,000,000**	**$20,000,000**

* Resources ongoing after 2022-23.

This issue was heard by the subcommittee at its hearing on May 18th, 2021.

Subcommittee Staff Comment and Recommendation—Approve as budgeted and **Adopt Placeholder Trailer Bill Language** consistent with the Administration's proposal.

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.

Wednesday, May 26, 2021
1:30 p.m.
State Capitol – Senate Chamber

PART B
VOTE ONLY CALENDAR

Consultant: Renita Polk

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KEY

AAB – Approve as Budgeted
BBL – Budget Bill Language
TBL – Trailer Bill Language
GB – Governor's Budget
SFL – Spring Finance Letter
MR – May Revision

Issue	Org Code	Department	Title	Total Funds	General Fund	Positions	Staff Comments	Staff Recommendation
0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY								
1	0530	HHS Agency	Office of Youth and Community Restoration (GB/MR)		GB: $3.4 million in 2021-22 and $3.4 million ongoing MR: $7.6 million in 2021-22 and $7.2 million ongoing	33	This issue was heard in Subcommittee No. 5 on March 4, 2021 and in Subcommittee No. 3 on February 5 and May 18, 2021. In those hearings the subcommittee discussed the need for language to clarify the office's functions and responsibilities as well as additional funding to support those activities.	Approve a total of $30 million ongoing General Fund to establish the Office, adopt placeholder BBL, and adopt placeholder TBL to clarify OYCR functions.
2	0530	HHS Agency	Child Welfare Services-California	$128.5 million	$68.1 million one-time		The proposed funding would provide for project resources in combined	AAB

			Automated Response and Engagement System				funding with DSS to continue the development and implementation of the project.	
4170 CALIFORNIA DEPARTMENT OF AGING (CDA)								
3	4170	CDA	BCPs (GB/SFL) - Funding for ADRCs	--	GB: $5 million SFL: $2 million ongoing	13	These issues were heard at the subcommittee's March 2, 2021 and May 6, 2021 hearings.	AAB
4	4170	CDA	BCP (SFL) – Health Insurance Counseling and Advocacy Program (HICAP) Modernization	$2 million HICAP Fund	--	--	This issue was heard at the subcommittee's May 6, 2021 hearing. The proposal would be funded via the HICAP Fund, and not General Fund.	AAB
5	4170	CDA	BCP (SFL) – Master Plan on Aging Implementation	--	$3.3 million ongoing	20	This issue was heard at the subcommittee's May 6, 2021 hearing.	AAB
6	4170	CDA	BCP /TBL (SFL)– Office of the Long-Term Care Patient Representative	$2.5 million ongoing CDPH Licensing and Certification Fund	--	6	This issue was heard at the subcommittee's May 6, 2021 hearing.	Modify – Approve $2.5 million General Fund to fund the Office of the Long-Term Care Patient Representative.
7	4170	CDA	BCP (MR) – Community Based Adult Services Certification	$1.9 million	$773,000 in 2021-22 and $946,000 ongoing	10	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB

			Workload					
8	4170	CDA	BCP (MR) – CalFresh Expansion Older Adult Outreach	$2 million ongoing	$1.1 million ongoing	2	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB
9	4170	CDA	BCP (MR) – Older Adults Recovery and Resilience	--	$106 million one-time to be spent over three years	16	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB and adopt placeholder BBL requiring an ongoing needs assessment and advising the continued implementation of the Master Plan for Aging for all programs.
4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)								
10	4300	DDS	TBL (GB) – Acute Crisis Clarification and Admission	--	--	--	This issue was heard at the subcommittee's February 23, 2021 hearing.	Adopt placeholder TBL
11	4300	DDS	BCP (GB) – Forensic Diversion	$2.3 million ongoing	$853,000 ongoing	3	This issue was heard at the subcommittee's May 6, 2021 hearing.	AAB
12	4300	DDS	BCP (GB/MR) – Porterville Fire Sprinkler		GB: $221,000 one-time MR: $3.9 million one-time	--	These issues were heard at the subcommittee's February 23, 2021 and May 20, 2021 hearings.	AAB

13	4300	DDS	TBL (GB) – Community Navigators	$5.3 million ongoing	$3.2 million ongoing	--	This issue was heard at the subcommittee's February 23, 2021 hearing.	AAB and Adopt placeholder TBL to implement a statewide navigator model and design an evaluation of efforts to reduce purchase of service disparities.
14	4300	DDS	TBL (GB) – Residential Facilities for Special Health Care Needs	--	--	--	This issue was heard at the subcommittee's February 23, 2021 hearing.	Adopt placeholder TBL
15	4300	DDS	Relocation to the Clifford L. Allenby Building -Phase 3 (SFL)	--	$5.2 million for two years	1	The proposed funding would prove two year limited-term resources associated with rent, information technology, and infrastructure costs necessary for relocation.	AAB
16	4300	DDS	BCP (SFL) - Deaf Community	$2.6 million ongoing	$1.8 million ongoing	1	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB
17	4300	DDS	BCP (MR) – Disability Employment Grant		$10 million one-time		This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB
18	4300	DDS	Early Start Outreach to Tribal Communities (MR)		$500,000 ongoing	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB

19	4300	DDS	TBL(MR) – Self Determination Supports	$10.3 million	$6.8 million		This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB and adopt placeholder TBL with changes to language dealing with cost effectiveness of the program.
20	4300	DDS	TBL (MR) - Implicit Bias Training	$700,000	$553,000	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB and adopt placeholder TBL
21	4300	DDS	TBL (MR) – Lanterman Act Provisional Eligibility	--	$23.8 million ongoing	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB and adopt placeholder TBL
22	4300	DDS	TBL(MR) – Competitive Integrated Employment and Paid Internship Program	--	--	--	This issue was heard at the subcommittee's February 23, and May 20, 2021 hearing.	Adopt placeholder TBL to expand work opportunities within the PIP and CIE.
23	4300	DDS	Emergency Preparedness Resources (MR)		$4.3 million in 2021-22 and $200,000 ongoing	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB
24	4300	DDS	Bilingual Staff Differential (MR)	$3.6 million	$2.2 million	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB
25	4300	DDS	Systemic, Therapeutic, Assessment, Resources, and Treatment Teams (MR)	$5.7 million	$4 million	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB

26	4300	DDS	TBL (MR) – STAR Home DGS Lease Exemption for Homes in Progress	--	--	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	Adopt placeholder TBL
27	4300	DDS	Infrastructure Package - One-Time Deferred Maintenance (MR)		$5 million	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB
28	4300	DDS	2018 Deferred Maintenance Reappropriation (MR)		$2.7 million	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB
29	4300	DDS	Supplemental Individuals with Disabilities Education Act Funding (MR)	$24.5 million American Rescue Plan Act Funds	--	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB
30	4300	DDS	Language Only (MR) – Home and Community Based Services Provider Compliance Date Change	--	--	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	Adopt placeholder BBL
31	4300	DDS	Caseload and Utilization Updates (MR)				This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB

4700 DEPARTMENT OF COMMUNITY SERVICES AND DEVELOPMENT (CSD)								
32	4700	CSD	TBL (GB) – Community Services Block Grant Income Eligibility	--	--	--	The proposed TBL revises the definition of "eligible beneficiaries" for the Community Services Block Grant program	Adopt placeholder TBL
33	4700	CSD	TBL (MR) - Low-Income Home Energy Assistance Program	$203.6 million American Rescue Plan Act Funds	--	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB and adopt placeholder TBL
34	4700	CSD	TBL (MR) - Low-Income Household Water Assistance Program	$90 million federal funds	--	--	This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB and adopt placeholder TBL to require CSD to notify the Legislature upon development of the program plan
5160 DEPARTMENT OF REHABILITATION (DOR)								
35	5160	DOR	BCP (SFL) – Reimbursement Authority for Deaf and Disabled Telecommunications Program	$2.3 million reimbursement authority		--	This issue was heard at the subcommittee's May 6, 2021 hearing.	AAB
36	5160	DOR	Provisional Language (MR)	--	--	--	The proposed language would remove the	Adopt language to conform with

			– Elimination of the Supplemental Provider Rate Increase Suspension				Supplemental Provider Rate Increase Suspension.	previous actions taken by the subcommittee to remove all HHS funding suspensions.
37	5160	DOR	BCP (MR) – Disability Employment Grant		$10 million one-time		This issue was heard at the subcommittee's May 20, 2021 hearing.	AAB
5175 DEPARTMENT OF CHILD SUPPORT SERVICES (DCSS)								
38	5175	DCSS	TBL (GB) – LCSA E-Signature	--	--	--	This issue was heard at the subcommittee's February 16, 2021 hearing. The proposed TBL authorizes the use of electronic signatures statewide for child support documents.	Adopt placeholder TBL
39	5175	DCSS	BCP (GB) - Local Courts Funding (AB 1058)	$23.8 million ongoing	$8.1 million ongoing	--	This issue was heard at the subcommittee's February 16, 2021 hearing.	AAB
40	5175	DCSS	BCP (GB) – Child Support Payment Methodology Study	$750,000 a year for two years	$255,000 a year for two years	--	This issue was heard at the subcommittee's February 16, 2021 hearing.	Reject
41	5175	DCSS	TBL (GB) – Performance Incentives	--	--	--	This issue was heard at the subcommittee's February 16, 2021	Adopt placeholder TBL

							hearing.	
42	5175	DCSS	BCP (SFL) – LCSA Support	$31.1 million ongoing	$10.6 million ongoing	--	This issue was heard at the subcommittee's May 6, 2021 hearing.	AAB
5180 DEPARTMENT OF SOCIAL SERVICES (DSS)								
43	5180	DSS	Update to SNB/TNB Benefits (GB)	--	$81.7 million	--	This issue was heard at the subcommittee's February 9, 2021 hearing.	AAB
44	5180	DSS	BCP (GB) – Oversight of ARF Closures	--	$1.1 million ongoing	--	This issue was heard at the subcommittee's March 2, 2021 hearing.	AAB
45	5180	DSS	BCP (GB) – CalFresh Operations Support	$554,000 in 2021-22 and $521,000 ongoing	$332,000 in 2021-22 and $313,000 ongoing	3	This issue was heard at the subcommittee's February 9, 2021 hearing.	AAB
46	5180	DSS	BCP (GB) – CalWORKs HAP Resources	$260,000 ongoing	$38,000 ongoing	1.5	This issue was heard at the subcommittee's February 9, 2021 hearing.	AAB
47	5180	DSS	BCP (GB) – CalWORKs HSP Resources	$350,000 ongoing	$178,000 ongoing	2	This issue was heard at the subcommittee's February 9, 2021 hearing.	AAB
48	5180	DSS	BCP (GB) – Child & Family Services Review QA Support	$499,000 ongoing	$281,000 ongoing	3	This issue was heard at the subcommittee's February 16, 2021 hearing.	AAB

49	5180	DSS	BCP (GB) – Children's Residential Facilities & Law Enforcement	$399,000 a year for two years	$344,000 a year for two years	3	This issue was heard at the subcommittee's March 2, 2021 hearing.	AAB
50	5180	DSS	BCP (GB) – Children's Services Policy & Program Support	$9.8 million ongoing	$6.7 million ongoing	56	This issue was heard at the subcommittee's February 16, 2021 hearing.	AAB
51	5180	DSS	BCP (GB) – CCL Resources	$2.3 million ongoing	$1.9 million ongoing	17	This issue was heard at the subcommittee's March 2, 2021 hearing.	AAB
52	5180	DSS	BCP (GB) – EVV Continuation	--	$1.2 million one-time	7.5	This issue was heard at the subcommittee's March 2, 2021 hearing.	AAB
53	5180	DSS	BCP (GB) – Equal Employment Opportunity Resources	$320,000 ongoing	$139,000 ongoing	2	This issue was heard at the subcommittee's February 16, 2021 hearing.	AAB
54	5180	DSS	BCP (GB) – Immigration Services Support	--	$316,000 a year for three years	2	This issue was heard at the subcommittee's February 16, 2021 hearing.	AAB
55	5180	DSS	BCP (GB)– Oversight of CWS Data Quality	$767,000 ongoing	$441,000 ongoing	5	This issue was heard at the subcommittee's February 16, 2021 hearing.	AAB
56	5180	DSS	BCP (GB)– Office of Equity Language Resources	$920,000 ongoing	$797,000 ongoing	4	This issue was heard at the subcommittee's February 16, 2021 hearing.	AAB

57	5180	DSS	BCP (GB)– Office of Foster Care Ombudsperson	$949,000 ongoing	$765,000 ongoing	6	This issue was heard at the subcommittee's February 16, 2021 hearing.	AAB
58	5180	DSS	BCP (GB) – Office of Tribal Affairs Support	$450,000 ongoing	$281,000 ongoing	3	This issue was heard at the subcommittee's February 16, 2021 hearing.	AAB
59	5180	DSS	TBL (GB) – Restaurant Meals Program Extension	--	--	--	The proposed TBL would extend the deadline to establish and implement a statewide Restaurant Meals Program to on or before September 1, 2021.	Adopt placeholder TBL
60	5180	DSS	TBL (GB) – Refugee Support Services Funding	--	--	--	This issue was heard at the subcommittee's February 16, 2021 hearing.	Adopt placeholder TBL
61	5180	DSS	TBL (GB) – CalFresh Over Issuance Timeframe Adjustment	--	--	--	The proposed TBL would limit the period in which a county may establish a claim to recover an overissuance of CalFresh benefits due to inadvertent household error or administrative error to the 24 months before the month the county determined the overissuance occurred.	Adopt placeholder TBL
62	5180	DSS	TBL(GB) – SNAP/CalFresh	--	--	--	The proposed TBL would authorize the	Adopt placeholder TBL.

			Waiver Authority				department to implement a waiver approved by the U.S. Secretary of Agriculture through all-county letters until regulations are adopted, if the waiver is approved for 18 months or longer.	
63	5180	DSS	TBL(GB) – Out of State Relative Caregivers	--	--	--	This issue was heard at the subcommittee's February 16, 2021 hearing. The proposed TBL would extend eligibility for payments under the Approved Relative Caregiver Funding Program for youth placed in the home of a relative out-of-state if the home meets specified requirements.	Adopt placeholder TBL
64	5180	DSS	TBL (GB)– In-Home Supportive Services Residual Program Eligibility Requirements	--	--	--	The proposed TBL would make individuals who receive state-funded full-scope Medi-Cal eligible for state and county funded IHSS benefits.	Adopt placeholder TBL
65	5180	DSS	TBL (MR) – IHSS Medi-Cal Residual	--	--	--	The proposed TBL would clarify that IHSS recipients who fail to	Reject.

			Conformity				comply with requirements to determine Medi-Cal eligibility would not be eligible for the IHSS-Residual program, a state funded benefit. This language may auto-terminate IHSS recipients from the program and could cause a disruption in IHSS services for the recipient and a disruption in provider payments.	Rejection of this language will avoid a disruption in services for recipients and their automatic termination from the program.
66	5180	DSS	TBL (GB) – Licensing Administration Certification Program Fees	--	--	--	The proposed TBL would revise the existing fee structure for administrator certification training programs.	Adopt placeholder TBL
67	5180	DSS	BCP (SFL) – Appeals Case Management System	$892,000	$341,000 two year limited-tem	2	The requested funds would be used to plan for interfaces that will interact with multiple statewide eligibility determination data systems and allow users better access to due process.	AAB
68	5180	DSS	BCP (SFL) – CWS-CARES System Resources	$1.3 million	$953,000 a year for five years	8	This issue was heard at the subcommittee's May 11, 2021 hearing.	AAB

69	5180	DSS	BCP (SFL) – Housing and Homelessness Data Reporting Solution		$247,000 ongoing	1	The proposed funding would assist with the planning process to develop a single system to capture CDSS' housing and homelessness programs data. This solution will collect information on program key performance indicators and case-level data.	AAB
70	5180	DSS	BCP (SFL) - State Verification Hub Staff Resources	$5.3 million in 2021-22 and $1.7 million ongoing	$531,000 in 2021-22 and $169,000 ongoing	9.5	This issue was heard at the subcommittee's May 11, 2021 hearing.	AAB
71	5180	DSS	TBL - IHSS State and County Sharing Ratio (MR)	$203.8 million	$57.3 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB and adopt placeholder TBL to maintain current IHSS collective bargaining tools
72	5180	DSS	Provisional Language (MR) – Single Allocation Partial Reversion				The May Revision includes a request for provisional language to revert $250 million appropriated in 2019 for the Single Allocation.	AAB
73	5180	DSS	TBL - CalWORKs Family Reunification	--	$9 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB and adopt placeholder TBL

			(MR)					
74	5180	DSS	CalWORKs Indian Health Clinics (MR)	--	$1.9 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB
75	5180	DSS	TBL (MR) - Federal Pandemic Emergency Assistance Fund	$202.6 million federal funds	--	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB and adopt placeholder TBL
76	5180	DSS	Language Only (MR) – Time on Aid	--	--	--	This issue was heard at the subcommittee's May 18, 2021 hearing. The requested language would extend the pause of the CalWORKs 48-month time clock (MTC) until DSS is able to implement the 60 MTC, which is May 2022.	AAB
77	5180	DSS	CalFresh Notice of Denial or Pending Status (MR)	$1.3 million	$650,000	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB
78	5180	DSS	Translations for CalSAWS Consolidated Portal and Mobile Functionality (MR)	--	$1 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB
79	5180	DSS	CWS/CMS Data Cleanup (MR)	$1.5 million	$583,000	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB

80	5180	DSS	CWS/CMS Migration (MR)	$5.7 million	$1.2 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB
81	5180	DSS	Revised CWS-CARES Estimate (MR)	$71.2 million	$39.4 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB and adopt placeholder BBL to require a longer JLBC review period from 10 days to 30 days.
82	5180	DSS	TBL - Placement Prior to Approval (MR)	$12.9 million	$9.8 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB and adopt placeholder TBL
83	5180	DSS	Stipend for Tribal Social Work Students (MR)	$4.2 million	$3 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB
84	5180	DSS	Child and Adolescent Needs and Strengths Assessment Workload (MR)	--	$3.4 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB
85	5180	DSS	BBL only - Federal Flexibilities for Former Nonminor Dependents 21 and Older.	--	--	--	This issue was heard at the subcommittee's May 18, 2021 hearing. Amendments to provisional language needed to comply with COVID-19 federal flexibilities related to the voluntary reentry into extended foster care for a nonminor dependent that	Adopt placeholder BBL

							exited extended foster care between January 27, 2020 and April 17, 2020 are requested.	
86	5180	DSS	Support for Unaccompanied Undocumented Minors (MR)	--	$20 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing. This request also includes provisional language to identify purposes of the allocation.	AAB and adopt placeholder BBL
87	5180	DSS	Migrant Border Arrival Support (MR)	--	$8 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB
88	5180	DSS	Rapid Response Funding (MR)	--	$100 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB and adopt placeholder BBL requiring an update to the Legislature by March 1, 2022 on the services and supports provided in this effort.
89	5180	DSS	Deferred Action for Childhood Arrivals and Naturalization Filing Fees (MR)	--	$25 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB
90	5180	DSS	County Expense Claim Reporting Information System (MR)		$1.3 million	--	This issue was heard at the subcommittee's May 18, 2021 hearing.	AAB
91	5180	DSS	Provisional	--	--	--	The requested language	Adopt placeholder

			Language (MR): Housing for the Harvest				would allow the reappropriation of unexpended funds appropriated in the 2020 Budget Act for the Housing for the Harvest Program.	BBL
92	5180	DSS	Provisional Language (MR): Emergency Child Care Bridge Program Reapprpriation	--	--	--	The requested language would include reappropriation language for the Emergency Child Care Bridge Program.	Adopt placeholder BBL
93	5180	DSS	Provisional Language (MR): Family Urgent Response System Reappropriation	--	--	--	The requested language would include reappropriation language for the Family Urgent Response System.	Adopt placeholder BBL
94	5180	DSS	Provisional Language (MR): Rapid Response	--	--	--	The requested language would allow the reappropriation of unexpended funds appropriated in the 2020 Budget Act for the Rapid Response Program.	Adopt placeholder BBL
95	5180	DSS	Provisional Language (MR): Wildfire Assistance for Immigrants	--	--	--	The requested language would allow the reappropriation of unexpended funds appropriated in the 2020 Budget Act for the Wildfire Assistance for	Adopt placeholder BBL

							Immigrants Program.	
96	5180	DSS	Provisional Language (MR): Housing and Disability Advocacy Program	--	--	--	The requested language would allow the reappropriation of unexpended funds appropriated in the 2020 Budget Act for the Housing and Disability Advocacy Program.	Adopt placeholder BBL
97	5180	DSS	Provisional Language (MR): CalNEW	--	--	--	The requested language would allow the reappropriation of unexpended funds appropriated in the 2017 Budget Act for the California Newcomer Education and Well-Being (CalNEW) Program. Trailer bill language on this issue is also proposed in the May Revise on this issue.	Adopt placeholder BBL
98	5180	DSS	TBL – California Newcomer Education and Well-Being	--	--	--	The proposed language would appropriate funds to administer to school districts with eligible refugee students to improve their English language proficiency and academic performance	Adopt placeholder TBL
99	5180	DSS	TBL (MR) – CalWORKs Two Year	--	--	--	The proposed language would prohibit a county from collect any	Adopt placeholder TBL

			Overpayment Collection Limit				nonfraudulent overpayment that occurred more than 24 months prior to the date the county discovered the overpayment.	
100	5180	DSS	TBL – CalFresh Rebase	--	--	--	The proposed language changes the date by which the department and stakeholders must update the budgeting methodology used to determine funding for county administration of CalFresh.	Adopt placeholder TBL
101	5180	DSS	TBL – CalWORKs Time on Aid CW 8 Application Form Waiver	--	--	--	The proposed language would make it easier for a former CalWORKs recipient who was excluded from a current assistance unit due to the 48 month time limit to be added to an existing unit	Adopt placeholder TBL
102	5180	DSS	May Revision Caseload Estimates		*See Table 1	--		Modify – AAB and conform to other subcommittee actions.

Table 1. May Revision Caseload Adjustments (Issues 129, 161, 162, and 163)—The May Revision proposes a net increase of $1,263,359,000 (increases of $287,547,000 General Fund and $975,812,000 Federal Fund,) primarily from updated caseload estimates, one-time American Rescue Plan Act of 2021, and one-time General Fund investments since the Governor's Budget. Caseload and workload changes since the Governor's Budget are displayed in the following table:

Program	Item	Change from Governor's Budget
California Work Opportunity and Responsibility to Kids (CalWORKs)	5180-101-0001 5180-101-0890 Reimbursements	(1,005,158,000) (278,434,000) 7,000
Child Care	5180-101-0001 5180-101-0890 Reimbursements Reimbursements (Prop 64)	60,395,000 - 4,160,921,000 89,053,000
Kinship Guardianship Assistance Payment	5180-101-0001	575,000
Supplemental Security Income/ State Supplementary Payment (SSI/SSP)	5180-111-0001	(57,817,000)
In-Home Supportive Services (IHSS)	5180-111-0001 Reimbursements	146,391,000 464,998,000
Other Assistance Payments	5180-101-0001 5180-101-0122 5180-101-0890	(11,105,000) 659,000 40,689,000

	5180-101-8075	100,000
	Reimbursements	3,750,000
County Administration and Automation Projects	5180-141-0001	(133,111,000)
	5180-141-0890	1,698,000
	Reimbursements	22,494,000
Child Welfare Services (CWS)	5180-151-0001	(40,166,000)
	5180-151-0279	-
	5180-151-0890	180,290,000
	Reimbursements	92,000