AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, FEBRUARY 8, 2021

2:30 PM, STATE CAPITOL, ROOM 4202

Due to the regional stay-at-home order and guidance on physical distancing, seating for this hearing will be very limited for press and for the public. All are encouraged to watch the hearing from its live stream on the Assembly's website at https://www.assembly.ca.gov/todaysevents.

We encourage the public to provide written testimony before the hearing. Please send your written testimony to: BudgetSub1@asm.ca.gov. Please note that any written testimony submitted to the committee is considered public comment and may be read into the record or reprinted.

A moderated telephone line will be available to assist with public participation. After all witnesses on all panels and issues have concluded, and after the conclusion of member questions, the public may provide public comment by calling the following toll-free number: ***1-877-692-8957 / Access Code: 131 54 202.***

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 1: OVERVIEW OF EMSA BUDGET AND PANDEMIC RESPONSE

PANELISTS

- **Dr. Dave Duncan**, Director, Emergency Medical Services Authority (Presenting)
- **Louis Bruhnke**, Chief Deputy Director, Emergency Medical Services Authority (Presenting)
- **Craig Johnson**, Chief Disaster Medical Services Division, Emergency Medical Services Authority (Q&A only)
- **Richard Trussell**, Chief of Administration, Emergency Medical Services Authority (Q&A only)
- **Han Wang**, Finance Budget Analyst, Department of Finance (Q&A only)
- **Steven Pavlov**, Principal Program Budget Analyst, Department of Finance (Q&A only)
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office (Presenting)
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office (Q&A only)

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

ISSUE 2: OVERVIEW OF OSHPD BUDGET, PANDEMIC RESPONSE, AND HEALTH CARE WORKFORCE

PANELISTS

- **Elizabeth Landsberg**, Director, Office of Statewide Health Planning and Development (Presenting)
- **Caryn Rizell**, Acting Deputy Director, Health Care Workforce Development Division, Office of Statewide Health Planning and Development (Presenting)
- **Eric Reslock**, Acting Chief Deputy Director, Office of Statewide Health Planning and Development (Q&A only)
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance (Q&A only)
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance (Q&A only)
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office (Presenting)
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office (Q&A only)

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 3: OVERVIEW OF CDPH BUDGET AND PANDEMIC RESPONSE

PANELISTS

- **Dr. Tomas Aragon**, Director and State Public Health Officer, California Department of Public Health (Presenting)
- **Susan Fanelli**, Chief Deputy Director of Policy and Planning, California Department of Public Health (Presenting)
- **Dr. Erica Pan**, Deputy Director of Center for Infectious Diseases, California Department of Public Health (Presenting)
- **Monica Morales**, Deputy Director of Center for Healthy Communities, California Department of Public Health (Presenting)
- **Adrian Barraza**, Assistant Deputy Director of Center for Infectious Diseases, California Department of Public Health (Presenting)
- **Scott Vivona**, Assistant Deputy Director for Center for Health Care Quality, California Department of Public Health (Presenting)
- **Dr. James Watt**, Chief of Division of Communicable Disease Control, California Department of Public Health (Q&A only)
- **Sara Bosse**, Public Health Director, Madera County (Presenting)
- **Michelle Gibbons**, Executive Director, County Health Executives Association of California (Q&A Only)
- **Jack Zwald**, Principal Program Budget Analyst, Department of Finance (Q&A only)
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance (Q&A only)
- **Erin Carson**, Finance Budget Analyst, Department of Finance (Q&A only)
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office (Presenting)
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office (Q&A only)

ISSUE 4: STAKEHOLDER PANDEMIC EARLY ACTION PROPOSALS AFFECTING PUBLIC HEALTH

PANELISTS

- **Sara Bosse**, Public Health Director, Madera County (Presenting)
- **Michelle Gibbons**, Executive Director, County Health Executives Association of California (Q&A Only)
- **Shamika Ossey**, Public Health Nurse, Emergency Preparedness & Response Division, LA County Department of Public Health (Presenting)
- **Mary June Diaz**, Government Affairs Advocate, SEIU California State Council (Q&A Only)

- **Amy Blumberg**, Director of Legislative Affairs,
  California Association of Health Facilities (Presenting)
- **Scott Vivona**, Assistant Deputy Director of Center for Health Care Quality,
  California Department of Public Health (Presenting)

4260 DEPARTMENT OF HEALTH CARE SERVICES

ISSUE 5: STAKEHOLDER PANDEMIC EARLY ACTION PROPOSALS AFFECTING MEDI-CAL

PANELISTS

- **Amy Blumberg**, Director of Legislative Affairs,
  California Association of Health Facilities (Presenting)
- **Erica Murray**, President and CEO,
  California Association of Public Hospitals and Health Systems (Presenting)
- **Veronica Palacios**, Emergency Room Eligibility Specialist
  Highland Hospital (Presenting)
- **Mary June Diaz**, Government Affairs Advocate,
  SEIU California State Council (Q&A Only)
- **Jen Flory**, Policy Advocate, Western Center on Law and Poverty (Presenting)
- **Lucy Quacinella**, **Esq**., Multiforum Advocacy Solutions,
  For Maternal Child Health Access (Presenting)
- **Will Lightbourne**, Director, Department of Health Care Services (Presenting)
- **Jacey Cooper**, Chief Deputy Director & State Medicaid Director, Department of Health Care Services (Presenting)

ITEMS TO BE HEARD

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

OVERVIEW

The Governor's budget on EMSA includes three budget change proposals (BCPs). The Subcommittee plans to discuss the following items under Issue 1:

1. The Governor's proposed budget for EMSA;
2. EMSAs role and responsibilities in the pandemic; and
3. One BCP that directly relates to the state's ability to respond to public health crises.

The other two BCPs included in the EMSA budget are described in Issues 6 and 7 in the Non-Presentation section of this agenda.

ISSUE 1: OVERVIEW OF EMSA BUDGET AND PANDEMIC RESPONSE, INCLUDING:

- REGIONAL DISASTER MEDICAL HEALTH RESPONSE LOCAL ASSISTANCE BUDGET CHANGE PROPOSAL

PANELISTS

- **Dr. Dave Duncan**, Director, Emergency Medical Services Authority (Presenting)
- **Louis Bruhnke**, Chief Deputy Director, Emergency Medical Services Authority (Presenting)
- **Craig Johnson**, Chief Disaster Medical Services Division, Emergency Medical Services Authority (Q&A only)
- **Richard Trussell**, Chief of Administration, Emergency Medical Services Authority (Q&A only)
- **Han Wang**, Finance Budget Analyst, Department of Finance (Q&A only)
- **Steven Pavlov**, Principal Program Budget Analyst, Department of Finance (Q&A only)
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office (Presenting)
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office (Q&A only)

PROPOSED BUDGET

For 2021-22, the Governor's Budget proposes $37.4 million for the support of EMSA, a 44.5 percent decrease from the 2020-2021 current year budget. Of this amount, approximately $17.7 million is budgeted for State Operations, while the remaining is for Local Assistance. This significant decrease represent a 71.3 percent reduction in General Fund from $42.4 million to $12.2 million.

The overall proposed budget for EMSA is displayed in the table below. The primary source of funding for this department is federal funds, which is labeled "Federal Trust Fund" and "Reimbursements," in the table below. Reimbursements are federal funds that come through other departments first, namely the Departments of Health Care Services and Public Health.

EMERGENCY MEDICAL SERVICES AUTHORITY *(Dollars In Thousands)*					
Fund Source	**2019-20 Actual**	**2020-21 Projected**	**2021-22 Proposed**	**CY to BY Change**	**% Change**
General Fund	**$47,972**	**$42,397**	**$12,154**	**-$30,243**	**(71.3%)**
Emergency Medical Services Training Program Approval Fund	$211	$135	$150	$15	11.1%
Emergency Medical Services Personnel Fund	$2,813	$2,704	$2,796	$92	3.4%
Federal Trust Fund	$2,931	$4,914	$4,861	-$53	(1.1%)
Reimbursements	$23,822	$15,568	$15,738	$170	1.1%
Emergency Medical Technician Certification Fund	$1,492	$1,607	$1,669	$62	3.9%
Total Expenditures	**$79,241**	**$67,325**	**$37,368**	**$29,957**	**(44.5%)**
Positions	118.6	70.8	74.8	4	5.6%

EMSA'S ROLE IN PANDEMIC RESPONSE

Legislative staff requested that EMSA answer various questions and requests for information related to EMSA's role in responding to the pandemic, and EMSA provided the following information.

EMSA's pandemic response activities:

1. Activated EMSA Department Operations Center (DOC) to support statewide medical operations.
2. Provided support to Alternate Care Sites, Federal Medical Stations, Long-term Care Facilities, and hospitals.
3. Coordinated the approval of 21,062 out-of-state medical professionals to practice in California.
4. Established oxygen depots in S. CA to support hospital critical oxygen shortages.
5. Provided COVID testing in partnership with CANG – Conducted 2,384 tests to support the Central Valley, Monterey, and Tulare County.
6. Providing critical medical supplies to local hospitals and health care providers.
7. EMSA became the central repository and hub for all State procured ventilators, IV Pumps, and BiPAP machines.

8. Coordinating and onboarding of approximately 1,000 Health Corps personnel, a statewide medical staffing initiative spearheaded by the Governor's Office.
9. Co-leading the ESF 8 Multi-Agency Coordination (MAC) group for scarce resource allocation and policy guidance.
10. Coordinating statewide patient movement.
11. Assisted hospitals in Southern and Northern California with expanding ICU capacity to support COVID surge.
12. Assisted Cal OES with deployment and management of FMS and developing a plan for future storage and maintenance.
13. Deploying and managing EMSA Mobile Medical Shelter structures (formerly Mobile Field Hospitals) –
14. Increasing medical surge and infection control capability for hospitals, ACS, SNFs and the CA Patton State prison.
15. Providing alternate care facilities with the Patient Unified Lookup System for Emergencies (PULSE) - enables medical providers to have access to patient health information.
16. Provided medical support during the unprecedented statewide wildfires at Cal Fire Base Camps.
17. Conducting regular meetings with local and State partners to discuss trends, protocols, EMS guidance, best practices, and improvement opportunities.

Resources deployed by EMSA to date:

1. 800+ CAL-MAT members (291 currently deployed).
2. 2,100 individual Cal-MAT member deployments to support 89 missions, including 1 quarantine site, 4 ACS, 2 FMS, 1 medical shelter, 57 Long-term Care Facilities, and 24 Cal Fire Base Camps.
3. 6,000 patients treated
4. 4,298 contract staff currently supporting 195 medical facilities (5,175 total including CANG, federal, fire/EMS and Health Corps).
5. 130 EMTs/Paramedics (National EMS Contract) – to provide fixed site medical support.
6. 100 AMR EMT and Paramedics – Contracted to provide fix site medical and logistical support.
7. 650 CA Health Corps personnel to date – 3,238 shifts at medical facilities.
8. 1,500+ Disaster Healthcare Volunteers, including MRC members at the local level.
9. 40 Mobile Medical Shelter Structures for medical surge.
10. Patient Movement Contracted Resources
    i. 21 Ambulance Strike Teams plus single units for various transports
    ii. 5,762 statewide COVID patient transports arranged through the all access transfer center.
11. 1,694 Ventilators to medical facilities; 12,929 units ready for immediate deployment.

Key challenges facing EMSA:

1. Staffing challenges, both trained medical and administrative to meet pandemic response activities.
2. Insufficient warehouse space for storing additional equipment such as ventilators.
3. Rapid need to expand all response programs including CALMAT, DHV, IT and communications support.

EMSA's work on health care workforce and challenges of the Health Corps:

1. EMSA coordinated the approval of over 20,100 out of state medical personnel.
2. EMSA was able to grow the CAL-MAT program from 180 members to approximately 1,100 members with another 1,000 members pending approval. The exponential growth was partly due to the large number of Health Corps registrants in the DHV system. Many Health Corp registrants became CAL-MAT members.
3. EMSA effectively deployed over 800 CAL-MAT members to support the COVID response.
4. The California Health Corps program relies on members volunteering to cover shifts to support facilities in their same geographic area.
5. While a large number of individuals originally registered for the program, a much smaller pool of registrants qualified and expressed interest in participating when contacted by EMSA and CDPH.
6. The majority of Health Corps registrants did not fully complete the process to onboard, either within the DHV system, or the application and screening processes conducted by Cal HR that are required to be employed by the State.
7. Of the approximately 5,000 screened applicants that potentially qualified to deploy in April 2020, 847 staff proceeded with the application and onboarding process and were approved to deploy as the initial pool within Health Corps.
8. Treating COVID+ patients is a significant commitment.
9. Effective measures to preserve regional hospital capacity resulted in minimal need for Health Corps staff at Sleep Train in the spring of 2020. Some motivated Health Corps workers at that site sought work elsewhere.
10. Reduced available pool of medical staff due to the nature of the COVID-19 virus affecting older population of health care workers.
11. Despite these limitations the Health Corps members have covered 2,892 shifts at 115 medical facilities throughout California including Alternate Care Sites, Correctional Facilities, and Skilled Nursing Facilities.

REGIONAL DISASTER MEDICAL HEALTH RESPONSE LOCAL ASSISTANCE BUDGET CHANGE PROPOSAL

EMSA requests $365,000 General Fund ongoing to improve regional disaster medical and health mitigation, preparedness, response and recovery by permanently funding an additional three local Regional Disaster Medical Health Specialist (RDMHS) in three California Governor's Office of Emergency Services (Cal OES) Mutual Aid regions.

Since 1989, California Health and Safety Code 1797.152 has required the establishment of a Regional Disaster Medical and Health Coordination Program in each California Mutual Aid Region which includes the voluntary position of Regional Disaster Medical Health Coordinator (RDMHC). The RDMHC's "shall be either a county health officer, a county coordinator of emergency services, an administrator of a local EMS agency, or a medical director of a local EMS agency" and in the event of a major disaster the RDMHC may coordinate the acquisition of medical, public, environmental and behavioral health mutual aid resources. The RDMHC also coordinates the development of plans for the provision of medical and public health mutual aid among the counties in the region. Currently, all of the RDMHC positions within the State of California are filled by appointed volunteers who hold other full-time local government positions. EMSA explains that, because of this, the RDMHC position is not able to address planning and development of a regional mutual aid system while still addressing day-to-day and emergent needs within the region and outside of the region. Therefore, EMSA believes that the voluntary program ultimately is not adequate to meet the disaster medical and health mutual aid planning and development needs of California.

In a catastrophic event the RDMHSs are responsible for assessing, requesting and coordinating public health and medical resources through the State for any one or more of the 137 MHOACS in California. EMSA states that, despite being vital to State, Regional and County medical and public health response, the RDMHS program has consistently been under-resourced and understaffed in every disaster response over the past several years, and this has been repeatedly reported and discussed in After Action Meetings and written into After Action Report Improvement Plans.

Beginning in the 2019-2020 fiscal year, the need for additional RDMHS staffing became a priority concern for COVID-19 response due to the inability of the single RDMHS support in each of the six Cal OES Mutual Aid Regions to address the significant amount of response needs coming from the Operational Areas. EMSA, working with CDPH, provided a temporary fix to double RDMHS staffing levels, which greatly helped the response efforts, and the six OES Mutual Aid Regions were awarded $180,000 ($30,000 each) to hire an additional RDMHS coordinator in each region. The costly lesson learned demonstrated the critical need to support each Mutual Aid Region with two permanent RDMHS positions, according to EMSA.

The 2020 Budget Act included ongoing $365,000 General Fund to provide three additional Regional Disaster Medical and Health Specialists to support local efforts to implement regional disaster preparedness, response, mitigation, and recovery activities in the three OES Administrative Regions. Additionally, current law requires that if EMSA determines by May 15, 2021, that reimbursement from the federal Emergency Management Agency (FEMA) for expenditures related to the three remaining regional disaster medical health specialists is not available or that actual reimbursement is less than estimated, the Director of Finance may augment EMSA's budget by an amount that is up to the difference between the actual reimbursement received for the 2020–21 fiscal year and the amount that was estimated, and no greater than $365,000.

BACKGROUND

EMSA's mission is to coordinate emergency medical services (EMS) statewide; develop guidelines for local EMS systems; regulate the education, training, and certification of EMS personnel; and coordinate the state's medical response to any disaster.

EMSA is comprised of the following three divisions:

- ***Disaster Medical Services Division*.** The Disaster Medical Services Division coordinates California's medical response to disasters. It is the responsibility of this division to carry out the EMS Authority's mandate to provide medical resources to local governments in support of their disaster response, and coordinate with the Governor's Office of Emergency Services, Office of Homeland Security, California National Guard, California Department of Public Health, other local, state, and federal agencies, private sector hospitals, ambulance companies and medical supply vendors to improve disaster preparedness and response.

- ***EMS Personnel Division*.** The EMS Personnel Division oversees licensure and enforcement functions for California's paramedics, personnel standards for pre-hospital emergency medical care personnel, trial studies involving pre-hospital emergency medical care personnel, first aid and CPR training programs for child day care providers and school bus drivers.

- ***EMS Systems Division*.** The EMS Systems Division oversees EMS system development and implementation by the local EMS agencies, trauma care and other specialty care system planning and development, EMS for Children program, California's Poison Control System, emergency medical dispatcher standards, EMS Data and Quality Improvement Programs, and EMS communication systems.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff requests EMSA provide a brief overview of EMSA's proposed budget, the RDMHS BCP, and an explanation of EMSA's roles and responsibilities related to the pandemic. Please also respond to the following:

1. Please explain the significant reduction in General Fund in the proposed EMSA budget?

2. Regarding the RDMHS BCP, would it not be justified and beneficial for California to have more than two RDMHSes in each Mutual Aid region?

3. Please identify a few of the most significant gaps in resources at EMSA that, if fortified, would enable EMSA to improve its emergency response capabilities. Are these gaps addressed in the Governor's budget?

Staff Recommendation: It is apparent that the state needs to increase its investments in public health and emergency response infrastructure, arguably well beyond what is being requested here, and therefore staff recommends that the Subcommittee consider supporting the RDMHS BCP when actions are taken later in the spring.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

OVERVIEW

The Governor's budget on OSHPD includes five budget change proposals (BCPs) and a proposal to establish an Office of Health Care Affordability. The Subcommittee plans to discuss the following items under Issue 1:

1. The Governor's proposed budget for OSHPD;
2. OSHPD's role and responsibilities related to the pandemic and in addressing health care workforce shortages and diversity; and
3. One budget change proposal (BCP) supporting the geriatric health care workforce.

The Governor's proposal to establish an Office of Health Care Affordability (and related BCP) is not included in this agenda because it would require a substantial amount of the Subcommittee's time and attention in order to properly evaluate and vet the proposal. At this point in time, given the severity of the pandemic, the Subcommittee is choosing to devote its very limited hearing time to proposals and issues that are more directly related to the COVID-19 crisis. Hence, this proposal is being deferred without prejudice and the Subcommittee hopes to be able to turn its attention to it later this spring.

The other three OSHPD BCPs are described in issues 8, 9, and 10 in the Non-Presentation section of this agenda.

ISSUE 2: OVERVIEW OF OSHPD BUDGET, PANDEMIC RESPONSE, AND HEALTH CARE WORKFORCE, INCLUDING:

- GERIATRIC CARE WORKFORCE BUDGET CHANGE PROPOSAL

PANELISTS

- **Elizabeth Landsberg**, Director,
  Office of Statewide Health Planning and Development (Presenting)
- **Caryn Rizell**, Acting Deputy Director, Health Care Workforce Development Division,
  Office of Statewide Health Planning and Development (Presenting)
- **Eric Reslock**, Acting Chief Deputy Director,
  Office of Statewide Health Planning and Development (Q&A only)
- **Madison Sheffield**, Finance Budget Analyst, Department of Finance (Q&A only)
- **Iliana Ramos**, Principal Program Budget Analyst, Department of Finance (Q&A only)
- **Corey Hashida**, Fiscal and Policy Analyst, Legislative Analyst's Office (Presenting)
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office (Q&A only)

PROPOSED BUDGET

For 2021-22, the Governor's Budget proposes $185.4 million for the support of OSHPD. The proposed budget reflects a 37.9 percent ($113.1 million) decrease from the current year budget, primarily reflecting a $105 million decrease in General Fund and a $27 million decrease in Mental Health Services Fund. The following table details the proposed budget for OSHPD:

OSHPD Budget
(Dollars in Thousands)

Fund Source	2019-20 Actual	2020-21 Projected	2021-22 Proposed	CY to BY $ Change	% Change
General Fund	$54,135	$141,671	$36,333	-$105,338	(74.4%)
Hospital Building Fund	$68,269	$64,248	$68,587	$4,339	6.8%
Health Data & Planning Fund	$37,309	$34,513	$46,771	$12,258	35.5%
Registered Nurse Education Fund	$2,200	$2,194	$2,205	$11	0.50%
Health Facility Construction Loan Insurance Fund	$5,212	$5,040	$5,234	$194	3.8%
Health Professions Education Fund	$10,983	$10,864	$10,724	-$140	(1.3%)
Federal Trust Fund	$1,584	$1,694	$1,573	-$121	(7.1%)
Reimbursements	$3,316	$3,099	$5,903	$2,804	90.5%
Mental Health Practitioner Education Fund	$827	$817	$829	$12	1.5%
Vocational Nurse Education Fund	$226	$225	$228	$3	1.3%
Mental Health Services Fund	$28,353	$29,692	$2,594	-$27,098	(91.3%)
Medically Underserved Account For Physicians, Health Professions Education Fund	$4,403	$4,401	$4,404	$3	0.07%
TOTAL EXPENDITURES	**$216,817**	**$298,458**	**$185,385**	**-$113,073**	**(37.9%)**
Positions	433.9	428.9	484.9	56	13.1%

PANDEMIC RESPONSE AND HEALTH CARE WORKFORCE DIVERSITY AND SHORTAGES

OSHPD Pandemic Response

Legislative staff asked OSHPD for a description of its role and responsibilities in responding to the pandemic, and OSHPD indicated the following:

1. Activated an operations center to track facilities, gather data and other types of information;
2. Established a dashboard for data on hospital capacity, PPE supplies and other pandemic-related health care issues;
3. Identified skilled nursing facilities (SNF) that could serve as expansion sites;

4. Established SNF Hero Awards; and
5. Provided technical assistance on various health care issues: e.g., vaccine storage, oxygen supplies, and school re-openings.

Health Care Workforce Diversity

As described under "Background" below, various OSHPD programs seek to increase diversity in California's health care workforce. The Subcommittee would like to request that OSHPD provide a thorough description of these programs and any evidence that they are effective. The Subcommittee also would like to explore the possibility of establishing a statewide Health Careers Opportunity Program (HCOP) within OSHPD, which would be modeled after the program that exists at California State University, Fresno.

According to the HCOP website, each year, HCOP serves nearly 200 Fresno State students who are engaged in addressing the growing health needs of communities. HCOP students receive necessary and on-going academic support, guidance and opportunities to become aspiring health professionals. HCOP connects students with fundamental resources to overcome their emotional, educational, financial and social challenges. As described on the HCOP website, "Dedicated faculty, staff, students and the community provide a personal touch in helping each student reach their journey. Once students reach the ranks of our university, as a HCOP student, we offer the resources and assistance to help prepare students to become competitive applicants for medical, dental, pharmacy, optometry, physician assistant, clinical psychology, chiropractic, podiatry, veterinary, clinical lab science, or public health programs." HCOP services include:

- Coordination with campus pre-health advising services
- Pre-Health conferences
- Health professional school site visits
- Health professional application assistance
- Professional development workshops
- Information regarding research opportunities
- Collaboration with pre-health campus clubs

GERIATRIC CARE WORKFORCE BUDGET CHANGE PROPOSAL

OSHPD requests $3 million one-time General Fund ($2.85 million in local assistance and $150,000 in state operations) to support geriatric care providers through OSHPD's existing health workforce development programs.

As a part of this BCP, OSHPD also requests provisional language making the state operation funds available for encumbrance or expenditure through June 30, 2023. Consistent with other OSHPD workforce programs, standing provisional language would authorize local assistance funding to be available for encumbrance or expenditure through June 30, 2027.

Currently, OSHPD's workforce development programs provide incentives in various health careers. Award recipients include those who plan to complete their service obligation working with geriatric populations, such as direct care staff, nurses, physicians, social workers, palliative care, and mental health practitioners.

OSHPD explains that their numerous health care workforce development programs include a variety of pathways for supporting minority and other underrepresented student populations and incentivizing service in areas with greater need. Through the Health Careers Training Program, the Health Care Workforce Development Division (HWDD) administers Mini-Grants to support under-represented, economically and educationally disadvantaged students in pursuit of health care careers by providing grants to organizations for health career conferences and workshops, and health career exploration.

Through repayment of qualified educational loans, HWDD's California State Loan Repayment Program (SLRP) increases the number of primary care physicians (including those with a gerontology specialty), dentists, dental hygienists, physician assistants, nurse practitioners, certified nurse midwives, pharmacists, and mental/behavioral health providers practicing in federally designated health provider shortage areas. In exchange for a loan repayment award, recipients agree to practice in a medically underserved area for two years.

The Health Professions Education Foundation (HPEF) is a 501(c)(3) nonprofit benefit corporation housed within OSHPD that administers six scholarship and six loan repayment programs to health professional students and graduates in exchange for providing medical and mental health services in underserved areas throughout the state.

OSHPD states that this proposed new investment reflects goals and strategies included in the Master Plan for Aging, related to increasing the geriatric workforce pipeline.

BACKGROUND

OSHPD develops policies, plans and programs to meet current and future health needs of the people of California. Its programs provide health care quality and cost information, ensure safe health care facility construction, improve financing opportunities for health care facilities, and promote access to a culturally competent health care workforce. OSHPD is made up of the following Department Divisions (as described in the budget):

Health Care Quality and Affordability

The Health Care Quality and Affordability Program provides a comprehensive understanding of health care cost trends and drivers of spending and implements strategies for controlling costs, while maintaining quality care and promoting savings for consumers. The Program increases public transparency on total health care spending, sets an overall statewide cost target and specific targets for different sectors of the health care industry, enforces compliance with the cost target, and promotes and measures quality and equity through adopting standard measures. The Program monitors health care market consolidation, conducts cost and market impact reviews, and collaborates with state regulating entities. The Program also sets goals and standards for the adoption and use of alternative payments models, prioritizes primary care and behavioral health investments, and monitors and addresses health care workforce stability.

Health Care Workforce

The Health Care Workforce Program, through the Health Care Workforce Development Division and the Health Professions Education Foundation, improves access to medical, mental, and dental health care providers in underserved areas throughout California. The Program conducts research to identify areas of unmet need and administers grants that provide financial incentives to individuals and institutions to increase the number of providers in those areas. The Program promotes health care workforce diversity and cultural competency. It includes the following programs:

- Song-Brown Health Care Workforce Training Program
- Mental Health Services Act Workforce Education and Training Program
- California State Loan Repayment Program
- Health Care Workforce Clearinghouse Program
- Health Professions Career Opportunity Training Program
- Health Workforce Pilot Projects Program
- Shortage Designation Program
- Health Professions Education Foundation Programs

Facilities Development

The Facilities Development Program safeguards public health, safety, and general welfare through regulation of the design and construction of health care facilities, including compliance with seismic safety requirements, to ensure they are capable of providing sustained services to the public.

Cal-Mortgage Loan Insurance

The Cal-Mortgage Program is modeled after federal home mortgage insurance programs and insures loans to public and nonprofit health care facilities for construction, renovation, and expansion projects. The Program underwrites loans, monitors the Cal-Mortgage insured loan portfolio, and administers the Health Facility Construction Loan Insurance

Fund. By facilitating access to private capital at no cost to taxpayers, the Program has improved the delivery of health care throughout California.

Health Care Information and Quality Analysis

The Health Care Information Program sets standards for, collects, and maintains financial and utilization data from approximately 7,000 licensed health facilities in California, as well as comprehensive demographic, diagnostic, and treatment data for all patients discharged from licensed hospitals, treated in emergency departments, or having had an ambulatory surgery procedure in hospital surgical clinics. This information is used by health care policymakers, health care providers, health planners, public and private sector health care purchasers, researchers, consumers, and the media. To further this mission, the Health Care Information Program is implementing new health care cost transparency data programs to collect and analyze prescription drug cost data, hospital supplier diversity data, and health care payment data to improve transparency, inform policy decisions, reduce disparities, and reduce health care costs.

STAFF COMMENTS/QUESTIONS

The Subcommittee staff requests OSHPD provide a brief overview of OSHPD's proposed budget, the Geriatric Health Care Workforce BCP, an explanation of EMSA's roles and responsibilities related to the pandemic, and discuss the state's progress on diversifying the state's health care workforce. Please also respond to the following:

1. Please explain the substantial decreases in both General Fund and Mental Health Services Fund in the proposed OSHDP budget.

2. Please describe OSHPD's programs that promote diversity in California's health care workforce, and any evidence of the effectiveness of those programs.

3. What are California's goals for increasing diversity in the health care workforce?

4. Would the administration be open to establishing a statewide HCOP within OSHPD?

5. How will OSHPD measure the effectiveness of the proposed new investment included in the Geriatrics Workforce BCP?

6. Will Geriatrics grants be available to providers already working in shortage areas, and if so, what does the state gain from these grants?

7. How will racial equity be achieved in the awarding of the Geriatrics grants?

Staff Recommendation: Workforce shortages and diversification are well-documented challenges in California, especially in geriatrics. Given this, the Subcommittee should consider supporting OSHPD's BCP on this subject, however an evaluation/accountability component should be added to the initiative. Moreover, if these funds prove to be effective, the Legislature may want to consider a much larger investment in this area than what is being proposed here.

4265 DEPARTMENT OF PUBLIC HEALTH

OVERVIEW

The Governor's budget for the California Department of Public Health (CDPH) includes 11 budget change proposals (BCPs), adjustments to tobacco tax revenue estimates (primarily Propositions 99 and 56) and related program changes, and four program estimates for: 1) AIDS Drug Assistance Program (ADAP); 2) Women, Infants and Children Program (WIC); 3) Genetic Disease Screening Program; and 4) Center for Health Care Quality (including funding for the state's contract with LA County). Finally, the budget includes a proposal to establish a new Department of Cannabis Control, and to shift cannabis-related resources and functions currently within CDPH to this new department. From this, Issue #3 in today's agenda covers the following:

- Overview of the proposed CDPH budget;
- Discussion of the state's pandemic response;
- Four BCPs directly related to the pandemic; and
- Support for Alzheimer's Disease Awareness, Research, and Training BCP.

The additional six BCPs are described in Issues 11-16 in the Non-Presentation section of this agenda, and the proposal to shift cannabis resources to a new department can be found in Issue 17 of this agenda. The four program estimates and tobacco tax adjustments will be reviewed by the Subcommittee when they are updated at the May Revise.

ISSUE 3: OVERVIEW OF CDPH BUDGET AND PANDEMIC RESPONSE, INCLUDING:

- **COVID-19 DIRECT RESPONSE EXPENDITURES BUDGET CHANGE PROPOSAL**
- **COVID-19 WORKPLACE OUTBREAK REPORTING (AB 685) BUDGET CHANGE PROPOSAL**
- **ADJUSTMENT TO SUPPORT INFECTIOUS DISEASE MODELING BUDGET CHANGE PROPOSAL**
- **HEALTH CARE AND ESSENTIAL WORKERS: PPE (SB 275) BUDGET CHANGE PROPOSAL**
- **SUPPORT FOR ALZHEIMER'S DISEASE AWARENESS, RESEARCH, AND TRAINING BUDGET CHANGE PROPOSAL**

PANELISTS

- **Dr. Tomas Aragon**, Director and State Public Health Officer, California Department of Public Health (Presenting)
- **Susan Fanelli**, Chief Deputy Director of Policy and Planning, California Department of Public Health (Presenting)
- **Dr. Erica Pan**, Deputy Director of Center for Infectious Diseases, California Department of Public Health (Presenting)
- **Monica Morales**, Deputy Director of Center for Healthy Communities,

California Department of Public Health (Presenting)
- **Adrian Barraza**, Assistant Deputy Director of Center for Infectious Diseases, California Department of Public Health (Presenting)
- **Scott Vivona**, Assistant Deputy Director for Center for Health Care Quality, California Department of Public Health (Presenting)
- **Dr. James Watt**, Chief of Division of Communicable Disease Control, California Department of Public Health (Q&A only)
- **Sara Bosse**, Public Health Director, Madera County (Presenting)
- **Michelle Gibbons**, Executive Director, County Health Executives Association of California (Q&A Only)
- **Jack Zwald**, Principal Program Budget Analyst, Department of Finance (Q&A only)
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance (Q&A only)
- **Erin Carson**, Finance Budget Analyst, Department of Finance (Q&A only)
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office (Presenting)
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office (Q&A only)

PROPOSED DEPARTMENT BUDGET

The Governor's proposed 2021-22 budget, displayed in the charts on the following page, provides CDPH approximately $4.2 billion overall, representing a $105 million (total funds), or 2.4 percent decrease from the current year CDPH budget. An unprecedented level of General Fund dollars, $1.1 billion, makes up 25 percent of the department's total budget while federal funds make up approximately 37.4 percent of the total department's budget. The unusually high level of General Fund reflects the key role this department plays in the current public health emergency. The major changes to the CDPH budget include:

Current Year COVID-19 Disaster Response – The Budget includes over $1 billion in 2020-21 which reflects state and federal support for emergency response measures including supporting enhanced laboratory capacity and testing, data-driven investigation, response and prevention, coordination with partners, and the Valencia Branch Laboratory. This total mainly reflects emergency funds and federal grants processed as of late Fall 2020; additional anticipated current year funding as of the Governor's Budget is carried in a statewide item.

Budget Year COVID-19 Disaster Response – The Budget includes over $820 million in funding to continue and build on the emergency response measures described above.

Transfer of Cannabis Resources – The Budget proposes to transfer from the Department of Public Health 119 positions and $29.0 million in 2021-22 to support the consolidation of resources for the new Department of Cannabis Control.

Licensing and Certification – The Budget includes $19.1 million for year three of the Los Angeles County contract and $4.5 million to support increased medical breach and caregiver investigation workload. The Budget also includes ongoing funding of $164,000 to support 0.5 positions for compliance and 0.5 positions for Healthcare-Associated Infections expertise to create regulations for a personal protective equipment (PPE) stockpile.

Alzheimer's Disease Awareness, Research, and Training – The Budget includes a one-time $17 million General Fund appropriation to expand Alzheimer's disease-focused programs, including a new caregiver and certification program, public awareness campaigns, and standard of care centers.

This chart displays the major sources of funding in the CDPH budget:

DEPARTMENT OF PUBLIC HEALTH *(Dollars In Thousands)*					
Fund Source	**2019-20 Actual**	**2020-21 Projected**	**2021-22 Proposed**	**CY to BY $ Change**	**CY to BY % Change**
General Fund	**$463,622**	**$748,987**	**$1,058,070**	**$309,083**	**41.3%**
Federal Funds	$1,517,420	$1,557,612	$1,587,791	$30,179	1.9%
Special Funds & Reimbursements	$755,198	$1,118,875	$608,522	-$510,353	(45.6%)
Licensing & Certification Fund	$193,927	$212,458	$257,179	$44,721	21.0%
Genetic Disease Testing Fund	$143,229	$139,453	$145,885	$6432	4.6%
WIC Manufacturer Rebate Fund	$210,098	$196,784	$174,414	-$22,379	(11.4%)
AIDS Drug Assistance Program Rebate Fund	$307,061	$373,037	$409,717	$36,680	9.8%
Total Expenditures	**$3,590,555**	**$4,347,206**	**$4,241,578**	**-$105,628**	**(2.4%)**
Positions	3,611.9	3,741.4	3,699.4	-42	(1.1%)

The following table shows proposed expenditures by program area.

DPH Program Expenditures *(In Thousands)*					
Program	**2019-20 Actual**	**2020-21 Estimate**	**2021-22 Proposed**	**CY to BY $ Change**	**CY to BY % Change**
Emergency Preparedness	$304,128	631,428	912,808	$281,380	44.6%
Healthy Communities	581,237	433,964	429,716	-$4,248	(1.0%)
Competitive Grants	-	-1,000	-	-$1,000	(100%)
Infectious Disease	746,245	1,248,743	773,504	-$475,239	(38.1%)
Family Health	1,441,420	1,493,213	1,556,718	$63,505	4.3%
Health Statistics & Informatics	38,298	32,497	33,822	$1,325	4.1%
County Health Services	163	54	169	$115	213.6%
Environmental Health	140,307	146,645	124,531	-$22,114	(15.1%)
Health Facilities	322,713	340,562	389,011	$48,449	14.2%
Laboratory Field Services	16,044	21,100	21,299	$199	0.9%
Total Expenditures	**3,590,555**	**4,347,206**	**4,241,578**	**-$105,628**	**(2.4%)**

CDPH PANDEMIC RESPONSE

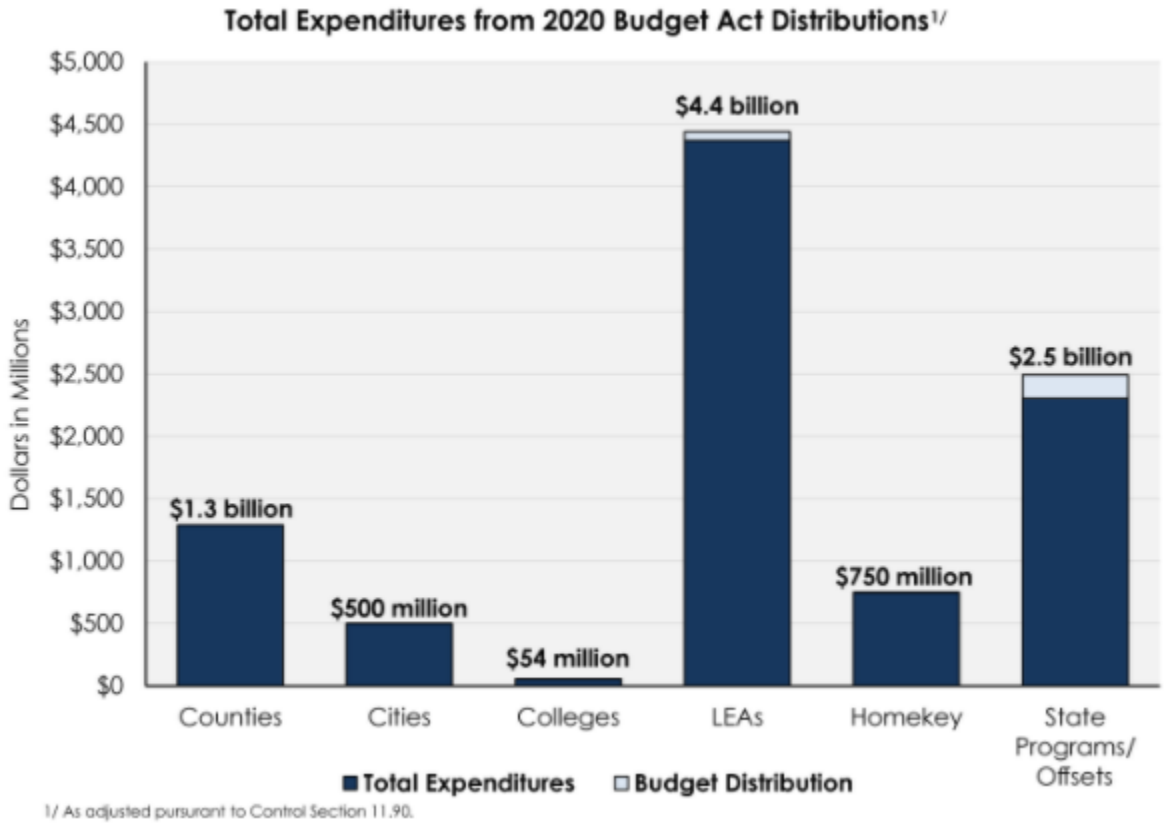
Given the complexity of COVID-19 spending in California, and the speed with which California has had to respond to the crisis, it is challenging to track, understand, and describe: how much money has been spent, on what it has been spent, sources of funding, and how effectively it has been spent. Fortunately, the LAO has developed a document which seeks to answer these questions, specifically in the context of CDPH. Specifically, the LAO handout covers:

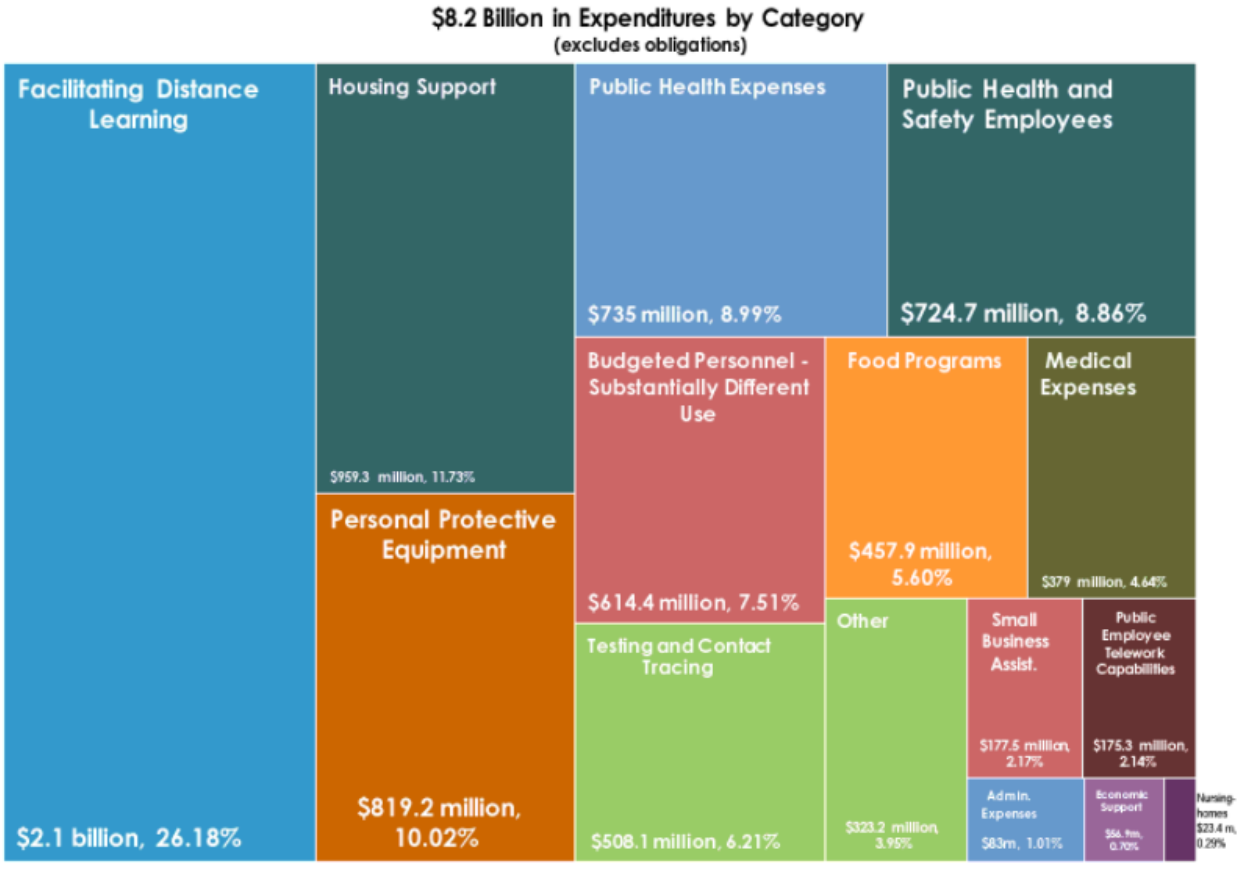
- Direct COVID-19 spending within the CDPH budget;
- Funding that flows through the CDPH budget to California's 61 local health jurisdictions (LHJs) for COVID-19 response;
- Provides a framework for evaluating midyear and budget-year proposals and actions related to COVID-19 within CDPH's budget; and
- Offers key public health issues for legislative consideration during the COVID-19 recovery.

The Pandemic's Budget (Information Provided by the Department of Finance)

In March, the Coronavirus Aid, Relief, and Economic Security (CARES) Act allocated federal Coronavirus Relief Funds (CRF) to state and local governments for COVID-19 expenditures incurred between March 1 and December 30, 2020 in response to COVID-19. Based on population, California received a total of $15.3 billion from the CARES Act — with $9.5 billion allocated directly to the state, $5.8 billion allocated to 15 large counties (including San Francisco), and 5 cities with populations over 500,000. In late December 2020, the date to spend these funds was extended by the Coronavirus Response and Relief Supplemental Appropriations Act through December 31, 2021. A conforming change to state law is required for recipients of the state funds to spend these funds after December 30, 2020.

Federal guidance associated with the CARES Act require states to submit quarterly expenditure reports in 17 categories associated with COVID-19 response and mitigation. The third reporting cycle covers expenditures incurred from March 1 through December 30. To meet this deadline — and to provide transparency in reporting how these funds are being spent — the Department of Finance has collected data from counties, cities, local education agencies, community college districts, and state agencies regarding expenditures and obligations to date. The chart below shows the total allocated in key areas and the percentage of funds spent to date.


Total Expenditures from 2020 Budget Act Distributions1/
Dollars in Millions
$5,000
$4,500
$4,000
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
$1.3 billion
$500 million
$54 million
$4.4 billion
$750 million
$2.5 billion
Counties
Cities
Colleges
LEAs
Homekey
State Programs/ Offsets
Total Expenditures
Budget Distribution
1/ As adjusted pursuant to Control Section 11.90.


$8.2 Billion in Expenditures by Category
(excludes obligations)
Facilitating Distance Learning
$2.1 billion, 26.18%
Housing Support
$959.3 million, 11.73%
Personal Protective Equipment
$819.2 million, 10.02%
Public Health Expenses
$735 million, 8.99%
Budgeted Personnel - Substantially Different Use
$614.4 million, 7.51%
Testing and Contact Tracing
$508.1 million, 6.21%
Public Health and Safety Employees
$724.7 million, 8.86%
Food Programs
$457.9 million, 5.60%
Medical Expenses
$379 million, 4.64%
Other
$323.2 million, 3.95%
Small Business Assist.
$177.5 million, 2.17%
Public Employee Telework Capabilities
$175.3 million, 2.14%
Admin. Expenses
$83m, 1.01%
Economic Support
$56.9m, 0.70%
Nursing-homes
$23.4 m, 0.29%

Epidemiology and Laboratory Capacity (ELC) Enhancing Detection Through Coronavirus Response and Relief Supplemental Funds

CDPH received official notification of the availability of additional, unanticipated federal funds on January 7, 2021. The federal ELC Enhancing Detection funds provide the state with $1.7 billion to support testing, contact tracing, vaccination, surveillance, containment and mitigation through the federal Centers for Disease Control and Prevention (CDC). ELC funding was previously provided to the state in the summer of 2020, however this funding is notably different in that the CDC has explicitly permitted its use for vaccination activities. Collectively, these funds will provide local public health departments with additional resources to mitigate the spread of the virus and reduce the number of hospitalizations related to COVID-19. These funds intend to build upon prior efforts funded through the initial allocation of ELC funds.

Of the total $1.7 billion in ELC funding, $1,187,498,000 will be provided to local governments and used to further six strategies: (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. Recently released federal guidelines include vaccination operations as an eligible use of these funds.

Vaccine Distribution

As has been well documented by the press, the distribution of the COVID-19 vaccines in California has been slower than anyone wanted, extremely confusing to the public, and arguably quite inequitable. Anecdotal information suggests that, thus far, the vaccines have been accessible to economically-advantaged individuals, while inaccessible to those at higher risk: Latino and African American essential workers.

CDPH identifies the following key challenges in the vaccine distribution:

- Unpredictability of the supply,
- Unpredictability of supplies has added to confusion around the management of distribution for two doses.
- Getting small batches out to many different locations,
- California having a decentralized public health system,
- Data issues and lags (many providers still need to do manual data entry, and therefore have chosen to focus on vaccinating people, rather than data entry), and
- California's surge peaked right when the vaccines arrived, so our health care systems were very taxed.

The Governor's budget announced the administration's intent to expend an additional $357 million, using DREOA authority, for vaccine distribution. The administration still has not shared a detailed plan for expending these funds.

On January 26, 2021, the Governor announced a major shift in how the state will handle the distribution of vaccines going forward. According to the Governor's press release, this new system is meant to simplify and standardize the vaccination process "with equity as a core focus." The vaccine distribution and operations effort will be led by Yolanda Richardson, Secretary of the Government Operations Agency, in consultation and partnership with Dr. Mark Ghaly, Secretary of Health and Human Services, and the California Department of Public Health.

The state plans to enter into two contracts with third party administrators (Blue Shield and Kaiser) to manage the distribution, replacing counties which have played this role up to this point in time. The vaccine provider network is expected to include public health systems, pharmacies, health systems, public hospitals, community health centers, pharmacies and pop-up and mobile sites with an immediate focus on allocating to today's high-throughput providers. The Governor states that local public health systems will continue to play a key role as vaccine providers to ensure the network reaches disproportionately affected (and hard to reach) Californians.

According to the press release:
"The new approach will continue to focus on equity. Vaccines will be allocated to make sure low-income neighborhoods and communities of color have access to vaccines, and providers will be compensated in part by how well they are able to reach underserved communities. Real time data will allow for adjustments to be made if initial equity targets are not met."

"Beginning mid-February, the state will implement a statewide standard under which health care workers, individuals 65+ and education and child care, emergency services and food and agriculture workers will be eligible to start making appointments to receive the vaccine, pending vaccine availability. Future groups will become eligible based on age. This statewide standard will move in unison across all 58 counties."

The Governor's new vaccine distribution initiative also includes the launching of My Turn, an IT system to help the public know when they are eligible to be vaccinated, make appointments for vaccination, and track vaccination data. My Turn will track individuals who have yet to receive a second dose in order to do additional outreach to them. My Turn will also report vaccination information to state data systems.

On February 3, 2021, the Sacramento Bee reported that the state's Community Vaccine Advisory Committee is contemplating making more changes to the populations to be prioritized for vaccination. Specifically, in response to significant public pressure, the

Committee is considering prioritizing individuals with disabilities or underlying medical conditions who face higher risks of hospitalization and death from COVID-19, rather than prioritizing just based on age.

BUDGET CHANGE PROPOSALS

COVID-19 Direct Response Expenditures Budget Change Proposal

The Administration proposes $1.8 billion one-time General Fund in fiscal year 2021-22 for various departments related to estimated direct response expenditure costs to continue responding to and mitigating the impacts of the COVID-19 Pandemic. In addition, it is requested that budget bill language be added to address the remaining uncertainties as the state continues its response to the COVID-19 Pandemic.

Current estimates of total direct COVID-19 Pandemic emergency response costs are approximately $13 billion, with an estimated net General Fund impact of approximately $2.5 billion. This represents costs incurred in the prior fiscal year as well as projected costs in fiscal years 2020-21 and 2021-22. In addition to the costs reflected in this proposal, caseload effects and COVID flexibilities are reflected in their respective health and human services budgetary Estimates.

The Budget proposes $820.5 million for the Department of Public Health (Public Health) to continue proactive response actions focused on mitigating the active spread of community transmission and building additional health care capacity.

This funding will predominately be used for statewide testing and its auxiliary components. Other significant Public Health response costs are in cost categories spanning multiple departments—notably contact tracing and hospital and medical surge. As noted above, these costs would continue to be administered through the DREOA funding mechanism as the amounts needed by individual departments is identified.

The table below reflects the estimated 2021-22 expenditures proposed in Public Health's budget, nearly all of which is assumed to occur in the period from July 1, 2021 through December 31, 2021. The Administration will continue to refine these assumptions and estimates throughout the spring.

BY 2021-22 (Whole Dollars)	
Statewide Testing	
Valencia Branch Lab	$483,166,000
Logistics Health, Inc. (OptumServe)	$316,717,000
FedEx Specimen Transportation (Currently in DGS' Budget)	($6,653,000)*
Misc. COVID-19 Testing and Other Costs	$20,666,000
Total	**$820,549,000**

* Non-Add

Valencia Branch Lab

On October 30, 2020, Governor Gavin Newsom announced the opening of the Valencia Branch Laboratory designed to enhance the state's COVID-19 testing capacity and shorten testing turnaround time. With increased capacity to process 150,000 tests per day, the Valencia Branch Laboratory allows for greater community access to testing. The Budget assumes that the lab will ramp-up testing to the maximum level beginning in March 2021. Beginning in August 2021, testing, and associated costs, are assumed to ramp down steadily through the end of calendar year 2021. From that point, the Budget assumes small residual costs to keep the facility in warm shutdown.

Logistics Health, Inc. (OptumServe)

To support the Valencia Branch Lab efforts described above, the state entered into a contract for a new specimen collection solution. Generally, costs under this contract are assumed to follow the same pattern as those at the Valencia Branch Lab, reaching maximum capacity through July 2021, and then phasing out gradually through the end of calendar year 2021.

Miscellaneous COVID-19 Testing and Other Costs

Miscellaneous costs for Public Health's state response operations include costs for service contracts, other operating costs, commodity purchases and other procurements, and a contract to provide revenue collection and banking services related to the Valencia Branch Laboratory.

COVID-19 Workplace Outbreak Reporting (AB 685) Budget Change Proposal

CDPH is requesting three positions and $677,225 General Fund appropriation in Fiscal Year 2021-22 and ongoing to create a new program to manage COVID-19 workplace outbreak reporting, as mandated by AB 685 (Reyes, Chapter 84, Statutes of 2020).

The CDPH Occupational Health Branch (OHB), within the Center for Healthy Communities (CHC), provides subject matter expertise for those aspects of the pandemic

response that involve the health of California's workers and the risk of COVID-19 at their jobsites, including consultation to local health departments on responding to workplace outbreaks.

OHB is a non-regulatory program that aims to improve worker safety and health in California by evaluating workplace hazards; tracking patterns and investigating the causes of work-related illness and injury; providing training, information, and technical assistance on work and health issues; and mobilizing partners to promote safer ways to work. OHB works closely with the California Department of Industrial Relations (DIR), Division of Occupational Safety and Health (Cal/OSHA), the program that enforces workplace safety and health regulations.

The COVID-19 pandemic has disproportionately affected workers, particularly those in essential industries who have continued to report to work throughout the pandemic. In addition, the pandemic has disproportionately affected certain racial and ethnic groups. Latinos, for instance, represent 39 percent of California's population, but 60 percent of its COVID-19 cases. These disparities are likely exacerbated by occupational factors; in particular, the large number of workers from racial and ethnic minorities employed in essential industries. For instance, preliminary CDPH analysis of COVID-19 fatality data indicates that Latino workers made up 81 percent of COVID-19 fatalities in the construction industry, 79 percent of COVID-19 fatalities in the restaurant and food service industry, and 93 percent of COVID-19 fatalities in the crop production industry.

AB 685 was passed in order to better understand and address these disparities. To date, efforts to do so have been hampered by the lack of reliable data about workplace outbreaks and occupational risk factors for COVID-19. AB 685 helps address this problem by mandating employer reporting of workplace COVID-19 outbreaks (defined as three or more cases at a worksite within a 14-day period) to CDPH. The law also mandates that CDPH post information about COVID-19 workplace outbreaks by industry on its website to increase public awareness. This budget proposal would give CDPH the necessary funding to implement the bill's provisions, and help understand and address occupational risk factors for COVID-19 in order to protect the health of California workers and their families and communities.

Adjustment to Support Infectious Disease Modeling Budget Change Proposal

CDPH requests one-time General Fund expenditure authority of $450,000 in 2021-22, and encumbrance or expenditure authority until June 30, 2023, to support infectious disease modeling activities as a part of the urgent COVID-19 pandemic response by increasing internal capacity to conduct, oversee, and utilize high-quality data modeling to inform public health emergency decisions and to participate in the COVID-19 Modeling and Analytics Consortium.

In February 2020, CDPH established a Coronavirus Modeling Team, tasked with providing epidemiologic estimates of the potential consequences of the novel coronavirus strain emerging worldwide. Based in part on those modeling projections, on March 4, 2020, Governor Gavin Newsom declared a State of Emergency for the COVID-19 pandemic. CDPH states that, since the beginning of the pandemic and emergency declaration, California's COVID-19 pandemic response has been primarily guided by science and public health evidence. Modeling and advanced analytics have been a core component of this evidence-based pandemic response. Currently, COVID-19 continues to challenge Californians, with over two million cases and demand for intensive care units (ICU) exceeding their capacity across multiple regions of the state. Disease control efforts are being supported by the massive scale up of diagnostic testing, treatments, and now vaccines. Simultaneously, the emergence of a more infectious COVID-19 strain may have substantial impact on the effectiveness of current and future public health control measures. The epidemiologic and economic impact, as well as the effect of this pandemic on health equity, are central areas of work for CDPH's Coronavirus Modeling Team.

CDPH states that this proposal is necessary in order to continue generating local and state level data to optimize pandemic responses by: 1) developing rapid and relevant assessments of the epidemiologic, economic, and equity impacts of the disease itself and of public health interventions; 2) increasing internal resources and capacity to conduct modeling, and 3) leveraging an essential public health partnership between the state and the public university system, the University of California (UC), Office of the President (UCOP), to increase capacity for generating evidence to inform policy and public health action.

In order to better develop public health relevant modeling that provides the evidence needed to combat COVID-19, UCOP, with input from CDPH, launched a California COVID-19 Modeling and Analytics Consortium in July 2020. This Consortium was developed to consolidate modeling and analytic activities across the UC system which will be used to inform state policy and programmatic action. Taking full advantage of the reach of the UC system, the Consortium spans across nine of the UC academic and health campuses and brings together over 150 investigators with diverse academic and technical expertise. While the Consortium currently serves as a convener of modeling and analytic activities across the UC system, engagement with CDPH is currently being formalized. With early engagement with the UC and CDPH, the Consortium aims to generate high impact locally responsive results for public health action. To ensure rapid results for priority public health issues, expanding the California COVID-19 Consortium effectively increases CDPH capacity to ask and evaluate various epidemiologic scenarios and conduct advanced analytics.

Since the State of Emergency began, modeling has played a critical role in informing numerous public health orders and policies including: statewide stay-at-home orders, recent regional stay-at-home orders based on intensive care unit (ICU) capacity,

statewide mask mandates, establish metrics for the Blueprint for a Safer Economy including the nation's first health equity metric, and now support planning for vaccine allocation and distribution. Modeling has also 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. The CDPH has developed case-based data sets to support the generation of this evidence, and through approved Data Use Agreements (DUA) has been able to refine modeling activities conducted by partners. Most recently, a first of its kind DUA between CDPH and the UCOP, representing nine of the UC academic and health campuses, to provide streamlined access to California COVID-19 data. This proposal is an extension of the previous model for collaborating with external academic partners to support California specific COVID-19 modeling.

Health Care and Essential Workers: PPE (SB 275) Budget Change Proposal
The CDPH, Center for Health Care Quality (CHCQ) requests 0.5 Research Scientist Supervisor I and 0.5 Associate Governmental Program Analyst and $164,000 in 2021-22 and ongoing from the Licensing and Certification Fund (Fund 3098) for establishing regulations for a personal protective equipment (PPE) stockpile to build an adequate future supply of PPE, as specified in the language of the bill, for all health care and essential workers in the state as mandated by SB 275 (Pan, Leyva, Chapter 301, Statutes of 2020).

SB 275 requires CDPH and the Office of Emergency Services, in coordination with other state agencies, to, upon appropriation and as necessary, establish a PPE stockpile for healthcare workers and essential workers so they are protected during the next public health emergency. In addition, the Department of Industrial Relations (DIR) shall assess a civil penalty for health care employers that fail to maintain the specified stockpile requirements for 90-day health emergencies. The bill specifies instances where DIR may exempt a health care employer from civil penalties. This bill also creates the Personal Protective Equipment Advisory Committee which consists of individuals who represent multiple types of hospitals and health systems, skilled nursing facilities, primary care clinics, physicians, health care workers, essential workers; a representative from the PPE manufacturing industry, consumer representative, a representative from an association who represents counties, and a representative from CDPH, Office of Emergency Services (OES), Emergency Medical Services Authority (EMSA), and California Department of Social Services (CDSS).

During a public health emergency or disaster, CDPH activates the Medical Health Coordination Center (MHCC) as part of California's Public Health and Medical Response system. Healthcare facilities or other public health and medical partners may request resources if they are unable to locate supplies through their normal vendors or supply chains. If resources cannot be located within a county or region, requests are made to

the state through the MHCC. Prior to the COVID-19 pandemic, the MHCC did not store or maintain a stockpile of PPE. However, the MHCC maintains warehouse capability and functionality to receive, store, and distribute medical countermeasures received from the federal stockpile in the event of a biological event like anthrax. The MHCC does not currently have permanent full-time warehouse staff and instead re-directs staff to support warehouse operations during emergencies. Due to the magnitude of requests for PPE during the pandemic, CDPH also executed several contracts with existing warehouses to store PPE procured to support healthcare workers and essential personnel.

Support for Alzheimer's Disease Awareness, Research, and Training Budget Change Proposal

CDPH requests $17 million General Fund ($10.2 million in Local Assistance and $6.8 million in State Operations) in 2021-22, available to be spent over a three-year period, to support Alzheimer's Disease Program activities that include:

- Grants focused on women, communities of color, and populations disproportionally impacted by Alzheimer's disease and related dementias and who were historically underrepresented in research including the LGBTQ+ community;

- A public awareness campaign focused on educating the public on the signs and symptoms of Alzheimer's disease and related dementias, as well driving the public to linguistically and culturally competent dementia care resources;

- A caregiver training and certification program expanding access to evidence-based dementia related education and training for caregivers (unpaid and paid, including In-Home Supportive Services);

- California Blue Zone challenge grants awarded to California cities or local health jurisdictions most prepared and willing to address Alzheimer's disease and related dementias and become dementia-friendly communities; and

- A statewide standard of dementia care for early detection and diagnosis, treatment, and care decisions throughout the progression of Alzheimer's disease and related dementias.

Public Health requests provisional language making the $17 million General Fund ($10.2 million in Local Assistance and $6.8 million in State Operations) available for encumbrance until June 30, 2024.

Alzheimer's Disease Program Statutory Authority and Description

Public Health's Alzheimer's Disease Program was established under California Health and Safety Code section 412 pursuant to AB 2225 (Chapter 1601, Statutes of 1984), and was expanded under California Health and Safety Code Section 412 pursuant to SB 139

(Chapter 303, Statutes of 1988). The mission of the Alzheimer 's Disease Program is to reduce the human burden and economic costs associated with Alzheimer's disease and related dementias, and ultimately to assist in discovering the cause and treatment of this disease. The program administers 10 California Alzheimer's Disease Centers 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. The program also awards grants through a competitive process to scientists in California engaged in the study of Alzheimer's disease and related dementias.

Historical Funding

Since 1985 the state has invested more than $90.7 million in the California Alzheimer's Disease Centers, which have leveraged the funds to raise more than $544.5 million in federal and private research money (California State Plan for Alzheimer's Disease, 2011).

In 1987, the California Revenue and Taxation Code was amended to authorize taxpayers to contribute amounts on their tax returns, in excess of any tax liability, and to establish a fund for research related to Alzheimer's disease, which is administered by Public Health. From 1989 to 2009, the Alzheimer's Disease Research Awards were supported by both the General Fund and the California “Alzheimer’s Disease and Related Dementia Research Voluntary Tax Contribution Fund.” In 2009, funding to the Alzheimer's Disease Program was reduced and the program discontinued General Fund research activities. From 2009 to 2017, research awards received funding only from donations made by California taxpayers through a tax checkoff (received in the Alzheimer's Disease and Related Disorders Research Fund), a checkoff that is scheduled to sunset on December 1, 2025.

Beginning in fiscal year 2018-19, the Alzheimer's Disease Program received $3.1 million, General Fund to fund research in connection with Alzheimer's disease and related dementias, and their caregivers. In fiscal year 2019-20, the Alzheimer’s Disease Program received $3 million for disease and related dementias with a focus on women and communities of color. In addition, $5 million in one-time General Fund expenditure authority was provided in the 2019 Budget Act, General Fund to fund research to and allocate grants for up to six local health jurisdictions over three fiscal years from 2019-20 to 2021-22 to support activities that are consistent with the United States Centers for Disease Control and Prevention published in the Healthy Brain Initiative State and Local Public Health Partnerships to Address Dementia, The 2018-2023 Road Map. (The above funding includes both Local Assistance and State Operations.)

BACKGROUND

As described in the budget:
The California Department of Public Health (Public Health) is dedicated to optimizing the health and well-being of all Californians through the following core activities:

- Protecting the public from communicable diseases.
- Protecting the public from unhealthy and unsafe environments, and improving social determinants of health and healthy communities.
- Preventing disease, disability, and premature death; and reducing or eliminating health disparities by embedding health and mental health equity language, tools, and approaches into all public health and partner agency policies, programs, systems, and resource allocation.
- Preparing for and responding to public health emergencies.
- Producing and disseminating data to evaluate population health status; inform people, institutions and communities; and to guide public health strategies, programs, and actions.
- Promoting healthy lifestyles for individuals and families in their communities and workplaces.
- Providing access to quality, population-based health services.

Emergency Preparedness
The Public Health Emergency Preparedness 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 Public Health emergency preparedness activities.

PUBLIC AND ENVIRONMENTAL HEALTH
The Public and Environmental Health programs provide public health services of: communicable disease control; chronic disease and injury prevention; environmental public health; maternal, child, and family health; and vital records. These programs function as part of the greater public health system throughout California.

Healthy Communities
This program works to support healthy communities and address health inequities by directing initiatives focused on chronic disease prevention and management, environmental health, occupational health, injury and violence prevention, and substance use and addiction. This program includes the Office of Oral Health, Office of Problem Gambling, California Tobacco Control Branch, Childhood Lead Poisoning Prevention Branch, Chronic Disease Control Branch, Chronic Disease Surveillance and Research Branch, Environmental Health Laboratory Branch, Environmental Health Investigations Branch, Nutrition Education and Obesity Prevention Branch, Occupational Health Branch, Injury and Violence Prevention Branch and Substance and Addiction Prevention Branch.

Infectious Diseases
This program works to prevent and control infectious diseases such as: HIV/AIDS, viral hepatitis, influenza and other vaccine-preventable illnesses, sexually transmitted diseases, tuberculosis, emerging infections, and foodborne illnesses. This program includes the Division of Communicable Disease Control, the Office of AIDS, the Office of Binational Border Health, and the Office of Refugee Health.

Family Health
This program works to improve and reduce disparities in health outcomes for girls and women of reproductive age, pregnant and postpartum women, infants, children, adolescents, and their families. This program includes Genetic Disease Screening; Maternal, Child, and Adolescent Health; and the Special Supplemental Nutrition Program for Women, Infants, and Children.

Health Statistics and Informatics
This program works to improve the public's health by managing information systems and facilitating the collection, validation, analysis, and dissemination of health statistics and demographic information on the California population. This program includes Vital Records and Public Health Informatics.

County Health Services
This program supports county-based public health information and services, including the Medical Marijuana Identification Card Program.

Environmental Health
This program works to protect and improve the health of all California residents by providing for the safety of food, drugs, medical devices, and manufactured cannabis products; conducting underage tobacco enforcement; overseeing the use of radiation and radioactive materials; regulating the disposal and handling of medical waste; and conducting other environmental management programs. This program includes Environmental Management, Radiologic Health, Drinking Water and Radiation

Laboratory, Food and Drug Safety, Manufactured Cannabis Safety, and the Food and Drug Laboratory.

LICENSING AND CERTIFICATION

Health Facilities
This program regulates the quality of care in over 10,000 public and private health facilities, clinics, and agencies throughout the state; licenses nursing home administrators; certifies nurse assistants, home health aides, and hemodialysis technicians; and oversees the prevention, surveillance and reporting of healthcare-associated infections in California's general acute care hospitals.

Laboratory Field Services
This program regulates California laboratory, blood bank, biologics, and tissue bank quality standards through licensure and oversight of approximately 22,000 clinical laboratories, public health laboratories, blood banks, biologics facilities, and tissue banks in California; and approximately 60,000 laboratory personnel in more than 30 different categories of laboratory personnel including cytotechnologists, medical laboratory technicians, phlebotomists, clinical laboratory scientists, and public health microbiologists.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present an overview of the proposed CDPH budget and the five BCPs described in this issue of the agenda. CDPH is also asked to provide an overview of CDPH's role and responsibilities in responding to the pandemic and highlight the most significant remaining COVID-19 challenges still facing the state.

The Subcommittee requests that the county-representative on the panel present an overview of significant local public health infrastructure needs and deficiencies, in the context of the pandemic.

The Subcommittee requests the LAO to present their analysis of the CDPH budget and pandemic-response funding.

Please also respond to the following:

For CDPH:

1. Please describe what has worked well and what has not worked well in terms of the shared public health responsibilities between counties and the state.

2. Have some counties fared better or worse than others in terms of resources, tools, expertise, etc. needed to protect their residents?

3. Have resources (vaccines, access to testing, PPE, etc.) been distributed equitably throughout the state?

4. What are the highest priority outstanding unmet needs at the state level that are slowing our progress towards ending the pandemic?

5. What is CDPH's role in the vaccine distribution at this point in time?

6. How will the state ensure equity in the new vaccine distribution system utilizing third-party administrators?

7. When will the administration release its plan for spending $357 million on vaccine distribution?

For Counties:

1. Please describe what has worked well and what has not worked well in terms of the shared public health responsibilities between counties and the state.

2. From all sources, have counties had sufficient resources to respond to the pandemic effectively?

3. Have some counties fared better or worse than others in terms of resources, tools, expertise, etc. needed to protect their residents?

4. Have resources (vaccines, access to testing, PPE, etc.) been distributed equitably throughout the state?

5. What are the highest priority outstanding unmet needs at the local level that are slowing our progress towards ending the pandemic?

6. How will counties spend the recently announced $1.2 billion in new funding, and how can the state hold counties accountable for spending it efficiently and equitably?

Staff Recommendation: Subcommittee staff recommends ongoing oversight by the Subcommittee and Legislature, and urges the administration to engage in regular close communication with the Legislature on the state's ongoing pandemic response. Furthermore, while we are all steeped in the current crisis, it's imperative that we not lose ground, and even make new strides, on other significant public health issues, such as Alzheimer's, chronic disease, and climate change.

ISSUE 4: STAKEHOLDER PANDEMIC EARLY ACTION PROPOSALS AFFECTING PUBLIC HEALTH

This Issue covers proposals from stakeholders that have been put forth as immediate and urgent responses to the pandemic, and which would have the greatest impact if approved and implemented earlier than July. All of these proposals affect programs and services provided by the Department of Public Health.

PANELISTS

- **Sara Bosse**, Public Health Director, Madera County (Presenting)
- **Michelle Gibbons**, Executive Director,
  County Health Executives Association of California (Q&A Only)
- **Shamika Ossey**, Public Health Nurse, Emergency Preparedness
  & Response Division, LA County Department of Public Health (Presenting)
- **Mary June Diaz**, Government Affairs Advocate,
  SEIU California State Council (Q&A Only)
- **Amy Blumberg**, Director of Legislative Affairs,
  California Association of Health Facilities (Presenting)
- **Scott Vivona**, Assistant Deputy Director of Center for Health Care Quality,
  California Department of Public Health (Presenting)

BACKGROUND

Proposal #1 from Counties Regarding Public Health Infrastructure

Counties (i.e., Local Health Jurisdictions) are making the following two requests aimed at building California's public health infrastructure so that the state may be better prepared for future pandemics, as well as to address the ongoing needs of the COVID-19 pandemic. These proposals have been put forward by the following organizations:

- County Health Executives Association of California (CHEAC),
- California State Association of Counties (CSAC),
- Health Officers Association of California (HOAC),
- Rural County Representatives of California
- Urban Counties of California

<u>$50 million Ongoing General Fund for Public Health Infrastructure and Equity</u>. Funding will support local health departments in hiring additional staffing to strengthen the capacity to perform the critical ongoing work of local health departments and improve health equity beyond the immediate pandemic. When not engaged in pandemic emergency response activities, public health is present in a wide array of critical work throughout our communities, including but not limited to public health nurse home visiting programs for new and expecting mothers, communicable disease surveillance and contact tracing, chronic disease prevention and wellness promotion, homelessness outreach,

immunizations, environmental health (e.g., restaurant inspections), and oral health services. With this flexible funding, staffing trained and dedicated to these areas can also be deployed during pandemics or to address other critical public health challenges.

$3.45 million General Fund for Public Health Infrastructure Study. Funding would be provided to the California Department of Public Health (CDPH) to contract with an appropriate entity to conduct an evaluation of local health department infrastructure and make recommendations for the staffing, workforce needs, and resources required to fund local public health accurately and adequately. Funding would also support the submission of a legislative report by CDPH.

Proposal #2 from the California Association of Health Facilities on Temporary Nursing Assistants in Skilled Nursing Facilities

The California Association of Health Facilities (CAHF), which represents a majority of skilled nursing facilities (SNFs) in California, requests that the state allow SNFs to employ temporary nurse assistants (TNAs), on a temporary basis, to help address the staffing shortage during the pandemic. CAHF estimates one-time costs for CDPH to approve the temporary nursing assistant training requirements of no more than $250,000 General Fund.

CAHF provided the following information:

"Nursing facilities are in desperate need of immediate staffing assistance during the COVID-19 pandemic. As an effective way to address the shortage of certified nursing assistants (CNAs) in nursing facilities and more quickly recruit direct caregivers, many states have authorized the utilization of temporary nurse assistants (TNAs) to provide direct care services to nursing home patients. Due to the pandemic, it is not only challenging to find CNAs but it is almost impossible for NAs to complete their training program and get a testing date set to obtain their certification. TNAs are provided with initial training and orientation, background checked and health screened. Their clinical training is under the supervision of nursing staff at the facility. Their clinical competency is observed and completed prior to providing any direct care services to patients. As they perform tasks, this is done under the supervision of a trained, experienced and certified nursing assistant. This streamlined option to train and provide timely employment to individuals seeking work in a nursing home would help address the current critical shortage of direct care staff in nursing homes. These TNAs would be counted as part of the 2.4 CNA direct patient care ratio for those services they are trained and have shown competency. CNAs would receive additional pay for their supervision of a TNA. Temporary nursing assistants would be required to obtain full certification within a reasonable timeframe after the pandemic is over."

STAFF COMMENTS/QUESTIONS

With over 41,330 deaths in California, the COVID-19 pandemic has very effectively demonstrated the weaknesses and inadequacies in California's public health infrastructure. We should expect the same results in the next pandemic, and continued dismal outcomes in the current crisis, if we continue to ignore the obvious unmet needs of our public health/emergency response systems. Not only have we not increased our state investments in public health in many years (decades really), but local public health realignment funding has decreased dramatically over the past 10-15 years, according to counties.

The Subcommittee requests that the stakeholders on this panel present their proposals, to be followed by reactions and feedback by CDPH. Please also respond to the following:

For CHEAC:

1. What are the most significant deficiencies in California's public health infrastructure?

2. Please explain how California's response to the pandemic could have been more effective with increased funding and a more robust local public health infrastructure.

3. Please provide a justification for the amounts of funding being requested for both proposals -- $50 million ongoing for infrastructure and $3.45 million one-time for an infrastructure study.

For CAHF:

1. What are the main reasons that SNFs have been short-staffed during the pandemic, and unable to quickly hire more staff (particularly Certified Nursing Assistants)?

2. Would the allowances for TNAs be in effect just during the public health emergency, or is CAHF proposing that they be permanent?
3. How can the state be sure that TNAs won't be taking jobs from CNAs?

4. Has CAHF explored ways to hire more CNAs rather than TNAs during the public health emergency?

Staff Recommendation: The Subcommittee should consider these proposals seriously as we continue to battle the pandemic, especially with regard to the ongoing staffing shortages in SNFs which continue to keep SNFs at highest risk of COVID-19 outbreaks and deaths.

4260 DEPARTMENT OF HEALTH CARE SERVICES

OVERVIEW

This issue covers proposals from stakeholders that have been put forth as immediate and urgent responses to the pandemic, and which would have the greatest impact if approved and implemented earlier than July. All of these proposals affect the Medi-Cal program which is operated by the Department of Health Care Services.

ISSUE 5: STAKEHOLDER PANDEMIC EARLY ACTION PROPOSALS AFFECTING MEDI-CAL

PANELISTS

- **Amy Blumberg**, Director of Legislative Affairs,
  California Association of Health Facilities (Presenting)
- **Erica Murray**, President and CEO,
  California Association of Public Hospitals and Health Systems (Presenting)
- **Veronica Palacios**, Emergency Room Eligibility Specialist
  Highland Hospital (Presenting)
- **Mary June Diaz**, Government Affairs Advocate,
  SEIU California State Council (Q&A Only)
- **Jen Flory**, Policy Advocate, Western Center on Law and Poverty (Presenting)
- **Lucy Quacinella**, **Esq**., Multiforum Advocacy Solutions, on behalf of…
  Maternal Child Health Access (Presenting)
- **Will Lightbourne**, Director, Department of Health Care Services (Presenting)
- **Jacey Cooper**, Chief Deputy Director & State Medicaid Director, Department of Health Care Services (Presenting)

BACKGROUND

Proposal #1 from the California Association of Health Facilities related to Medi-Cal Reimbursements for Direct Labor Costs in skilled Nursing Facilities

The California Association of Health Facilities (CAHF), which represents a majority of skilled nursing facilities (SNFs) in California, proposes to remove the Medi-Cal reimbursement caps on labor costs in order to cover their full direct labor costs. The purpose of this is to enable SNFs to increase wages and thereby recruit and retain staff more successfully. CAHF estimates the cost of this proposal to be: $158 million total funds ($79 million General Fund).

According to CAHF:
"One of the major challenges for skilled nursing facilities is to pay competitive wages under a Medi-Cal reimbursement rate that is capped, limited by budgeted funds and paid to facilities two years in arrears. In order to give skilled nursing facilities the ability to pay more competitive wages to staff, labor costs should be directly paid to facilities without the current reimbursement caps in place.

The AB 1629 reimbursement system was designed to reimburse facilities on a facility-based audited and pre-determined cost-based rate. Unfortunately, facility rates are not actually structured to fully fund nursing facility costs for labor. Rates are first set at the 95th percentile of a nursing facility's labor costs and then are further limited based on a facility's peer group (geographic area) then additionally the rates are reduced by the state's overall programmatic budgetary limit (also known as the 'shave' or 'ratchet'). Currently Medi-Cal rates are reduced approximately 5.5% due to these budgetary limits. By removing the labor portion of the rates from the lesser percentile, the geographic capping and the overall budgetary limits (shave) a facility would be adequately reimbursed for their labor costs incurred and provided assurances that if they increase wages Medi-Cal rates will eventually fully reflect the increases paid as well."

Proposal #2 from the California Association of Public Hospitals and Health Systems Regarding Pandemic Costs for Public Hospitals

The California Association of Public Hospitals and Health Systems (CAPH) is seeking a direct investment of at least $300 million for public health care systems in the following areas: 1) unreimbursed costs associated with the increase in Medi-Cal fee-for-service (FFS) COVID-19 patients; 2) vaccine distribution to support their efforts to vaccinate low-income and vulnerable populations; and 3) staffing and other personnel needs.

CAPH provided the following detail:
"Costs associated with the increase in Medi-Cal FFS COVID-19 patients: Public health care systems have experienced a dramatic increase in the number of Medi-Cal patients requiring COVID-19 hospitalization, particularly those requiring care in intensive care units. For Medi-Cal FFS patients, which comprise roughly 30% of public health care systems' hospitalizations, public health care systems receive no state General Fund; they must provide the entire non-federal share. Yet, the federal portion only covers roughly 65% of public health care systems' costs. As a result, as public health care systems' COVID-19 hospitalizations rise, so do their unreimbursed costs. State funding would be used to help offset these costs and support public health care systems' efforts to continue providing much-needed services for Medi-Cal FFS patients with COVID-19.

Vaccine distribution: As stated, public health care systems are partnering closely with public health departments and are expanding their vaccine capabilities and staffing at a moment of unprecedented demand. These systems can play a significant role in helping vaccinate their entire patient population, expand community sites, and conduct other

outreach efforts to vulnerable and high-risk populations. State funding would support public health care systems' initial efforts in this space; however, should our role increase, additional resources would be needed.

Staffing and other personnel needs: Expanding staffing has been a particular challenge as public health care systems work to meet the simultaneous demands for patient care, vaccination, and testing services. Their workforce is stretched thin and exhausted from a year-long pandemic. Temporary staffing to support and relieve their employees has come at a premium due to the needs across the state and the country, increasing uncompensated costs across systems. State funding would be used to offset some of public health care systems' uncompensated costs associated with additional staffing needs related to the COVID-19 pandemic."

Proposal #3 from Western Center on Law and Poverty Related to Telephone Self-Attestation of Medi-Cal Applicants

Western Center on Law and Poverty (WCLP) proposes to clearly authorize counties to allow for electronic (i.e., telephone) attestation as part of the Medi-Cal application and renewal processes, in order to address a barrier to Medi-Cal enrollment. WCLP proposes the adoption of the following language:

> "All insurance affordability programs must accept self-attestation, instead of requiring an individual to produce a document, for age, date of birth, family size, household income and property, state residence, pregnancy, and any other applicable criteria needed to determine the eligibility of an applicant or recipient, to the extent permitted by state and federal law. Electronic and telephonic forms of self-attestation must also be accepted."

WCLP provided the following explanation:

"Due to the pandemic, DHCS has relaxed the self-attestation requirements for situations where documentation is unavailable to someone applying for Medi-Cal (MEDIL I 20-25). 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's 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 (ACWDL 19-17). Our understanding is that this language is required most often for income discrepancies or when income documentation is unavailable. We know the MEDIL procedures will expire when the public health emergency is declared over, though we may be seeing increased applications then as the economic fallout will likely trail the pandemic for some time and we will also be facing a lot of redeterminations.

Since state and federal law already lay out when self-attestation is permitted, we're really just aiming to ensure that when it is used, we can move away from paper to streamline the process. Federal law already requires electronic databases to be checked first for income – this would not change that. DHCS would also still 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. We just want to 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 we have been told will take some time to program in on the county computer systems SAWS side. Counties have already been doing this during the pandemic, so we do not anticipate 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. DHCS would be required to modify its MAGI verification plan (delete the word "paper" from "paper documentation") with CMS and potentially its state plan. And the change would, of course, be subject to federal approval though we are aware of other state verification plans that are worded in a more flexible way than our current plan."

Proposal #4 from Maternal Child Health Access Related to the COVID-19 Uninsured Group Application Simplification

In response to the pandemic, DHCS established a special coverage category ("COVID-19 Uninsured Group") in Medi-Cal to cover COVID-19 testing and treatment costs for uninsured individuals who do not qualify for Medi-Cal. The application for this coverage includes questions about immigration status, which Maternal Child Health Access (MCHA) asserts deters people from applying for coverage. Therefore, MCHA proposes to eliminate these questions from the application.

MCHA explains the following:

"The new application form that was launched on August 28, 2020 for Medi-Cal's COVID-19 Uninsured Group deters immigrant and mixed status families from applying. [MCHA] urges the Department to eliminate questions No. 18-20 from the MC 374 and instead adopt back end sampling or other proxy approaches to claim federal match for the COVID-19 Uninsured group, as has been successfully done for other Medi-Cal programs.

The Department has made clear that all otherwise eligible applicants qualify under Medi-Cal's COVID-19 Uninsured group without regard to citizenship or immigration status—a policy clarification that is greatly appreciated. The problem stems, however, from the fact that the application form requires applicants to state whether they are citizens or "have an eligible immigration status" (No. 18 and 19 of the MC 374) and then asks for nine pieces of information (No. 20 a-i). Such questions have a chilling effect, and they also send the incorrect message that some categories of immigrants cannot qualify."

Proposal #5 from Maternal Child Health Access related to Access to Blood Pressure Monitors

In order to maintain good access to blood pressure monitors and cuffs, by high-risk populations during the pandemic, MCHA urges the administration to treat blood pressure monitors and cuffs as a pharmaceutical benefit, rather than as durable medical equipment, so that they will be carved out of managed care consistent with the new Medi-Cal Rx program, which shifts nearly all pharmaceuticals out of managed care and into fee-for-service beginning April 1, 2021. Medi-Cal Rx was created through Executive Order (N-01-19) on January 7, 2019.

MCHA provided the following background and explanation:
"We strongly recommend that blood pressure monitors and cuffs be included in Medi-Cal Rx for beneficiaries in both the managed care and fee-for-service delivery systems. These items should be carved out from the plans' contractual obligations and instead included as a pharmacy benefit under Medi-Cal Rx. Similarly, for fee-for-service beneficiaries, these items should also be included under Medi-Cal Rx as a pharmacy benefit instead of excluded as durable medical equipment (DME).

We begin by underscoring the extreme risk of mortality associated with this issue: approximately 40% of pregnancy-related deaths are from conditions that often manifest as hypertension, including stroke (cerebrovascular accidents), hypertensive disorders of pregnancy, cardiomyopathy, and other cardiovascular conditions. Black individuals are disproportionately impacted by these conditions, which helps to explain the stark racial disparities in maternal mortality and major morbidity. In California the maternal mortality rate for black women is four times as high as the rate for white women.

Careful, timely and consistent monitoring of blood pressure is essential to detecting and treating these conditions early and preventing life-threatening complications. Self-monitoring, which allows individuals to check blood pressure outside of their in-person visits, is not only cost-effective but also empowers patients. Checking one's own blood pressure has become a central component of telemedicine prenatal visits, a care model endorsed by ACOG that has been indispensable during the COVID-19 pandemic. The importance of self-monitoring blood pressure during pregnancy is highlighted in the December 3, 2020 U.S. Surgeon General's Call to Action to Improve Maternal Health, which urges payors to "[promote telehealth, as appropriate, for women . . .and support remote monitoring of highly prevalent and harmful conditions like hypertension" (page 38). In fact, many commercially insured patients are being instructed to purchase blood pressure monitoring equipment so they can benefit from telemedicine visits without compromising safety. If Medi-Cal patients are not provided with easy access to this necessary equipment, inequities in care, safety, and quality will be exacerbated."

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the stakeholders to present their proposals, and requests DHCS to provide reactions and feedback to these proposals, and respond to the following:

1. Is there a policy justification, or just fiscal, for not reimbursing SNFs for their full labor costs?

2. Per the proposal from MCAH, access to blood pressure monitors is a good example of the need for equity in the Medi-Cal program; do you feel that the state is doing everything possible to ensure access to this life-saving device?

Staff Recommendation: All of these proposals represent opportunities for the Medi-Cal program to provide better access to care and/or higher quality care, particularly during the pandemic. Therefore, the Legislature and Administration should consider them seriously.

NON-PRESENTATION ITEMS

The Subcommittee does not plan to have a presentation of the items in this section of the agenda, unless a Member of the Subcommittee requests that an item be heard. Nevertheless, the Subcommittee will ask for ***public comment*** on these items.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 6: COMMUNITY PARAMEDICINE OR TRIAGE TO ALTERNATE DESTINATION ACT OF 2020 (AB 1544) BUDGET CHANGE PROPOSAL

BACKGROUND

EMSA requests $2.3 million General Fund over three years beginning in 2021-22 to implement AB 1544 (Gipson, Gloria, Chapter 138, Statutes of 2020). AB 1544 creates the Community Paramedicine or Triage to Alternate Destination Act of 2020, which would authorize a Local Emergency Medical Services Agency (LEMSA) to develop and seek approval for a program that provides the various community paramedic or triage paramedic services.

AB 1544 requires EMSA to provide additional ongoing services and oversite to LEMSAs regarding community paramedicine programs as well as promulgate and update multiple chapters of regulations. In order to ensure the successful implementation of these new responsibilities, EMSA is requesting limited-term General Fund resources of $768,000 in FY 2021-22 and $789,000 in FY 2022-23, and $789,000 in FY 2023-24 to address the increased workload associated with the implementation of AB 1544.

Community paramedicine is a new and evolving model of community-based health care in which paramedics function outside their customary emergency response and transport roles. Community paramedic programs are designed to address specific local problems and to take advantage of locally-developed collaborations between emergency medical services and other health care and social service providers.

California, through EMSA and the Office of Statewide Health Planning and Development (OSHPD) has piloted community paramedic programs for six years. Independent evaluators from the University of California at San Francisco (UCSF) have found the pilots to be safe and an effective means of utilizing paramedics to improve the health and safety of the public by allowing expanded access to health care services and case management.

Community paramedics (CP) are licensed, experienced paramedics who have received specialized training and work within a designated CP program under local medical control. Paramedics are uniquely positioned for expanded roles as they are: (1) geographically

dispersed in nearly all communities; (2) inner-city and rural; always available 24/7/365 and rapidly dispatched; (3) trusted and accepted by the public; (4) trained to make health status assessments and recognize and manage life-threatening conditions outside of the hospital; and (5) operate under medical control as part of an organized system.

AB 1544 authorizes California to implement 6 types of community paramedicine projects as established in its Health Workforce Pilot Project (HWPP) #173. Additionally, AB 1544 authorizes LEMSAs to utilize the following types of community paramedicine projects:

1. Post-Discharge Short-term Follow Up: Provides follow-up care to recently discharged patients to decrease hospital readmissions within 30 days.

2. Frequent EMS Users: Provides case management services to frequent 911 callers and frequent visitors to emergency departments to reduce their use of the EMS system.

3. Directly Observed Therapy for Tuberculosis: Collaborates with the local public health department to ensure people with tuberculosis infection receive and take required medications to prevent its spread.

4. Hospice: Collaborates with hospice agency nurses, patients, and family members to treat patients in their homes, according to their wishes, instead of transporting the patient to an ED.

5. Alternate Destination – Behavioral Health: Offers people, who have behavioral health needs, but no emergent medical needs, transport to a mental health crisis center instead of an ED after screening by the CP.

6. Alternate Destination – Sobering Centers: In response to 911 calls, offer people who are acutely intoxicated but do not have acute medical or mental health needs transport directly to a sobering center for monitoring instead of to an ED.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 7: OFFICE OF LEGISLATIVE, REGULATORY AND EXTERNAL AFFAIRS AND LEGAL OFFICE INCREASED WORKLOAD BUDGET CHANGE PROPOSAL

BACKGROUND

EMSA requests $286,000 General Fund ongoing and two permanent positions to meet the increased workload within the Office of Legislative, Regulatory and External Affairs (LEA) to coordinate external affairs; public engagement related to emergency preparedness and disaster response and mitigation; and intergovernmental communications in support of EMSA's lead role under California's Emergency Support Function 8 (ESF-8) – Public Health and Medical.

The requested resources will also address increased workload within the Legal Office associated with mandated reporting tasks, AB 434 (Baker, Chapter 780, Statutes of 2017) compliance, and creation of content and ongoing workload associated with implementation of EMSA's intranet.

Legislative, Regulatory and External Affairs Office (LEA)
LEA serves as the central point of contact for EMSA. It is responsible for all state and federal legislation, all EMSA regulatory matters and actions, policy matters, and public-facing programming. EMSA has a responsibility to publicize EMS-related events, educate the public on injury and illness preparation, support the State in disasters, and communicate program progress, legislative issues, and rulemaking activity using various platforms (print media, social media, photography, and videos). Currently, the EMSA LEA office consists of one CEA (Deputy Director), two full-time SSMI Specialists, and one part-time student assistant to perform the entire workload for LEA.

Legal Office
The EMSA may deny, revoke, suspend, or place on probation a paramedic's license pursuant to California Health & Safety Code Section 1798.200. Proceedings against a paramedic's license must be held in accordance with Chapter 5 (commencing with Section 11500) of Part I of Division 3 of Title 2 of the Government Code (Administrative Procedure Act). The EMSA legal counsel is responsible for EMT-P disciplinary actions under Section 1798.200.

The EMSA Legal Unit provides legal services to the EMS Personnel Division's licensure and enforcement sections. As such, it is the Legal Unit's responsibility to prosecute EMT-P licensees who violate the California Health and Safety Code or the California Code of Regulations. EMT-P discipline is an administrative action against the license to ensure that the public's health and safety is maintained and protected. Depending on the facts and circumstances of the individual case, the actions may range from an administrative fine, for a minor offense, to actual license revocation, for serious matters that put the public's health and safety at risk. All EMT-P licensees are entitled to due process through

the Administrative Procedure Act ("APA", California Government Code Section 11370 et seq.) and an independent tribunal through the Office of Administrative Hearings. EMT-P licensees that are placed on probation, either through a Stipulated Settlement Agreement or by an Administrative Law Judge's order, are monitored by EMSA's probation office in the Enforcement Unit.

The Legal Unit currently consists of an Administrative Advisor (CEA), attorney, one retired annuitant (RA) attorney, one staff services analyst (SSA), and one student assistant. The Administrative Advisor (CEA), provides legal services to EMSA, which include: advice functions to the Director, review of contracts, legal support for all EMSA divisions, review of local EMS agency solicitations and ambulance exclusive operating areas (EOA), public records act request review, and subpoena and litigation response, employee discipline, and paramedic enforcement case supervision. The attorney and retired annuitant attorney prepare paramedic enforcement cases, negotiate settlements, and represent EMSA at administrative hearings at various locations throughout the State. The SSA and student assistant provide administrative support to the Administrative Advisor (CEA) and all three attorneys.

Student assistant support costs are currently funded by the EMSP Fund (0312) and are approximately $20,000 per year. These funds will be redirected to support the Staff Services Analyst position being requested and the legal office will discontinue using student assistants.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

4140 OFFICE OF STATEWIDE HEALTH POLICY AND DEVELOPMENT

ISSUE 8: ADMINISTRATIVE SUPPORT SERVICES BUDGET CHANGE PROPOSAL

BACKGROUND

OSHPD requests a net-zero adjustment to the OSHPD's total special funds (increase of $6,000 Hospital Building Fund, $31,000 Health Data and Planning Fund, $4,000 Mental Health Services Fund, and decrease of $41,000 Health Facility Construction Loan Insurance Fund) to support administrative services related to accounting and human resources.

FI$Cal Increased Workload

In July 2017, Financial Information System for California (FI$Cal) was implemented as OSHPD's financial system. The FI$Cal system modified previous processes, approval structures, and accounting practices. Post implementation, OSHPD has found that many tasks require more time to perform, which has caused a backlog of accounting processes.

As a result of FI$Cal implementation, OSHPD has seen an increase in the length of time needed for various processes. OSHPD did not have enough staff to accommodate the increase in critical accounting steps and associated workloads. Inadequate staffing levels have resulted in delays in the payment processing, unreconciled documents, encumbrances, increased use of the Revolving Fund, and prompt payment penalties. Below are examples of increased workload:

- As the book of record, FI$Cal now centrally captures information through several additional processes. Addresses must be verified, State Controller's Office (SCO) must validate taxpayer information and if erroneous, OSHPD must work with the vendor/supplier to request additional/correct information. In addition, a conflict of interest letter must be provided if the vendor/supplier is a state employee. The volume of Purchase Order (PO) activities that requires a new vendor/supplier set up averages 1,500 transactions per fiscal year.

- On average, staff require about 30 minutes additional for entry, reviewing adjustments and corrections, and handling time to process a new PO encumbering funds against a multiyear agreement in FI$Cal. There are about 75 of these agreements, adding about 37.5 hours of work, spread across each year, depending on the various service dates.

Department of Finance, Office of State Audit and Evaluations Audit
In Fiscal Year 2019-20, OSHPD was audited by the Department of Finance, Office of State Audit and Evaluations. As part of the audit findings, the audit identified that delays in monthly processing of Plans of Financial Adjustment (PFAs) resulted from the significant staff resources required to close Fiscal Year 2017-18.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 9: REIMBURSEMENTS FOR HEALTH CARE PAYMENTS DATA PROGRAM BUDGET CHANGE PROPOSAL

BACKGROUND

OSHPD requests $5,009,000 in reimbursement authority to the General Fund for Fiscal Year 2021-22, $5,316,000 in 2022-23, $4,736,000 in 2023-24, and $4,743,000 in 2024-25. Reimbursement authority will enable OSHPD to use federal funds to support the Health Care Payments Data (HPD) System through the end of the Project Approval Lifecycle process. HPD costs eligible for federal funds include state staff and services, operating expenses, and contracted services.

Established by AB 1810 (Committee on Budget, Chapter 34, Statutes of 2018), the HPD System will collect statewide health care information to support greater health care cost transparency and inform policy decisions regarding the provision of quality health care and the reduction of health care costs and disparities. AB 80 (Committee on Budget, Chapter 12, Statutes of 2020) amended Chapter 8.5 of Part 2 of Division 107 of the California Health and Safety Code (HSC) and established the Health Care Payments Data Program. The statute identifies OSHPD as the responsible state organization to develop the HPD System no later than July 1, 2023.

As specified in statute, the intent for the HPD Program is to:

- Establish a system to collect and aggregate information from many disparate systems regarding health care costs, utilization, quality, and equity, with the goal of providing greater transparency and public benefit;

- Improve data transparency to achieve a sustainable healthcare system with more equitable access to affordable and high-quality health care for all;

- Encourage use of such data to deliver health care that is cost effective and responsive to the needs of enrollees, including recognizing the diversity of California and the impact of social determinants of health.

To implement the provisions of AB 1810, the 2018 Budget Act included a one-time $60 million General Fund appropriation, available for encumbrance or expenditure until June 30, 2025. HSC §127674 delineates how the HPD Program will be funded, including information on expenditure of the $60 million General Fund appropriation, creation of the HPD Fund, the collection of data user fees, and the use of federal financial participation (FFP). Specifically HSC §127674 directs OSHPD to maximize FFP from the Medicaid program by working through the sole state agency for Medicaid, the State Department of Health Care Services (DHCS), and shall do so while relying on moneys appropriated from the General Fund in the 2018 Budget Act, and on an ongoing basis using any federally allowed fund source. This BCP facilitates the mechanism of federal reimbursement.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 10: SB 17 ATTORNEY FEES BUDGET CHANGE PROPOSAL

BACKGROUND

OSHPD requests $457,000 in 2021-22 and $567,000 in 2022-23 from the California Health Data and Planning Fund to support State Office of the Attorney General (AG) fees for legal services provided to OSHPD associated with SB 17 (Hernández, Chapter 603, Statutes of 2017). OSHPD also requests provisional language providing increased expenditure authority in the case that 2021-22 attorney fees exceed the amount in this request.

Pursuant to Health and Safety Code Section 127683, the Managed Care Fund—administered by the Department of Managed Health Care (DMHC)—and the Insurance Fund—administered by the Department of Insurance (DOI)—shall cover the actual and necessary expenses of OSHPD for SB 17's pharmacy reporting-related workload. As such, this proposal results in a corresponding revenue transfer from the Managed Care Fund and the Insurance Fund to the California Health Data and Planning Fund.

SB 17

SB 17 requires prescription drug manufacturers to give a 60-day notice to state purchasers, health care service plans, health insurers, and pharmacy benefit managers if the cumulative increase of the wholesale price of a drug over the last two calendar years is over 16 percent. In addition, it also requires drug manufacturers to report certain information related to these price increases and related to the introduction of new drugs that exceed the Medicare Part D threshold for a specialty drug to OSHPD. OSHPD is required to publish the information on its website at a minimum of a quarterly basis and within 60 days of receipt from a manufacturer for price increases and new drugs. Failure by the prescription drug manufacturers to report this information to OSHPD is subject to a civil penalty of $1,000 per day.

PhRMA vs David Lawsuit

In a lawsuit originally filed December 8, 2017, the Pharmaceutical Research and Manufacturers of America (PhRMA) brought an action against Governor Jerry B. Brown and Director of OSHPD (Robert P. David at the time) seeking to enjoin the implementation and enforcement of Section 4 of SB 17 (codified as Chapter 9 of Part 2 of Division 107 of the Health and Safety Code) and have it declared unconstitutional and void. PhRMA's suit alleges that this section of SB 17 is an unconstitutional violation of the dormant commerce clause, a violation of the first amendment freedom of speech rights of PhRMA members, and in violation of the due process clause of the fourteen amendment.

As of December 2020, the case remains before the United States District Court, Eastern District of California, with the court hearing preliminary motions and discovery yet to

begin. On December 17, 2020, the court heard arguments on PhRMA's motion for summary judgment, with no decision issued to date.

Legal Fees Budget

Government Code Section 11044(b) requires the AG, who oversees the Department of Justice (DOJ), to charge an amount sufficient to recover the costs incurred for legal services provided to state department and agencies. DOJ receives a direct General Fund appropriation to provide services to "small-pot" clients. Each of these clients use less than 1000 hours of service annually. The list of small-pot clients is updated annually, and the Department of Finance is required to review the projected associated costs. Since costs for these services are paid centrally, they are "no-cost" services to recipient departments. OSHPD was included in the AG's Small Client Pot that afforded 1,000 hours in services at no cost to OSHPD and moved to a billable client in 2004.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 11: CALIFORNIA PARKINSON'S DISEASE REGISTRY PROGRAM EXTENSION (AB 2821) BUDGET CHANGE PROPOSAL

BACKGROUND

The CDPH, Center for Healthy Communities (CHC), California Parkinson's Disease Registry (CPDR) is requesting a one-time appropriation of $408,591 General Fund to support redirection of two existing positions and to continue outreach and surveillance efforts. The approval of AB 2821 (Nazarian, Chapter 103, Statutes of 2020) extends the authority of CPDR to continue data collection until January 1, 2022, and this proposal seeks fiscal support for the legislatively mandated extension period.

In addition, CDPH requests provisional language to permit acceptance of public or private funding sources to the extent non-state funds are made available for this purpose. This will ensure the preservation of General Fund resources should other funding resources be made available.

Parkinson's disease (PD) is a chronic, progressive neurological disease. It is the second most common neurodegenerative disease in the United States, and complications of PD rank as the 14th leading cause of death in the nation. It is estimated that approximately one million individuals in the United States suffer from PD (2017 estimate), with 70,000 newly diagnosed cases per year. A study commissioned by the Michael J. Fox Foundation (MJFF) estimated the total economic burden of PD in the US in 2017 was $51.9 billion, including a direct medical cost of $25.4 billion and an additional $26.5 billion in indirect and non-medical cost. For 2017, it is estimated that approximately 117,000 Californians are living with PD. Currently, little is known about how PD is distributed among different population groups and whether the patterns of the disease are changing over time.

In 2004, citing the California Cancer Registry (CCR) as a model, AB 2248 (Frommer, Chapter 945, Statutes of 2004), Health and Safety Code (HSC) 103860 was enacted requiring CDPH to establish a program of epidemiologic assessment of the incidence of PD, and to establish a system for the collection of information to determine the incidence of PD among Californians. By providing information about the epidemiology of PD, as well as by providing a database for other scientific studies, the program serves individuals with PD, those at risk of PD, and the families and communities of both. However, HSC 103860 states "provisions may be implemented only to the extent that funds are available for this purpose," and state General Fund support was not allocated for the program until 2017. In 2017, SB 97 (Committee on Budget and Fiscal Review, Chapter 52, Statutes of 2017) created the Richard Paul Hemann CPDR in HSC 103870, requiring health care providers diagnosing or providing treatment to PD patients to report each case of PD to the CDPH.

In response, the State allocated $3.7 million in General Fund support between July 1, 2017 and June 30, 2020. Mandated reporting began on July 1, 2018.

CPDR is now processing data received from the first two years of mandated reporting (July 1, 2018 through June 30, 2020). CPDR has received case reports from over 500 reporting entities, including some of the larger health systems in California (e.g., Kaiser Permanente and Sutter Health), as well as individual/private medical practices. As of June 30, 2020, reporting entities have submitted 276,705 records to the registry. Of those records, approximately 86 percent were submitted via the automatic electronic interface. It is important to note that the number of records reported to the registry does not represent the number of individuals with PD in California. Ongoing data processing includes the deduplication of case records and other quality control measures.

AB 2821 extends the authority of CPDR to continue collecting data for an additional year. The requested one-year fund appropriation of $408,591 will be used to support the redirection of two positions and technological resources required to continue data collection and surveillance within the registry. Specifically, this includes the consolidation of case records, ensuring compliance from reporting facilities, and the disclosure of information to qualified researchers. Additional use of funds includes outreach through stakeholder meetings, information technology system maintenance, and consulting expenditures.

Provisional language will also allow acceptance of public or private funding sources to the extent non-state funds are made available for this purpose. This will ensure the preservation of General Fund resources should other funding resources are made available.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 12: IMPROVING THE CALIFORNIA PRENATAL SCREENING PROGRAM BUDGET CHANGE PROPOSAL

BACKGROUND

CDPH requests 3 positions and $449,000 in State Operations expenditure authority in 2021-22 and ongoing and Local Assistance expenditure authority of $3.9 million in 2021-22 and $20.2 million in 2022-23 and ongoing from the Genetic Disease Testing Fund (Fund 0203) in order to meet current standards of care and improve the screening process for the California Prenatal Screening Program.

The mission of the CDPH Genetic Disease Screening Program (GDSP) is to serve the people of California by reducing the emotional and financial burden of disability and death caused by genetic and congenital disorders. Health & Safety (H&S) Code sections 124975-124996 and 125050-125119 require CDPH to administer a statewide genetic disorder screening program for pregnant individuals that is fully supported by fees. H&S Code section 125055 (g)(1) states that CDPH "shall expand prenatal screening to include all tests that meet or exceed the current standard of care as recommended by nationally recognized medical or genetic organizations."

California law requires that all pregnant women be offered prenatal screening through the state-sponsored California Prenatal Screening (PNS) Program. The PNS Program has been operational in California since 1986. Historically, about 75 percent of pregnant individuals voluntarily have participated in the program. Currently, a pregnant patient's blood serum sample is sent to one of five state-contracted Newborn and Prenatal Screening regional laboratories and tested for levels of two to four pregnancy hormones, depending on the pregnancy trimester, using biochemical methodology. The analytic results are reviewed for quality assurance and used to calculate a risk for two chromosomal abnormalities (trisomy 21 and trisomy 18), and neural tube defects (NTDs).

Trisomy 21, or Down syndrome, is caused by an extra copy of chromosome 21. Trisomy 18, or Edwards syndrome, and trisomy 13, or Patau syndrome, are caused by an extra copy of chromosome 18 or 13, respectively; for both conditions, most babies born will have severe intellectual disability, and difficulty with growth and development. They usually have severe multiple birth defects and death during the first year of life. The two most common types of neural tube defects are spina bifida (an opening in the spine, which can cause paralysis and loss of bowel and bladder control) and anencephaly (a large part of the skull is missing and most of the brain does not develop).

A new screening methodology has been developed and over time has demonstrated improved performance for prenatal screening. It is called "Cell-free DNA" (cfDNA) screening, referring to the fact that fetal DNA can be detected in a pregnant woman's blood. The cfDNA screening involves the extraction of maternal and fetal cells from a

pregnant individual's blood sample and can be used to detect the same chromosome abnormalities as the current PNS program plus an additional chromosome abnormality for which the program does not currently screen (i.e., trisomy 13). This new test is more reliable in terms of false positive and detection rates resulting in fewer women being referred for diagnostic follow-up services. The American College of Obstetricians and Gynecologists (ACOG) recommends prenatal genetic screening to all pregnant women regardless of maternal age or risk of chromosomal abnormality. ACOG stated that cfDNA is the most sensitive and specific screening test for the common fetal aneuploidies. The American College of Medical Genetics and Genomics (ACMGG) indicated that cfDNA has been rapidly integrated into prenatal care and new evidence strongly suggests that it "can replace conventional screening for Patau, Edwards, and Down syndromes across the maternal age spectrum."

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 13: BOOKS FOR LOW-INCOME CHILDREN BUDGET CHANGE PROPOSAL

BACKGROUND

CDPH requests one-time General Fund expenditure authority of $5 million in State Operations in 2021-22 and associated provisional language to allow transfer of funds to Local Assistance, for an early childhood literacy program for Women, Infants and Children (WIC) participants.

The WIC program is a division in the CDPH Center for Family Health. It is a federal supplemental nutrition program that provides supplemental food benefits to WIC participants. The food benefits are redeemed using the California WIC Card at WIC authorized food vendors. The WIC Division operates a $1 billion program through 84 local agencies that serve nearly 1 million of California's most economically and nutritionally vulnerable residents. The WIC program is fully funded by an annual grant from the U.S. Department of Agriculture. WIC provides nutrition services and food assistance to low-to-moderate income families for pregnant and postpartum women, infants and children up to their fifth birthday. In addition to the categorical eligibility requirement, participants must be at or below 185 percent of the federal poverty level and have a nutritional risk.

A registered dietician or a WIC nutritional assistant performs program eligibility and nutritional needs assessments. Participant services include nutritional service planning, determination of supplemental food, and assessment of breastfeeding needs. Information is also gathered to provide family referrals for health and psycho/social needs such as prenatal care, immunizations, and housing. Improving social determinants of health and promoting childhood and family resiliency is a public health priority. Early childhood development, including the promotion of early literacy and kindergarten readiness is a priority for the Center for Family Health.

WIC has a history of involvement with early literacy efforts. The Centers for Disease Control and Prevention has funded the development of the Learn the Signs. Act Early program to support infant/child developmental assessment in WIC settings for early referral; early identification and referral is a critical emergent reader milestone. The U.S. Office of Disease Prevention and Health Promotion has identified in Healthy People 2020 that education is a key determinate of long-term health outcomes.

Evidence has demonstrated that children from low-income families and/or dual language learners gain the most from early childhood literacy programs. Recognizing the importance of getting books into households with small children, many programs, have developed distribution strategies designed to increase the number of books children have in the home. These strategies have included partnering with WIC. Promoting child literacy is an important endeavor and while not the primary mission of WIC, leveraging the existing WIC platform to reach thousands of low-income families in a place that is familiar, has

proven successful for emergent learning programs both nationally and in California. Utilizing the WIC platform is an effective way to introduce families, many of whom are new to their communities and our country, to important early literacy practices, books, and resources.

As part of ongoing outreach, which is a federal requirement, many WIC Local Agencies have worked or continue to work with their First 5 commissions and other health and human services programs. These community relationships result in co-locations, as well as additional funding resources to build a robust experience for WIC families. In working with First 5, WIC Local Agencies have been involved and led projects to address dental health, developmental screening, mental health screening, breastfeeding, obesity, physical activity, and improving childcare nutrition practices. USDA federal funding for WIC does not cover the costs of these activities so local agencies often apply for outside resources as they consider other health needs of the WIC population.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 14: MEDICAL BREACH ENFORCEMENT SECTION EXPANSION BUDGET CHANGE PROPOSAL

BACKGROUND

The CDPH Center for Health Care Quality (CHCQ) requests 17 positions and $2.6 million from the Licensing and Certification Program Fund in 2021-22 and ongoing, to expand the Medical Breach Enforcement Section (MBES), and to comply with existing state law that require CDPH to investigate, and if necessary, administer penalties against individual persons and/or health care providers.

CHCQ is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and quality of health care for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to determine compliance with federal and state laws and regulations. CDPH receives funds through Title XVIII and Title XIX grants from Center for Medicare and Medicaid Services and licensing fees paid by health care facilities. CHCQ licenses and certifies over 11,000 health care facilities and agencies in California in 30 different licensure and certification categories.

SB 541 (Alquist, Chapter 605, Statutes of 2008) established section 1280.15 of the Health and Safety Code (HSC), which authorizes CDPH to investigate and assess fines to any licensed medical facility for any reported breach of their patient's confidential medical information. AB 211 (Jones, Chapter 602, Statutes of 2008) established the California Office of Health Information Integrity (CalOHII) under the California Health & Human Services Agency (CHHS) to ensure the enforcement of state confidentiality laws against individuals and Non-CDPH licensed entities.

SB 857 (Committee on Budget and Fiscal Review, Chapter 31, Statutes of 2014) transferred from CalOHII to CDPH, the duty to impose administrative fines on providers of health care for the unauthorized use of medical information. CHHS transferred three investigative staff to CDPH to enforce any violations of HSC § 1280.15 - 1280.17. Since the advent of HSC, § 1280.15 in 2009, over 1,600 licensed health facilities have reported nearly 42,000 medical breach incidents involving the illegal access to, use of, or disclosure of patient medical information.

In 2016-17, CDPH expanded the MBES from 3 investigative staff to 17. The primary goal of this expansion was to use non-clinical staff assigned to field offices to take over the investigation workload of all pending medical breach privacy complaints and facility reported incidents. CDPH uses Special Investigators (SIs) and Associate Governmental Program Analysts (AGPAs) to conduct MBES investigations.

By expanding MBES and centralizing the investigation workload, CHCQ will free up clinical staff in the field offices from investigating any privacy breach intakes, thus allowing them to redirect their time to workload of a more clinical nature. Currently, the MBES has taken over the breach workload for 12 out of the 19 field offices. The seven remaining field offices are currently using Health Facility Evaluator Nurses (HFEN) to investigate any non-clinical breach incidents, and CHCQ needs to redirect this workload to the MBES to improve efficiency and standardization of MBES investigations.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 15: SKILLED NURSING FACILITY STAFFING REQUIREMENTS COMPLIANCE (AB 81) BUDGET CHANGE PROPOSAL

BACKGROUND

The CDPH Center for Health Care Quality (CHCQ) requests six positions and $939,000 from the Licensing and Certification Program Fund in 2021-22 and ongoing, to implement the provisions of AB 81 (Committee on Budget, Chapter 13, Statutes of 2020), which affects the Quality and Accountability Supplemental Payments (QASP) program for skilled nursing facilities (SNFs) in California.

CDPH contracts with Department of Health Care Services (DHCS) through an interagency agreement to audit compliance of SNF staffing hours for purposes of determining QASP or penalties. Current law authorizes CDPH to assess administrative penalties upon the determination that a SNF has not met statutorily mandated direct care service hours per patient per day. CDPH currently audits all freestanding SNFs annually. During the annual audits, CDPH audits 24 days of staffing data to ensure compliance with the direct care services hours per patient per day. Under current law, a facility would not be issued a penalty for non-compliance but would lose eligibility for the QASP. QASP amounts may change annually. For 2018-19, the total payout was $75.6 million.

AB 81 makes changes to the SNF QASP program administered by DHCS and CDPH. This bill increases the fines for SNFs that fail to meet staffing requirements. For SNF noncompliance of five to 49 percent of audited days, the fine increases from $15,000 to $25,000 and from $30,000 to $50,000 for facilities that fail to meet staffing requirements for over 49 percent of the audited days. This bill also grants appeal rights to SNFs that are non-compliant with staffing requirements for one day.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 16: TIMELY INVESTIGATION OF CAREGIVERS BUDGET CHANGE PROPOSAL

BACKGROUND

CDPH requests seven positions and $1 million from the Licensing and Certification Program Fund (Fund 3098) in 2021-22 and ongoing, to improve the timeliness of investigations of complaints against caregivers.

CHCQ is responsible for regulatory oversight of licensed health care facilities and health care professionals to assess the safety, effectiveness, and quality of health care for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to determine compliance with federal and state laws and regulations. CDPH receives funds through Title XVIII and Title XIX grants from the Centers for Medicare and Medicaid Services and licensing fees paid by health care facilities. CHCQ licenses and certifies over 10,000 health care facilities and agencies across California in 30 different licensure and certification categories.

The Professional Certification Branch (PCB) administers the certification of certified nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators. The branch receives complaints alleging unprofessional conduct against these four health care professional types and conducts investigations.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has no concerns or questions about this proposal.

Staff Recommendation: It is recommended that the Subcommittee approve this proposal later in the spring, absent any new concerns being raised about it.

ISSUE 17: TRANSFER CANNABIS RESOURCES TO PROPOSED NEW DEPARTMENT

BACKGROUND

The Governor's Budget reflects a decrease of 119.0 positions and $29.0 million expenditure authority in CDPH State Operations. This decrease includes $28.4 million in Cannabis Control Fund (Fund 3288) and $527,000 in Reimbursement Fund (Fund 0995). The proposed changes will support the consolidation of resources within the proposed new Department of Cannabis Control.

STAFF COMMENTS/QUESTIONS

The proposed new Department of Cannabis Control will be considered by Assembly Budget Subcommittee #4. If the Assembly chooses to support the proposal to establish a new department, expressly for the purpose of consolidating state government functions related to cannabis, it makes sense that these cannabis resources and responsibilities currently at CDPH be transferred to the new department.

Staff Recommendation: It is recommended that Sub 1 take an action, later this spring, that conforms to any actions taken either by Subcommittee #4 or the full Budget Committee on the larger proposal to establish a Department of Cannabis Control.